

DUMFRIES AND GALLOWAY NHS BOARD



Agenda and notice for meeting on Monday 2 February 2009 at 1.30pm

VENUE: Conference Suite, Crichton Hall

John Burns
Chief Executive

AGENDA

211 Apologies for absence

212 Declarations of Interest

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

213 Minute of the Meeting held on 1 December 2008

The Board is asked to approve the Minute of the meeting held on 6 October 2008

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214 Matters Arising

215 Patient Safety

This paper provides Board with a progress report on the patient safety programme.

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216 Patient Experience: Reporting Period – November, December 2008 and January 2009

This paper reports information gathered from the NHS Dumfries and Galloway electronic feedback system through enquires and complaints.

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217 Infection Prevention and Control Update

This paper is a routine update on specific aspects of infection control.

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218 Reports from Committee Chairs

*Audit Committee – Mr Keith Warford
Healthcare Governance Committee – Mrs Heather Brash
Scrutiny Committee – Mr M Keggans*

ITEMS OF STRATEGY

219 Summary of Discussion and Outcomes of the Three NHS Board Workshops on the Clinical Strategy

This paper reports to Board on the discussion and outcomes of the three Board Workshops held in December 2008 and January 2009.

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ITEMS OF PERFORMANCE / DELIVERY

220 Financial Performance: 9 Months to 31 December 2008

This paper presents to Board the financial performance to 31 December 2008.

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221 Capital Plan Update

This paper reports on the steady progress being made with the capital plan although a number of changes have arisen since last reported to Board in November.

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222 Waiting Time and Activity Report

This report summarises activity and waiting times as at 31 December 2008.

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223 Accident & Emergency Department Alterations

This paper notes the current position with regard to the Accident and Emergency Departmental Alterations Project.

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ITEMS FOR DECISION / DISCUSSION

224 NHS Boards: Public Health Allocation 2008 - 09: Additional Resources for Alcohol Treatment

This paper advises Board of progress and service developments over the past six months and seeks agreement to the spending and service development proposals for 2009-10.

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225 Authorised Signatories

This paper seeks approval of an alteration to the cheque signatory list.

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226 The Roles of Child Health Commissioner and Children's Services Manager

This paper proposes changes to the role of Consultant in Dental Public Health and Child Health Commissioner.

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227 24 Hour Laboratory Services at Galloway Community Hospital

This paper asks Board to consider proposals to reinstate on-call cover for the laboratory service at Galloway Community Hospital.

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228 Board Briefing

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

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229 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.

230 Date of Next Meeting

The next meeting of the NHS Board is Monday 2 March, 2009.

ITEMS FOR NOTING

- 231 Framework Scotland (Principal Supply Chain Partners) for Acute Mental Health Facility and Dumfries and Galloway Royal Infirmary Rebuild and Refurbishment Programme

This papers Board of the outcome of the short-listing for Principal Supply Chain Partners for the above projects.

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- 232 Register of Members' Interests

This paper brings to the Board the updated Register of Members' Interests.

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- 233 Minute of Area Clinical Forum held on 10 December 2008

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- 234 Minute of Community Planning Joint Board held on 13 November 2008

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- 235 Minute of Regional Planning Group held on 14 November 2008

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DUMFRIES AND GALLOWAY NHS BOARD

Minute of the meeting Dumfries and Galloway NHS Board held on 1 December 2008



Minute Nos: 191 -208

Present

Mr M Keggans	Chairman
Mr J Burns	Chief Executive
Mr J Ace	Director of Health Services
Mrs L Ace	Director of Finance
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	Non Executive Member
Mr E Hunter	Non Executive Member
Mr I Hyslop	Non Executive Member
Mr A Johnston	Non Executive Member
Mr D Lockhart	Employee Director
Dr R Park	Non Executive Member
Ms C Sharp	Director of HR and Workforce Strategy
Mr K Warford	Vice Chairman

Apologies

Hazel Borland	Nurse Director and Director for Patient Safety
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Attending

Mrs M Christie	Associate Nurse Director
Dr A McCullough	Medical Director – Acute Services
Mrs J Wilson	Board Administrator

Chairman's Opening Remarks

The Chairman welcomed everyone to the December Board meeting and commented on the interesting and informative workshop on patient focused public involvement during the morning. The Chairman advised Members of a meeting with John Swift from the Public Appointments Unit and noted that the Non Executive Board Member vacancy had been advertised. The closing date is before Christmas and dates are in the diary to seek an appointment by April. The Chairman also highlighted the launch of the Compact, which was attended by a large number of stakeholders, and the Community Planning Joint Board where the discussion was the greener theme. SVQ certificates have been presented both at Easterbrook Hall and Dumfries and Galloway Royal Infirmary to over seventy staff. The Director of Finance interviews were held during the previous week and Chairmen met with the Cabinet Secretary at the regularly monthly meeting in Edinburgh. Last Friday saw the regular MP / MSP meeting attended by Alex Fergusson and David Mundell.

This is Laura Ace's last formal Board meeting. Laura has made a significant contribution to the business of the Board and has consistently maintained a strong and stable financial position. On behalf of the Board the Chairman thanked Laura for that and also wished her all the very best in her new post.

191 Apologies

Apologies as noted above.

192 Declarations of Interest

No declarations were intimated

193 Minute of the Meeting held on 3 November 2008

Mr Warford asked that Item 175 reflect waiting times reduction money.

Mrs Brash noted that item 179 did not reflect the intensity of the Board discussion and the feelings of Members regarding the action the Board felt it had to take. The Chief Executive suggested that paragraph two of the minute read "Board Members expressed significant concern at the recommendation and there was a lengthy discussion on whether the Board could take a different view". The minute should be further amended to note "The Board accepted the recommendation not to agree the minor relocation application from Lloyds Pharmacy Ltd., trading as Lloydspharmacy, notwithstanding the individual views held by Board Members".

With these amendments the minute was approved as an accurate record.

194 Matters Arising

General Pharmaceutical Services Minor Relocation Applications

The Chief Executive confirmed that a letter had been sent to the Director of Primary Care, Scottish Government Health Directorate, highlighting the nature

of the discussion, the strength of feeling and asking if there was a timetable for the review of regulations which is required for the Pharmacy Care Plan to be a valuable document.

Reperfusion Service

The Chief Executive reminded Members of the concerns expressed previously regarding the Scottish Ambulance Service provision generally in the region. The Chief Executive had undertaken to meet with the Chief Executive of the Scottish Ambulance Service and that meeting took place two weeks ago, with the Director of Health Services and the Medical Director present. There was a very positive discussion and the Interim Chief Executive and the Regional Manager of the Scottish Ambulance Service have agreed to a joint workshop session of the two Executive Teams recognising the clinical strategy and some of the changes made within NHS Dumfries and Galloway. The Scottish Ambulance Service are keen to discuss with the Board how they can work in closer partnership in terms of the provision of services and the skills they can bring to the region. Following the workshop with the Executive Teams, the Chief Executive will report back to Board.

195 Patient Safety

The Chief Executive presented this report and highlighted a faculty site visit on 18 November by the Scottish Faculty, supported by colleagues from the Welsh programme. They were very positive about the work that was being taken forward in this region and visiting an unplanned area received the same message on patient safety and staff involvement. Importantly it was highlighted that some of the work is very innovative in terms on the NHS in Scotland. An area highlighted was the paediatric advance warning score. The paediatric team have built on their experience to develop the score and are now being invited to speak and share this development in other areas. The current round of annual reviews are very encouraging with patient safety very much part of the agenda and it is important to maintain the pace of improvement and develop spread plans on a three monthly basis. This was found to be very effective last year and a discipline maintained going forward. Two papers, medicine reconciliation and hand hygiene, have been accepted for the international forum. Next year there is a 'developing dynamic improvement' programme being taken forward which will provide an opportunity to share some of the tools and techniques to support teams in progressing this work.

The Board

- noted progress.

196 Patient Experience: Reporting – September, October, & November 2008-11-28

The Chief Executive presented this paper which set out the work being done in this area. The Chief Executive highlighted the Better Together National Programme and the interest expressed in being one of the pilot sites. Building on the patient experience walkrounds, now looking to bring on a small number of volunteers in the early stages to take forward this pilot. Sixty

patients and visitors have engaged with the Patient Services Manager about their experience and 94% expressed satisfaction or high satisfaction. Where areas of concern are highlighted, the aim is to fix them for the individuals without there being a resulting complaint. This has been a very positive pilot and the benefits are already being seen. During the annual performance reviews patient experience has been raised with managers to ensure their agenda is very much sighted on the wider programme of improving patient experience, using feedback successfully and continued improved service delivery.

The Board

- noted the report

197 Reports from Committee Chairs

Healthcare Governance Committee

Mrs Brash reported on the Healthcare Governance Committee held on 12 November. The theme of the meeting was quality, so that in addition to regular papers on adverse incidents and patient safety, the Committee received papers on the patient experience, the Quality Improvement Scotland (QiS) Annual Exception Report and the implementation schedule for the Scottish Consumer Council Call for Improvement Report. The unacceptable actions policy was discussed and progress was noted on the Carers Information Strategy. The Committee discussed the Care of the Deceased Patient, Health Records Management Code of Practice Action Plan and the follow-up audit of "cold chain" maintenance in GP practices. Also received and debated were external reports on Safer Management and Use of Controlled Drugs, the Review of the Scottish Stroke Care Audit and the Review of Palliative Care Services in Scotland.

Staff Governance Committee

Mr Keggans reported on the Staff Governance Committee held during the morning. Committee looked at a number of reports coming back for consideration, the health and safety update and mandatory training information; again a very positive position where all key indicators broadly in the right direction. HEAT targets in staff governance were also reviewed. Sickness absence remains a challenge and work is ongoing in all areas to reduce numbers and ensure improvement.

The Board

- noted the verbal reports from Committee Chairs.

198 Carers Information Strategy

Mrs Christie, Associate Nurse Director, presented this paper which outlined the progress to date. A Carers Information Working Group with appropriate and proportionate representation is well established and in addition there is an extensive communication network with all of the care agencies. The group developed an action plan and central funding has been allocated over a three

year period which has supported the appointment of a facilitator for two years to progress much of the work, in particular, the delivery of training. A mapping exercise to identify existing resources, initiatives and work in progress, the needs of carers etc has been carried out to ensure that future activity complements and builds on existing good practice. Single shared assessment documentation utilised across Dumfries and Galloway has now been amended to include a specific section on carers. Awareness raising sessions were held during the summer but unfortunately the response was disappointing. However, from January, pharmacies had agreed to attach carers' information on prescriptions. The establishment of Carer Registers in GP practices is work ongoing and this will be audited next year to measure if carers' health needs are being met. Evidence suggests that the crisis time tends to be out of hours and work is currently ongoing in partnership with NHS24 to explore how this might be addressed. A local helpline is scheduled for the spring for the out of hours period and front line staff are now receiving training in awareness raising.

Mr Hunter commented that the registration of carers is fundamental and enquired what the timescale will be for that work to be completed and how hidden carers would be identified. The Associate Nurse Director confirmed that this work was progressing, that the register would be reviewed with each practice and that working with staff should support identifying all people who have a caring role. A timescale for this work was not confirmed.

Mr Campbell enquired if this work, in partnership with the Council and others, was led by the Health Board. The Associate Nurse Director confirmed that the Scottish Government has requested that the Health Board be the lead.

Dr Park introduced a word of caution in that the establishment of a carers register is a massive task and difficult to maintain. Identifying carers and their health needs is challenging and should not be underestimated.

The Board

- noted progress to date and endorsed the paper.

199 Financial Performance: 7 Months to 31 October 2008

The Director of Finance presented this item and reported very little change in the financial position and trends since last month, with a slight improvement in surgical stores and nursing pay but a slight deterioration in other areas such as medical records. The financial forecast makes allowance for a range of liabilities which are expected to crystallise in the final part of the year. These will need to be monitored closely and it is possible that even at year end their value will not be known for certain and judgements will required to be taken and will be of particular relevance to members of the Audit Committee. There is also reliance on the completion of a number of schemes, some of which are not yet started. One area specifically noted was the long list of IT projects. Many of these projects are small in themselves and support the e-health strategy and having received the support of the Chief Executive these will be progressed at a cost of £400k. The Finance Director asked Directors to ensure that funding listed in appendix 6 was utilised as planned and that any

projects suitable for progression be taken forward.

Mr Warford enquired what the Board's exposure and liability was in terms of twenty-four hour medical cover and doctors training. The Director of Finance advised that this year was covered and future needs were being addressed.

Mr Hunter highlighted item 15, medical records and enquired if the overspend was being addressed. The Chief Executive confirmed that all the overspend areas were being discussed with the appropriate operational managers to understand and address the issues but noted that there will be ongoing challenges in a number of areas.

The Board

- noted the financial performance to 31 October 2008.

200 Waiting Time and Activity Report

The Director of Health services presented this item. In terms of activity October was a particularly busy month on the acute side and some of the cost pressure drivers are directly attributable to activity. October was also a busy month in terms of elective activity as waiting times are driven down but there was also a higher non elective activity than historic trends suggested. There had been a very busy and full hospital in November. In terms of waiting times, Accident and Emergency waiting time has again achieved 98% in October although this may not have been maintained in November which currently looks to be 97%, entirely due to waits for beds. Non elective activity is beginning to impact on our achievement of waiting time targets which is broadly good with one breach not related to capacity. On course to achieve a fifteen week guarantee by the end of December and currently in dialogue with the Scottish Government on achievability of that and keen to look at sites that will achieve the March target in December. Diagnostics has become much more comfortable in terms of MRI, ultrasound and general diagnostic tests and confident of reaching four / six weeks by the end of year. Cancer waits were last reported at 92.4% and attached at appendix 4 is an example of the cancer staging pathways being used currently. This is what cancer trackers use to keep patients on target and chase and escalate through to the relevant booking department to maintain position or, if necessary, catch up if required. The number of stages required to manage a patient through in sixty-two days and the achievement of 93% becomes more challenging as each new diagnostic step comes in. The National Improvement Team has visited and were complimentary on progress but more work is required to reach 95%. The Board is broadly in a good position to achieve all of the 31 March targets and also in a good position to bring forward the fifteen week guarantee to 31 December.

Mr Warford noted the trend in ophthalmology. Mr Ace confirmed that these referred to follow ups; this was addressed in the waiting times meeting held this morning and follow up times are growing in ophthalmology, diabetics and orthodontics. A locum consultant has been appointed in diabetes and a full review of all three hundred orthodontic patients is being undertaken and it is anticipated that all will be treated by the end of March. It is important to

ensure that job plans, capacity plans etc provide sufficient capacity to ensure that these waits don't build again in the future.

The Board

- noted the content of the report.

201 Performance Report – Quarter 3 2008/09

The Director of Health Services presented this paper and highlighted a number of targets.

- H2 Dental Registrations – have reached 2011 target in terms of 3 – 5 year olds;
- E1 CHI Utilisation – target to ensure that 95% of laboratory requests include a CHI number and consistently in the 91-93% range. Dumfries and Galloway has asked to be a CHI producer. CHI expands and covers other diagnostic tests next year;
- E2 Sickness Absence – very satisfactory data for a number of months but current spike in data takes us above trajectory which is of some concern. Managers validation of sickness absence explored at annual performance reviews and good levels of engagement.
- E3 Personal Development Plans (PDP) – the position is under reported due to the number of paper based PDPs not recorded on the system; closer to the target than reported;
- A7 Accident and Emergency Attendances – data broadly in line with target but if moves away a very limited number of further remedial actions available to reduce attendances; and
- T3 Prescribing of Anti-Depressants – currently above trajectory and a lot of work ongoing on this. In a good place in terms of our co-ordinated and national action plans.

There are a raft of other indicators published including day case rates; other productivity very positive in terms of DNAs and average length of stay. There is a HEAT standard on operating on hip fracture within twenty-four hours. This is an important indicator of survival rates at thirty days and longer and achieving high levels with 100% consistency.

The Chairman asked when the October / November data on sickness absence rates would be available. The Director of HR and Workforce Strategy advised that the formal data from the national SWISS system was published seven to eight weeks after the end of the month. Although there is a time delay responding as quickly as possible and exploring opportunities to get more real time information through HR.net or the SSTS.

Mr Hunter highlighted anti-depressant prescribing as NHS Dumfries and Galloway was one of the higher Boards in Scotland. The Director of Public Health reminded Members that the health and wellbeing survey in early 2007 reported a higher than average rate of depression in Dumfries and Galloway. The Medical Director advised Members that extensive research has been done in a small number of practices and that 80% of prescribing is repeat, which is challenging. This target is aimed at preventing increased prescribing and the

work being done in the practices has resulted in data which provides a lot more understanding of the challenge.

Mr Warford commented that the work to achieve the high level of dental registration should be recognised and advised Members that the CHI number was a major topic of discussion at the e-health board. Mr Warford sought clarity on 33 DDD (daily defined doses) in respect of anti depressants and the Medical Director advised that there are many different types of anti depressants and the recommended dose varies for each. When looking at the total consumption you look at this in terms of daily defined dose; it's a complicated measure of different things together.

The Chief Executive reaffirmed the position on sickness absence that through the annual performance reviews there has been a great deal of reassurance around work to address this. In terms of anti depressant prescribing, it was highlighted at the Area Clinical Forum that some drugs may be being prescribed for other conditions and therefore is the measure against the right information. The Medical Director advised that he had not compared the figures with the national data. The Director of Health Services confirmed that the figures are the national figures which fit Chapter 4 of the BNF (British National Formulary). Nothing has been excluded but concentration should be on what is being prescribed for mild to moderate depression.

The Board

- noted the updates on the local delivery plan targets and trajectories.

202 Endowment Funds Report as at 30 September 2008

The Director of Finance presented this item which provided the half year report as Trustees of the Endowment Fund. The paper focuses on the continued turbulence in the markets but the Board still received a very high level of support from members of the public and this has been utilised in some very good areas. In terms of investment aspects, it was highlighted that there was a significant amount on deposit in the Bank of Scotland and the advice was to roll it over for another month. In terms of future strategy the investment advisers are thinking to move in to equities but there has been no decision. The Board is maintaining a safe position in the meantime.

Mr Johnston highlighted a legacy to cover the cost of a generic worker in Castle Douglas and enquired if employment of a member of staff was within the parameters of the Endowment Trust. The Director of Finance confirmed that the fund managers work within parameters.

The Board

- noted the report to 30 September.

203 Patient Failing to Attend Scheduled Dental Appointments (DNAs) at IDH Sites

The Medical Director presented this paper which sought approval from the Board to approve IDH to charge patients if they should fail to attend. General Dental Practitioners (GDP) are able to charge if patients fail to attend as the

dentist has failed to generate income. The salaried service has a different view in that the dentist hasn't lost out and the philosophy is not to charge for non attendance. IDH will move to a full GDP contract in just over a year's time but meantime they have a top up in order to have a regulated income. The important issue is the scale of the problem; it is approximately 3000 missed appointments every six months. This is phenomenal when there are still patients on a list seeking to be allocated and a lot of dentists time is being wasted. This does not impact on the income to the dentist or IDH but impacts on the Board, £55k every six months. The reason for the proposal is not to penalise people but to ensure we work more effectively. Advance notice allows the appointment to be offered to another patient.

Mrs Brash enquired as to the period of notice before implementing this proposal and the formal publicity to ensure there was understanding and also understanding that this money would not be coming to the Board.

Mr Johnston asked how much understanding there was of the problem, there are a significant number of patients failing to attend and what has been done to address the situation. Mr Johnston also enquired what action would be taken if a patient failed to pay the penalty.

The Medical Director advised that this would not be a deterrent unless there was appropriate notice and that the information would be added to the appointment card to address the communication issue. The benefit to the Board would be indirect in that the aim is to provide care to the maximum number of people. There is also cost avoidance in that if £55k of treatment is carried out that is funded from the non cash limited central funds. If that income is not achieved then a top up payment is applied. There are many reasons why patients do not attend. IDH have done work to understand why, for example it is inconvenient, and have gone a considerable way to improve accessibility by offering evening and Saturday morning appointments. Enforcement has not been addressed meantime but there are a proportion of people who do not pay.

The Director of Health Services advised that DNAs at Dumfries and Galloway Royal Infirmary have been reduced from 9% to 4%; this is difficult to do but can be achieved by engaging with patients, understanding reasons for non attendance and introducing innovative ways to contact patients. Chronic non attenders tend to be from slightly disadvantaged groups and this will target our most vulnerable groups. A Patient Focused Public Involvement (PFPI) approach may be supportive in this situation.

Mr Warford supported the Director of Health Services' comments and enquired if there was any evidence amongst DNAs that these tend to be among the more disadvantaged. The figures equate to 915 hours in a six month period, 1830 hours year and demonstrated 3500 more patients that could be treated by the service. This must be a main driver for change.

The Director of Public Health also supported the Director of Health Services' comments. Currently there is insufficient information about this DNA group and may be a group of people with financial difficulties, mental health problems

or English not the first language and if we seek to penalise these groups of people it is likely that the response will be they do not seek dental registration. A PFPI approach may be a helpful way forward before any decision is made.

Concerns were also raised regarding equality and diversity and the practicalities of what can be done in the year prior to IDH moving to GDP status.

The Chief Executive summarised the discussion and confirmed that IDH operate under an NHS Dumfries and Galloway banner. There is no understanding of what is causing the DNAs, there is no demonstration or evidence that an impact assessment has been carried out and the paper does not suggest there is any penalty for those that don't turn up and don't pay so does not empower that decision. Importantly patients who do not attend for dental treatment are impacting on their own ability for dental care but also taking away the opportunity for others who could. More work is required to understand the root cause of those not attending and a pro-active communication should be taken forward through the local media to inform the public of the situation; it is a loss of opportunity for the public. Once there is understanding of the DNAs and what lies behind them support can be provided to those trying to provide the service and take lessons from some of the acute services experience.

The Board

- deferred any decision on charging to better understand the DNA rates.

204 The Adult Support and Protection (Scotland) Act 2007

The Medical Director presented this item and advised Members the Act became law at the end of October and imposes statutory duties on a range of organisations to ensure the welfare of those who might be at risk. Primary responsibility lies with the Local Authority and gives them a duty to investigate and enquire whenever a vulnerable person may be suffering harm. This could be a care home, relatives, individuals not connected to the person and it may, on occasion, be the individual themselves. The main contribution that the Health Board makes is that it has to provide information; information on recognising there might be an issue and, secondly, where social work require a medical examination or medical information, an obligation to provide that to them. We have good working between police, social services and health and should be able to make this very effective very quickly. Any action that is taken should be entirely with the support and consent of the individual. Use of the Act should be a last possible resort. There is a significant need to ensure this works effectively as there is symmetry with child protection and adverse publicity if this is not being done effectively. The information leaflet advised that the Board has two staff taking a major role in this and, lastly, the Board is in receipt of £10k to implement training for frontline staff. Various modules and training has been organised and should fit with pre-existing training. This is a relatively straight forward process but it is important to ensure that staff are aware.

Mr Warford enquired if patients are already listed as adults with incapacity this

will be known but how do staff ensure that the appropriate information is available. The Medical Director advised that the principle is that frontline workers must be aware of the question, “is this person suffering harm?”. No single organisation has ownership and responsibility and frontline staff must take action; the Act provides clarity.

Mrs Brash commented that this was statutory and there was no flexibility and that if someone was considered to be in danger they would be removed from that situation and enquired if this was done without appropriate representation. The Medical Director confirmed a person would be removed to a place of safety but would only be done with the patient’s expressed consent, otherwise a Sheriff’s Order would be required. The other process is to have a banning order which would be more common. It is also important to recognise in that seeking consent from the person at risk they may have difficulty expressing their view, such as in the case of grown up children harming their parent. Advocacy is mentioned frequently throughout the Act and there would be an advocate for the individual before any enquiry got underway.

The Director of Public Health reported that there have been differences in thresholds between agencies in child protection and enquired if there were discussions ongoing to have something explicit in place to ensure thresholds are the same. The Medical Director advised that the threshold is very low in that if concern is raised the social work department have a duty of enquiry and potential investigation.

The Director of HR and Workforce Strategy highlighted the information in the paper in terms of the monitoring form and the issue of a diversity impact assessment. Whilst acknowledging that this is a statutory requirement it is important to reflect on the implementation of statutory guidance such as this. A positive approach is required as we progress to policy development.

The Chief Executive asked the Medical Director to follow up on the point of thresholds as it is important to have that understanding.

The Board

- noted the duties and roles the NHS will take on as a result of the implementations of this Act; and
- noted the development of the Health Adult Protection Committee

205 Board Briefing

The Chief Executive presented this item and highlighted

- the rapid improvement event which has been taken forward. Important work we will hear more of in the months ahead;
- new appointments – Craig Marriott has been appointed as Finance Director. Craig is currently an Associate Director of Finance with NHS Lothian.
- NHS annual carol service;
- the launch of the compact; and
- through the briefing this month we have highlighted where colleagues

have had the opportunity to present some of their work or where we have been successful with awards which demonstrates and recognises the hard work going on in departments across the Board.

The Board

- noted the briefing

206 Any other competent business

Board Workshop on Monday 8 December

The Chairman reminded Members of the workshop on Monday 8 December which provides an opportunity to work through the clinical services strategy, the work to date and the next steps.

207 The Date of the Next Meeting

The date of the Next NHS Board is Monday 2 February 2008

208 The Minute of Healthcare Governance Committee held on 10 September, 2008

The Board

- noted the minute of the Healthcare Governance Committee held on 10 September 2008.

DUMFRIES AND GALLOWAY NHS BOARD**2 February 2009****PATIENT SAFETY**

Author Maureen Stevenson **Sponsoring Director**
 Hazel Borland, Nurse Director and Director for Patient Safety

Date: 23 January 2009

RECOMMENDATION

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

SUMMARY

The third Learning Set of the Scottish Patient Safety Programme (SPSP) took place in Edinburgh from 13-14 January, with 25 delegates from NHS Dumfries & Galloway joining the 500 delegates from across Scotland. A presentation was made by NHS Dumfries & Galloway within the Medicines Management breakout session.

Spread of the improvement methodology and change package is continuing throughout DGRI with our aim to have all relevant changes implemented reliably in the appropriate clinical areas by the end of 2009. Spread of the patient safety programme beyond the acute setting took place in October with a local learning session for Community Hospitals. The second learning session is planned for 24-25 January when hospital teams will present their work to date. This event will be supported by Jason Leitch, National Clinical Lead and Ros Gray, SPSP Facilitator.

Continuing to align our organisation's safety, risk, quality improvement and development work is crucial to sustaining improvement and enabling the organisation to meet and exceed our ambitions. Adopting the change methodology into the way in which we plan, change, deliver and monitor healthcare in Dumfries & Galloway will help to build capability.

Delivering Dynamic Improvement will take the learning from our use of the improvement methodology and build it into the mainstream, supporting the embedding and alignment of patient safety and our other improvement work in the day to day work of the organisation.

Achieving our Patient Safety Goals

The improvement work throughout the acute hospital will drive towards achievement of the over arching goals of the Patient Safety Programme in addition to those specific to the individual workstreams:

- To reduce mortality by 15%
- To reduce adverse events by 30%
- To reduce hospital acquired infection by 50%

Progress has been made towards achieving these high level goals by focusing on reliable processes, initially in pilot wards who have prototyped and tested process improvement but increasingly beyond these areas as the change package continues to spread into new areas.

Community Hospitals are now testing some of the interventions found to be successful in the Acute setting, adapting them to their care delivery models but ultimately driving towards the same outcome goals outlined above.

Summary of Progress

	<i>% of clinical areas in DGRI spread to</i>	<i>Other services/specialties beyond pilot area where you're starting to put into practice the Model for Improvement methodology</i>
Critical Care		
Ventilator bundle	100%	Spread beyond ICU not appropriate
Central Line bundle	100%	Implemented in ICU and Theatres – 90% coverage of all central lines. Ward 8, A&E, SHDU, testing January 2009
Multidisciplinary rounds	100%	Implemented in ICU
Daily Goal sheets	100%	Implemented in ICU
General Ward		
Safety huddles	75%	Implemented in Ward 9, Ward 12, Ward 14, Ward 8, ICU, Ward 10, SHDU, Kennedy Suite, Out Patient Department, Ward 18. Testing in Ward 3, Ward 6, Ward 7, Ward 15, Ward 16, ICU, A&E.
SBAR	80%	Nursing, Medical and AHP staff trained and using SBAR - Hospital at Night Team using for Medical Handover. Being used routinely throughout DGRI for nursing handover and inter-ward transfer. Child Protection Team and Diabetes Team using for referrals.
EWS/outreach team	100%	Early warning score existed pre-collaborative, development work in all general wards by MEWS Facilitator. Paediatric EWS developed and implemented in A&E and Ward 15
Leadership		
Walkrounds	100%	2 nd round commenced August 2008. Review of process underway to maximise effectiveness.
Medicines Management		
Reconciliation (all points)	60%	Implemented in Pre-Assessment, Cancer Services, Ward 18, Ward 15. Refining process in medical wards starting with testing in Ward 7 using medical clerk-in proforma and testing in Wards 12 and 9. Ward 18 testing reconciliation at discharge. Large scale test of patient record commenced in Out Patient Department. Small scale testing in A&E, SHDU
Anticoagulation management	20%	Testing in Ward 10, Ward 6, Ward 16
Peri-operative Management		
Safety briefings	75%	Implemented in Theatre 1, Theatre 2, Theatre 3, Theatre 4, Theatre 5, Theatre 6, Theatre 7, Theatre 11, Theatre 12, Theatre 9, Theatre 10
DVT prophylaxis	50%	Implemented Ward 16, Ward 6
Beta blocker use	75%	Implemented Ward 16 Testing Ward 3, Ward 6
SSI bundle	75%	Implemented Ward 16 Testing Ward 6, 3
SBAR	65%	Implemented Ward 4, Ward 6 and Ward 16 for handover. Preparing to test in Out Patient Department.
Infection control		
Hand hygiene	100%	Bundle implemented in all wards, Cancer Services, Theatre Reception Recovery, Day Surgery Unit. Testing in Theatres and preparing to test in Out Patient Department.

Sustainable Improvement

The focus of frontline teams on reliable processes has led to movement in outcome, but we must ensure that the improvements made are sustainable over time. Using the principles of reliable design, teams are improving process reliability through an understanding of factors which may contribute to error. To sustain these improvements the NHS Institute for Innovation and Improvement has identified four key elements that require to be present:

- **Change has benefits for patients and staff**

All elements of the change package have been identified by the Institute for Healthcare Improvement as those most likely to deliver the outcome goals of the programme and as such all have benefits for patients. For example, reductions in central line bloodstream infections and MRSA bloodstream infections. However, some have had unexpected benefits for staff making their sustainability more likely. For example, the use of SBAR for handover has reduced the amount of time staff spend in handover, increasing time available for direct patient care, in addition to ensuring that the relevant, critical clinical information is passed from one shift to the next.

- **Effective communication of the evidence**

Frontline teams are becoming increasingly skilled in the use of data to demonstrate their improvement work and to question this when they are not achieving the desired result. Increasingly wards are displaying information on their patient safety work for patients and families to see. Sharing of learning is taking place across and between wards and between hospital sites. The start of the Community Hospital programme has brought about opportunities for sharing learning between Community Hospitals and between the acute and community settings. Our model for spread makes use of social networks and formal and informal structures for communication.

- **Adaptability of the improved process**

Processes tested on pilot wards are now being tested in new ward and clinical areas in order that they can be adapted to different care processes. There is no assumption that something which works well in one ward will work well in another ward or in all wards. Frontline staff have ownership of the changes being made in their working environment.

- **Effectiveness of the system to monitor progress**

The ability of the system to monitor progress is continually developing with work to link outcome measures back to the work being done by frontline staff.

Whilst the patient safety programme has clear outcome goals the wider impact of the programme in transforming thinking on safety and quality must be borne in mind. By providing all staff with the tools, expertise and confidence to question the systems they work with and to deliver improvement projects at a local level the programme provides a foundation for sustained improvement. Forty staff from DGRI have now attended learning sessions delivered by IHI and have extensive knowledge and experience of driving change in clinical areas. Representatives from this group are sharing their knowledge with colleagues in DGRI and with the wider staff group through their involvement with the Community Hospitals Programme and providing coaching and mentoring support to staff in unrelated wards or clinical areas testing elements of the change package. Spreading the use of the improvement methodology beyond the patient safety programme will be supported and enhanced by the Delivering Dynamic Improvement Programme which will commence in February 2009. Sharing the philosophy of the patient safety programme and the approach to active learning this programme will use learning sessions and action periods to:

- Develop dynamic team working
- Enable flexible teams to respond and change to deliver improvement in patient care
- Engender shared responsibility by managers and clinicians to deliver sustainable change
- Develop a shared understanding of the model for improvement and its application in delivering dynamic change

Conclusions and Recommendations

Achieving a culture of safety and reliability is central to the organisation's ability to embed and sustain an environment of continuous quality improvement. As testing the various elements of the change package continues to spread through the acute hospital and starts in Community Hospitals, the capability of frontline staff to make changes to the systems they work in and improve patient care will increase our capacity to make change happen at the frontline.

The Spread plan is on track to deliver all key changes in all relevant clinical areas across DGRI by the end of 2009. Sustaining reliable process over time will be crucial to ensuring that we meet the challenging outcome measures whilst adding additional changes as part of Scottish Patient Safety Programme.

Aligning the delivery of improvement methodology of various Board improvement / change work stream will support staff in delivering change and improvement at the frontline whilst continuously improving the quality of experience of care delivered.

The Board are asked to note the progress 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</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	
Compliance with Corporate Objectives	<i>Corporate Objective 2</i>
DIVERSITY ASSESSMENT	
<i>No diversity assessment carried out.</i>	

DUMFRIES AND GALLOWAY NHS BOARD

2 February 2009

**PATIENT EXPERIENCE:****Reporting Period –November, December 2008 and January 2009****Author:**

Carol Reece, Patient Services Manager

Sponsoring Director

Hazel Borland, Nurse Director and Director for Patient Safety

Date: 21 January 2009**RECOMMENDATION**

The NHS Board is asked to consider the Patient Experience Report for the period November and December 2008.

SUMMARY

Patient Services are pleased to lay before Board an evolving monthly report based on the summation of Patient Experience information.

This report covers information gathered from the NHS Dumfries and Galloway electronic feedback system, through enquiries and complaints.

INTRODUCTION

Our aim is to secure resolution for individuals who bring us their complaints and to support learning across the organisation through disseminating the lessons from our considerations and investigations.

A number of initiatives are currently being implemented with the aim of improving the quality of the complaints process, standardising the supporting structure which will enable demonstrable improvements in the quality of service leading to public confidence in the complaints process.

LINES OF ENQUIRY

Over the 2 month reporting period, Patient Services have received 49 lines of enquiry, 29 of which have been registered as complaints. 20 letters of thanks have been received in respect of Medical and Surgical Wards DGRI, A & E, Cardiology, Orthopaedics, Rheumatology, ENT, Alexandra Unit, Thomas Hope Hospital, Kirkcudbright Hospital and Newton Stewart Hospital. In patient episodes over November and December were 4817.

Of the 20 enquiries, 1 from November remains open, all enquiries have been closed in December. Issues have been in respect of NHS 24, Mental Health, discharge letters, car parking, maintenance on wards, appointment letters and Dental Allocation/Services, under the themes of communication, care and provision/allocation of treatment.

COMPLAINTS

Of the 29 complaints, 10 were upheld, 3 upheld in part, 5 not upheld. Of the 10 outstanding, process delay and Festive Leave is cited as the reason; either during the investigation, collation of evidence or finalising response.

Issues have been in respect of General Medicine, General Surgery, Gynaecology, Dental Services, Nithsdale LHP, Stewartry LHP, Wigtown LHP, Out of Hours Service, Mental Health under the themes of Clinical Treatment (34%), Staff Attitude and Behaviour (17%), Communication (10%), Cleanliness and Laundry (7%).

98% of complaints were acknowledged within 3 working days, 10% of complaints were responded to within 5 days and 28% were responded to within 20 working days.

In order to improve the processes and reduce delays the Patient Services Team is using the model for improvement to try some small tests of change. This includes using SBAR to summarise a complaint and the issues raised and a proposal to start meeting more complainants.

REPORTS TO THE PROCURATOR FISCAL

We are in communication with the Procurator Fiscal on one complaint received in September 2008, which has been responded to.

PUBLIC SERVICE OMBUDSMAN

We are currently in correspondence with the Public Services Ombudsman on 2 complaints. We have provided the Ombudsman with relevant correspondence and await their decision on whether they will investigate further.

MONITORING FORM

Policy/Strategy Implications	<i>Complaints Policy</i>
Staffing Implications	<i>Ensuring staff learning 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 to take account of any risk.</i>
Best Value	
Compliance with Corporate Objectives	<i>Corporate Objective 2 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>
DIVERSITY ASSESSMENT	
<i>Not undertaken as applies to all users.</i>	

DUMFRIES AND GALLOWAY NHS BOARD

Monday 2 February 2009

**Infection Prevention and Control Update****Author**

Sam Whiting, Infection Control Manager

Sponsoring Director

Hazel Borland, Nurse Director and Director for Patient Safety

Date: 20 January 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 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.

The Scottish Government has required 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.

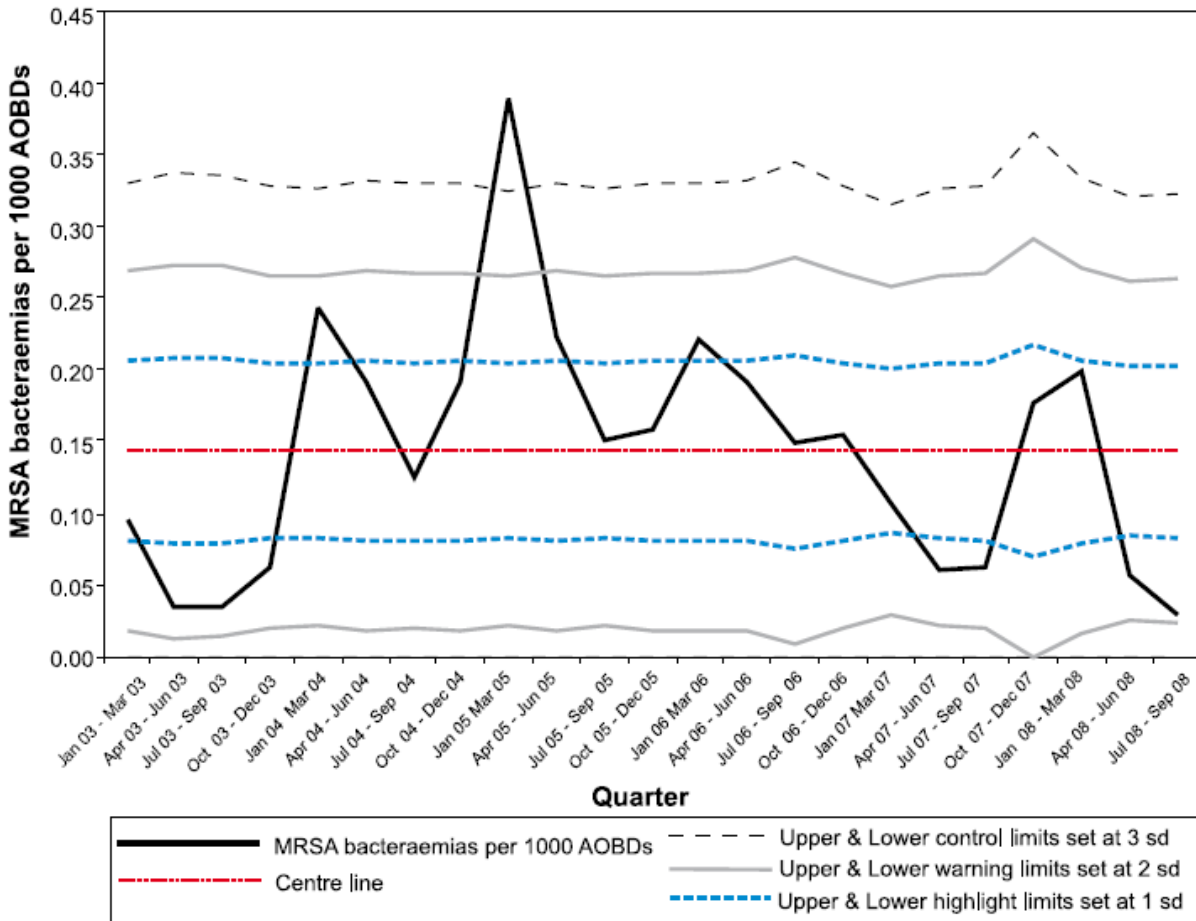
Through the proactive approach taken by NHS Dumfries and Galloway on key infection control issues including mandatory training, antimicrobial prescribing, cleaning and hand hygiene, NHS Dumfries and Galloway has been able to confirm implementation of 21 of the 24 actions (Appendix A). The remaining 3 actions are on track for implementation within the required timescale.

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, 172 days have elapsed since the last Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia and 20 days have elapsed since the last Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia in Dumfries and Galloway.

SPC chart of quarterly MRSA bacteraemia per 1000 AOBs in NHS Dumfries and Galloway, 1 January 2003 to 30 September 2008.



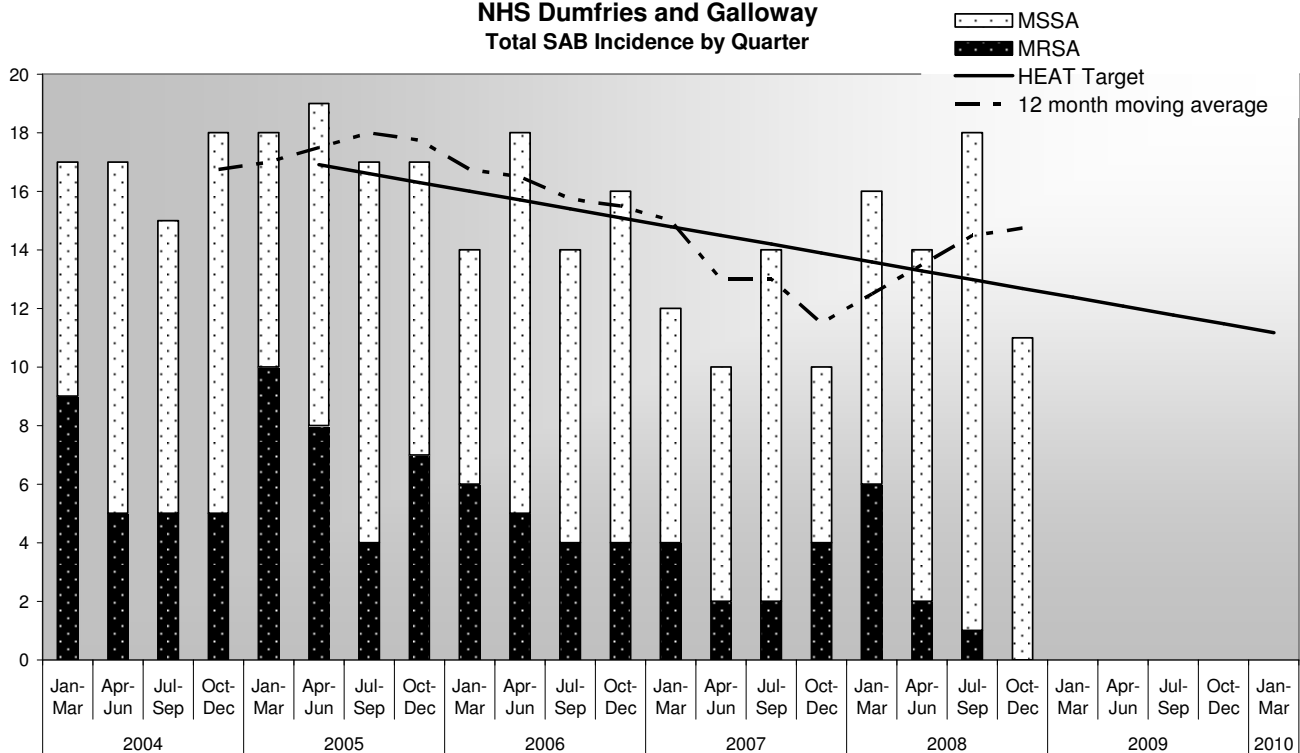
The graph above represents the MRSA bacteraemia rate per 1000 Acute Occupied Bed Days (AOCB) for NHS Dumfries and Galloway as a Statistical Process Control (p) chart.

The statistical process control chart suggests that with the exception of the quarter 1 January 2005 to 31st march 2005, where the rate was higher than the upper control limit, the MRSA bacteraemia rate in NHS Dumfries and Galloway has remained stable throughout the period 1 January 2003 to 30th September 2008.

In the Quarter from July 2008 to September 2008, NHS Dumfries and Galloway had an SAB rate of 0.38 per 1000 AOCB which was slightly below the Scottish average of 0.43 per 1000 AOCB.

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 quarterly SAB incidence against the HEAT target trajectory.

NHS Dumfries and Galloway
Total SAB Incidence by Quarter



Ongoing initiatives to reduce cases include:-

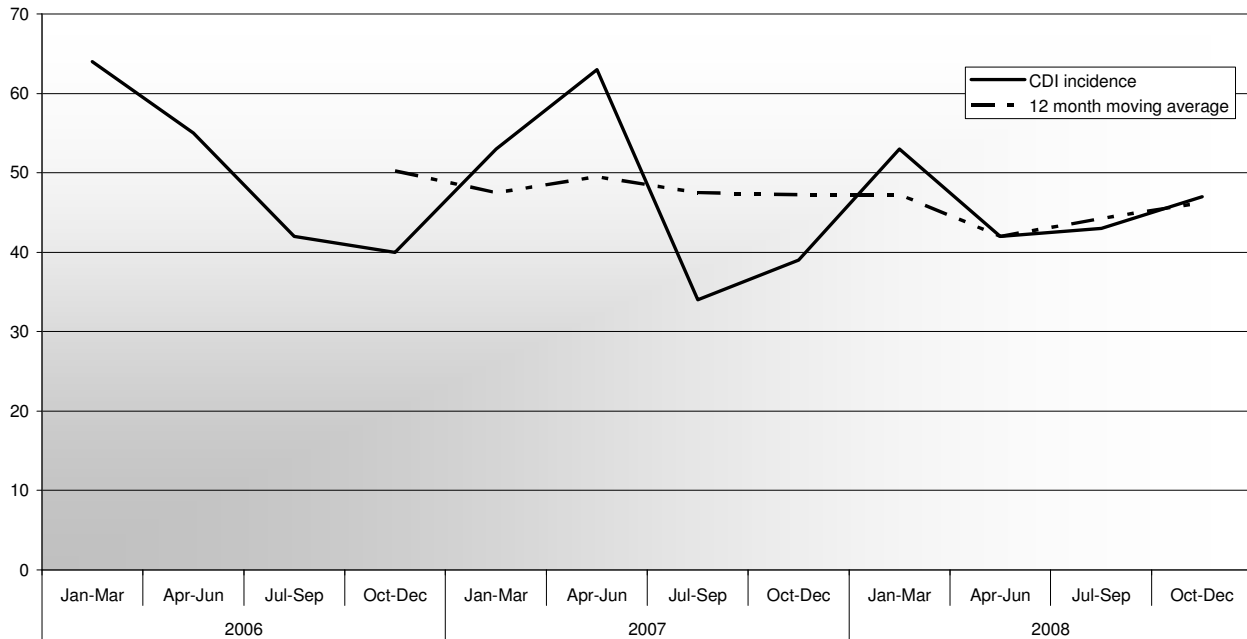
- Through the Patient Safety Programme, a care bundle for the use of peripheral intravenous cannula is currently being tested in a number of clinical areas within Dumfries and Galloway Royal Infirmary (DGRI).
- There is a planned increase in MRSA screening from February 2009.
- Ongoing compliance with 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. Until recently, this was done by the Infection Control Team but is now being completed by the clinical teams caring for the patient.

Clostridium difficile Infection (CDI)

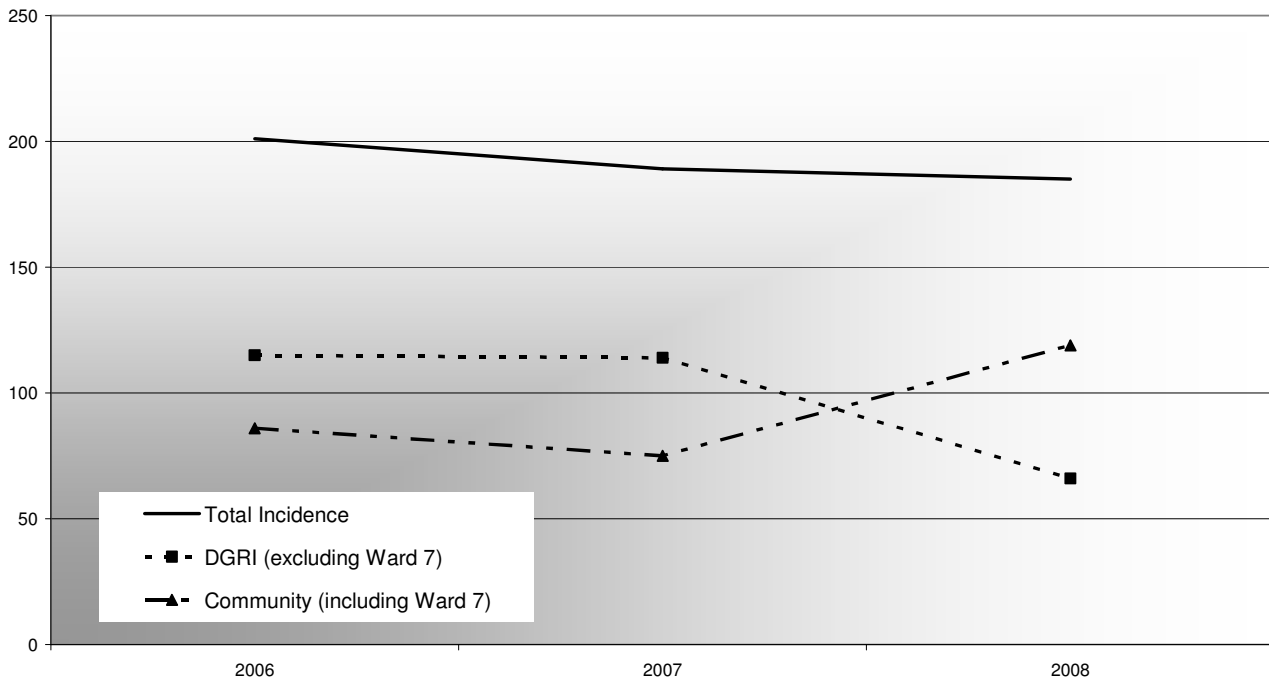
The graph below shows the total quarterly incidence of *Clostridium difficile* infection (CDI) from January 2006 to December 2008 across NHS Dumfries and Galloway.

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 CDI Incidence by Quarter



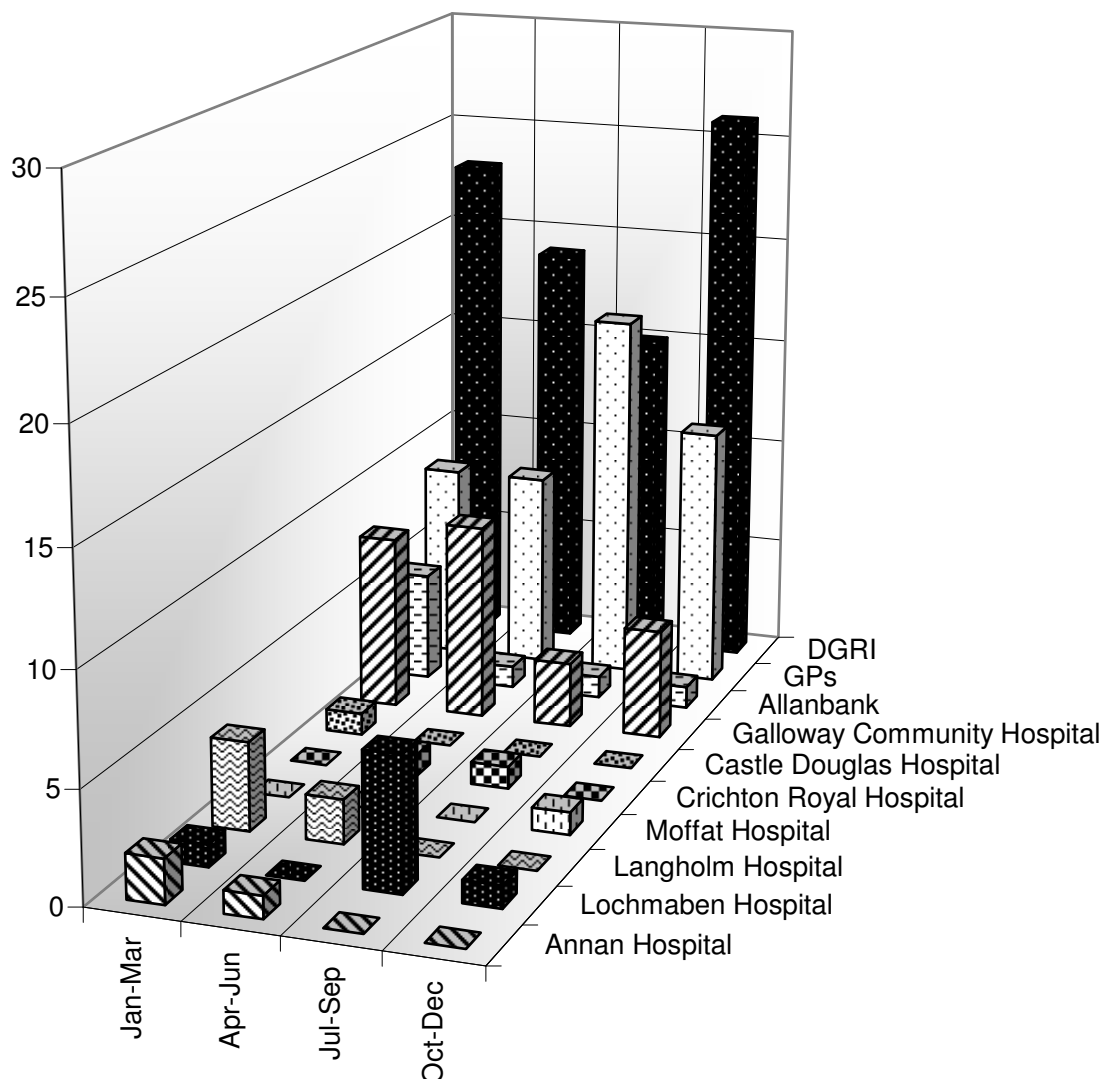
NHS Dumfries and Galloway
Total Clostridium difficile Incidence by Year



The graph above shows a reduction in CDI incidence within the acute environment of DGRI which reflects the significant improvement in antimicrobial stewardship and application of infection control precautions. However, this improvement has had little impact on the overall incidence due to an increase in cases diagnosed in the community.

The following graph shows the incidence of CDI by quarter and location during 2008.

NHS Dumfries and Galloway 2008 CDI Incidence by Quarter and Location

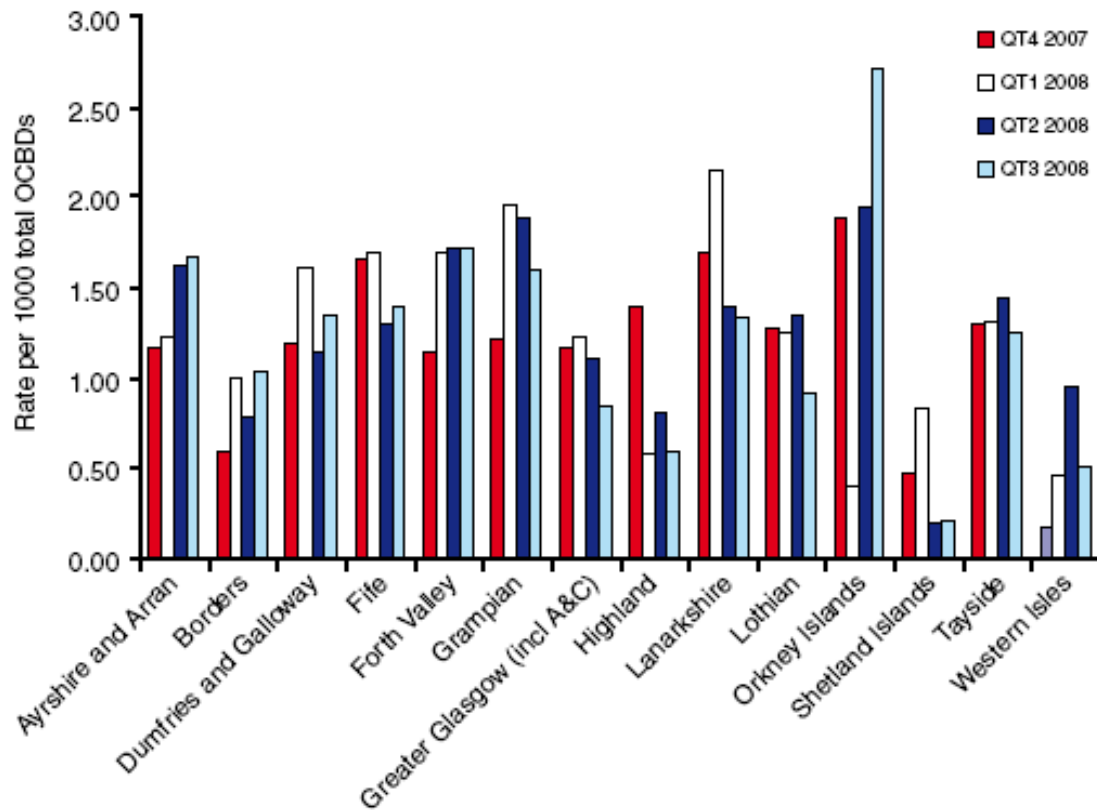


The Scottish Government Health Directorate (SGHD) has set a HEAT target of a 30% reduction in CDI rates. Trajectory calculations are awaited from SGHD and will be added to future graphs when available.

A recent report by Health Protection Scotland (HPS) on CDI in Scotland identified a Scottish average rate at 1.29 per 1000 total occupied bed days (OCBD) from October 2007 to September 2008. During the same period the rate for Dumfries and Galloway was slightly higher at 1.32 per 1000 OCBD. It is possible that the reason for this is linked to incomplete records reducing the denominator. It is also worth noting that patient age is a key risk factor for CDI and NHS Dumfries and Galloway has an older population profile compared to other Board areas.

The graph below produced by HPS summarises the CDI rate by Board area and Quarter. In this graph, HPS have not included data relating to patients aged below 65 years.

Quarterly rates of CDI per 1000 total occupied bed days in acute and non-acute hospitals in 14 NHS Boards in Scotland,



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:

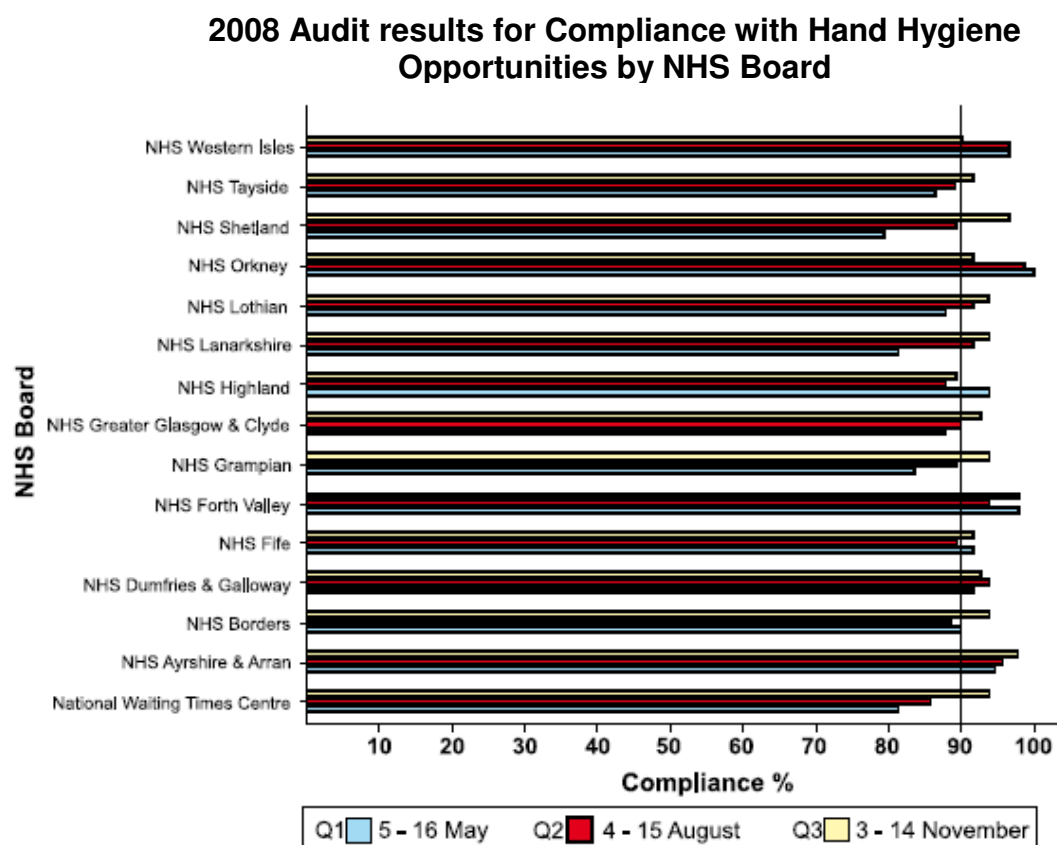
- Implementation of a CDI focussed acute antimicrobial formulary
- GP formulary reviewed and updated
- The Microbiology laboratory has stopped reporting cephalosporin sensitivity
- Antimicrobial restricted list developed and in use.
- Antimicrobial Formulary compliance audits are conducted weekly
- Feedback 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. Until recently, this was done by the Infection Control Team but is now being completed by the clinical teams caring for the patient.

An antimicrobial awareness week is planned for February 2009. This will be targeted towards both acute and community staff as well as patients and the wider public.

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.

The most recent national hand hygiene audit was conducted in November 2008. NHS Dumfries and Galloway achieved an overall audit score of 92%. The graph below compares the audit results for all the main Scottish Health Boards.



The table below shows the breakdown of audit scores by hospital.

<u>Hospital</u>	<u>Hand hygiene compliance</u>
Kirkcudbright Hospital	100%
Moffat Hospital	100%
Galloway Community Hospital	100%
Castle Douglas Hospital	100%
Newton Stewart Hospital	100%
Lochmaben Hospital	95%
Thornhill Hospital	95%
Annan Hospital	90%
Thomas Hope (Langholm) Hospital	90%
Dumfries and Galloway Royal Infirmary	89%

An audit of visitor hand hygiene compliance was conducted in November 2008 in Galloway Community Hospital. This audit assessed the proportion of visitors that used the alcohol gel on entering a ward and identified that 72% of visitors did use the alcohol gel.

Hand hygiene signage has been improved with a display in the main entrance of DGRI asking visitors to use the gel at ward entrances. Signage is also currently being improved in clinical areas in DGRI.

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 633 completed Cleanliness Champions and 462 in training in Dumfries and Galloway. There are also a further 31 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.

On 26th March there will be a Cleanliness Champions conference building on the success of the conference in November 2007. Champions will be updated on infection control topics as well as practical tips on changing practice and behaviour.

Outbreaks

The last outbreak in Dumfries and Galloway was an outbreak of Norovirus affecting one ward in Dumfries and Galloway Royal Infirmary in December 2008. In total, 14 patients and 2 members of staff were affected by illness. Appropriate control measures were instigated and the outbreak was managed effectively.

Cleaning

Recent cleaning results by locality are listed below. These are aggregated cleaning audit scores for the period November 2008 – December 2008 based on compliance with the national cleaning specification.

Area	Cleaning audit Scores	
	Nov	Dec
Stewartry Locality	99.0%	99.0%
Annandale and Eskdale Locality	98.2%	98.2%
Wigtownshire Locality	98.2%	97.9%
Dumfries and Galloway Royal Infirmary	96.1%	96.3%
Nithsdale Locality	97.0%	97.0%

Incidents and Risk

As part of NHS Dumfries and Galloway adverse incident reporting system, the Infection Control Team has been asked to review 2 incidents since 1st November 2008. Both incidents occurred in January and are currently being investigated.

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

Completion Date: April 2009 Status: Green

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: Green

MONITORING FORM

Policy/Strategy Implications	<i>HEAT targets</i>
Staffing Implications	<i>Not applicable</i>
Financial Implications	<i>Not applicable</i>
Consultation	<i>Not applicable</i>
Consultation with Professional Committees	<i>Not applicable</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>
DIVERSITY ASSESSMENT General update paper – not applicable	

DUMFRIES AND GALLOWAY NHS BOARD

2 February 2009

**Summary of Discussion and Outcomes of the three NHS Board Workshops on the Clinical Strategy****Author** Jamie Megaw**Sponsoring Director****Date:** 2 February 2009

Mr John Burns, Chief Executive

RECOMMENDATION

The Board is asked to note the discussion and the outcomes of the three Board Workshops held on 8 December 2008, 12 January 2008 and 27 January 2009.

Introduction

This paper sets out the information provided and highlights discussion and actions at three Board workshops held to discuss progress with the NHS Board's emerging clinical services strategy.

NHS Board Workshop 8 December 2008

At this workshop a presentation was given by the Chief Executive setting out the strategic context of the NHS Dumfries and Galloway Clinical Services Strategy. Reference was made to the Scottish Government five strategic aims (Wealthier and Fairer, Healthier, Safer and Stronger, Smarter, Greener) and further national policy including Better Health Better Care, Delivering for Remote and Rural Healthcare, Developing Community Hospitals, Patient Experience and *Gaun Yersel*. The Board were also asked to note the local policy context Better Health Better Healthcare.

There was a further presentation on benchmarking of NHS Dumfries and Galloway against other Health Boards in terms of admission rates per 1000 per population and occupied bed days. The workshop attendees also received detail on population projections for Dumfries and Galloway until 2031, the impact on the working age population and the need for the organisation to plan for capacity in the future.

Following on from this the workshop attendees were then guided through the four scenarios that had been developed through the Clinical Strategy Model of Care Work and discussed with stakeholders at regional and local events. Draft bed numbers within each scenario were also presented to attendees although they were asked to note that further modelling would be required before final bed numbers were confirmed.

There was also an update on the level of Stakeholder involvement through the process from the Local Health Partnership Service Reviews to Public Focus Groups held from October to

November 2008. The outcome of the recent stakeholder events was a strong preference for Scenario C. This view was consistent across the region. Further detail on public involvement is presented in Appendix One.

The fixed points within the Clinical Strategy and the service and bed modelling required to understand the impact of the scenarios were presented. The four feasibility criteria (accessibility, capability, performance and affordability) used by the Clinical Strategy Core Team to develop the options were also discussed by attendees.

Having set out the backdrop of work to date a series of options were presented for discussion. At this point there were two options in scenario A, two in scenario B, twelve in scenario C and 3 in scenario D.

At the end of the presentation there was round-table discussions on the information presented. In the subsequent feedback three further options were proposed and the Clinical Strategy Core Group were asked to develop these further options. These options developed a range of Intermediate Care Facilities across the region offering a combination of intermediate in-patient care and community specialist rehabilitation.

Following on from the workshop the three options were developed by the Clinical Strategy Core Group. These options were; C13, which had two community rehabilitation intermediate care facilities across the region; C14, which had three such facilities; and C15, which had four such facilities. Work was subsequently undertaken by Health Intelligence unit to understand the impact on accessibility to intermediate care and community rehab within options C13 – C15.

NHS Board Workshop 12th January 2009

Invitation to this workshop was extended to include the lead clinicians within the LHPs and those based at Dumfries and Galloway Royal Infirmary. A paper was sent out in advance describing the progress made following the Board Workshop on the 8th December 2008 and highlighting proposed changes to the long list of options. The attendees received a presentation from the Chief Executive on progress from the 8th December workshop. The fixed points were again presented and after further discussion the workshop attendees agreed the fixed points as described.

Further information on the refinements to bed modelling was provided and the new options proposed at the 8 December 2008 workshop were described. These were C13, C14 and C15. The locations of the facilities were identified by Health Intelligence using mapping software to identify optimal locations across the whole of the region. Following discussion the workshop attendees agreed to leave the decision making until the end of the session. Having deferred the discussion the Board returned and using the feasibility criteria felt that options C13, C14 and C15 failed against the accessibility criteria. Option C16, a variation of C15, was presented to the Board. In this option there are four intermediate care facilities plus Dalrymple Ward. It differed in variation to C15 because Annan was considered instead of Lochmaben as the location for the Annandale and Eskdale Intermediate in-care and community rehabilitation facility.

There was concern raised about the lack of intermediate in-care provision within Dumfries, and recommended that Option C16 was further refined to position intermediate in-patient care within Dumfries.

Information was presented on option D4 which built upon the service model in scenario D. Option D4 described two facilities across the region providing inpatient care: the Galloway Community Hospital providing 46 beds and the other being a redeveloped Dumfries and

Galloway Royal Infirmary providing 400 beds. In this option there would be no in-patient services delivered from community facilities. After discussion it was agreed to remove this option from the short-list based on accessibility but recommended that it formed a baseline for comparison against the preferred options.

NHS Board Workshop 27th January 2009

There was an update on progress with the development of the clinical strategy since the previous workshop. This included discussions at the Area Medical Committee and Area Clinical Forum, 18 staff meetings, and the Stakeholder Reference Group.

The workshop discussed the role of Allanbank beds and the importance of intermediate care beds in Dumfries. It was agreed the discussions should begin between the NHS Board and Allanbank on future contractual arrangements.

The workshop was briefed on the outcome from the stakeholder reference group held on the 23rd January and attended by 39 stakeholders who represented a wide range of perspectives. It was highlighted that the majority of participants supported the reasons used to exclude options from the shortlist (89-100%). It was made clear that there were reservations by some participants regarding the options on the shortlist. These participants were concerned about access to healthcare in mid and upper Nithsdale and also in the northern part of Annandale and Eskdale. Following discussion on these points a series of actions were proposed at the workshop which would seek to understand the demand for and optimal position of a facility in mid and upper Nithsdale, as well as the options available to the Board to improve access to intermediate care within the two areas identified. The Chief Executive agreed to circulate the results of this work to Board members.

There was an update on progress within workforce planning from the Director of HR and information on the life cycle costs of buildings from the Head of Estates. There was also an update on the DGRI redevelopment project and Board members were forewarned that rapid and effective decision-making will be required to support the project.

The workshop concluded with a summary of the key dates over the next few months:

- Stakeholder Option Appraisal events – 23rd-27th February
- NHS Board workshop – 2nd March
- NHS Board Meeting – 16th March
- Formal Consultation – 2nd April – 1st August
- NHS Board Meeting – 10th August

Appendix One

Clinical Services Strategy Development Process

Public participation is at the centre of the developing Clinical Services Strategy for NHS Dumfries and Galloway. The process to October 2008 to develop the Clinical Services Strategy can be summarised in four stages. The following table describes stakeholder involvement at each stage. By October 2008 82 events had been held.

Clinical Services Strategy Stage	Stakeholder Involvement
Local Health Partnership Service Reviews	Over 1000 members of the public were consulted across the region. Meetings were held with local groups including community councils, elderly forum, rural partnership forum etc.
Model of Care Development	Public members on dementia and rehabilitation groups. Service users participated in pathway mapping workshops for fracture hip, acute assessment and stroke. Emerging models of care presented to groups with public members including Stroke MCN, Alzheimer's Scotland, User Carer Group, Nithsdale Public Involvement Group. 451 current service users across Dumfries and Galloway were interviewed using participatory appraisal methodology.
Stakeholders develop benefit criteria and score scenarios against criteria	300 members of the public and 34 stakeholder groups invited to attend workshops. 156 stakeholders attended workshops to develop benefit criteria. 116 stakeholders attended second series of events to score scenarios against criteria. Events held in Dumfries and Stranraer and stakeholders included staff, public and partner agencies.
Public Focus Groups held across the region to seek opinion and comment on scenarios	14 public focus groups held across the region attended by 223 people.

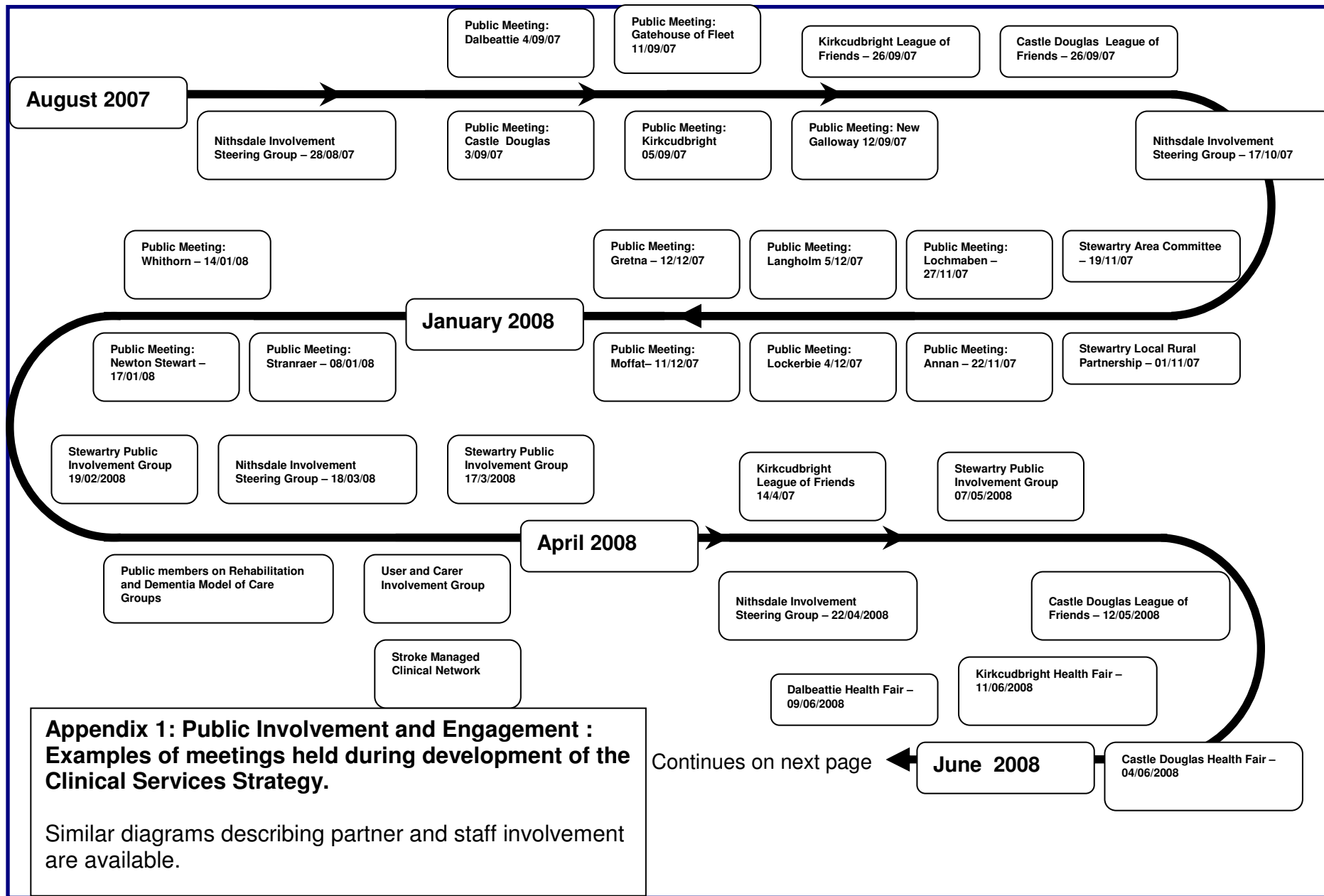
To determine stakeholder preference for the emerging models of care the Board held a series of workshops to engage with staff, public and partner agencies. The events were held in Dumfries and Stranraer with a 156 stakeholders identifying the benefits they felt were important to access models of care and subsequent options. From 1100 comments 6 benefit criteria incorporating 31 key features were identified and agreed by the stakeholders. In order of priority the benefit criteria are:

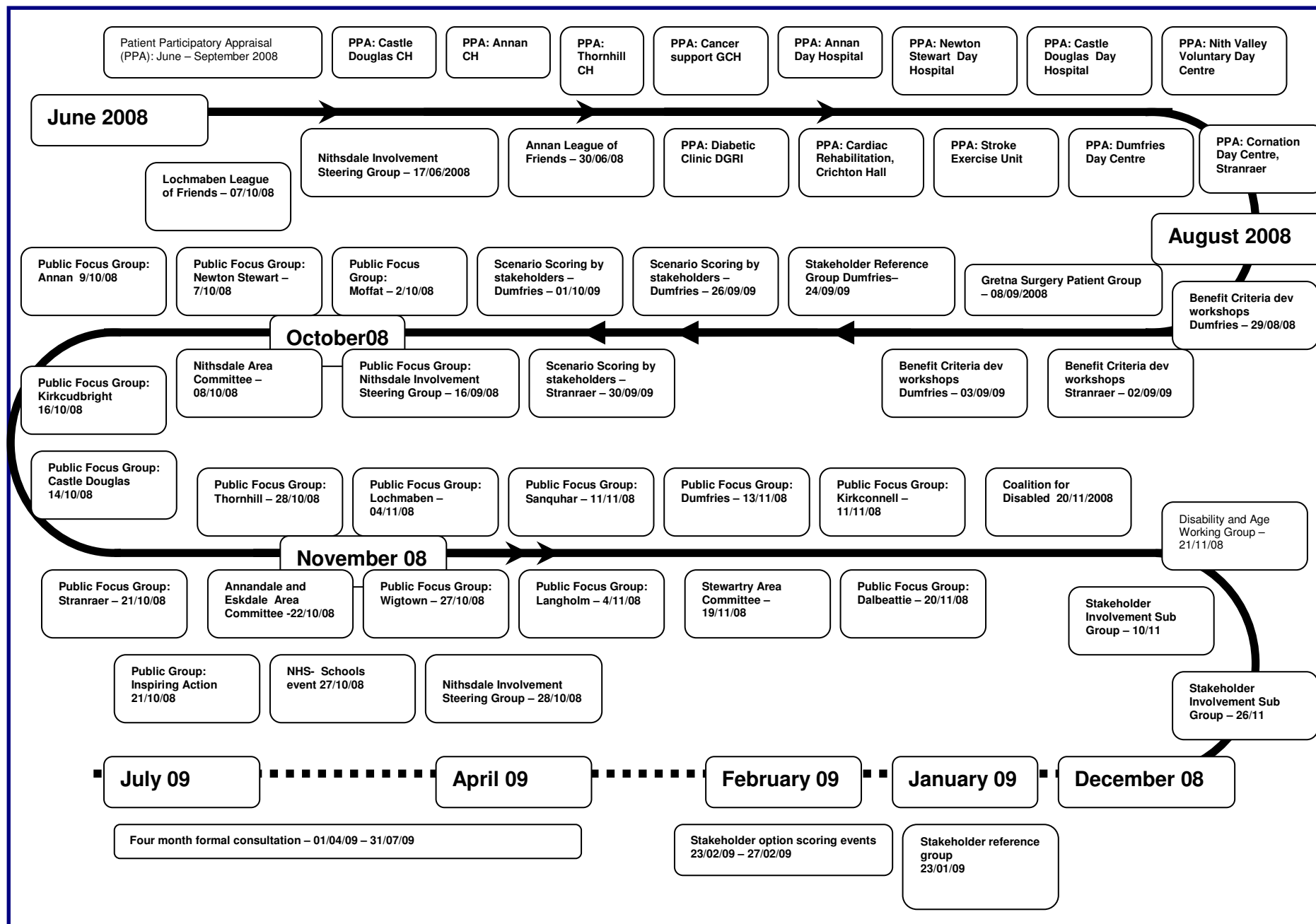
- Quality of Patient Care
- Appropriate numbers of adequately trained staff
- Sustainability and safety of services
- Clinical effectiveness and integration of services
- Equity of access to care across the region
- Quality of physical environment

The stakeholder group at subsequent events scored four scenarios against the benefit criteria. This determined the stakeholders preferred scenario. The overall scores were:

Scenario:	A	B	C	D
NHS Staff	525	561	677	600
Public	577	595	727	659
Partners	537	568	679	607
Overall Scores	541	571	690	616

Maximum Score = 1000





MONITORING FORM

Policy/Strategy Implications	<i>This paper describes the outcome of three Board workshops which have contributed to the continuing development of the NHS Board's clinical strategy. The clinical strategy has significant positive impact on the Board's ability to deliver on local and national policy. The strategy also underpins the DGRI redevelopment project</i>
Staffing Implications	<i>This paper has no direct implication on staffing. The clinical strategy will have an impact on future staffing. The exact impact will depend on the final option</i>
Financial Implications	<i>This paper has no direct financial implication and the acting Finance Director was present in the discussions</i>
Consultation	<i>Not required for the content of this paper but the clinical strategy development process is following a robust engagement process with staff and other stakeholders</i>
Consultation with Professional Committees	<i>ACF, APF, PACS and AMC have all been consulted on the emerging clinical strategy</i>
Risk Assessment	<i>Not required for the content of this paper</i>
Best Value	<i>Not required for the content of this paper</i>
Compliance with Corporate Objectives	<i>The clinical strategy will support the NHS Board to achieve all corporate objectives</i>
DIVERSITY ASSESSMENT <i>Not required for the content of this paper</i>	

DUMFRIES AND GALLOWAY NHS BOARD

2 February 2009

Financial Performance: 9 Months to 31 December 2008

Author
Katy Lewis, Deputy Director of Finance

Sponsoring Director
Katy Lewis, Deputy Director of Finance

Date 26 January 2009

RECOMMENDATION

The Board is asked to note the financial performance to 31st December 2008.

SUMMARY

The Board's financial plan for 2008/09, now enshrined as a target, is to spend all in year income plus £2.5million of previous year's reserves. This would leave the Board with £4.6 million to carry into 2009/10 to support its clinical strategy. The Board also has to deliver £4.6 million of efficiency savings under the Efficient Government initiative.

There is a significant level of new initiatives in this first year of the new spending review period and many will not have a full year's spend by March 2009. Already we are forecasting £2.5 million of spend, previously assumed for 2008/09, which will fall beyond March 2009. Although there is a familiar pattern of overspends against a number of issued budgets, greater than expected income combined with early positive indications on some of the larger efficiency measures means these are contained within the parameters of the original plan.

Substantial work is underway to proactively bring forward potential 2009 initiatives and to assess and incorporate into the plan the potential impact of some of the identified risks. Active financial management is required in the remaining months of the financial year to deliver the target position.

Income

1. Since the November Board, forecast income has increased by £1.1 million to £295 million. Appendix 1 details the movements.
2. Primary medical services allocations for 2008/09 have now been confirmed, the overall impact of changes to the global sum and other allocations has reduced income due by £158k. Additional investment in enhanced services of £208k for 2008/09 has been notified to support developments in palliative care, osteoporosis, ethnicity and closer working between primary and secondary care.
3. Additional waiting times funding for tranche 4 has been released with Dumfries and Galloway receiving £180k in additional funding.
4. The Healthcare Associated Infection Team have issued to Boards additional funding of £110k to support local surveillance systems for control of infection and MRSA screening.

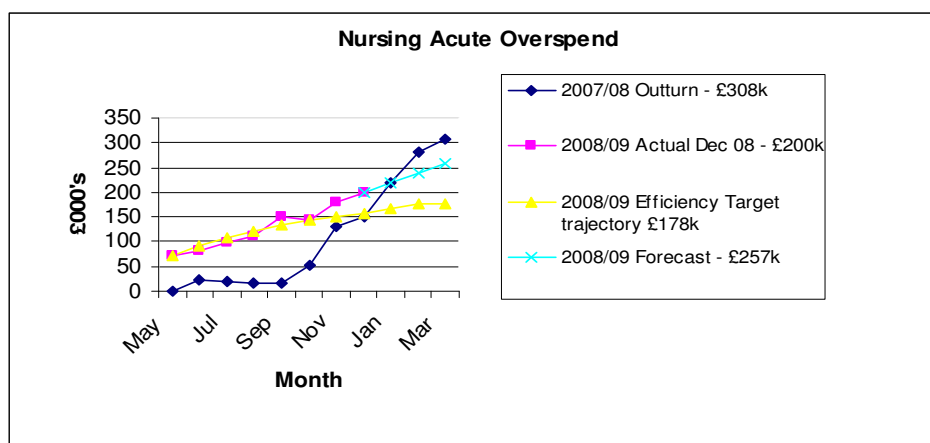
5. To support the sustainability of primary care dental service provision within Dumfries and Galloway, a further £347k has been confirmed for 2008/09 to continue the current arrangements and to support the changes to dental services in Gardenhill.
6. The amount of income which is topsliced to fund a range of national developments has reduced by £106k this month releasing this funding to be reinvested locally.
7. Other income has increased by £180k.

Financial Performance

8. Appendix 2 is a summary of the Board's overall financial performance for the year to 31st December. Operating budgets show a £466k overspend to date moving to a forecast £2.419 million overspend by the year end. This is the in year position and uses £2.5 million of previous year's reserves.
9. Commentary on some of the key factors behind the departmental overspends is set out below.

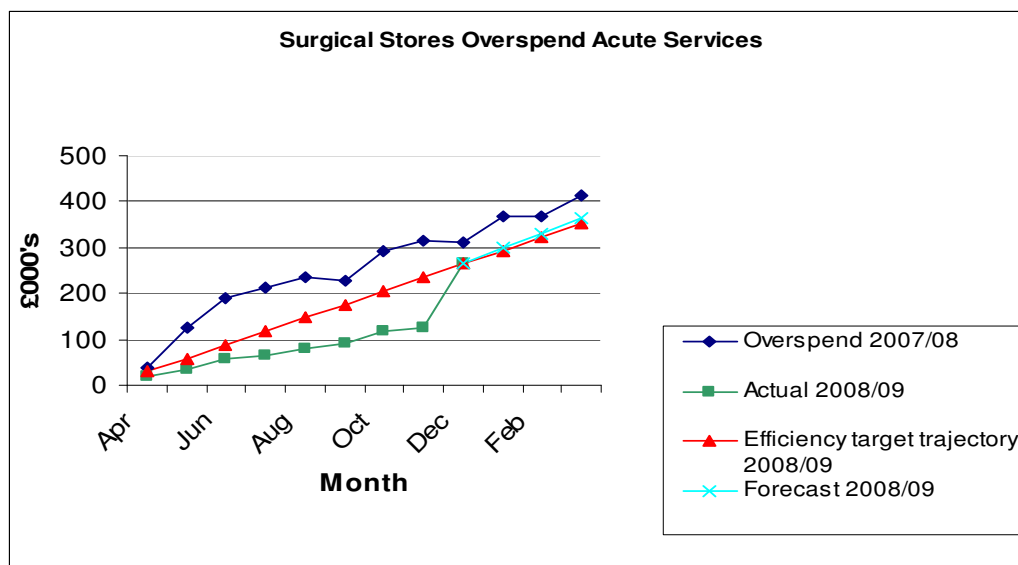
Medicine, Surgery and Anaesthetics

10. Medicine, Surgery and Anaesthetics are £1.175 million overspent to date and are forecasting a year end overspend of £1.214 million on their combined £44.1 million budget (2.8%). Appendix 4 details the main areas of overspend.
11. Nursing pays are £200k overspent to December 2008 (£144k at October 2008). An efficiency target to reduce this overspend to £178k for 2008/09 has been agreed and the graph below monitors progress made to achieve this target. Current financial forecasts indicate that the progress made towards achieving this target has slipped with a projected year end position of £257k overspend.



12. Acute medical costs are £143k overspent to December 2008 (£32k at October 2008) and are forecast to be £230k over at the year end.
13. Drugs budgets are forecast to overspend by £298k at the year end (£182k at October 2008). It has been assumed this overspend will be funded from the central drugs reserve and budgets will be realigned to reflect this budget allocation over the next month. The reasons for the increased spend continues to be the high usage of Lucentis is continuing with higher than anticipated drug spends in Neurology, Rheumatology and Dermatology which are expected to continue to the year end.
14. Surgical stores and lab supplies are overspent by £266k at December 2008 (£118k October 2008). There has been a significant increase in expenditure during December that

has moved the forecast outturn position to £365k, with the efficiency target now looking unachievable. The reasons for the increase are related to surgical activity casemix and some stocking up of items over Christmas that indicate that the high level of spend will not continue into the final quarter.



Waiting Times

15. Previous expenditure projections assumed this budget would spend to the level of resource allocated. However, it now looks likely that the required activity can be delivered with £250k less expenditure than budgeted. Discussion regarding Golden Jubilee activity are ongoing to ensure that value for money can be achieved on the activity and cost levels contracted.

Local Health Partnerships (LHPs)

15. The primary care prescribing position to October 2008 is £399k underspent (£304k as at August 2008). Expenditure on high cost drugs continues to be the only area that is overspent. See Table 1 for details.

Table 1 – Primary Care Prescribing Expenditure, April-October 2008 (GIC)

LHP	Allocation (£)	Expenditure (£)	Over(-)/underspend (£)	Over(-)/underspend (%)
Dumfries & Upper Nithsdale	£5,870,940	£5,677,581	£193,359	3.3%
Annandale & Eskdale	£4,010,045	£3,883,041	£127,004	3.2%
Stewartry	£2,562,582	£2,493,572	£69,010	2.7%
Wigtownshire	£3,750,215	£3,564,948	£185,267	4.9%
Non-LHP Expenditure plus High Cost Drugs	£1,708,138	£1,883,934	£-175,796	-10.3%
TOTAL	£ 17,901,920	£ 17,503,076	£398,844	2.2%

17. The level of gross prescribing underspend remains as previously predicted at a level of £775k. However, even with savings arising from category M and Pharmaceutical Price Regulation Scheme, the net prescribing underspend is reduced to £250k. Changes to prescribing discount achievable are the primary reason for the lower underspend with discount rates from October 2008 reducing to 1% (April to September at 7.9%).

Operational Services

18. Overall operational services is reporting a £722k overspend to December (£528k at October 2008) date with a forecast outturn position of £717k overspent (£1,386k at October 2008). The forecast overspend has reduced this month as funding has been issued to budgets for the increase in energy contract prices from October 2008.
19. The forecast overspend in patient administration (medical records) this month is £269k (£205k year to date). The overspend relates to a range of areas including additional waiting times activity (£65k), backlog coding work (£51k), storage of records (£24k) and other identified pressures. This was discussed at the Annual Performance Review and a detailed action plan was prepared.

Other Clinical Services

20. The Women's Services Directorate is £216k overspent to date (£159k October 2008) with a £192k outturn position (£174k October 2008). The main overspending areas based are ward 4 nurse staffing (£98k), medical staffing (£50k), midwifery staffing (£29k) and ward 4 supplies (£25k).
21. Whilst mental health services have been reporting an underspend all year, this month the forecast position has increased to £461k underspent. Delays in appointing to new services and ongoing vacancies in nursing and administration, changes to medical staffing and savings on rehab staffing costs have all contributed to this underspend. This budget is under review to ensure the phasing of the additional resource allocated to mental health has been correctly reflected in financial planning. The service is actively recruiting to any filled substantive vacancies which will minimise the recurring underspend.

Reserves

22. The schedule of sums held for spending during 2008/09, but not yet released into budget, is set out in Appendix 5. The total at December 2008 is £6.039 million and has been reduced by the Finance Department's estimate of likely slippage on ring fenced projects of £0.948 million.
23. Appendix 6 provides a further update on the impact of the range of new initiatives, for which we have a full year's income (and in many cases ringfenced income from previous years), commencing part way through the year. 51% of the spend of new money allocated (£2.5 million) is currently forecast to take place in next financial year. Our ability to carry forward funding is most likely fixed at a maximum of £4.5 million. Accommodating this additional funding in our plans presents a challenge and is requiring us to bring forward a range of schemes that would otherwise have been scheduled for 2009 to attempt to balance expenditure between years.
24. Appendix 5 indicates that £1.4 million is being held for liabilities and service plans which are not yet sufficiently certain in order to release a fixed budget.

Risks

25. Although almost all staff have been assimilated on to Agenda for Change pay scales, a number of retrospective adjustments are due. Whilst provisions for this have been increased to reflect potential liabilities, the outcome of the review process is unlikely to be concluded until next financial year. A process has been introduced to reassess this each time further information becomes available.

26. Maintaining 24 hour medical cover against a backdrop of needing to reduce working time below 48 hours and the possibility of gaps in our allocation of doctors in training, represents a significant service risk with potential solutions involving substantial extra investment.
27. Progress on efficiency schemes, particularly in the waiting times redesigns initiatives, appears strong. Although there has been a downwards revision in estimates due to snagging with some of the utilities schemes and the nursing overspend, achieving the full £4.6 million efficiency target within 2008/09 should be possible.
28. The increased need to carry forward earmarked funding is placing our medium term financial plan under pressure.

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>
DIVERSITY ASSESSMENT	
N/A	

DUMFRIES AND GALLOWAY NHS BOARD

2 February 2009

**CAPITAL PLAN UPDATE****Author**

Susan McMeckan, Divisional Finance Manager

Sponsoring Director

Katy Lewis, Deputy Director of Finance

Date

22 January 2009

RECOMMENDATION

The Board is asked to note:

- the allocations received to date;
- the progress on approved schemes;
- the likely adjustments to the 2008/09 capital programme;
- the commitments made in the forward capital plan.

SUMMARY

Steady progress is being made with the Board's capital plan although a number of changes which affect the current year forecast have arisen since the last paper was presented at November Board including:

- The anticipated sales proceeds from the Garrick site will not be within this financial year.
- The land purchase associated with the Lochfield Road project is unlikely to progress in this financial year.

Dialogue has been maintained with the Scottish Government Health Department (SGHD) with regards to these changes.

Capital Allocation and Anticipated Receipts

1. Since the November Board, an additional £61k has been received for specific schemes, the implementation of mobile data protection (£32k) and Susceptibility testing equipment for Labs (£29k).
2. The sale of the Garrick site is not expected to be completed in 2008-09. Work continues to ensure the sale is advanced in due course.
3. Our income is now anticipated at £10,910k for 2008/09 as detailed in Appendix 1.

2008/09 Planned Expenditure and Progress to Date

4. The latest estimate submitted to SGHD indicates an annual spend level of £8,015k, a reduction of £871k from previously reported.

5. The main changes in expenditure forecasts relate to:
 - the delay in the land purchase for the Lochfield Road development, a reduction of £480k;
 - estimated savings from purchasing equipment through national contract, a reduction of £252k;
 - a number of projects have now completed and no further costs are anticipated, a reduction of £190k. Any small balances coming forward on these projects will be managed within the overall forecast.
 - timing of project expenditure on the A&E project, Family Planning & Sexual Health and Ophthalmic grants have been offset by accelerating expenditure on equipment, a net increase of £50k.
6. Appendix 2 sets out a summary of the budget approved at November Board, the adjustments proposed and the related expenditure to end of December 2008.
7. A brief update on the progress of all approved capital schemes is included as Appendix 3.

Forward Capital Plan

8. On the basis that the 2008/09 capital programme will proceed as set out in Appendix 2, the in-year carry forward will be £2,895k bringing the total available to support future priorities to £12,506k.
9. The carry forward would be used in the forward plans as set out in Appendix 4. This illustrates there is sufficient funding to cover existing commitments with £15.9 million left in 2012/13 to go towards further schemes including the very significant DGRI project.
10. Appendix 5 details the schemes which make up the future commitments summarised in Appendix 4. Any additional projects approved during this period will have a result in a reduction in capital availability for future years.

Areas of Financial Risk

11. Monitoring protocols are in place to ensure projects are progressed as speedily and efficiently as possible and forecasts are kept up to date on a monthly basis. Any further slippage in the programme will be managed by accelerating schemes throughout the year.

MONITORING FORM

Policy/Strategy Implications	Capital Plan, Property Strategy and IM&T Strategy
Staffing Implications	None
Financial Implications	Capital charge implications and revenue expenditure built into financial strategy
Consultation	Heads of Service and Project leads
Consultation with Professional Committees	Yes, as appropriate
Risk Assessment	No
Best Value	Yes - projects take cognisance of guidance
Compliance with Corporate Objectives	To continue to improve and upgrade the infrastructure that supports service delivery
DIVERSITY ASSESSMENT N/A	

**NHS Dumfries Galloway
2008-09 Capital Allocations Summary**

Appendix 1

	Total £k
<u>Received</u>	
Formula	9,951
<u>Additional Allocations</u>	
- Ophthalmic Equipment	195
- Kelloholm PCC	614
- GP Managed Technical Service withdrawl	50
- IT Equipment - SISCAG	5
- West of Scotland Adolescent Unit (topslice)	(69)
- Dental Decontamination	103
- Mobile data protection	32
- Susceptibility testing equipment	29
Total allocations/income received	<u><u>10,910</u></u>
<u>Anticipated</u>	
- Income from Sale of Property	0
Total Anticipated Capital Funds	<u><u>10,910</u></u>

2008-09 CAPITAL EXPENDITURE STATEMENT	2008-09			YTD Actual Prd 9 £000s	Expenditure outstanding £000s
	Approved Nov Board £000s	Adjustments proposed £000s	Approval requested Feb 2009 £000s		
	I.M. & T				
IM&T balance of approved Capital Budget	189		189	3	186
Clustering Considerations	61		61	61	0
Replacement Telephone System-Annan	0		0	0	0
Late Costs - 07/08 IM&T Projects	0		0	0	0
	250	0	250	64	186
Equipment					
Replacement Medical Equipment - Recurring	950	0	950	538	412
Replacement Medical Equipment - A&E Trolleys	107	1	108	108	0
Replacement Medical Equipment - Haematology	0	0	0	0	0
Replacement Medical Equipment - Analyser	165	0	165	0	165
Rolling Programme - General Equipment	50	30	80	18	62
Rolling Programme - Catering Equipment	50	23	73	73	0
Rolling Programme - X-ray Equipment	300	(16)	284	185	99
Angiography Equipment	823	(236)	588	0	588
CSSD Steriliser	45	0	45	45	0
CT Scanner	523	0	523	0	523
Ophthalmic Equipment	141	(52)	89	69	20
Susceptibility testing equipment	0	29	29	0	29
Late Costs - 07/08 Equipment Projects	0	0	0	0	0
	3,154	(221)	2,933	1,036	1,897
Estate					
Acute Mental Health Development	100	0	100	2	98
Family Planning & Sexual Health	471	(71)	400	104	296
DGRI A&E Refurbishment	0	110	110	0	110
DGRI Biomass Boiler	110	0	110	110	0
DGRI CT Scanner Rm	144	0	144	9	135
DGRI Dental Centre - Clinical Skills Room	120	0	120	103	17
DGRI Education Centre	516	0	516	334	182
DGRI MRI Scanner & Electrical Substation	886	(83)	803	803	0
DGRI Outpatients Department Entrance	65	(5)	60	60	0
DGRI Pre-Admission, Assessment and Admissions	63	1	64	64	0
DGRI Residences - valves	38	1	39	39	0
DGRI Theatre Upgrade - Ventilation	300	(45)	255	255	0
DGRI Traffic Management & Car Parking	350	0	350	114	236
DGRI X-Ray Refurbishment	355	0	355	269	86
DGRI/GCH Ophthalmology Redesign	169	(34)	135	135	0
Gatehouse Primary Care Centre	226	0	226	211	15
GCH - Helipad	58	(16)	42	42	0
Greencroft & Hospital Extension	604	0	604	589	15
Kelloholm PCC: Provisional	32	0	32	8	24
Lochfield Road GP Development	550	(480)	70	46	24
Nithbank Purchase of SAS Site	196	(9)	187	187	0
Late costs - 07/08 Estates Projects	24	(4)	20	11	9
	5,377	(635)	4,742	3,495	1,247
Additional schemes to be identified	105	(15)	90	0	90
TOTAL PROJECTS APPROVED	8,886	(871)	8,015	4,595	3,420

PROGRESS ON 2008/09 SCHEMES

IM&T

Steady progress is being made with the implementation of the agreed IM&T development programme. The key development areas include:

Acute Operational Services Support

- Bed Management deployed across DGRI and Community Hospitals
- Digital Dictation (Winscribe) deployed to 270 doctors
- Digital Letter production facility, integrated to TOPAS
- eReferral (HEAT Target) to streamline referral management directly from GP system to TOPAS system
- Establish Document Management in Occ Health services and A&E Departments

Hospital Wide Services

- To complete the roll-out of the new Secure DG Network.
- To deploy Single sign on technologies
- To replace Main Data Stores with Larger capacity and replicated services
- To provide CHI access/label printing facilities where required
- PC upgrade programme – over 479 PCs will be replaced/upgraded and remote management support facilities installed.
- 5 Health Centre/Community Hospital Telephone systems being replaced

Primary Care Services

- Nine GP server replacements
- 287 New PCs installed
- New networking equipment deployed to all GP practices
- 7 GP telephone systems being replaced
- Complete all GP practices to work with Document Management systems
- Carry out full DR checks on all Remote Servers

Security

- Address all aspects of the new Scottish Government mobile security management policy
- Implement new Information Governance ways of working

Major Developments

- Prepare for work programme to digitise the paper Case Note (pilot study in Mental Health)
- Procure a new Laboratory system
- Prepare for upgrading Computing infrastructure with a virtualized Server environment

Information Services Developments

- Complete work on new reporting environment for major activity monitoring purposes.
- Improve the management of Waiting times through the production of New Ways data
- To commence work to address the 18WRTT data collection challenges

No slippage is anticipated on this programme which covers both capital and revenue expenditure.

Further schemes

Two additional papers have been developed to seek support to progress:

- video conferencing equipment for a number of areas within the organisation.
- a web based electronic dashboard for providing high level indicators across the organisation.

If these are successful funding will be required in this financial year.

EQUIPMENT

2008-09 Replacement Medical Equipment. Equipment purchases are continuing to ensure the programme remains within target to spend the £950k allocation. Any slippage is being managed by reprioritising other medical equipment requirements.

2007-08 Approved Medical Equipment. The Lab analyser has now been ordered with delivery expected in January 2009.

Catering Equipment. The phased work on the DGRI canteen continues with work to be completed by the end of 2008-09. Additional funding has been pulled forward to allow all the required equipment to be purchased.

X-Ray Equipment. The £300k allocation for X-ray equipment has been used to purchase a DR System required for the completion of Phase 2 of the refurbishment. The purchase of the Ultrasound Machine of national contract is underway bringing a slight saving on this.

Angiography Equipment. Work is progressing for the procurement of this equipment, the company has been selected however a number of options still to be selected by clinicians. Delivery will be before the 31 March 2009. Costs are expected to be less than budgeted.

CT Scanner. Tender work is complete and site visits about to commence, company has been selected, delivery during March 2009. Costs are less than budgeted, savings from national contract.

General. Additional funding has been allocated to support the costs of additional schemes including an obese body store for the mortuary, a scissor lift at the loading bay.

Susceptibility Testing Equipment. Additional funding was received from SGHD for the purchase of the equipment for the Laboratories. This has been procured and is undergoing testing prior to payment of invoice.

ESTATES

Acute Mental Health. The appointment of the preferred Principal Supply Chain Partner (PSCP) under the Framework Scotland arrangement took place in January 2009. The successful company Laing O'Rourke will now work with us to progress final OBC approval from the Scottish Government to allow us to move onto preparation of the FBC. The original timescale for completion by January 2011 are still seen as realistic for this project.

Family Planning and Sexual Health. Project to extend Laurel Bank on schedule and within budget. Completion expected mid May 2009.

CT Suite. Project underway from January 2009 with completion planned for end of March 2009. Hire of mobile CT unit for 5 weeks maximum within that time frame.

Education Centre. Work is progressing well with this scheme, anticipated completion date mid May 2009, 10 weeks earlier than planned and within budget.

Traffic Management. The work to the East car park is progressing on programme and due to be completed by the last week of February. Thereafter, work will move onto the North car park for about 4 weeks with completion due by the end of March 2009.

X-Ray. Phase 3 (final) is progressing well and completion is still anticipated within this financial year. The mobile Cath Lab has been operational one day per week during this phase and will continue until end of Phase 3 works.

Kelloholm PCC. The project management of this proposal has now been passed to the Council. It is intended that plans and tender documentation be developed this year with the aim of appointing a contractor and commencing work in early April.

Lochfield Road. Planning application submitted. Purchase of site continues to progress slowly, the budget for the land purchase has been removed from the 2008-09 forecast due to the risk of not concluding before 31 March 2009. Assuming approval of PTCC, tenders sought mid March to mid April '09 with a start on site at end May 2009. Allowing a contract period of 18 months gives an estimated handover in early November 2010. Four weeks for commissioning means that the facility will be open to patients before Christmas 2010.

SCHEMES – NOW COMPLETE

Biomass Boiler.

Dental Centre – Clinical Skills Room

Electrical Substation.

MRI.

Ophthalmology Redesign.

Outpatient Department Entrance.

Pre Admission, Assessment and Admissions Unit.

Residencies – Valves.

Theatres.

Gatehouse Health Centre. .

GCH Helipad. .

Greencroft.

SAS Nithbank Site.

SCHEMES - BUSINESS CASE PROGRESS

DGRI. Revised proposals for the modernisation programme are now under development and the Initial Agreement has been approved by Capital Investment Group. The appointment of the preferred Principal Supply Chain Partner (PSCP) under the Framework Scotland arrangement took place in December 2008. The successful company BAM will now work with us to develop the Outline Business Case for August 2009.

	Prior Yrs	2008/09	2009/10	2010/11	2011/12	2012/13
	£k	£k	£k	£k	£k	£k
<i>Allocations</i>						
Formula		9,951	10,089	10,229	10,229	10,229
Further allocations anticipated		959	1,858	1,070	0	0
Income from Sale of Property		0	450	0	0	0
		10,910	12,397	11,299	10,229	10,229
<i>Commitments</i>						
IM&T		250	1168	250	250	250
Equipment		2,933	1,302	1,250	1,250	1,250
Estate projects*		4,832	10,993	14,138	8,405	250
		8,015	13,463	15,638	9,905	1,750
Under/(Over) Commitment		9,611	2,895	(1,066)	324	8,479
Cumulative Unallocated Capital		9,611	12,506	11,440	7,425	15,904

Notes

* This does not include the DGRI Redevelopment project, residences or any other project not specifically listed in Appendix 2.

DUMFRIES & GALLOWAY NHS BOARD - 5 YEAR PLAN

APPLICATION	2009-10	2010-11	2011-12	2012-13	2013-14
	£000s	£000s	£000s	£000s	£000s
Rolling Programmes					
IM&T	250	250	250	250	250
Medical Equipment	950	950	950	950	950
General Equipment	50	50	50	50	50
Catering Equipment	50	50	50	50	50
X-ray Equipment	200	200	200	200	200
Estates	250	250	250	250	250
	1,750	1,750	1,750	1,750	1,750
Schemes approved					
Acute Mental Health Development	7,070	11,929	8,155	0	0
Family Planning & Sexual Health	204	0	0	0	0
DGRI Education Centre	49	0	0	0	0
Kelloholm PCC: Provisional	556	53	0	0	0
Lochfield Road GP Development	2,864	1,906	0	0	0
Ophthalmic equipment	52	0	0	0	0
	10,795	13,888	8,155	0	0
Schemes expected to go ahead					
IM&T Additional schemes	918	0	0	0	0
	918	0	0	0	0
TOTAL APPLICATION	13,463	15,638	9,905	1,750	1,750

Other schemes currently being worked up					
Carbon Management programme	268	428	0	0	0
DGRI Aseptic Suite	0	0	0	0	0
Labs system replacement	0	0	0	0	0
Additional schemes	0	0	0	0	0
	268	428	0	0	0

DUMFRIES AND GALLOWAY NHS BOARD**2 FEBRUARY 2009****WAITING TIME AND ACTIVITY REPORT****Author**

Jennifer Watt, Divisional Finance Manager

Sponsoring Director

Jeff Ace, Director of Health Services

Date

26 January 2009

RECOMMENDATION

The Board is asked to note the content of this report.

SUMMARY

This report summarises activity and waiting times performance relating to NHS Dumfries and Galloway residents as at 31st December 2008. It also compares activity levels with the same period in the previous year.

1. BACKGROUND

NHS Dumfries and Galloway has agreed local access targets with the Scottish Government's Performance Directorate.

Inpatients, Day Cases	12 weeks from GP referral to a first outpatient appointment from 31 st March 2009
Outpatients	12 weeks from GP referral to a first outpatient appointment from 31 st March 2009
8 Key Diagnostic tests	no patient to wait longer than 4 weeks for one of the tests from 31 st March 2009

(The National access targets for the same time frame are 15, 15 and 6 weeks respectively.)

In addition to these the following targets remain in place:-

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

2. ACTIVITY

The activity schedule (Appendix 1) gives an indication of the activity throughout NHS Dumfries and Galloway for the period to 31st December 2008.

The trends of previous months continue with the emergency activity continuing at a higher level than the previous year. (December emergency activity 8% higher than previous year) This increase continues to contribute to the bed pressures at DGRI in particular. Accident and Emergency activity shows little variation from previous year.

3. CURRENT WAITING TIMES

Position as at December 2008

Appendix 2 shows the end of December waiting times position using the 'new ways' methodology.

There were no breaches of the 18 week target in either outpatients or inpatients and day cases.

The locally agreed 15 week target for both inpatient/day cases was achieved. However there were three breaches of the outpatient 15 week local target for December 2008.

There were two breaches in Oral Surgery and one in Orthopaedics. An unforeseen change in clinic date did not allow a 'reasonable offer' to be made i.e. giving three weeks notice of change in all three cases. Due to software reporting issues this was not highlighted early enough for adequate remedial action to be set in place. It should be noted that one of these patients will also breach the January 2009 15 week target as they have chosen to have their appointment in February.

The software reporting issue that prevented these breaches being highlighted soon enough to rectify within the 'new ways' rules has been resolved to ensure this does not reoccur.

Return outpatients

The table highlights the ongoing capacity issues regarding return outpatients within various specialties.

Specialty	Number >8 weeks optimum date (14/1/09)	Number >8 weeks optimum date (June 08)	Action
Endocrinology	189	186	Locum Consultant input has helped to reduce growth. Review of service continuing.
General Medicine	97	141	
Ophthalmology	426	150	Looking at potential of additional clinics to address issue in short term
Orthodontics	403	323	Validation of for treatment waiting list now nearing completion. Re-advertising consultant post.
	1115	800	

Diagnostics

There are 6 breaches of the 9 week target of referral to reporting. These were all in MRI.

HEAT targets

Appendix 3 shows the current position against HEAT targets in inpatients/day cases, out patients and diagnostics. It is encouraging to see the near achievement of the 15 week targets and the continued reduction towards the achievement of a 12 ,12 and 4 targets.

Accident and Emergency Waiting Time

The overall 4-hour performance for NHS Dumfries & Galloway was **98%** in December 2008. This is the eighth consecutive month that the system has achieved 98% or higher performance. Early analysis of January data shows a substantial increase in waits for available beds that has increased breach numbers and it is possible that we will fail to achieve 98% for the first time since February 2008.

4. CONCLUSION

The increased non elective activity continues to put a strain on the system. However there continues to be a focus on achieving and maintaining all waiting times targets and maximising the effect of the funding used.

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 8</i>
Diversity Assessment	<i>None required</i>

NHS Dumfries and Galloway

Comparison of Activity April to December 2007 & 2008

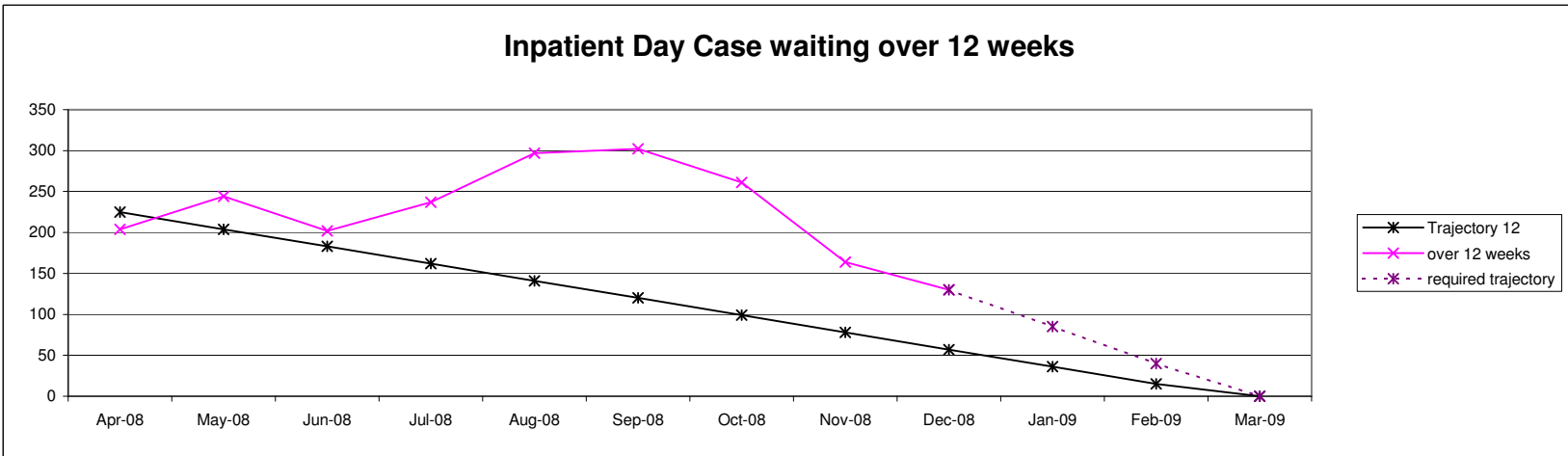
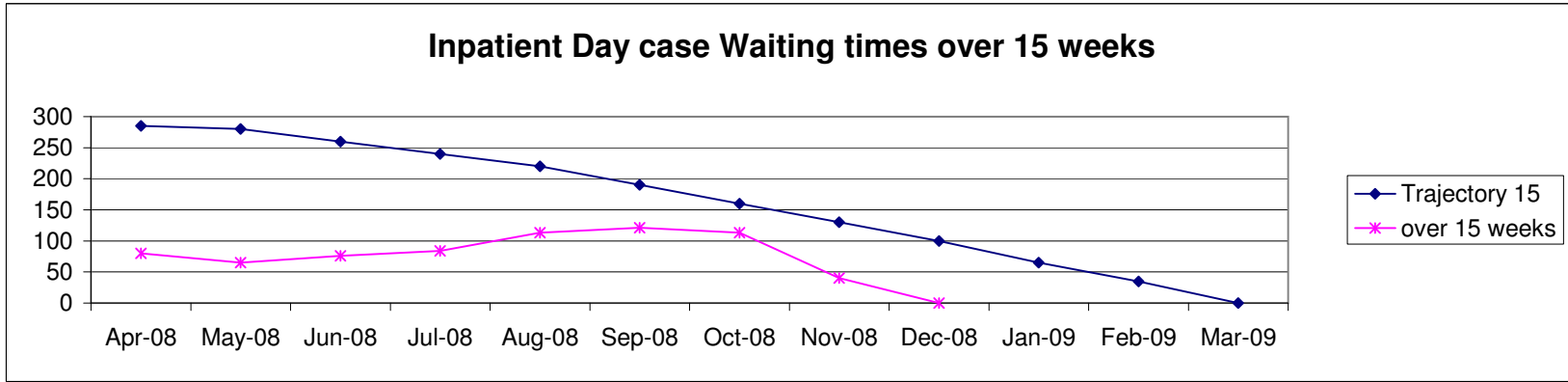
		April to Dec 2007	April to Dec 2008	% Variance
Elective	(Acute, Maternity and Geriatric)			
	Inpatients	5,873	5,669	-3.5%
	Day Cases	11,107	11,528	3.8%
	Day Patients (Haemodialysis)	6,386	6,347	-0.6%
	New Out patients	25,694	26,976	5.0%
	Return Outpatients	52,220	55,227	5.8%
Emergency	(Acute, Maternity and Geriatric)			
	Inpatients	13,577	14,063	3.6%
	A&E	37,485	37,447	-0.1%
Births		1,102	1,067	-3.2%
Community Hospitals				
	Occupied bed days	29,768	31,076	4.4%
Mental Health	(General & Psychogeriatric - CRH)			
	Inpatients	392	395	0.8%
	Occupied bed days	20,011	17,604	-12.0%
Labs		1,714,938	1,876,683	9.4%
Radiology (GP referral based activity)		11,786	11,665	-1.0%

Inpatients and Day Cases Total					
	between 0 and 12 weeks	between 12 and 15 weeks	over 15 weeks	over 18 weeks	Total
ALL	1867	143	0	0	2010
Percentage of total waiting made up of	93%	7%	0%	0%	
Cardiology	29	0	0	0	29
Community Dental	50	2	0	0	52
ENT	115	7	0	0	122
Gastroenterology	10	0	0	0	10
General Medicine	18	0	0	0	18
General Surgery	409	34	0	0	443
Gynaecology	113	13	0	0	126
Medical Paediatrics	8	0	0	0	8
Neurology	7	0	0	0	7
Ophthalmology	265	1	0	0	266
Oral Surgery	319	33	0	0	352
Pain Relief	26	7	0	0	33
Rehabilitation Medicine	2	0	0	0	2
Trauma & Orthopaedics	414	45	0	0	459
Urology	82	1	0	0	83
	1867	143	0	0	2010

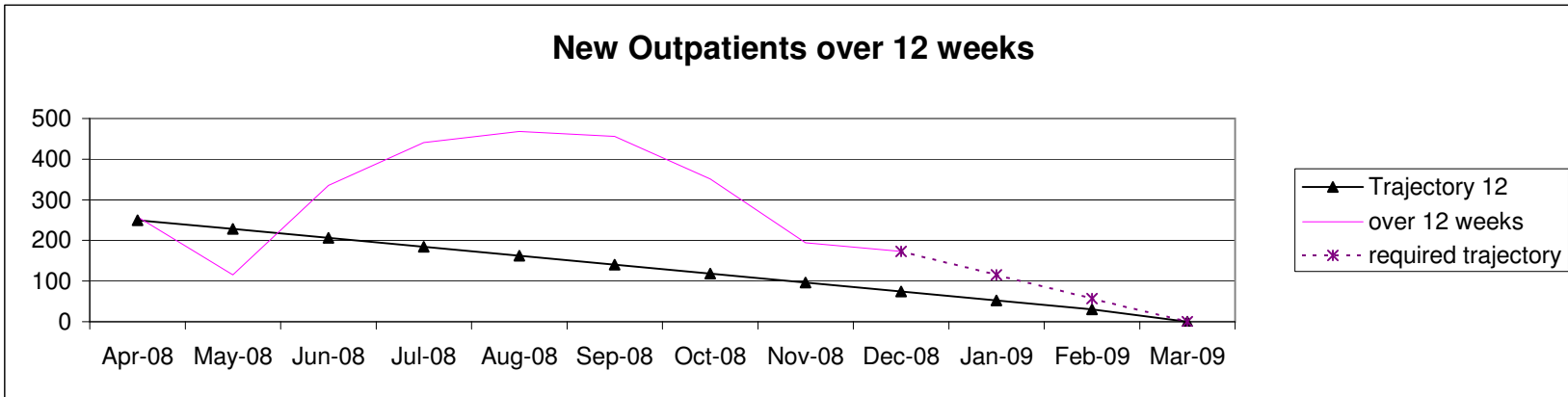
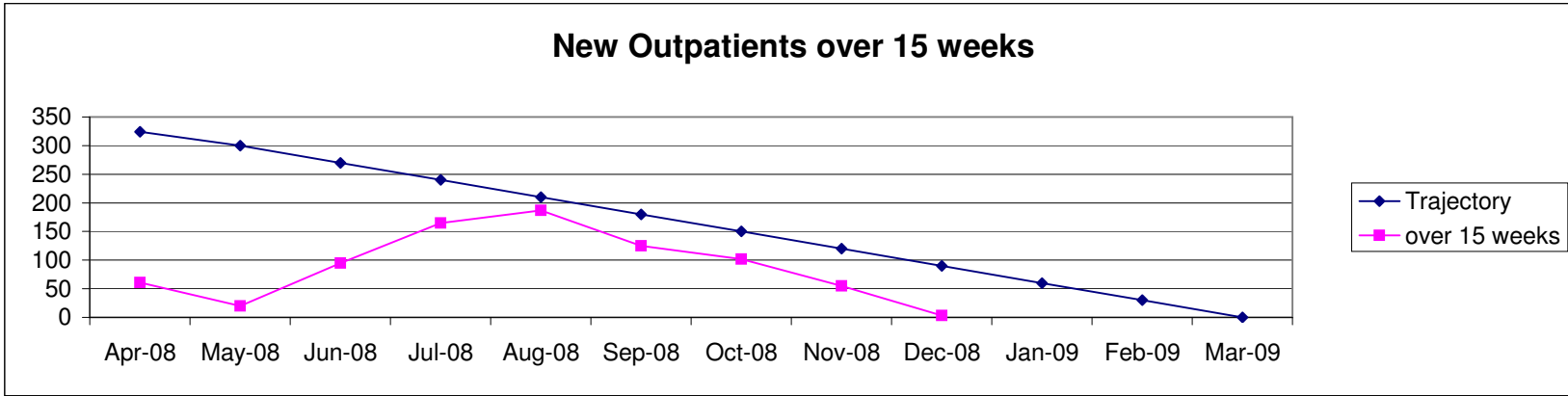
Outpatients					
	between 0 and 12 weeks	between 12 and 15 weeks	over 15 weeks	over 18 weeks	Total
ALL	4620	172	3	0	4795
Percentage of total waiting made up of	96.4%	3.6%	0.1%	0.00%	
Anaesthetics(Pain)	81	1	0	0	82
Cardiology	260	14	0	0	274
Clinical Oncology	13	0	0	0	13
Dermatology	194	0	0	0	194
Endocrinology & Diabetes	141	6	0	0	147
ENT	340	15	0	0	355
Gastro enterology	108	0	0	0	108
General Medicine	206	3	0	0	209
General Surgery	501	3	0	0	504
Geriatric Medicine	25	0	0	0	25
Gynaecology	362	11	0	0	373
Haematology	21	0	0	0	21
Medical Paediatrics	119	1	0	0	120
Nephrology	8	0	0	0	8
Neurology	107	5	0	0	112
Ophthalmology	552	2	0	0	554
Oral Surgery	262	2	2	0	266
Orthodontics	173	3	0	0	176
Palliative Medicine	1	0	0	0	1
Rehabilitation	11	0	0	0	11
Rheumatology	70	0	0	0	70
Trauma & Orthopaedics	863	97	1	0	961
Urology	202	9	0	0	211
	4620	172	3	0	4795

Diagnostics					
	between 0 and 4 weeks	between 4 and 6 weeks	over 6 weeks	over 9 weeks	Total
Upper Endoscopy	123	23	1	0	147
Lower Endoscopy	20	0	1	0	21
Colonoscopy	66	14	0	0	80
Cystoscopy	56	16	2	0	74
CT Scans	97	5	0	0	102
MRI	149	51	4	6	210
Ultrasound	278	63	9	0	350
Barium Studies	11	2	0	0	13
	800	174	17	6	997
Percentage of total waiting	80%	17%	2%	1%	

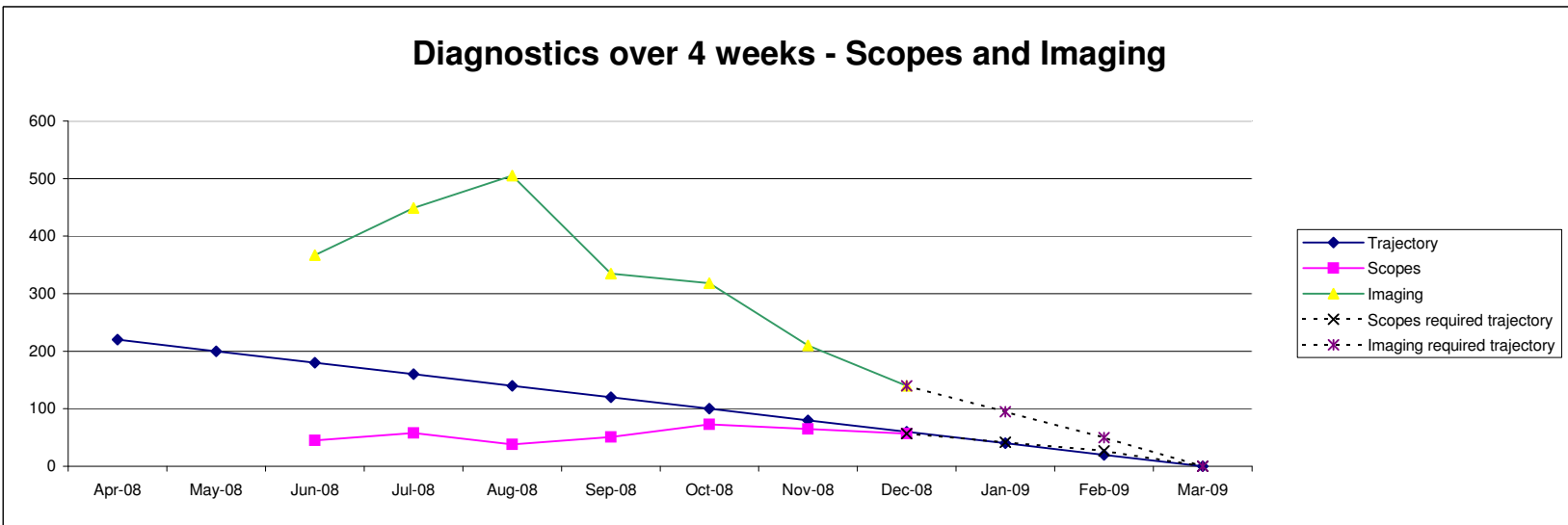
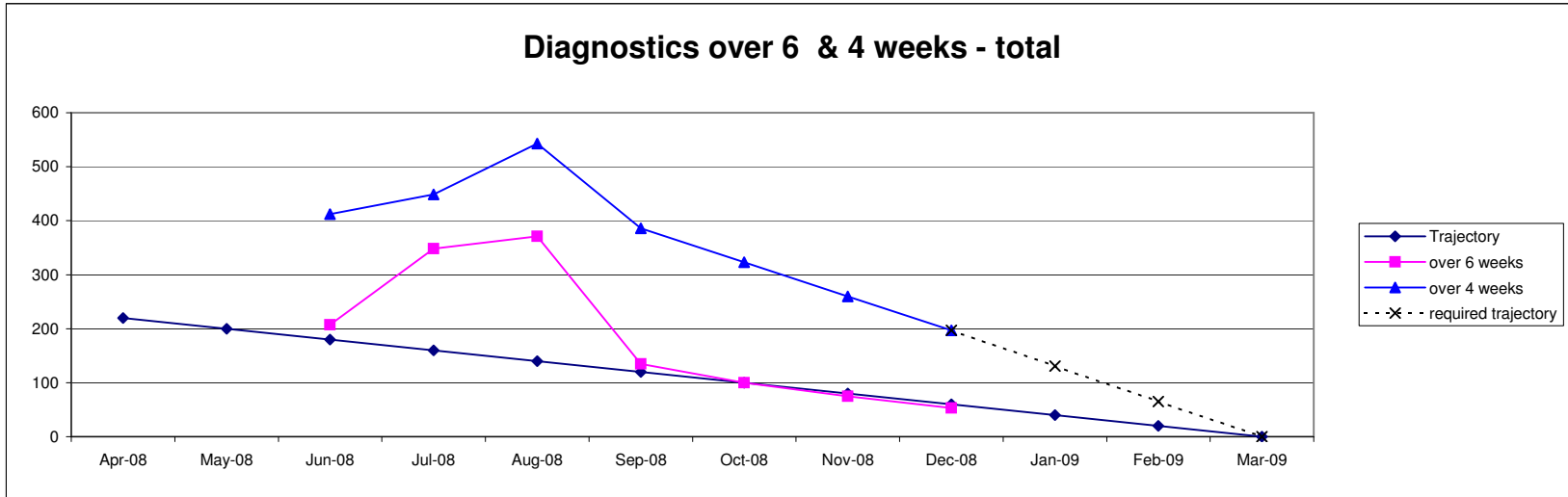
Dumfries and Galloway NHS



Dumfries and Galloway NHS



Dumfries and Galloway NHS



DUMFRIES AND GALLOWAY NHS BOARD

2 FEBRUARY 2009

**ACCIDENT AND EMERGENCY DEPARTMENT ALTERATIONS****Author**

John Knox, General Manager – Acute Services

Sponsoring Director

Jeff Ace, Director of Health Services

Date

20 January 2009

RECOMMENDATION

The Board is asked to note the current position with regard to the “A&E Departmental Alterations” Project, approved at meeting of the December 2008 NHS Board.

SUMMARY

This project (*costing £659k*), which commenced on 19th January 2009, following the decant of several services/staff which were previously located in A&E to other areas within the hospital, is expected to be completed within 13 weeks ie end-April. This smaller scale refurbishment was an interim solution to address the most pressing needs of the department, following on from the Board’s decision to discount the £4 million 16 month major proposal to redevelop the A&E, in view of the future plans for the refurbishment of DGRI.

The refurbishment (*also including provision of dedicated accommodation for Patient Focused Booking/NHS 24 and improvements to the Alexandra Unit showers and bedrooms*) will provide for A&E:

- A dedicated A&E X-ray facility, providing service to A&E, orthopaedic out-patients and general out of hours X-ray cover for the DGRI wards
- Improved layout of the resuscitation suite
- Improved environment in the waiting area, including creating a directly accessible toilet near the entrance to A&E
- Redevelopment of the old orthopaedic area to create a facility for the streaming of patients into minor/major flow groups
- A dedicated waiting space for the X-ray room
- Conversion of the 6 existing assessment and treatment cubicles to 4 larger cubicles
- Upgrading of flooring and ceiling tiles in line with control of infection guidance
- Upgrading of the duct work (not plant) associated with the ventilation and medical gases

PROGRESS

The A&E Working Group, which developed this revised proposal, has continued to meet to oversee the refurbishment. This group now consists of representatives from A&E consultant/nursing, radiology, medical records, estates, infection control and xchange network.

Although the desired timetable for completion was 31st March 2009, the work will extend partly into 2009/10. A detailed timetable, consisting of 4 phases which will allow services to continue during the duration of the work, has been agreed. This is summarised below:

Phase 1

- Patient Focused Booking/NHS 24: provision of new office accommodation/call centre for 10 people. To be used throughout the day by 10 PFB staff and at night by 5 NHS 24 staff.
- Disabled toilet in A&E waiting area.
- Minor Injuries Unit: 4 new treatment rooms and an office. Double access doors from waiting area to minor injuries unit.
- Alexandra Unit showers and bedrooms. Replace 9 defective showers to provide adequate drainage. Replace carpets with vinyl in bedrooms. This element of the project will take 13 weeks.
- New store area for CBRN equipment.

Phase 2

- Convert 6 existing treatment rooms to 4 new larger treatment rooms.
- Upgrade existing shower and disabled toilet.
- New staff changing area/locker area.

Phase 3

- Renovate waiting area (*entrance end*); to include new flooring, ceilings and lighting.
- New double reception desk with disabled access.
- Upgrade existing reception office.

Phase 4

- A&E entrance. Replace flooring, ceiling and lighting.
- Renovate waiting area (*plaster room end*); to include new flooring, ceilings and lighting.

Appendix 1 sets out the proposed works on a floor plan.

BENEFITS

The undernoted is a brief description of the benefits the refurbishment will provide to the service –

- *A dedicated A&E X-ray facility, providing service to A&E, orthopaedic out-patients and general out of hours X-ray cover for the DGRI wards. This will include a dedicated waiting space for the X-ray room:*

Provision of a 24 hour X-ray facility within A&E will significantly contribute to patient flow as well as patient and staff safety. The A&E X-ray room will become the default facility for the whole hospital during the out of hours period. This will allow clinical activity to be concentrated to a more secure and convenient environment.

- *Improved layout of the resuscitation suite, together with conversion of the 6 existing assessment and treatment cubicles to 4 larger cubicles:*

The changes to the resuscitation areas and cubicles will provide proper space around patients for staff and equipment to work safely. Under the current layout there is space for only a single resuscitation bay. This can lead to rationing of the access to the resuscitation room on an almost daily basis. The planned improvements allow for two properly equipped resuscitation bays with facilities for advanced airway interventions.

- *Improved environment in the waiting area including creating a directly accessible toilet near the entrance to A&E. Also included is the upgrading of flooring and ceiling tiles in certain areas of the department, in line with control of infection guidance:*

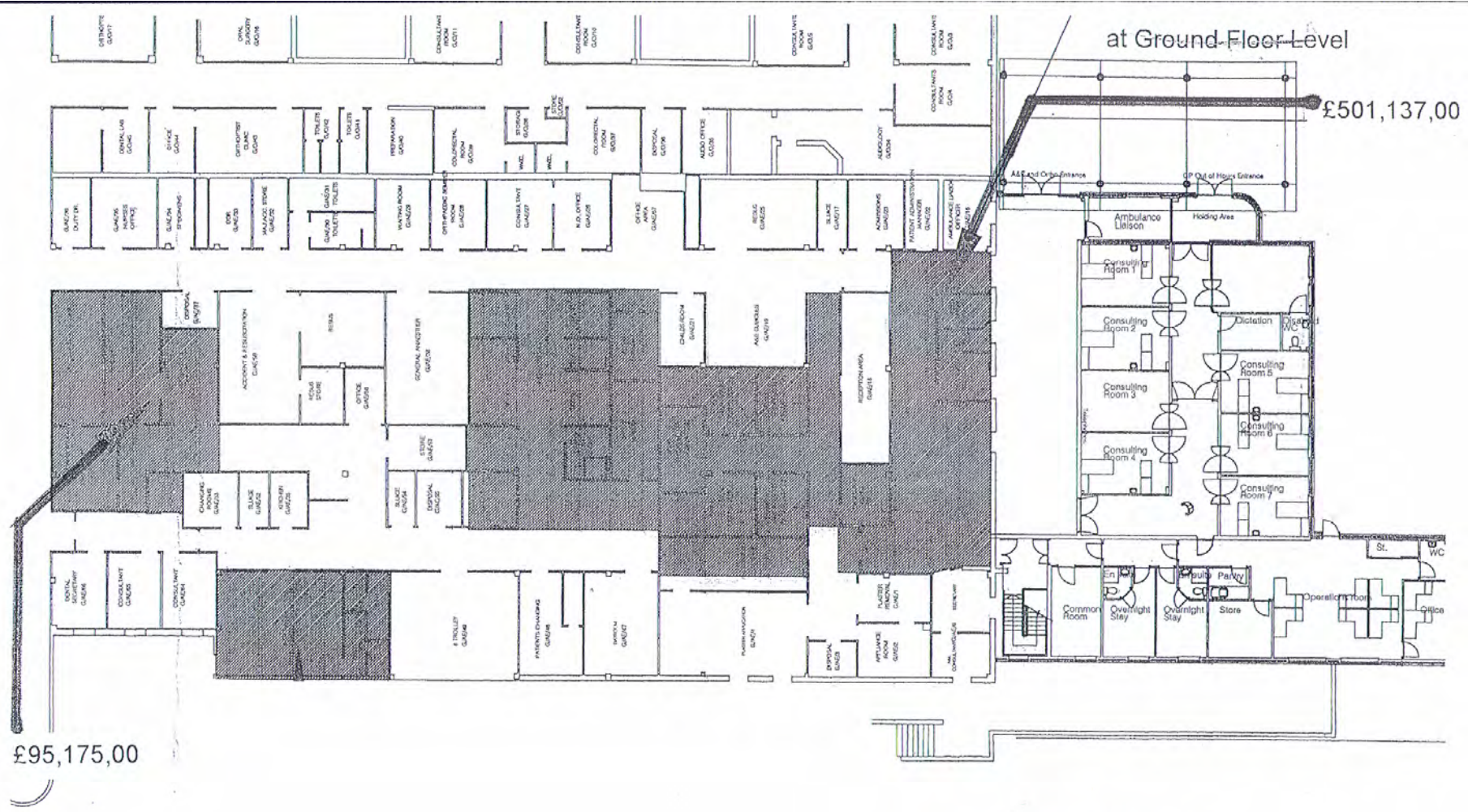
The improved environment part addresses patient experience and has an element of reducing risk of infection. Significant areas of the A&E department have been partitioned with temporary plasterboard walls. These were never envisaged as long-term structural elements and have begun to deteriorate markedly. The scheme also creates an easily accessible patient toilet.

- *Redevelopment of the old orthopaedic area to create a facility for the streaming of patients into minor/major flow groups:*

The conversion of the orthopaedic area is to allow service redesign. A move towards streaming of patient flow into 'majors' and 'minors' will allow far more efficient processing of patients, particularly important at times of peak demand. Efficient use of staff will allow focusing of resources to high acuity patients in the major area leading to improvements in patient safety and quality of care. The adoption of this way of working is an essential step towards the proposed new 'acute assessment' model of care.

Monitoring Form

Policy/Strategy Implications	Delivering emergency services within DGRI
Staffing Implications	No change in staffing numbers
Financial Implications	Funding confirmed
Consultation	Direct service involvement alongside estates and control of infection
Consultation with Professional Committees	See above
Risk Assessment	Decant planning now complete Plan is phased to allow continuity of services
Best Value	Yes – governance arrangements, option appraisal, competitive tendering, etc.
Compliance with Corporate Objectives	To promote and embed continuous improvement Delivering efficient services
DIVERSITY ASSESSMENT	
N/A	



at Ground-Floor-Level

£501,137,00

£95,175,00

Costs include VAT
but not professional fees

Appendix 1

DUMFRIES AND GALLOWAY NHS BOARD

2 February 2009


NHS BOARDS: PUBLIC HEALTH ALLOCATION 2008-09 – ADDITIONAL RESOURCES FOR ALCOHOL TREATMENT

Author Jim Parker, Lead Officer –
Substance Misuse

Sponsoring Director
Dr Derek Cox
Director of Public Health

Date: 15 January 2009

RECOMMENDATION

The Board is asked to note

- progress being made towards the delivery of the Alcohol Brief Intervention HEAT target;
- progress made in the delivery of the Local Alcohol Action Plan during 2008-09; and
- and agree the further proposals and spending plans for the Local Alcohol Action Plan for 2009-10.

SUMMARY

At its meeting of 7 July 2008 the Board considered a paper advising of the additional resources being made available by the Scottish Government to provide alcohol treatment services for the three year period 2008-09 to 2010-11 and the accompanying HEAT target for alcohol brief interventions for this Board area' The Board agreed the spending proposals contained within said report for 2008-09.

This paper advises the Board of progress and service developments over the past six months and seeks agreement to the spending and service development proposals for 2009-10.

INTRODUCTION

1. At its meeting of 7 July 2008 the Board was advised of a new HEAT target which had been introduced for the cumulative delivery of Alcohol Brief Interventions for each NHS Board area over the three year budget period 2008-09 to 2010 - 11.
2. Accompanying this new HEAT target were additional resources provided to NHS Boards to assist them in meeting their HEAT targets and to develop the appropriate 'downstream' services to help secure and maintain sensible and appropriate drinking levels throughout the community.

3. The allocations for NHS Dumfries and Galloway were as follows:

2008-09	£898,000 (confirmed)
2009-10	£1,136,000 (projected)
2010-11	£1,244,000 (projected)
4. A three year development plan was presented to the Board. However, given the large sums being invested in Dumfries and Galloway and the requirement to meet the HEAT targets as set by Government, the Board only agreed the spending plans presented for 2008-09 and requested that papers be brought forward before the commitments for 2009-10 and 2010-11 were agreed.
5. This report provides the Board with information on the progress being made towards meeting the prescribed HEAT target and the information they require to take an informed decision on the proposals for allocation of the resources for alcohol treatment services coming to Dumfries and Galloway in 2009-10.

H4 HEAT TARGET

6. Significant progress is being made in pursuit of the HEAT target.
7. The target is to achieve an agreed number of screenings using a setting appropriate screening tool and appropriate brief interventions in line with SIGN Guideline 74 by the end of 2010-11. The target is seen as incremental in nature and the reporting requirement for 2008-09 is simply the number of brief interventions that have been delivered.
8. The targets for Dumfries and Galloway by the end of 2010-11 are to achieve 23,237 screenings and 4,357 brief interventions. As of 31 December 2008 there had been 915 screenings and 294 brief interventions delivered.
9. The infrastructure to deliver the target is being constructed and includes the following:

9.1 Development of a Local Enhanced Service (LES)

An LES has been introduced as of 1 January 2009. At the time of writing fourteen GP practices regionwide have contracted to provide this enhanced service. The expectation is that all Practices will sign up to deliver the service.

Payment per brief intervention under the LES has been set at £60 for each completed intervention. During the pilot phase for this method of delivering services the payment was set at £200 for each completed intervention. This reduced payment reflects the range of community supports developed to support the work of general practitioners and further quantification of the requirements of a brief intervention. As previous budgets were calculated using the higher payment, further resources are being freed up to develop an even greater range of community supports for those who have addressed or are addressing their drinking problems. We will also be targeting early intervention and prevention strategies which are further discussed below.

9.2 Direct Support for General Practice

A software package has been purchased and its installation and development costs offered free of charge to each Practice. This package, Bluebay, offers a range of supports to general practice. It gives prompts to GPs when alcohol may be a factor in a patient's presentation, it reminds GPs when reviews are due, it collects and collates the information on activity required for reporting to Government and it can generate invoices for payments for work completed. Unfortunately Bluebay is not fully compatible with the IT systems used by a handful of Practices in Dumfries and Galloway and we are working on modifying the package so that it will be universally applicable.

By calculating the number of adult patients registered with each Practice as a percentage of those registered across Dumfries and Galloway and then applying this percentage to the HEAT Target we have been able to advise each Practice of the minimum numbers of screenings and brief interventions they should be intending to deliver each month. This information will assist us to reach our HEAT Target and allow us to intervene early with those Practices who are not meeting the targets.

9.3 Training

The Government have informed us that only brief interventions delivered by appropriately trained staff can count towards the HEAT Target. We had eight members of staff put through a 'Training for Trainers' course delivered by Health Scotland and thus managed to offer training to a few key staff across Dumfries and Galloway. We have identified and secured funding to employ a full time trainer for two years to accelerate this process. At the present time we have estimated that over five hundred members of staff will require to be trained (doctors, nurses, midwives, pharmacists and dentists). A programme is being developed and should begin to deliver by April or May of this year. By increasing the pool of appropriately trained staff we anticipate a corresponding and accelerating increase in the numbers of brief interventions being delivered.

The local training programme will be delivered in partnership between a voluntary sector partner and colleagues from within the PAL Centre.

9.4 Acute Care

9.4.1 Ante-Natal

Plans are well advanced to begin delivering screenings and brief interventions in ante-natal settings in Dumfries and Stranraer in the very near future. Working alongside nurse managers, we have identified appropriate screening tools, staff training needs, backfill costs, IT support requirements and the administrative support required to put an appropriate, costed structure in place.

9.4.2 Accident and Emergency

Discussions have begun with nurse managers on the structures required to deliver screenings and brief interventions in Accident and Emergency settings. In addition, the Alcohol Liaison Nurse post, based at Dumfries and Galloway Royal Infirmary (DGRI) to help

facilitate the delivery of brief interventions in Accident and Emergency has been recruited to. Clearly the nature and demands of the service are different from that of the ante-natal setting discussed above. It is probable that we will need to provide staff hours input at peak periods (week-ends, week-end overnights) to enable the service to cope with our needs as well as the service developments proposed above for ante-natal care settings. Once again, we expect to be able to have the appropriate structure in place in the very near future.

FUTURE DEVELOPMENTS

10. The Scottish Government is currently piloting delivery of brief interventions in other NHS and non-NHS settings including within pharmacies, dental surgeries, Scottish Prison Service, Criminal Justice Social Work settings and generic social work settings. Outcomes from the pilots should be published during 2009 and, locally, we would intend to incorporate recommendations into our 2010-11 Action Plan which will be presented to the Board for their agreement in a year's time.

REVISED TARGETS

11. Given the development of the infrastructure to deliver brief interventions already outlined to the Board, the introduction of the LES, the plans in ante-natal care and accident and emergency settings, the impetus now apparent in delivering such services and the rapid expansion in staff trained to deliver brief interventions, the milestones now set to deliver the HEAT Target are as follows:

by 31 st March 2009	500 delivered
by 31 st March 2010	2,000 delivered
by 31 st March 2011	4,357 delivered

The Board may wish to be regularly advised of the progress being made against these (numerical) targets.

COMMUNITY SERVICES TO SUPPORT PRIMARY CARE

12. In circumstances where a brief intervention is not sufficient to address a patient's drinking related difficulties it is important that other services are available which do so.
13. Each of the four former districts of Dumfries and Galloway now has in place a community nurse who provides, manages and monitors a community detoxification service and a counsellor, provided by voluntary sector partners, who offers a confidential one-to-one counselling service which focuses on the issues associated with problem drinking. During 2008-09 over 170 patients have been referred to the counselling service.
14. At its July 2008 meeting the Board agreed to the development of a relapse prevention service starting in the east of the region and developing in the west during 2009-10. This service, provided by voluntary sector partners, will work alongside primary care and community based services and address the practical day to day issues faced by problem drinkers, including debt management, accommodation related issues, relationship related issues and basic life

management skills, all geared towards minimising the probability of relapsing into former behaviour patterns. Recruitment has taken place for this service but as yet it is too soon to provide the Board with any feedback as to activity or outcomes. We do believe, however, that this service will be key to ensuring patients maintain either an abstinent or sensible drinking regime in their lifestyle.

15. The further development of community services is discussed later in this paper.

ALCOHOL ACTION PLAN 2008-09

16. The plan presented to the Board in July 2008 is summarised in Appendix 1 to this paper and the costings in Appendix 2.

17. Whilst there has been some slippage with recruitment, the plan has been almost fully delivered. Systems have been put in place to monitor both activity and outcomes wherever possible and reporting arrangements agreed with partner agencies. This information will be available to the Board in future reports if they so wish.

ALCOHOL ACTION PLAN 2009-10

18. The developmental proposals for 2009-10 can be seen in Column 2 of Appendix 2 and include the following:

- 18.1 Nurse Manager for the Specialist Substance Misuse Service in the west of the region.
- 18.2 Dual Diagnosis/Alcohol Liaison Nurse for the west of the region offering a service to Galloway Community Hospitals.
- 18.3 Occupational Therapist (Substance Misuse) to enhance relapse prevention strategies in the west of the region.
- 18.4 Further development of a regionwide relapse prevention service.
- 18.5 Provision of backfill / locum costs for staff required to undergo Brief Interventions training.
- 18.6 Provision for additional resources allocated to Accident and Emergency Service if required.
- 18.7 Administrative support to Acute Care to collect the information regarding brief interventions in pursuit of the HEAT Target.
- 18.8 Resources for local Alcohol and Drug Community Forums to develop preventative and early intervention projects.
- 18.9 Identified resources for a pilot community detoxification project in a primary care setting.

SUMMARY AND CONCLUSIONS

19. This paper advises the Board of the progress made in the development of the structures designed to delivery H4 HEAT Target as required by the Scottish Government and the further service developments proposed for alcohol treatment services in 2009-10.

20. Significant progress has been made over the past six months in addressing the demands created by the HEAT Target. The infrastructure is now in place which should enable great strides to be made during 2009-10 to meet the target.
21. The service developments proposed for 2009-10 come within available (projected) budget. They will increase the range of services available in the community and begin to address issues around prevention and early intervention as contained in Scottish Government guidance.
22. The Board is asked to agree the contents of this paper and advise how they may wish to be kept informed of progress being made against targets.

MONITORING FORM

Policy/Strategy Implications	<i>The Service Development proposals in this paper will assist the Board in meeting its HEAT target in respect of alcohol misuse and commitments made in the Dumfries and Galloway Substance Misuse Strategy.</i>
Staffing Implications	<i>This paper proposes the creation of new posts within the NHS and in the services provided by partners in the Council and Voluntary Sector. There will be implications for staff in Primary and Acute Care in terms of the delivery of BIs. Work is currently ongoing with Managers in Acute Care Settings to manage these implications.</i>
Financial Implications	<i>Implications have been discussed with colleagues in Finance. Main risk to the Board is if the Scottish Government change their spending plans for 2009-10 and 2010-11. We will have this information in the very near future and, if necessary, make revised plans to cater for revised budgetary allocations.</i>
Consultation	<i>The contents of this paper have been previously discussed at the ADAT and agreed. Colleagues in Finance have confirmed that the proposed spend is within budget.</i>
Consultation with Professional Committees	<i>The LES for Alcohol Misuse has been discussed by the LMC prior to circulation for signing by each practice.</i>
Risk Assessment	<i>Some new service developments are required to enable this NHS Board to meet its HEAT target relating to alcohol misuse. These developments are included in this paper. Board are asked to agree the proposals for 2009-10 pending Scottish Government allocations as projected in this paper.</i>
Best Value	<i>The proposals contained in this paper will provide the Board with best value for the resources it has to allocate; the targets it has to meet and the equity of service provision it strives to achieve.</i>
Compliance with Corporate Objectives	<i>These proposals will assist NHS Dumfries and Galloway meet Scottish Government targets. They are also designed to reduce health inequalities, promote partnership working and develop a skilled, trained workforce.</i>
DIVERSITY ASSESSMENT	
<i>All of the proposals in this paper are designed to promote equal opportunities, equity of service provision and access to services.</i>	

APPENDIX 1

LOCAL ALCOHOL ACTION PLAN 2008-09

PROPOSAL	PROGRESS
1. Service Manager East - Specialist Substance Misuse	In Post
2. 0.5 Staff Grade Doctor - DGRI	In Post
3. Alcohol Liaison Nurse - DGRI	In Post
4. Increase OT availability to Integrated Alcohol Service (East)	Achieved
5. Children's Primary Mental Health Worker	Awaiting Agenda for Change Grading
6. Develop Relapse Prevention team in East of Region	Posts advertised
7. Aberlour Family Support Project	In development
8. Young Carers Service	Achieved
9. Develop and sustain Arrest Referral Scheme	Achieved
10. Social Worker - Children in Transition from child to adult focussed Services	Post advertised
11. HEAT Target <ul style="list-style-type: none"> ❖ Develop Local Enhanced Service Contract ❖ Provide appropriate IT systems ❖ Brief interventions trainer 	Achieved Achieved Achieved

APPENDIX 2**LOCAL ALCOHOL ACTION PLANS**

	2008/09	2009/10
<u>Allocation</u>		
Funding Letter 20 March 2008	897,971	0
Future funding assumptions	0	897,971
	0	238,000
	0	0
Carry forward from previous year	<u>322,402</u>	<u>383,948</u>
	<u>1,220,373</u>	<u>1,519,919</u>
<u>Devolved</u>		
CASUMS - Children MH Worker	40,000	40,000
CASUMS - Travel/Other Supplies	5,000	5,000
CASUMS - Children's Primary MH Worker	16,000	50,000
Psychologist (funded 0708 BBV 0 0809 50:50 BBV:ADAT)	20,000	10,000
Cameron House - Com Detox Services	158,000	158,000
Cameron House - Dual Diagnosis Specialist	40,000	40,000
Cameron House - Dual Diagnosis/Com Detox - Travel/ other supplies	30,500	39,591
Cameron House Admin Support	17,000	17,000
Cameron House Service Manager East	25,000	50,000
Cameron House Service Manager West	0	50,000
Cameron House Comm Detox/Alcohol Liaison Nurse West	0	44,000
Cameron House Alcohol Liaison Nurse DGRI	22,000	44,000
Cameron House Occupational Therapy East	6,000	12,000
Cameron House Occupational Therapy West	0	31,000
DGRI Alcohol/Emergency Nurse (Provisional)	0	30,000
DGRI Staff Grade Doctor	16,000	25,000
Sub-total	<u>395,500</u>	<u>645,591</u>
<u>Commitments</u>		
ADSSWS - Counselling Service - Nithsdale	32,000	32,800
ADSSWS - Counselling Service, A & E, Stew & Wig	64,000	65,600
ADSSWS - Integrated Drug Service Stewartry	18,000	18,000
ADSSWS - Premises Rent Stranraer	11,000	25,000
ADSSWS - IAS Practice Supervision	15,000	15,000
ADSSWS - Counsellor moved from B1205	0	32,000
Apex Scotland - Arrest Referral Scheme	40,000	40,000
Choices for Life Event - Transport (DGC)	17,000	0
Contribution towards residential rehab DGRC	15,000	0
	32,569	33,384
GOPR/HH Training - STRADA	20,000	5,000
GP Payments - Alcohol Misuse in PC (HEAT Target)	60,000	90,000
IT Costs to meet HEAT Target	8,000	2,000
Brief Interventions Trainer (HEAT Target)	11,000	22,000
Brief Interventions Trainer Admin support (HEAT Target)	0	7,500

Minerva Agency Staff	8,356	0
Social Workers (ISS) 2 x Fixed Term 2 years	0	80,000
Blue Light Discos	3,500	3,500
Turning Point/ADSSWS Relapse Prevention Workers	28,000	168,000
Aberlour Trust Family Support Project	20,000	40,000
Princess Royal Trust for Carers Young Carers Worker	12,500	25,000
Tier 1 Local Prevention Work	0	20,000
Primary Care Nurse Pilot	0	10,000
Princess Royal Trust for Carers - project start up costs	3,000	0
Social Worker - Transitions Service	<u>22,000</u>	<u>44,000</u>
Sub-total	<u>440,925</u>	<u>808,784</u>
Total	836,425	1,454,375
Underspend	383,948	65,544
Underspend/Carry Forward		

2 February 2009**Authorised Signatories****Author**
Katy Lewis**Sponsoring Director**
Katy Lewis, Deputy Director of Finance**Date** 7 January 2009**SUMMARY AND RECOMMENDATION**

The NHS Board is asked to approve an alteration to the cheque signatory list.

Approval of Cheque Signatories

1. In section 24.1(m) the authorisation of bank account signatories is a matter reserved for Board. The signatory list has been reviewed in the light of staff movements and past experience and the following amendment is suggested:
 - Craig Marriott, recently appointed Director of Finance, is added to the authorised cheque signatory list as from 1 March 2009, replacing Laura Ace.
 - Laura Ace is taken off the authorised cheque signatory list as from 1 January 2009.

Monitoring Form

Policy/Strategy Implications	<i>SFIs</i>
Staffing Implications	<i>None</i>
Financial Implications	<i>None</i>
Consultation	<i>None</i>
Consultation with Professional Committees	<i>N/A</i>
Risk Assessment	<i>N/A</i>
Best Value	<i>Yes</i>
Compliance with Corporate Objectives	<i>Sound Governance</i>
DIVERSITY ASSESSMENT	
N/A	

DUMFRIES AND GALLOWAY NHS BOARD

Agenda Item 226

2 February 2009


**The Roles of Child Health Commissioner and
Children's Services Manager**
Author

Dr Derek Cox, Director of Public Health

Sponsoring Director

Dr Derek Cox, Director of Public Health

Date: 22 January 2009**RECOMMENDATION**

1. The Board is asked to authorise the creation of a full time post of Consultant in Dental Public Health, to act both as a Consultant in Dental Public Health and as the Board's Child Health Commissioner
2. The Board should consider what future arrangements would be appropriate for the management of children's services and seek to receive a future paper on more definite proposals for this post.

SUMMARY

It has proved impossible to recruit to our current post of half time Consultant in Dental Public Health.

The Board's Child Health Commissioner/Children's Services Manager is due to retire in May 2009. It is unlikely that we would be able to recruit someone to take on both of these tasks for the future, but the role of Child Health Commissioner is itself not a full time role.

Consultants in Dental Public Health have, like Consultants in Public Health Medicine, a very broad training and experience in Public Health and are well able (if inclined) to fulfil generic public health roles. Most other Scottish Board's Child Health Commissioners are Consultants in Public Health Medicine.

It may be possible to recruit a full time Consultant in Dental Public Health who would be able to fulfil both these roles.

Two attempts have been made to recruit a part time (2.5 days per week) Consultant in Dental Public Health, firstly as a part time job and secondly as a full time job in association with NHS Health Scotland. Neither of these attempts provided a suitable candidate. NHS Health Scotland has now decided to recruit a full time Consultant in Dental Public Health and this puts the Board back in the position of attempting to recruit to this post on a part time basis.

At the same time, our Child Health Commissioner/Children's Services Manager is due to retire in May. Both of these roles, in the era of Integrated Children's Services Planning, are becoming more intensive and it is not thought that a single replacement for our current member of staff would be able to carry out both functions satisfactorily. At the same time, the role of Child Health Commissioner does not require, of itself, a full time post.

Considering both problems, an opportunity presents itself to recruit a single full time member of staff who would fulfil both of these half time roles.

Consultants in Dental Public Health, whilst specialising in matters to do with oral and dental health, also have a very broad public health training and experience and are well able to carry out other generic public health responsibilities. Whilst it is not exclusively the case, the majority of Scottish Boards have consultants in public health medicine fulfilling the Child Health Commissioning role and whilst giving this role to a consultant in dental public health would be unusual it would not be without logic.

Financial Implications

The budget currently available within the Public Health Directorate, in relation to both of these posts, is £158,898.00. The cost of employing a full time consultant in dental public health is variable, dependant upon the consultant's seniority. At the maximum of the consultant salary scale the cost to the Board would be £123,508.00 but the cost initially could be as low as around £90,000 per year.

There is a considerable carry forward in the current ring fenced oral health budget and with permission of the Scottish Government it may be possible to use some of this under spend towards the consultants costs for a period of two years. Whatever surplus is available (a minimum of £35,390.00), would be available to transfer to the Health Service's Directorate to contribute towards the funding of new arrangements for the management of children's services. This will certainly require a full time post and so this new arrangement creates a funding gap in child health management. It is envisaged that this can be addressed through the utilisation of existing management resources but further detailed proposals regarding this will be the subject of a future Board paper.

MONITORING FORM

Policy/Strategy Implications	<i>Please describe any implications this paper has for Board/other strategies or policies</i>
Staffing Implications	<i>Please describe any implications this has for staffing (e.g. additional resources, saving on staff time and whether or not HR/APF have been involved)</i>
Financial Implications	<i>Please indicate here if the paper has any financial implications and if these have been discussed with the Finance Director</i>
Consultation	<i>Please describe any consultation that has taken place or is planned</i>
Consultation with Professional Committees	<i>Indicate here if the Boards Professional Advisory Committees have been consulted or engaged in this work</i>
Risk Assessment	<i>Indicate here if a risk assessment has been carried out or is planned</i>
Best Value	<i>Confirm here that the principles of Best Value (as contained in Guidance to Managers circulated in February 2007 and as set out in detail on www.scotland.gov.uk/topics/government/14838/PublicServices) have been taken into account in developing this proposal.</i>
Compliance with Corporate Objectives	<i>Indicate here which corporate objectives are addressed in this paper</i>
DIVERSITY ASSESSMENT Please describe in this section the action that has been taken to ensure that where appropriate a diversity assessment has been undertaken (see notes below). Where necessary please attach the Rapid Impact Checklist.	

DUMFRIES AND GALLOWAY NHS BOARD

2 February 2009

24 HOUR LABORATORY SERVICE AT GALLOWAY COMMUNITY HOSPITAL**Author****Sponsoring Director**

Dr Ewan Bell – Clinical Lead for Diagnostics

Jeff Ace – Director of Health Services

Date: 20 January 2009**RECOMMENDATION**

The Board is asked to consider proposals to reinstate on-call cover for the laboratory service at Galloway Community Hospital including the introduction of routine Saturday and Sunday morning and an extension to the routine working day to include cover for the Renal Unit. The on-call service commenced on 1 September 2008.

SUMMARY

Without a laboratory on-call service at Galloway Community Hospital, some emergency diagnostic test results are delayed as samples have to be sent by taxi to Dumfries for processing. There is an increasing demand for better turnaround times of diagnostic results which has led to the Stranraer laboratory increasing the repertoire of tests that are undertaken locally rather than sent to Dumfries. The opening of the Renal Unit in Stranraer has necessitated the laboratory to extend the working day beyond 5pm to enable tests from renal patients to be processed.

BACKGROUND

Historically, the lab at Galloway Community Hospital only processed urgent specimens with all routine work being sent to DGRI. An on call service was available until 2005 when due to staffing constraints; the service had to be withdrawn. Until 2007/08 there was no renal service available in Stranraer.

Sending samples by road to Dumfries for processing out of hours can result in a delay in appropriate treatment of emergency patients with commensurate increase in

risk. The inability to process samples from renal patients beyond 5pm would compromise the continuity of the current renal service.

To enable us to provide a 24/7 diagnostic laboratory service at Galloway Community Hospital and taking account of workload demand patterns, service would be best provided through a mixture of extension to the routine working day (service requirement for the new Renal Unit), routine Saturday and Sunday morning working and on-call cover.

The recommendation is for a routine working day of 8am – 7pm Monday to Friday. The working pattern (shown below) is based on three members of staff (the system takes into account that there will be a fourth member of staff off at all times e.g. annual leave, compensatory leave, mandatory training, CPD etc).

hrs of day	AM	7	8	9	10	11	MD	12	PM	1	2	3	4	5	6	7
Core time				9am				lunch 1230-130						finish 520pm		
early start/finish		8am						lunch 12-1pm						finish 430pm		
Late start/finish						1030		lunch 1-2pm								finish 7pm

A routine Saturday and Sunday morning working is also proposed (9am – 12pm) in order to process routine and urgent work from the hospital wards and departments. This would be paid as per AFC agreements.

The on-call rota arrangements are based on a 1 in 4 rota. There is agreement from the GCH staff that the rota can fall to a 1 in 3 during holiday periods and possibly short-term sickness absence. If the rota falls below that or there is long-term sickness the area laboratories at DGRI would have to be incorporated into the rota to provide cover.

The new system will be linked to annual pay awards and also have a workload trigger (as per the agreements at DGRI).

A proposed fixed payment of £56.51 is suggested. This will include a superannuated payment of £17.83 per session (as for DGRI) and a non-superannuated payment of £38.69 (equates to 2 calls) per session.

Saturday / Sunday / Christmas day / Boxing Day / January 1st and 2nd would be equivalent to two sessions per day.

FUNDING

1. On-call costs

The current service at Galloway Community Hospital has an annual staff budget of £125k. Based on the model described above the new service would cost £157k in 2008-09 with a recurring cost from 2009-10 of £164k. A breakdown of this cost is shown in the table below.

A funding gap of £32k for 2008-09 and £39k on a recurring basis exists.

Proposal for re-establishment of 24 hour Laboratory service at GCH

2008/09

4.2 WTE

	£
Annual Salary	113,144
Sat/Sun am	6,253
On costs exc On call	25,730
On call (sup) 7 months	3,929
On call (non sup) 7 months	6,231
On call on costs	<u>1,307</u>
Total On call costs	11,467
Protection	770
TOTAL	<u>157,364</u>
Less pays currently funded	<u>125,372</u>
Additional funding required	<u><u>31,992</u></u>

2009/10 Full year effect

4.2 WTE

	£
Annual Salary	113,144
Sat/Sun am	6,253
On costs exc On call	25,864
On call (sup) 12 months	6,254
On call (non sup) 12 months	10,682
On call on costs	<u>2,240</u>
Total On call costs	19,176
Protection	0
	<u>0</u>
TOTAL	<u>164,437</u>
Less pays currently funded	<u>125,372</u>
Additional funding required	<u><u>39,065</u></u>

The Board Management Group specifically questioned the cost of the out-of-hours BMS service and, in particular, whether better value for money would be achieved through an extension of Point of Care testing at Stranraer.

2. The Alternative POCT Costing

Dr Angus Cameron defined the tests that must be provided out-of-hours at GCH as

- FBC
- INR
- U&E
- Amylase
- Paracetamol
- Salicylate

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
Capital costs	£	£	£	£	£	£
FBC analyser (Haematology)	13,500	0	0	0	0	0
INR analyser (Haematology)	300	0	0	0	0	0
Spotchem EZ & EL (Biochem)	11,750	0	0	0	0	0
CRP reader (Biochem)	646	0	0	0	0	0
Revenue costs						
Maintenance (Haematology)		0	3,800	3,800	3,800	3,800
Maintenance (Biochemistry)		0	2,115	2,115	2,115	2,115
Reagent costs (Haematology)		3,682	4,050	4,455	4,455	4,455
Reagent costs (Biochemistry)		13,910	15,301	16,832	16,832	16,832
EQAS / QC approx		2,000	2,000	2,000	2,000	2,000
Capital Charges		6,064	5,881	5,698	5,514	5,331
Sub-total		£25,656	£33,147	£34,900	£34,716	£34,533
Staff costs						
Overtime Pay Protection		4809	4809	4809	4809	4809
BMS1 Installation & evaluation of POCT and staff training 1 WTE (with oncosts)		39,702	0	0	0	0
BMS1 0.4 WTE support & ongoing training (with oncosts)		0	15,880	15,880	15,880	15,880
Total	£26,196	£70,167	£53,836	£55,589	£55,405	£55,222

Notes / assumptions

1. To safely introduce new POCT analysers, which will give different results from the current GCH and DGRI analysers, it is anticipated that a 1.0 WTE BMS1 will be required to perform evaluation and comparisons of the 4 new analysers, develop SOPs and train GCH staff to perform the analysis (as per CPA requirements).

2. To maintain EQAS, QC, support and continue to educate GCH staff (as per CPA) it is anticipated that an additional 0.4 WTE BMS1 will be required.
3. It is estimated that 60 minutes is required for each patient sample to be analysed. This is currently built in to the on-call BMS service costings. There is currently no provision within GCH for the POCT analysis to be performed by GCH Nursing or Medical staff.
4. Reagent costs shown are gross and would partly be offset by reductions in DGRI reagent costs. However POCT reagents will cost approximately six times their conventional equivalent and the small offset will be at least matched by increased taxi usage to transport inconclusive test samples to DGRI.

Conclusions and Recommendation

The three options, with advantages and disadvantages can be summarised as;

- no GCH out-of-hours service – taxi samples to DGRI
- Point Of Care Testing
- continuation of current reinstated BMS on-call service

1. Taxi samples to DGRI

- **Disdvantages**
 - Currently at 1.5 samples per on-call session - £65 per sample = £45k pa
 - Turnaround time per sample >3 hours (inequality of diagnostic services to GCH patients)

2. POCT

- **Advantages**
 - Near patient
- **Disdvantages**
 - Instead of 3 current GCH analysers (which are compatible with DGRI analysers) to do the same tests – 4 new NPT analysers would need to be purchased, each from a different manufacturer, with different sample requirements, normal ranges and incompatible results
 - Manual entry of results with potential for error (POCT kits cannot be interfaced with the lab computer system) – a real patient safety issue
 - Enormous on-going training, support, maintenance, quality control, external quality assurance of each POCT kit
 - There is no risk-free POCT potassium assay - so for every potassium measured by arterial blood gas analyser at GCH a sample would have to be sent by taxi to DGRI for analysis (£45k pa)
 - Pin-prick for each of the 4 NPT analysers
 - No cross-matching available at GCH
 - Increased turn-around-time compared to lab

3. Current staffed on-call system

- **Advantages**

- Already in place and working effectively
- Same service in GCH and DGRI
- Same tests offered
- Same normal ranges
- No post-code diagnostics / equality of service provision
- Less clinical risk
- On-site blood transfusion service – patient safety
- More effective use of blood

It is therefore recommended that we move to the staffed on-call system as outlined.

Monitoring Form

Policy/Strategy Implications	<i>Case seeks to provide sustainability of services in the West of the region in line with model of care projections.</i>
Staffing Implications	<i>As noted in the paper.</i>
Financial Implications	<i>As noted in the paper.</i>
Consultation	<i>Staff engagement has been undertaken. No public consultation is required on a proposal.</i>
Consultation with Professional Committees	<i>Consultation with Medical Staff Committees at both DGRI and Galloway Community Hospital.</i>
Risk Assessment	<i>Advantages and disadvantages are addressed in the paper.</i>
Best Value	<i>As noted in the paper.</i>
Compliance with Corporate Objectives	<i>2 & 4</i>
Diversity Assessment	<i>Neutral</i>

DUMFRIES AND GALLOWAY NHS BOARD

Date: 2 February 2009

Board Briefing**CONTENTS**

Delivering Dynamic Improvement
 Dumfries and Galloway Royal Infirmary Refurbishment Project
 Fellowship Award for Dynamic Career
 Healthy Living Award
 Progress with the Kelloholm Development
 Rheumatology Department Patient Satisfaction Audit
 Winter Pressures

REGULAR FEATURES

Better Health, Better Care
 New from the Scottish Executive including HDLs
 Current Consultations
 Chief Executive's Diary
 Chairman's Diary

Better Health, Better Care**Integrated Drug Service**

The Integrated Drug Service in Dumfries was redesigned under the banner of the "Stabilising Prescription Project". The original pathway to treatment was for people to be assessed by our partners in the Integrated Drug Service, Alcohol & Drug Support South West Scotland (ADS), and then if they required more specialist assessment, including substitute prescribing, they were referred on to the NHS Service.

The two challenges with this pathway were:

1. Access to treatment with the NHS Specialist Service was determined by the rate at which people could move through treatment and transfer back to shared care with GPs or be discharged. In Dumfries, at the time the project was initiated, only the 99 George Street practice was signed up to the Enhanced Service for people with drug problems.
2. Service users who saw their primary need as a substitute prescription did not engage with the support offered by ADS after their initial assessment.

The new pathway provides speedier access to prescribing with waiting times for access to substitute prescribing reducing from around twelve weeks to a maximum of two weeks from initial contact with the Integrated Drug Service. This could only be achieved with ADS becoming involved in the support of stable service users who could not be transferred to their GPs. For this group of people we retain responsibility for the prescription which is reviewed by the Intermediate Specialist GP who works with the Integrated Drug Service in Dumfries one session per week. The key-worker role is transferred from our Team to ADS thus creating space in the nurses caseloads and allowing this service to guarantee that the specialist assessment will be completed no more than four weeks after the stabilising prescription has started.

The stabilising prescription is linked to the initial appointments with the ADS workers and has had positive impact on engagement and the ongoing support they can provide; it also provides an opportunity for service users to reduce their illicit drug use until the specialist assessment is completed and the titration of medication is started.

Much of the success of the project was due to the commitment of Charlotte Clarkson, Unit Manager at Cameron House, and Hugh Robertson, Manager at Alcohol and Drug Support S W Scotland (ADS), who supported and led the staff through the change process. Other gains from the development have been greater role clarity and understanding between professionals from different organisations and what they can bring to integrated care. Following a positive evaluation that identified

... "that the service has developed effective working relationships with both service users and partner agencies. It indicates that although there was some apprehension in the beginning, teething problems have been overcome and a good working relationship developed between the two partner organisations" Evaluation Report, Oct 08 Hazel Thomson

The new care pathway is now being introduced across Dumfries and Galloway

Congratulations: Fellowship Award for Dynamic Career

At the UK Radiology Conference in Birmingham the president of the College of Radiographers awarded a Fellowship of the College to Barrie Pilkington. Barrie, who is currently working at Dumfries and Galloway Royal Infirmary, has had a varied and dynamic career and has been an active member of the society and, in particular, the specialist group of the Association of Paediatric Radiographers.

Delivering Dynamic Improvement

NHS Dumfries and Galloway launches its major development programme "Delivering Dynamic Improvement" on 4 and 5th February. The purpose of the programme is to develop shared leadership and "change-able" capabilities to lead dynamic improvements within and across our services. Managers and clinical leaders will be

equipped with the tools to sustain high performance. Throughout the year we will bring together one hundred and thirty managers and clinical leaders to be inspired by experts in the field and work together to maintain momentum of their improvements and innovations. We will also be drawing on health quality improvement tools which are at the centre of our achievements with patient safety.

The Board has been invited by the Chartered Institute of Personnel and Development (CIPD) to participate in a prestigious three year action research project because of the novel approach the Board is taking to sustaining high performance. The involvement with the CIPD extends our learning and opportunities to share and exchange with high performing companies (public, private and voluntary, UK based and multi national companies) and establishes the conditions to deliver dynamic improvements for patients, staff and our communities.

Dumfries and Galloway Royal Infirmary Refurbishment Project

Five Framework Scotland consortia were interviewed as potential partners for the rebuild and refurbishment of Dumfries and Galloway Royal Infirmary (DGRI). Following consideration of presentations and responses to the questions, BAM Construction were nominated and accepted as our potential Principal Supply Chain Partner (PSCP) for this project.

BAM, and the individual members of its supply chain, have a proven track record throughout Scotland and in the healthcare sector in particular. They have had over £900m of health framework projects awarded over the past four years. Projects finish on time and on budget and 70% of their turnover is derived from repeat business.

BAM have experience in partnership working through the 'Procure21' and 'Designed for Life' Frameworks. Across all of the national frameworks they have chosen to partner with strategic supply chain organisations who are particularly strong in healthcare design. This ensures that there is access to a local, national and international knowledge base and ensures that best practice is disseminated to all projects nationwide.

Approach to DGRI Redevelopment Project

BAM's approach to working with us to deliver this project is summarised as follows:

- A partnership approach based on mutual understanding and an approach that will allow all parties to apply their particular skills in a manner that will facilitate the best design, delivery and healthcare outcomes.
- Enabling the Board to be in effective control at all times as an informed client.
- The provision by BAM of a core team of national and local specialists operating within a tried and tested framework structure.
- The use of established processes to quickly identify the key issues.

- Continuity of leadership and core team support throughout the duration of the project.
- During all phases of the project clear and consistent financial reporting of the status of the project will be provided which will allow key decisions to be made with the most accurate information to hand.
- Encourage consolidated joint approach to the control and management of risk.

Supply Chain Members

Each member of the BAM supply chain has committed a senior member of staff as project lead, they will see the project through to completion and form part of the supply chain core management team.

The team has experience of major hospital refurbishment and extension schemes, including the provision of single bed ward designs.

BAM

BAM Construction Ltd (formerly HBG) is an internationally backed group with an annual turnover of £7.5bn. BAM has operated in Scotland since 1960 and is one of the top three building contractors in the region.

Nightingale Associates / BMJ Architects

Experience of major healthcare projects including design of single bed wards.

Tribal Consulting Health Care Planners

Will work with us to define a deliverable hospital development that will support best clinical practice for future models of care and present a flexible solution capable of accommodating future change.

Arup Engineering Design Services

Arup is a global firm providing engineering design services in all areas of the built environment. They have been responsible for many major hospital developments in Scotland including the civil / structural design for the Beatson Oncology Centre.

Hulley & Kirkwood Mechanical and Engineering Building Services Consultancy

Hulley & Kirkwood is a dedicated M&E design Consultancy with extensive experience of major healthcare projects. Their design ethos is to provide low energy buildings through a holistic integrated design team approach to the built environment.

Doig + Smith**Quality Surveyors and Cost Management Services**

Has fifty years experience working with healthcare organisations throughout Scotland on new build and refurbishment projects, including Glasgow ACADS, Beatson Oncology and Glasgow and Edinburgh Royal Infirmaries.

FES/ Balfour Kilpatrick**M&E Subcontractors**

Forth Electrical Services and Balfour Kilpatrick are two of the largest M&E contractors in the country. They have a strong track record in the healthcare sector.

Turner & Townsend**Project Management**

Provided consultancy services to a variety of healthcare clients throughout UK.

Healthy Living Award

Following the success of Dumfries and Galloway Royal Infirmary achieving the Healthy Living Award this has now also been achieved in both Crichton Hall and Nithbank. The Healthy Living Award rewards catering establishments for serving healthier food and finding ways of helping customers make better food choices. Future plans within the Catering Department include applications for Galloway Community Hospital, Lochmaben Hospital and Annan Hospital. Consideration is also ongoing within Newton Stewart Hospital.

Progress with the Kelloholm Development

Progress is on target with developing proposals for the shared facility in Kelloholm to be used by NHS Dumfries and Galloway, Dr Baker and Partners, Council Social Work Department and Customer Services Centre. This centre will replace existing premises in Kelloholm in a modern fit for purpose building.

From 15 September 2008 the Council have taken the lead role in the procurement of the project with support from NHS colleagues. The Council's Design Services Department has been appointed as the Design Team for the project and are progressing the design with input from user groups.

A project programme has been produced that indicates the following key dates:

Planning application submitted	9 Jan 2009
Building warrant applied for	6 Feb 2009
Tender period	3 Mar – 3 April 2009
Commence construction	1 June 2009
Complete construction	5 March 2010
Project complete	16 March 2010

The project complete date is in line with the date in the Kelloholm update paper presented at the September 2008 NHS Board Meeting.

An information evening was held on Monday 19 January in Kelloholm. At this meeting members of the Joint Project Board presented their ideas for the finished building. Stakeholders and the general public contributed to the design development by discussing various aspects of the proposals which provided vital information for the Architects to consider in their revised plan. Revised drawings will be displayed in various locations in the locality to ensure everyone is familiar with what is intended and kept up to date with progress.

Rheumatology Department Patient Satisfaction Audit

The Rheumatology Department recently carried out a patient satisfaction audit. With help from the Audit Department, a questionnaire was devised and circulated at the Thursday morning Rheumatology Clinic in Autumn 2008. In general the results were very positive and the comments made indicating areas of improvement have been acted on. Comments relating to possible improvements included car parking problems, time waiting to see the doctor, later clinic appointments for those traveling a distance and more privacy for patients who need help with self-assessment questionnaires.

Winter Pressures

NHS Dumfries and Galloway experienced a substantial increase in activity across the festive period. The nature of activity increase across the winter, its impact on health service performance and lessons learned for future winter plans will be the subject of detailed analysis for presentation to NHS Board in the spring. Early high level data shows;

- out of hours activity and emergency admissions were broadly as anticipated for December in general and the festive period in particular;
- A&E activity has increased across December and January. The system coped well in December but performance, as measured by compliance with the four hour target, has deteriorated in January (on data extrapolated from the first twenty-one days of the month) as shown;

A&E Attendances Winter 2007/08 and 2008/09

	Dec-07	Dec-08	% Change	Jan-08	Jan-09	% Change
Attendances	3,890	4,052	4.16	3,805	3,964	4.17
Waits > 4 Hours	79	81	2.53	110	125	14.07

NB - Jan 09 figures are extrapolated from first 21 days.

The most significant reason for the decrease in performance appears to be reduced bed availability (although all categories of breach analysis have increased). Hospital admissions in December and early January have been consistently high but not out of line with previous winters. However, length of stay in January does appear to have increased (suggesting either greater dependence of patients or a reduction in efficiency of patient throughput) which has put very significant pressures on bed availability.

Early indications are that the situation in Dumfries and Galloway is very typical of the activity in the rest of the West of Scotland. Our review of winter pressures management will attempt to put local performance into this wider context.

New from Scottish Executive Health Department

CMO 2008 11 (1) Changes to the Advisory Committee on Dangerous Pathogens (ACDP) Guidance on "Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection"; and (2) Refurbishment of Endoscopes Potentially Contaminated with CJD Agent

The revised Annex J now advises that simplified local policy and procedures should be put in place. The list of questions previously suggested is now replaced with a single question to all patients about to undergo any surgery or endoscopy, asking if they have ever been notified as being at risk of CJD or vCJD for public health purposes.

PCA (M)(2008)13 Closer Working Allocation to NHS Boards

This circular confirms Board allocations to encourage closer working with GP practices towards common purposes.

PCA (M) (2008) 14 Scottish Enhanced Services Programme for Primary and Secondary Care (SESP): 2009/10

This circular confirms funding for SESP for 2009/10 and outlines plans to develop the programme from April 2009 onwards

PCS (DD) 2008/10 GP Trainers: Continuing Professional Development Awards

The Doctors' and Dentists' Review Body (DDRB) have recommended in their Thirty-Seventh Report for 2008 that the Continuing Professional Development supplement of £750 per annum for GP trainers should continue for another year from 1 April 2008 until such time as the review of remuneration for GMP trainers is complete.

CEL 53 (2008) NHS Scotland Dress Code

This letter advises NHSScotland employers of the launch of the Dress Code on 16 December 2008. This replaces the interim Dress Code that was issued on 7 July 2008.

PCS (OCP) 2008/1 Pay Uplifts for Staff on Organisational Change Protection

Agreement has now been reached to increase "target earnings" for staff who went on to "no detriment" protection of Whitley pay, prior to 1 October 2004, under NHSScotland's organisational change protection policy.

CMO (2009) 1 Hepatitis C: Testing and Diagnosis in Primary Care

Provides a reminder of the good clinical reasons for testing and diagnosis of Hepatitis C in primary care, and extracts from and links to relevant guidance on Hepatitis C testing and diagnosis.

CEL 56 (2008) Supporting Documentation for New Specialty Doctor and Associate Specialist 2008 Contracts

This Chief Executive Letter (CEL) provides supporting documentation to help NHS employers and eligible doctors and dentists with the implementation of the new contracts.

CMO 2008 12 Antiviral Prescribing for Seasonal Influenza

This letter provides advice on the use of influenza antiviral for those at risk from the flu.

CEL 52 (2008) Pay and Conditions of Service: Executive and Senior Management Pay 2008/09

This letter announces the following amendments to the pay arrangements for those on the Executive and Senior Management pay arrangements introduced by HDL(2006)23, HDL(2006)59, CEL(2007)4 and CEL (2007)22. The amendments take effect from 1 October 2008.

CMO (2008) 10 Procedure for the Release of Oseltamivir from Local Stocks

A letter from the CMO and CPO informing NHS boards' flu leads, public health directors and other personnel about procedures for issuing avian flu vaccine

PCA (M)(2008)1 General Medical Services: Statement of Financial Entitlements for 2008

This circular introduces a revised Statement of Financial Entitlements (SFE) for GMS Contractors for 2008.

PCS (AFC) 2008/6 Rates of Pay for Staff who Undertake On Call Duties on a Less than 1 in 12 Basis Under Agenda for Change

Sets out arrangements which have been agreed through the Scottish Terms and Conditions Committee should be put in place nationally for staff working an agenda for change on-call system who are on-call less than 1 in 12.

PCS (AFC) 2009/1 Payment During Periods of Annual Leave

Outlines new arrangement for paying staff during periods of annual leave.

CEL 54 (2008) New Funding for Local Surveillance Systems

Allocation of £2m from 2008/09 Healthcare Association Infection budget to support NHS Boards in further development of robust local surveillance systems for the prevention and control of infection.

CEL 55 (2008) New Funding for the National MRSA Screening Programme

Allocation of £1million to NHS Boards from the 2008/09 Healthcare Associated Infection budget to assist with preparing for the introduction of the national MRSA Screening Programme from 2009/10

FOI Requests

During November and December thirty-four 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
4-11-08	Gordon Blackwell Director of Research The National Health Intelligence Service	<p>Formularies Please would provide us with copies of all the prescribing formularies that are active in your organisation</p> <p>ScriptSwitch How many of the GP practices in your organisation are using the software package ScriptSwitch? What is the total number of GP practices in your organisation? What would you estimate the annual savings in your organisation to be through the use of ScriptSwitch?</p> <p>Alternative Providers of Medical Services (APMS) Please would you supply a list of any Alternative Providers of Medical Services (APMS) with which you have contracts for service provision.</p>	5/11/08
05/11/08	Ross Ingebrigtsen SNP Central Belt	<p>The total amount spent by NHS Dumfries & Galloway on gas & electricity in</p> <p>1) 2003/4 2) 2007/8 3) anticipated expenditure in 2008/9 4) Expected expenditure in 2009/10 (if available)</p>	4/12/08
05/11/08	Newlife	<p>The amount of money spent by your organisation* on the provision of equipment** in your area. The amount of children In your area with disabilities*** and the way In which your organisation collects and records this Information.</p> <p>• Does your organisation monitor / measure unmet need**** If yes, how is it monitored / measured.</p>	3/12/08

		<p>*We require information from each organisation separately; if you are unable to achieve this or would like to provide joint spending figures (with another local statutory body) please state so clearly in your response.</p> <p>**The term equipment includes such items as wheelchairs, buggies, specialist beds, standing frames, hoists and specialist seating. We do not include structural adaptations, consumables such as nasal gastric tubing and incontinence supplies, IT equipment or surgical aids.</p> <p>***As defined under the Disability Discrimination Act 1995.</p> <p>****We would define 'Unmet Need' as instances whereby a child with a disability requiring a piece of equipment has been unable to obtain that equipment through statutory services because of criteria, policy, budget etc.</p>	
07/11/08	Lyndsay Moss	<p>1) Please can you supply details of the occasions where the health board has funded treatments that are not recommended by the Scottish Medicines Consortium (SMC) since January 2007 to the current date? Please include the name of the drug funded and the date it was approved for funding by the board (if available).</p> <p>2) Please can you also list the occasions where the board has refused to fund a treatment under exceptional prescribing measures, including the name of the treatment refused and the date since the start of 2007?</p>	14/11/08
7/11/2008	Mary Scanlon The Scottish Parliament	<p>How many patients With Clostridium Difficile were admitted to hospitals In your health board area from the Care Home Sector? What is the percentage of cases 01 Clostridium Difficile admitted to hospitals In your Health Board area? Which came from the Care Home sector? How many patients were admitted to hospital from the Care Home Sector with other types of infections? And what percentage of the overall infected patients group came from the Care Home Sector (excluding Clostridium Difficile)?</p>	3/12/08

13/11/08	Lyndsay Moss The Scotsman	1) Please can you tell me how many people are currently on the board's waiting list to be able to register with an NHS dentist? 2) If possible, please can you provide the a figure for the number of people on the NHS dentist waiting list for the comparable period last year	9/12/08
13/11/08	Liz Longden	a) the date of appointment with GP at which referral to a neurologist was made (if applicable and if available) b) the date of appointment with clinical neurologist at which referral for an MRI scan was decided c) the date on which referral for a neurological MRI scan was received and officially logged i.e. the moment at which the 'waiting time' begins d) the date on which the first MRI scan was carried out	12/12/08
18/11/08	Paul Hutcheon Sunday Herald	How much the health board has received in fees/charges from patients outside the European Union.	18/11/08
17/11/08	Kelly Holgate Document Co-ordinator Binley's	Annual Report 2007-2008 Business Plan 2008-2009 onwards Clinical Governance Report 2007-2008 Director of Public Health Report 2007-2008	19/11/08
11/11/08	Gordon Blackstock	Can you tell me how many health professionals have reported to your board that they have been physically assaulted by members of the general public in 2008? Can you also give the same figure for the last four years (2004, 2005, 2006, 2007)? Out of the total assaults can you tell me where the assaults happened (i.e home visits, surgery or hospitals) and who they were on (i.e doctors, nurses or other professionals). Can you also include how many of these assaults were referred to the police and if they resulted in any prosecutions?	8/12/08
25/11/08	Gordon McPherson	Whether your Health Board has a Patient Information Leaflet	18/12/08

		covering the signs and symptoms to look out for regarding Deep Vein Thrombosis (DVT).I would be grateful if you could forward a copy of the Leaflet, if available to	
26/11/08	Iain Harrison	<p>How many claims for compensation were submitted to your health board by patients/members of the public in the financial years 2003/04 to 2007/08?</p> <p>Of those, how many resulted in the health board paying out compensation?</p> <p>In relation to question 2, please provide details for each claim including the amount paid out and the reason for the claim?</p> <p>How many claims for compensation were submitted to your health board by your own staff in the financial years 2003/04 to 2007/08?</p> <p>Of those, how many resulted in the health board paying out compensation?</p> <p>In relation to question 5, please provide details for each claim including the amount paid out and the reason for the claim?</p>	29/12/08
27/11/08	Graham Grant Daily Mail	<p>figures for each of the last five years detailing any funding or payment the board has given to any outside body, eg support groups, representing the lesbian, gay, bisexual and transgender (LGBT) community.</p> <p>Please give the amount each organisation received, the name of the organisation and reason for the award or payment (and year it was given).</p>	9/12/08
4/12/08	Jackie Baillie Scottish Parliament	The information which I require is all local policy papers on prevention and control of c-diff in healthcare settings within NHS Dumfries & Galloway.	6/12/08
28/11/08	Michael McLeod Reporter	Seeking all FOI requests from x or Capital Press, HE Media, Trading as Centre Press, Capital Press and north Scot.	11/12/08

1/12/08	Polly Jones Scottish Parliament	All information relating to away days, corporate events and conferences held by the health board in the last year and planned for the future.	29/12/08
1/12/08	Polly Jones Scottish Parliament	Information relating to the salary and bonuses of the Chief Executive of the Health Board last year, this year, and where possible, next year.	5/12/08
5-12-08	Michael MacLeod Deadline Press & Picture Agency	How many people received cosmetic surgery in your NHS area? How many of these cases were females, and how many were males? What was the age of the oldest and youngest people who received cosmetic surgery, and what process did they have done? How many of each type of cosmetic operations were carried out in 2007? (Please list body-part and number of times for each year	7/1/09
8/12/08	Lauren Mackie Synovate Healthcare	Pharmacy information	15/12/08
11/12/08 -	Alex Laurie @ Deadline	For each of the last five years, can you supply me with the number of injured children referred to police/social work/other child protection representatives by medical staff. If possible can the figures be broken down into hospitals and GP practices. Can you supply me with the criteria for these referrals. Development Session on efficiency and productivity and the current economic climate	9/1/09
15/12/08	Dr Richard Simpson MSP	Junior doctor information request	07/01/09
15/12/08	Dr Richard Simpson MSP	Staff Vacancies	14/01/09
15/12/08	Dr Richard Simpson MSP	Agenda for Change	07/01/09
15/12/08	Dr Richard Simpson MSP	European Working Time Directive	21/01/09
16/12/08	Nick Bostock	GP Practices	09/01/2009

	GP Newspaper	GMS Contacts GMS Premises	
15/12/08	Paul Hutcheon Sunday Herald	Since January 1st this year, how much has your organisation spent on away days and team building events? Please break down the costs for each individual away day/team building event, the organisation providing each service, and where each event was held.	24/12/08
17/12/08	Randeep Aujla	Questionnaire regarding antibiotic use	29/12/08
17/12/08	Alex Laurie Reporter Deadline Scotland	How many times in the past five years have you discovered unauthorized cameras in NHS-owned properties and establishments? How many times in the past five years have you discovered unauthorized microphones in NHS-owned properties and establishments? How many times in the past five years have you discovered other unauthorized surveillance devices in NHS-owned properties and establishments? Can you supply me with the information on where these devices were found within the NHS-owned properties and establishments? Has anyone been charged in connection with the finding of these devices? Was anyone then prosecuted after the devices were found?	24/12/08
16/12/08	Keith Small Morhamburn The Scottish Policy Practice	The total medicines budget and medicines spend for the 2006/2007 financial year for your whole NHS Board area. The total budget for medicines spend for 2008/2009 and 2009/2010 for your NHS Board.	24/12/08
16/12/08	Keith Small Morhamburn The Scottish Policy Practice	How much your NHS Board has received in funding for medicines research development & trials from: a) Pharmaceutical companies b) Scottish Government (including Chief Scientist's Office and Enterprise agencies)	24/12/08

		c) UK funding councils d) Charities	
18/12/08	Penny Wilson-Webb Chief Executive and Company Secretary, Rarer Cancers Forum	Information in relation to cancer treatment and funding	14/01/09
23/12/08	Gordon Blackstock	<p>just a quick note as I've received a few emails regarding my use of the word 'discretionary' and what it means. To avoid any misunderstanding can this word be omitted from the request, which should now just read "<i>how much was paid in bonuses for non-health professionals in 2008 in your health board</i>".....</p> <p>can you tell me how much was paid in discretionary bonuses for non-health professionals in 2008 in your health board. By non-health professionals I mean those workers in the administrative side of the NHS like NHS managers etc. Can you also tell me what this figure was for 2004.</p> <p>Can you also tell me what the job title is of the people who were awarded these discretionary bonuses.</p>	30/12/08

Current Consultations

From	Topic	Response Due by
Scottish Government	Patients Rights <i>No response sent</i>	16 January 2009
Scottish Government	Guidance on the Role of the Chief Social Work Officer <i>Response submitted 19/12/08</i>	19 December 2008
Vivienne Gratton	Forensic Network Manager psychological Therapist Reports <i>No response submitted</i>	30 November
Scottish Government	Proposal to Develop an Acknowledgement and Accountability Forum for Adult Survivors of Childhood Abuse <i>Response sent 13/1/09</i>	16 January 2009
Scottish Government	European Commission's Consultation on patients rights in cross border healthcare <i>No response submitted</i>	3 December 2008
Scottish Government	Changes to eligibility criteria for providers of primary medical services <i>No response submitted</i>	17 December 2008
NHS Health Scotland Equalities Development	<ul style="list-style-type: none"> • External Recruitment and Selection policy • Commissioning a Trainers Database • Managing Consultations policy • Publications Policy <i>No response submitted</i>	31 December 2008
Scottish Government	Inspection, Assurance and Public Confidence <i>Response submitted 12/12/08</i>	12 December 2008
Review of Fatal Accident Enquiry	Review of Fatal Accident Inquiry Legislation	20 February 2009

Big Thinking	Big Lottery Fund Consultation	27 February 2009
Scottish Government	Identity Cards Secondary Legislation	13 February 2009
Scottish Government	Modernising Scientific Careers	29 February 2009
Scottish Government	Forced Marriage: A Forced Remedy	27 March 2009
Scottish Government	Arrangements for NHS Patients Receiving Private Healthcare <i>Response sent 13/1/09</i>	12 January 2009
Margo MacDonald	End of Life Choices	9 March 2009
Scottish Ambulance Service	Health Plan 2009/10 – 2011/12 <i>No response sent</i>	16 January 2009
Scottish Government	Climate Change (Scotland) Bill	27 February 2009
Scottish Government	Standing for Office : Time Off Entitlements and Encouraging Civil Engagement	

Chief Executive's Diary Key Events

February	
2	Scrutiny Committee
2	NHS Board
3	Board Management Group
4	Delivering Dynamic Improvement
5	18 Week RTT Programme Board – Edinburgh
5	Delivering Dynamic Improvements
9	Infection Control Committee
10	Workshop with the Third Sector
11	Management Steering Group - Edinburgh
12	18 Week RTT Diagnostic Steering Group - Edinburgh
13	Community Planning Joint Management Team
13	18 Week RTT Programme Board - Edinburgh
16 / 18	Annual Leave
19	Children's Services Chief Officer Group
23	Option Appraisal Event – Castle Douglas
24	Option Appraisal Event – Stranraer
25	Option Appraisal Event – Dumfries
26	Area Partnership Forum
26	Strategic Co-ordinating Group
26	Option Appraisal Event – Thornhill
27	Cervical Cytology Laboratory Review Steering Group - Edinburgh
27	Option Appraisal Event - Lockerbie
March	
2	NHS Board

Chairman's Diary Key Events

February	
2	Scrutiny Committee
2	NHS Board
4	Wigtownshire LHP Visit
5	Wigtownshire LHP Visit
10	Workshop with the Third Sector
11	Nithsdale LHP Visit
12	West of Scotland Chairs meeting – Glasgow
16	Interviews
23	Chairmen's Ministerial Meeting – Edinburgh
25	Stewartry LHP Visit
26	Stewartry LHP Visit
March	
2	NHS Board

Chief Executive Appointments to Regional and National Groups

Member of Cancer Waiting Times Delivery Group
 Chair of Cervical Cytology Laboratory Review
 Joint Chair of Diagnostic Strand Steering Group (Delivering for Health)
 Member of Employers Reference Group for NHS Scotland
 Member of Joint Future Implementation Advisory Group
 Member of National Diagnostic Delivery Team
 Chair of NHSScotland Shared Support Services Project Board
 Chair of Occupational Health and Safety Services Review
 Chair of Regional Imaging Group
 Chair of Regional Workforce Steering Group for West of Scotland
 Member of Review Body Distinction Awards
 Chair of SCAN
 Member of Scottish Patient Safety Alliance National Advisory Board
 Chair of the West of Scotland Regional Planning Group

DUMFRIES AND GALLOWAY NHS BOARD

2 FEBRUARY 2009

FRAMEWORKS SCOTLAND (PRINCIPAL SUPPLY CHAIN PARTNERS) FOR ACUTE MENTAL HEALTH FACILITY AND DUMFRIES AND GALLOWAY ROYAL INFIRMARY REBUILD AND REFURBISHMENT PROGRAMME

Author

Jeff Ace, Director of Health Services

Sponsoring Director**Date:** 16 January 2009**RECOMMENDATION**

The Board is asked to note the outcome of the short-listing process for Principal Supply Chain Partners for the above projects.

SUMMARY

Interviews and selection processes took place in December 2008 and January 2009 to nominate Principal Supply Chain Partners (PSCP) to work on the above two projects. Five potential partners applied in each case. These teams each presented on their expertise and experience in the field and were then subject to detailed questions from an expert panel. The process was quality assured by staff from Health Facilities Scotland (HFS).

BAM Construction were nominated by the panel as the preferred PSCP to work on the rebuild and refurbishment of DGRI. Laing O'Rourke Construction were nominated as preferred PSCP to deliver the Board's new mental health inpatient facility.

We are now working with HFS, the Board's Cost Advisors and each nominated team to deliver a formal contractual framework for delivery of the projects.

BACKGROUND

The 'Framework Scotland' procurement process was launched in November 2008. It follows very similar initiatives in Wales ('Design for Life') and England ('Procure 21') which aim to improve the effectiveness of capital procurement in the NHS. In

Scotland, Boards are now required to contract for schemes over £5M with one of five Principal Supply Chain Partners;

- BAM Construction
- Interserve
- Morrison's Construction
- Robinson Dawn
- Laing O'Rourke

These groupings bring together expertise such as health planning, architects and construction companies that enable an effective partnership with Health Boards from Outline Business Case through to handover of the facility. There is now a substantial body of evidence from the NHS in Wales and England to suggest that this method of procurement delivers better value than the more traditional approach of multiple tenders for different parts of the asset delivery process.

The Rebuild and Refurbishment of DGRI

The five Framework Scotland consortia were interviewed on 10 December 2008 as potential partners for the rebuild and refurbishment of DGRI. The appointment will initially be to produce an Outline Business Case in line with our Initial Agreement with the Scottish Government and the timetable previously agreed with the NHS Board (most recently at our workshop of 8th December).

The interview panel comprised:

- Director of Health Services (as Chair)
- Edwin Hunter, Non Executive Director
- Medical Director – Acute Services
- Director of Finance
- General Manager – Operational Services
- Head of Estates & Property
- Project Manager

Following consideration of presentations and responses to detailed set questions, BAM Construction were nominated as our potential PSC partner for this project. Work is now underway with HFS and our cost advisors to devise a fees structure, target price and all appropriate contract documentation. It is anticipated that this will be ready for Board consideration by end of February 2009.

Mental Health Inpatient Facility

The Outline Business Case for this project was approved by Board in 2007 following a formal consultation process on appropriate models of care. On 8 January 2009 we

interviewed the five Framework Scotland consortia as potential partners for this development. The appointment will initially be to produce a Full Business Case.

The interview panel on this day comprised:

- Director of Health Services (as Chair)
- Keith Warford, Non Executive Director
- Clinical Director of Mental Health
- General Manager – Mental Health
- Project Manager
- 2 * Commissioning Managers
- User/Carer Representative
- Divisional Finance Manager

Following consideration of presentations and responses to set questions, Laing O'Rourke Construction were nominated as our potential PSCP partner. We will now work with HFS and our cost advisors to devise a fees structure and all appropriate contract documentation. It is anticipated that this will be ready for Board consideration by end of March 2009.

CONCLUSION

Whilst this procurement process is new to NHS Scotland, it has been extensively and successfully used in the rest of the UK to deliver NHS capital schemes. Its success locally will of course require high quality project management to ensure effective collaborative working with our PSC partners.

MONITORING FORM

Policy/Strategy Implications	<i>In line with Board objectives to provide first class hospital facilities.</i>
Staffing Implications	<i>Potential workforce implications are being worked through.</i>
Financial Implications	<i>Capital costs are included in Scottish Government projections – revenue challenges are currently under evaluation.</i>
Consultation	<i>This proposal will be subject to formal consultation in 2009. Extensive public engagement is ongoing.</i>
Consultation with Professional Committees	<i>Has been repeatedly reviewed at Area Clinical Forum and Area Partnership Forum.</i>
Risk Assessment	<i>Will form part of the Outline Business Case.</i>
Best Value	<i>Best value analysis will form part of the Outline Business Case.</i>
Compliance with Corporate Objectives	<i>2 & 4</i>
DIVERSITY ASSESSMENT	

DUMFRIES AND GALLOWAY NHS BOARD

2 February, 2009

Register of Members' Interests**Author:** Jennifer Wilson**Sponsoring Director**
John Burns, Chief Executive**Date:** 19 January, 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 and 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>
DIVERSITY ASSESSMENT	
<i>Requirement to comply with regulations applies to all Board Members</i>	



REGISTER OF MEMBERS INTERESTS

December 2008

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 <i>Registerable interest category</i>	Column 2 <i>Description of interest</i>	Column 3 <i>Members Registering an Interest in this Category (and Description of interest)</i>	
		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.	Mr A Campbell	Crichton Development Company

Column 1 <i>Registerable interest category</i>	Column 2 <i>Description of interest</i>		
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	Chairman, Urr Parish Hall 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 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

Area Clinical Forum



Minute of the Area Clinical Forum meeting held in the Occupational Therapy Dept , DGRI on Wednesday 10th December 2008

Present

Hazel Dykes (Chair)

George Rhind, Kim Heathcote, Paul Beardon,
James Callaghan, Simon Willetts, Marian McDonald,
Robin Park, Richard Colbeck, James Currie

In Attendance

Jan McCulloch, Sarah Kirk, Maggie Morrison, Maureen Stevenson,

Apologies

Andrew Cairns

1. **Apologies**

2. **Minute of the Previous Meeting**

The Minute of the meeting held on Wednesday 22nd October 2008 was approved

3. **Matters Arising**

a) ACF Event

There had been a disappointing turnout from the committees for the event. The first Board Workshop on the Clinical Services Strategy will be held on Monday and will include the non-executive directors.

b) Counterweight

Robin spoke of the discussions about delivering the programme in primary care at the LHP Committee. The LHP Committee were of the same opinion as GP Sub and agreed that practices should take the training offered and see if it can be delivered. Training sessions have been arranged for the New year.

c) Replacement for CMT

There has been no feedback on the management structure which will replace CMT.

4. **ACF Chairs meeting with Cabinet Secretary, Nicola Sturgeon**

Hazel informed members that all the Health Board annual reviews had been completed. How to measure the effectiveness of the ACFs had been an outcome along with how the psychology profession fits within the ACF structure.

How ACFs could influence at operational management level was also questioned and Chairs raised the effect that funding cuts was having on clinical services.

New guidance will be issued by the Scottish Government on the in the New Year for all ACFs and Professional Advisory committees

5. **Committee Updates**

Allied Health Professions Committee – Recent meeting that John Burns attended to speak of the Clinical Services Strategy. Linking with Area Nursing, Midwifery Committee to discuss the AHPAC strategy.

Area Dental Committee

Recent work has included funding directions and working out a formula to analyse bids received.

Area Pharmaceutical Committee

Community Pharmacy leads the committee - contract applications and relocations considered.

Healthcare Scientists Forum

This was launched by the Scottish Government at the end of July 2008 and will hold its first meeting in January.

Medical Staff committee/GP Sub committee

Sub committees of Area Medical Committee with representatives from the consultant group – and GP body feeding into the Area Medical Committee as the parent committee

Area Nursing, Midwifery and Health Visiting Advisory Committee

Recently re-established with a strong membership and a wide representation.

LHP Committee

Hybrid committee with a membership from LHP manager and clinicians who has an uncertain future at present with the uncertainty about the future of LHPs.

6. **Any Other Business**

- a) It was agreed that for future ACF meetings a time limit of 20 minutes for a presentation including a question and answer session should be implemented. Also a proforma will be issued to anyone wanting to present which will outline the structure of a presentation and the advice being sought by an individual.

The proforma will be designed for discussions at the January meeting.

Date of Next Meeting
21st January 2009
7.00pm – Joint Session

8. Falls Strategy

Sarah Kirk and Maggie Morrison, Falls Co-ordinators presented this strategy which is targeted at all residents within D&G who are at risk of falling. This primarily consists of older people, but also includes other groups such as patients with Parkinson's disease, diabetes mellitus or orthostatic hypotension.

This strategy seeks to minimise the number of falls that occur. However, falls will always occur and it is therefore important to minimise the impact of a fall, both physically and psychologically.

There are three main elements to this strategy.

- a community-based program providing general preventative services.
- an integrated, primary-care based system to provide effective support and treatment to patients who have fallen.
- ensuring hospitals, care homes and day centres have appropriate procedures in place to identify and manage people who are at high risk of falling.

Prevention

The community based program will provide appropriate advice and intervention to targeted community groups. This will include school healthy-eating campaigns to ensure good bone health, falls prevention talks in appropriate social setting for older people, and community based early intervention exercise classes.

Support and Treatment

Patients who have previously fallen or are identified as being at risk of falling require effective intervention. Initially, a multi-factorial assessment will be carried out by a GP and the local Community Rehabilitation Teams (CRT).

This will allow the majority of falls, particularly those that are non-medical in nature to be treated within the community. Complex or unexplained falls will be referred to specialist services as appropriate.

Hospitals, Care Homes and Carers

It is important to ensure that hospitals, care homes and other carers can effectively manage patients at risk of falling. This includes ensuring that there are mechanisms to record falls and thereby identify and manage high-risk patients.

Training for staff is essential, both to highlight the services available, and to alert them to the necessity of treating the underlying cause, not just the symptoms.

Implementation of this strategy is overseen by a clinical falls prevention co-ordinator, who will develop the multifactorial assessments and provide clinical advice and support to the CRTs. They will also develop appropriate pathways, increase staff awareness, lead on community-based prevention initiatives and act as a champion for positive falls prevention and bone health work.

Funding for the Falls Co-ordinator posts ceases at the end of March and although ACF was keen to support the development of the strategy members questioned its sustainability.

It was agreed that once the business case has been developed it should be brought to a future ACF meeting.

9. **Patient Safety Initiative**

Maureen Stevenson attended the meeting to bring members up to date with the Patient Safety Initiative. Although initially the strategy has been focused in the acute setting, a programme of work has been started in the Community Hospitals. Dumfries and Galloway is the first Health Board in Scotland to implement the strategy in Community Hospitals.

Some of the recent new which have taken place have included:-

- ◆ A new induction programme for staff has been implemented.
- ◆ Adverse incidents are looked at in different ways.
- ◆ Case note reviews are now done on a monthly basis.
- ◆ Ward 9 is being used as a test area for the hand washing programme.

Many changes have occurred with minimal resources and the methodology that has been trialled and used can be transferred to other areas. The programme will continue to be rolled out to the community hospitals and Maureen agreed to update a future ACF meeting.

10. **Matters Arising** **Management of Patients requiring ICU/HDU Services**

Deferred

11. **18 week Referral to Treatment (RTT)**

Deferred

12. **Any Other Business**

It was agreed that for future ACF meetings a time limit of 20 minutes for a presentation including a question and answer session should be implemented.

It was also agreed that from the New Year future meetings would be finished by 8.30pm

A proforma will be issued to anyone wanting to present which will outline the structure of a presentation and the advice being sought by an individual. The proforma will be designed for discussions at the January meeting.

COMMUNITY PLANNING JOINT BOARD**Meeting of Thursday 13 November 2008****Council Hall, Council Offices, Dumfries.****Present****Chair: Ivor Hyslop** Leader, Dumfries and Galloway Council**Vice Chair: Mike Keggans** Chairman
NHS Dumfries & Galloway**Brian Collins** Chairman, Swestrans**John Burns** Chief Executive, NHS Dumfries and
Galloway**Rob Davidson** Councillor (SNP Group Leader)**David Gass** Regional Director South,
Scottish Enterprise**Mike Gilboy** Local Economic Forum**Joyce Harkness** Executive Officer, Dumfries and
Galloway Federation of Councils of
Voluntary Services**Philip Jones** Chief Executive, Dumfries and Galloway
Council**Mike Leslie** Chief Superintendent, Dumfries and
Galloway Constabulary**Jane Maitland** Councillor (Independent Group Leader)**Gordon Mann** Local Economic Forum**Sandra McDowall** Councillor (Liberal Democrat Group
Leader)**Ronnie Nicholson** Councillor (Labour Group Leader)**Irene Mungall** Chief Executive, Dumfries and Galloway
Citizens Advice Service**Apologies****Patrick Shearer** Chief Constable, Dumfries and Galloway
Constabulary

In attendance

Peter Bulmer	Corporate Director Planning and Environment Services, Dumfries and Galloway Council (Item 7)
Liz Manson	Corporate and Community Planning Manager
Chris Miles	Scottish Natural Heritage (Item 7)
Alistair McNeil	Scottish Environment Protection Agency (Item 7)
Gary White	Crichton Carbon Centre (Item 7)
Robert Lee	Crichton Carbon Centre (Item 7)

1. MINUTE OF MEETING OF COMMUNITY PLANNING JOINT BOARD OF 18 SEPTEMBER 2008

1.1 **AGREED** as a correct record.

2. MATTERS ARISING**2.1 NOTED**

- the consultation and engagement programme for the development of the Community Plan and Single Outcome Agreement(SOA) was well underway and would be complete within the timescale and budget allocated by the Board; and
- Summit of Public Sector Leaders and the First Minister to be held on Wednesday 26 November 2008 about the SOA and Concordat.

2.2 AGREED

- Joint Board members be notified of the consultation events with existing groups so that they could attend and participate to demonstrate their leadership for the development of the new Community Plan and SOA;
- to make an additional approach to the Universities at the Crichton for them to participate in the engagement process;
- to circulate available presentations from the recent national Conference and the local Council event on SOAs to Board members;
- that the Task Group on funding for voluntary sector organisations be accelerated in recognition of the commitment in the Compact and general ongoing planning needs of local organisations to establish their funding arrangements for 2009/10 and beyond; and
- an update on the Fairer Scotland Fund arrangements be circulated to the Joint Board members and discussed at the next meeting.

3. PERFORMANCE REPORTING ON SINGLE OUTCOME AGREEMENT

3.1 **NOTED** that a pro-forma was being produced by the Local Outcome Leads identifying progress against targets to end September 2008 to support the Joint Management Team and Board members in monitoring progress of the SOA and expressed concern that performance data was not yet available on Covalent to assist in this work.

3.2 **HIGHLIGHTED** the need for training in early course on Covalent for both support staff and Board members to maximise the use of this tool for performance monitoring.

3.3 **AGREED** that two appropriate voluntary sector representatives be invited to attend each of the Themed Discussion events.

4. **COMMUNITY PLANNING BUDGET MONITORING REPORT**

NOTED the Community Planning budget monitoring report to 31 October 2008 and that the end of year outturn was forecast to be on budget.

5. **DRAFT AGENDA FOR MEETING ON 22 JANUARY 2009**

AGREED the draft agenda for the meeting on 22 January 2009 with the 'healthier' theme to be the Themed Discussion topic and the development of the Regional and Local Third Sector Forums included in the Update Report.

6. **MINUTES**

6.1 **NOTED** minutes of meetings of Local Rural Partnerships as follows:

Nith - 17 September 2008

Stewartry - 6 October 2008

Wigtown - 17 September 2008

6.2 **HIGHLIGHTED** the importance of regular meetings or events for the LRPs and that the Community Planning Office should provide assistance to ensure this takes place.

7. **THEMED DISCUSSION ON 'GREENER' STRATEGIC OBJECTIVE**

Discussion took place with representatives of guest organisations about the current position and future development of issues within the Strategic Objective 'greener'.

Appendix 1 details the issues raised during the debate.

**West of Scotland NHS
Regional Planning Group**

**Draft Minute of the Meeting held on Friday 14th November 2008 at 10.00 a.m.
Board Room,
NHS Lanarkshire Board Offices, 14 Beckford Street, Hamilton**

Present:

Mr Tim Davison	Chief Executive, NHS Lanarkshire (Acting Chair)
Mr Tom Divers	Chief Executive, NHS Greater Glasgow & Clyde
Mr John Burns	Chief Executive, NHS Dumfries & Galloway
Dr Wai Yin Hatton	Chief Executive, NHS Ayrshire & Arran
Mrs Jill Young	Chief Executive, National Waiting Times Centre Board
Mrs Pauline Howie	Chief Executive (Interim) Scottish Ambulance Service
Ms Heather Knox	Director of Regional Planning
Mrs Patricia Leiser	Director of Regional Workforce Development
Ms Helen Byrne	Director of Acute Services, Strategy Implementation & Planning NHS Greater Glasgow & Clyde
Mr Ian Ross	Director of Strategic Implementation, Planning & Performance, NHS Lanarkshire
Dr Allan Gunning	Executive Director of Policy, Planning & Performance, NHS Ayrshire & Arran
Mr Stephen Whiston	Head of Planning, Contracting & Performance, NHS Highland Argyll & Bute CHP
Mrs Fiona Ramsay	Director of Finance & Planning, NHS Forth Valley
Mrs Deirdre Evans	Director, National Services Division
Ms Linda Bamford	General Manager, Scottish Ambulance Service
Mrs Justine Westwood	Interim Head of Planning NHS 24
Mrs Denise Brown	Head of E-Health Information & Chair of Regional E-Health Group, NHS Ayrshire & Arran
Mrs Christine Livie	Regional Project Lead, West of Scotland Regional Planning (Minute)

In attendance:

Ms Judith Hope	Divisional General Manager, Women & Diagnostics Division, NHS Lanarkshire In attendance for Agenda item 4
Ms Anne MacPherson	Associate Director of Human Resources, NHS Greater Glasgow & Clyde, Acute Division - In attendance for Agenda item 4
Dr Bob Masterton	Executive Medical Director, NHS Ayrshire & Arran, In attendance for Agenda item 5
Dr Mike Fried	In attendance for Agenda item 6
Ms Jean Bruce	In attendance for Agenda item 6

1. Welcome and Apologies

Apologies were noted from:

Miss Fiona Mackenzie	Chief Executive, NHS Forth Valley (Chair)
Dr Ken Ferguson	Medical Director/Depute Chief Executive, National Waiting Times Centre Board
Dr Derek Cox	Director of Public Health, NHS Dumfries & Galloway
Ms Carole Anderson	Employee Director, National Waiting Times Centre Board
Mr Paul Wilson	Director of Nursing, NHS Lanarkshire
Mr Derek Lindsay	Director of Finance, NHS Ayrshire and Arran

2. Minutes of the meeting held on 18th September 2008

Not discussed.

3. Matter Arising/Actions from last meeting

An action note had been circulated in advance of the meeting. Mr Divers asked the group to note that Dr Ian Wallace had discussed the policy for the management of orphan medicines with both pharmacy and medical director colleagues in the West and a paper relating to this would come to the January 2009 meeting of the RPG. Ms Knox advised that this was also being discussed within the two other RPGs.

ACTION: TOM DIVERS/ HEATHER KNOX

4. Workforce Update

4.1. Radiography Out of Hours Framework: Presentation

Mr Burns introduced this item and provided the RPG with some background. The Radiography Out of Hours Working Group was established by the West of Scotland Regional Workforce Planning Group. The role of the group was to review the current provision and establish a regional approach to both the definition and remuneration of Imaging Out of Hours working arrangements with a move away from standby and on call systems. The group was tasked with bringing forward proposals to the Programme Board for review and endorsement. Mr Burns then introduced Ms Anne MacPherson and Ms Judith Hope to deliver their presentation. He asked the RPG to focus on the framework and advised that discussions were ongoing in Boards around some of the financial issues. A background paper had been circulated outlining the work of the group.

Ms MacPherson and Ms Hope talked through the presentation:

Slide 1 – Background information

Slide 2 – Process and Activity undertaken to develop the framework

Slide 3 – Partnership Working & Communication

Slide 4 – Recommendations – Summary and Next Steps

In particular the group were looking for sign up to the principles of the framework

Mr Davison thanked Ms MacPherson and Ms Hope for the presentation; he then invited comments from the RPG.

Dr Gunning supported the framework and sought clarity on the process of reaching an agreement. Ms McPherson explained there had been commitment from Chief Executives in the first instance and full support from the Society of Radiographers (SoRs). NHS Ayrshire and Arran were represented on the Radiography Out of Hours Working Group and some staff groups had already been sighted on this and had acknowledged that organisational change would be required. Mr Burns reiterated that it would be important to have a short period of dialogue within Boards and to firm up the financial arrangements.

Mr Divers was supportive of the framework and asked how it connected to the 4 tier role development model, Ms MacPherson responded saying that Boards were looking at skill mix and role development and these needed to be built into the model. Mr Divers expressed the view that it would be useful to consider these two developments together. Mrs Leiser commented on the development of level 4 practitioners, saying that the Tier 4 model had not been sufficiently developed, the full implementation of the level 4 model may be difficult.

Mr Ross asked if significant costs would be involved depending on which option was chosen. Ms Hope responded saying that Boards have costed all models. She explained that all four models were flexible and it was for each Board to decide on which of the options they chose. Andy Goor from NHS Lanarkshire was leading the work on finance.

Mrs Evans sought clarity on whether the framework was applicable to the Breast Screening Service within NHS Ayrshire and Arran and NHS Greater Glasgow and Clyde, she felt that breast screening radiographers should be included. Mr Burns agreed to have a separate discussion outwith the meeting with Mrs Evans regarding this.

ACTION: JOHN BURNS/DEIRDRE EVANS

Dr Hatton asked if there was a need for Boards to have a coordinated evidence based impact assessment on the impact of the framework, it was discussed and agreed that it would be sensible to have this in place and would avoid the need for Boards to do this separately, this would however require further work.

ACTION: ANNE MACPHERSON/JUDITH HOPE

Mr Whiston commented that the framework was not particularly helpful to NHS Highland, whilst the framework would be a solution in the West, it may create problems in Highland; particularly in relation to radiography staffing. Ms MacPherson responded saying that the focus had been on West of Scotland Boards but the framework document could be used as a resource by any system when reviewing their Out of Hours Radiography Service. She agreed to discuss this with Mr Whiston outwith the meeting.

The RPG was supportive of the principles outlined in the presentation and agreed on the next steps i.e. the need to complete the financial work and to include this within the framework, this would then be circulated to Boards for engagement and communication at local level in advance of the next RPG meeting in January 2009 when the framework would be formally signed off.

ACTION: ALL BOARDS

5. MRSA Screening

It was agreed to discuss this later in the meeting.

6. Critical Care Audit

Mrs Howie welcomed Dr Mike Fried, Clinical Lead and Ms Jean Bruce, Audit Assistant for the Scottish Audit of Inter Hospital Transfers of Acutely Ill Adults. Dr Fried then delivered a presentation on the results of the audit. The aims of the audit had been to identify the number of acutely ill adults who are transferred between hospitals by Scottish Ambulance Service front line vehicles. The slides provided information on the number of transfers, staff resources and deployed and time implications. The recommendations from the audit were as follows:

- Audit has confirmed significant IHT activity conveyed by front line ambulances
- Inform clinicians re use of ambulance service
- The critical care trolley is preferred choice for critical care land to land transfers
- Establish quality criteria for IHTs
- Establish process and outcome audit of IHTs aided by cab based ePRFs
- Review original IHT business case

The RPG noted the results of the audit. Mr Davison thanked Dr Fried for the presentation and invited comments from the RPG. Mrs Howie advised that SEAT Planning Group had agreed to work with individual Boards to assess the findings and agree future actions. She explained that the SAS was trying to further tier services; she suggested one issue that could be explored would be to establish if there was an appetite for a National Coordination Centre.

Mr Divers suggested that the information from the audit should go back to West of Scotland Boards for further discussion. He expressed concern about some of the figures provided in the slides around 'lack of bed numbers' and it was agreed that this should be reworded. Following further discussion, the RPG agreed that Boards would engage with the SAS on an individual basis, Mrs Howie would make contact through Directors of Planning in each Board area; this would include the National Waiting Times Centre Board.

ACTION: PAULINE HOWIE

The agenda returned to item number 5 on MRSA Screening

Mr Davison welcomed Dr Masterton to the meeting and invited him to provide an update on the pilot project to screen patients for MRSA before admission to hospital. NHS Ayrshire and Arran, NHS Western Isles and NHS Grampian were participating in the pilot as 'Pathfinder' Health Boards. The pilot would run for a period of one year.

Dr Masterton outlined some of the key features around the implementation of the pilot within NHS Ayrshire and Arran:

He reported that 4,000 patients had been screened in the first quarter – 75 per cent of the numbers predicted and treatment rates were about half the anticipated number. Screening was applicable to all inpatients prior to admission excluding obstetrics and paediatrics. £1.2m had been given to fund the pilot; costs were below this at present.

A key issue identified with Ayrshire and Arran was around the staffing of laboratories. At present reporting was being done by biomedical scientists. Space requirements were also an issue. There had been a very positive response from staff and patients who were happy to participate. There had been no adverse impact on services as a direct result of screening and MRSA was on the way down. There were still some groups of patients where there were concerns about the ability of the screening to pick up 100 per cent of the patients and this was a particular issue in orthopaedics and vascular surgery. There had been an improvement in patient flow and bed management staff had found it helpful.

Mr Davison noted that discharge screening was still an issue; he also noted that an interim report on the Pilot would be issued by the National Programme Board in March 2009.

Jill Young commented that she would be happy to share the data from the Jubilee on hospital acquired infection; these would need to be looked at again in detail as surgical procedures carried out at the Jubilee were no longer all elective.

Following further discussion, the RPG agreed that it would be helpful to receive a further update on the pilot at a future meeting of the RPG. (Possibly March 2009 if the interim report was available)

7. Annual Planning Event 9th March 2009

Ms Knox had circulated a paper in advance of the meeting. The paper outlined a proposed draft format for the Annual Planning Event and sought views from Boards on the format. The date agreed for the event to take place was Monday 9th March 2009. The RPG considered the proposals in the paper and after some discussion it was agreed that suggestions for topics and workshops should be sent to Ms Knox before the end of November. It was also agreed to send out information publicising the event before the Christmas break.

**ACTION: ALL BOARDS TO FORWARD SUGGESTIONS TO HEATHER KNOX
ACTION: EVENT INFORMATION TO BE CIRCULATED: HEATHER KNOX/CHRISTINE LIVIE**

8. Specialist Services Workstream

Mr Divers provided an update from the recent meeting of the Specialist Services Group (SSG) on 7th November 2008.

Eating Disorders

Colin Sloey, Chair of the Regional Eating Disorders Group had submitted a report to the SSG for consideration, the purpose of the report had been to scope out the options for the provision of a NHS Eating Disorders Service as an alternative to the current independent sector provision for the population of the West of Scotland. The SSG had agreed to explore further the preferred option of the Regional Eating Disorders Group which was to continue to purchase inpatient beds from the independent sector, consolidate the service change currently underway and reassess the situation in two years time. The Regional Eating Disorders Group would work jointly with planners to take this piece of work forward and an update on progress would come to the RPG in January 2009.

ACTION: HEATHER KNOX

Wheelchair and Seating Services

Mr Divers informed the RPG that he had discussed with Anne Harkness, the Business Case recently submitted to the National Wheelchair Programme Project Board. Anne Harkness and Richard Colvin had recently attended a meeting with Andrew McLeod where it was agreed that more detail was required for the West of Scotland Business Case, Anne had agreed to provide this information.

There had been some discussion at the meeting regarding the funding, which had initially been agreed for a three year period, this was problematic given that many of the developments were of a recurring nature.

Andrew McLeod stated that his understanding was that the money would be in the baseline after the end of the project and he had been relatively reassured by recent conversations with finance colleagues. He understood

that to deliver the scale of change necessary it had to be recurring and he had no difficulty with the statement from the West. This would be further discussed at the next meeting of the National Project Board.

Regional Child Health Group

Mr Divers reported that two of the areas currently being focussed on by this group were around the bids for the National Delivery Plan and Child Protection/Orthopaedic issues.

Cancer

Mr Divers asked Ms Knox if the CEPAS and CPORT bids to support e-prescribing of cancer drugs had been approved. Ms Knox informed him that these had been signed off at the recent West of Scotland Directors of Finance Group (DoFs); Mr Divers thanked the DoFs for their input.

Bariatric Surgery

Ms Knox had circulated papers relating to this, which had also been discussed within SEAT and North of Scotland Planning Groups. A template mapping current service provision throughout Scotland (during July and August 2009) had been issued by Gavin Brown SEAT Planning Group.

In the discussion that followed, the RPG acknowledged that Bariatric Surgery provision was becoming an issue in some health board areas. Mr Divers made reference to an issue raised with the Cabinet Secretary by Cathie Craigie, Labour MP (Cumbernauld and Kilsyth) the issue was that, within the same GP practice, patients from different localities (in this particular case Twechar and Kilsyth) have a different eligibility for access to specialist services within NHS Greater Glasgow and Clyde.

The RPG agreed that it would be appropriate to set up a short life working group with representatives from West of Scotland Boards to explore a regional approach to Weight Management Services/Bariatric Surgery. Mr Davison asked for nominations from Boards. Mr Ross agreed to lead on the work, Ms Knox agreed to assist.

ACTION: IAN ROSS/HEATHER KNOX

Mr Divers agreed to forward information from the Scottish Health Technologies Group on Bariatric Surgery to Mr Ross for information.

ACTION: HEATHER KNOX TO ACTION ON BEHALF OF TOM DIVERS

9. Glasgow New Children's Hospital – Update on progress

Ms Byrne provided a brief update on the new hospital

- At the NHS Greater Glasgow and Clyde October Board meeting, the procurement option for the new hospitals and laboratory project was agreed
- The second gateway will take place in January 2009
- Thereafter, in early February, OJEU will be issued with Stage 1 - Employers Requirement Evaluation occurring in Oct 2009 and Stage 2 - Tender Response Evaluation in October 2010
- Further and ongoing work will need to be undertaken with West of Scotland Boards and NSD on activity levels/redesign in the new Children's hospital

10. Update on Boards' Strategic Changes

Greater Glasgow and Clyde

Mr Divers reported that GG&C was out to formal consultation on the Vision for the Vale of Leven Hospital. It is likely the two areas of contention will be unscheduled medical services and adult mental health. Consultation will run for a 13 week period until end January 2009, with a paper to the Board on the outcomes on 24th February 2009.

Ayrshire and Arran

Dr Gunning reported that the Board would meet next week regarding a decision on mental health services; the preferred option was to consolidate inpatient services on the Irvine site.

11. Any Other Business

Mrs Young informed the RPG that the critical care units at the Golden Jubilee had been full to capacity. She reported that the Jubilee was in breach of waiting time guarantees in terms of cardiac surgery. There was a need to take up spaces in the independent sector. An aggressive recruitment campaign was ongoing.

Dr Hatton asked if the MSAG recommendations around the Neonatal Services Review could be discussed at the Board Chief Executives meeting on 19th November 2008. There were concerns over Boards not being consulted on the review. Ms Knox agreed to sight Miss Mackenzie (in her capacity as Chair of the CEs group) on this and ask that it be included for discussion.

ACTION: HEATHER KNOX

Ms Bamford asked the RPG to note that Patient Transport staff in West Central Division were taking forward a project aimed at making improvements to the Patient Transport Service in their division. Those who volunteered for the project included ambulance office assistants, ambulance care assistants and trade union representatives as well as representatives from NHS GG&C and the local Patient Transport Service Management Team. The group have worked together using 'lean' principles to identify a number of opportunities for making improvements and eliminating inefficiencies. A workshop was held on 6th November 2008, with good attendance from NHS GG&C managers and SAS staff, the workshop was to understand, agree and plan for taking a number of projects forward.

Mr Davison proposed that it would be helpful for the RPG to carry out a stocktake of working arrangements in view of Mr Diver's pending retiral in March 2009 and in light of Miss Mackenzie's desire to relinquish her position as Chair of the RPG. This was agreed.

ACTION: HEATHER KNOX

12. Reports for Noting

The RPG noted the following reports:

- a) Dates for future RPG meetings from July 2009 – May 2010
- b) Directors of Finance – Draft Minute 12 September 2008
- c) National Service Division update