

## Annual Review Submitted Written Questions

**Question:** Why are the canteen facilities at Dr Gray's Hospital closed over some public holidays and what arrangements are put in place for staff and visitors to heat food and prepare hot drinks?

**Our Answer:** The canteen facilities at Dr Gray's are open on all public holidays with the exception of Christmas Day and Boxing Day and 1<sup>st</sup> and 2<sup>nd</sup> of January. During these times the canteen is still accessible to staff and patients with snack and hot/cold drink vending machines available for use. There is also a microwave available for heating food.

**Question:** Grampian NHS uses 0845 telephone numbers. Dialling these is free from BT landlines and some other telephone providers. What is the additional cost to Grampian NHS of using 0845 telephone numbers instead of standard telephone numbers?

**Our Answer:** Dialling 0845 is charged at the same rate as national calls from BT and most other landline providers. It is "free" when the caller subscribes to a tariff with an inclusive call package. There is no cost to NHS Grampian for using 0845 but there are benefits to both the organisation and to callers. One major benefit of 0845 numbers is the ability to give messages to the public and re route calls in the event of a major incident.

In the fairly recent helicopter incident a large number of calls were being received by the switchboard. Utilising the functionality associated with the 0845 numbers, we were able to inform the public calling the main switchboard that we were responding to a major incident and give them the option of listening to a recorded update on the situation.

The other main advantage is the ability to redirect calls in the event of a local exchange or telephone system failure.

From a caller's perspective they no longer reach an engaged tone and have to re-dial – instead calls go into a queue. All hospital wards also have a local direct dial number which is given to relatives so that they can phone the ward directly.

**Question:** There is not enough support for carers at home caring for their families (e.g. daughter caring for mothers in ill health). Also I cannot get to chiropody appointment as I am ill and no transport available. I would like to know why the District Nurse asks questions about owning your house when you are newly out of hospital and very weak after surgery.

**Our Answer:** The role played by carers cannot be underestimated and the need to support them is acknowledged. Aberdeen City Council and NHS Grampian both provide significant funding on an ongoing basis for a Carer Support Service provided by Voluntary Service Aberdeen. The Aberdeen Partnership is actively working to improve the wellbeing of its citizens including carers. This included holding the first Annual Carers' "Thank You" event in June this year ; allowing carers to benefit from activities such as Aberdeen Golden Games (Free Sports Festival) and inviting carers to

attend a forthcoming social event for older people.” 20% of the Change Fund in Aberdeen is being targeted towards Carers’ Support.

We operate a domiciliary chiropody service for those who are housebound. Scottish Ambulance Service provide transport for patients who fulfil certain criteria which is now booked directly with them by phone.

When a District Nurse does an initial assessment for the provision of equipment in a patient’s home she is required to ask who owns the home as there are legal, health and safety requirements to be considered which would have to be agreed with the owner eg if a piece of equipment has to be wall mounted. Alternatively the nurse may have been asking to offer relevant benefits signposting.

**Question::** Why is it when people go into hospital they can pick up infections such as Legionnaires disease, C.Diff, MRSA?

**Our Answer:** When people are ill and admitted to hospital their defences against infection are generally low. Many people will carry different infections and in hospital they are brought together in a confined space. Infections are also carried by ‘well’ staff and visitors into the hospital. All of this combined means the potential for infections transferring between individuals in hospital and in eg care homes is high unless there are stringent systems in place to prevent this. One of the simplest and most effective means of minimising transfer is through handwashing and we monitor compliance with this meticulously. Ensuring cleanliness of the hospital and the equipment we use is also key. In addition to this we are careful about the prescribing of certain antibiotics which are known to lower resistance to infection. I am pleased to report that hospital associated infections are at an all time low.

**Question:** Considering the significant evidence of the deleterious effects of motor traffic on health, should this issue not be tackled by NHS Grampian to a similar degree as smoking, alcohol and obesity?

We the residents of Tillydone community are concerned about plans to construct a major traffic highway through our neighbourhood. This will most certainly effect our health and wellbeing and compound our lower than average health status as indicated by the NHS 'Traffic Lights' document recently issued. This is more than a Tillydrone issue, and should be a concern to all city residents considering that the only two 'Traffic Light' indicators for Aberdeen City which fall below the Scottish average are both traffic related. i.e. traffic accidents and asthma, and that Aberdeen City is failing to deal with air quality in several locations that breach European regulations.

Tillydrone residents believe that this is an issue which the population are not fully advised on, has lacked consideration by planners and decision makers, and remains unaddressed by NHS Grampian whose role should be to bring the health effects of transport into wider discussion: i.e. to balance transport and economic objectives with health.

**Our Answer:** We greatly welcome the interest of the Community Council in the complex interaction between health and environment. There is considerable evidence linking raised levels of air pollutants to aggravation of pre-existing respiratory and cardiovascular illness. We are however also aware that the impact assessment undertaken on the new road by Aberdeen City Council reported an overall neutral impact upon local air quality.

A Health and Transport Action Plan was commissioned by NHS Grampian and NESTRANS, and produced in 2008. This plan sets out the commitment of agencies towards improving health and reducing inequalities, looking specifically at promoting 'active' travel and the links between transport and public health. Central to this plan is to establish initiatives which provide support for people to use alternatives to private motorised transport. In doing so, we hope that people will be less reliant on private cars and will see public transport, walking and cycling, as feasible options. At the same time, we are developing ways to improve access to healthcare services, by providing services closer to home and by establishing a transport 'hub' which will offer journey advice to patients and carers.

Based on the Traffic Lights data, it is clear that residents of Tillydrone have a generally poorer health status than other parts of Aberdeen and Grampian. However, the changes we envisage locally for transport, particularly in reducing private car usage should have a positive impact on health, particularly on air pollution, road safety and physical fitness of individuals.

We would like to continue engaging with the Community and the Community Council in tackling health concerns. Smoking for example, remains an important health issue and given that we know that most smokers actually want to quit, there are opportunities to promote and make better use of smoking cessation services. In so doing, we may make a more substantial impact on asthma and related illnesses.

**Question:** Are there enough District Nurses/nursing resources to support patients in the community?

**Our Answer:** A redesign of community nursing services has been carried out in Aberdeen City with the aim of maximising available nursing resource and also to provide some flexibility to enable the service to respond to the changing needs of the population. Staffing levels are closely monitored at all times to ensure the quality of patient care is not compromised where there are shortages.

We are aware that around half of our Health Visitor workforce is aged over 55 so we are working with The Robert Gordon University to ensure additional training places are available. We are also introducing other grades of nursing staff to our workforce such as staff nurses and nursery nurses to undertake specific duties.

**Question:** Since Ophthalmology has been incorporated with two other departments one of which is Immunology and the fact that several long

serving consultants have retired this last couple of years and Mr Blanco is working on his special project for Glaucoma research and does not do many clinics, many people have remarked that they never seem to get to see the same person twice, often their records are not available and they have to tell each person they see some brief history. Why is this? The clinics are so busy and therefore also waiting times seem to have lengthened both for operations and appointments?

**Our Answer:** Ophthalmology has not been amalgamated with Immunology; however the link is that Professor Forrester (a retired honorary Ophthalmology Consultant) now heads up the Academic Immunology Department. Professor Blanco is also an honorary consultant with NHS Grampian and has glaucoma as his specialist interest.

There have been 2 retirements and 1 migration to Aberdeen University in recent years at Consultant level, all of whom have been replaced. Professor Blanco's NHS clinical commitments are now covered by Miss Kumarasamy and Miss Ford.

It is not unusual in a specialty such as Ophthalmology to see a number of different clinicians. Although consultants have sub-specialty interests, they are part of a wider multi-disciplinary team, ranging from junior doctors, optometrists, nursing and orthoptists, all of whom may contribute to a patient's care. In addition as a teaching Board we support new and junior clinical staff.

The problem of unavailability of notes has been identified previously and there has been a concerted effort to improve. We are beginning a phased roll out of Electronic Patient Records (EPR), which will ultimately remove the need for the paper-trail. In the meantime, all clinicians in the Ophthalmology Department have access to previous clinical letters and previous visual field tests on computer. This is then complemented by a brief clinical history taken from the patient to ensure that both clinician and patient are comfortable progressing with the appointment.

We have looked at average waiting times for outpatient appointments and inpatient treatment and these remain at around 5-5.5 weeks for both. Maximum waits have reduced over the last two years.

**Question:** What efforts are being made to ensure that front line staff are protected from deficit cuts to budgets and ward and beds are maintained?

**Our Answer:** This is an important issue for everyone at the current time. During a time of financial constraint it is important that we continue to review how we maintain and where possible improve services to our patients. As part of the budget setting process we look closely at areas where savings can be made e.g. procurement process (changes have already resulted in savings); reduction in staff (including Government target to reduce senior management by 25%); managers have been asked to look at their budget and staffing levels and to identify what could be done with less money. The 'Safe Affordable Workforce' (SAW) scheme has enabled managers to look carefully

at what is required in their department and to involve staff in determining how best to configure our staffing profile to provide a safe and efficient service.

We also recognise that in addition to financial pressures our services are facing pressures as a result of increasing demands. We face a number of challenges including an ageing population and a 5 to 8% increase in the drugs bill each year. This, along with the current financial situation, means that we will be working in a challenging environment for some years to come.

NHS Grampian has a responsibility to operate within our financial resources in an efficient way whilst ensuring that services are safe. There can be a perception from people that are or have been in hospital that nursing staff are overworked. Nurses, along with other frontline staff, are very important and are committed through the Safe Nursing Establishment (SANE) to ensure that we maintain the right level of nursing resource.

The introduction of the 12 hour shift has enabled wards to be covered at less expense and some staff prefer these shifts as it gives an extra 'day off'. We have had to make these changes and manage as best we can. There are a number of national programmes including 'Releasing Time to Care' which are helping nurses to work more efficiently. We are also considering the skill mix of staff e.g. Maternity Care Assistants who are trained to support women with breastfeeding which allows midwives to focus on other duties.

**Question:** What is the evidence that hands of visitors to hospital increase the risk to patients of acquiring harmful infections? If there is evidence, why is hand gel not advertised at every opportunity? For example, the message could be shown on letters sent to patients who are to be admitted to hospital advising their visitors, on an electronic screen at the entrance to hospitals, at the door of every ward such that it cannot be missed when visitors arrive. Also, who is responsible for replenishing hand gel when they are empty?

**Our Answer:** There is evidence that visitors can bring infections in to the patient bedside from home. In particular viral infection such as the winter vomiting bug. Also visitors can take a bug or the seed of a bug from one area in the hospital to another, for example via door handles.

The suggestions on how to advertise the importance of handwashing are very helpful and we use them in our strategy related to hand washing. In terms of the placement of gels we want to make absolutely sure that gels are placed at the entrance of all clinical areas, and we would ask visitors to gel when they go in and out of these areas.

Patients are sent general HAI information, including hand hygiene information, prior to their in-patient admission in their pre-admission packs. We frequently conduct hand hygiene awareness campaigns targeted at staff and visitors and these do include the use of our plasma screen TVs in public areas. We have also used patient line to promote good hand hygiene by patients and their visitors.

Hand gel is replenished by ward staff in ward/clinical areas and by domestic staff in public areas.

**Question:** How much training in the needs of disabled people is currently being undertaken by NHS Grampian?

**Our Answer:** Each year since 2007, Equality and Diversity Training Seminars have been provided for over 600 NHS Grampian staff. This training covers the 9 “protected characteristics” which includes disability. The Knowledge and Skills Framework level four requirement comprises 2 x 90 minute seminars. The seminars cover the needs of disabled people and carers. Feedback from participants has been uniformly excellent.

There is also an Equality and Diversity level two seminar which comprises one 90 minute seminar. This is aimed at basic grade and supervisory level staff. It covers the same areas including disability, but not in as much depth. Given the recent numbers attending, it is likely that over 800 staff will receive either level four or level two training in the 2012/13 financial year.

In late 2010/early 2011, the NHS Grampian Disability Discrimination Act Review Group (DDARG) started to develop a “dedicated” disability seminar for staff which also covers the needs of carers. The DDARG has 27 members, most of whom are disabled or Chairs of local disability organisations. This 90 minute seminar was written and produced by disabled people who are members of the DDARG and is co-presented by disabled people. This seminar is now being rolled out across NHS Grampian. The latest seminar was on 27<sup>th</sup> June 2012, when 60 Aberdeen City CHP dental staff attended as part of their protected learning time. Again, feedback from participants has been excellent.

Given that there are at least three disabled people required as co-presenters at each seminar, this seminar does take longer to arrange but does make a big impact on staff.

**Question:** Is it possible for there to be some volunteer guides operating in the long main corridor at ARI? Although things are signposted, many people do struggle to find various departments and all of the signs are confusing. They could wear sashes to be easily identified and guide people to where they wish to be.

**Our Answer:** We do have ‘meeters and greeters’ in ARI and the Children’s Hospital at evening and weekend visiting times to help visitors and give directions. We could consider other areas where people could be positioned to help.

The current wayfinding project is working to divide the hospital into zones which should make it easier for people to find their way around the site. When you receive your appointment letter you will be directed to a specific zone. We are also working in partnership with the WRVS to enhance the role around volunteering and working with staff.

We recognise that it is likely to get more difficult for people in the next few years while services are reconfigured when the Emergency Care Centre (ECC) opens. The ECC will replace approximately 40% of the inpatient beds on the site but we still need to improve the 60% left. When wards move to the ECC, this will create turning space to close and upgrade other ward areas, which will allow us to address backlog maintenance issues. Without turning space it would be almost impossible to carry out any major maintenance work. There is a plan in place, but with a number of moves involved this could be another benefit of increasing the number of volunteers to help people – not just at the main entrances, but other entrances too.

**Question:** With regards to the targets set by the Government, how fair are these for NHS Grampian when it could be said that the North East is treated unfairly when allocation of funding takes place? Understand that NHS Grampian has to work within budgets, but how much can the fairness of budget allocation be challenged?

**Our Answer:** The allocation of funding to NHS Boards in Scotland is based on a formula which considers the size of the population, inequalities, rurality etc. NHS Grampian has historically had a reduced allocation compared with NHS Boards, but this is being addressed through the NRAC (National Resource Allocation Formula) work.

The Scottish Health and Social Care Directorate are supportive of accelerating the achievement of parity of funding across Scotland and we will receive a further contribution in the next financial year to close the gap. It will however take many years for the position of parity to be achieved.

**Question:** Are there enough NHS dentists in Aberdeen for the population? If not, why not?

**Our Answer:** In Aberdeen City 2 new /extended practices have opened in the last 2 months. These practices have offered circa 20,000 NHS places for patients. To date 2-5,000 places have been used. There are now at least 6 practices offering immediate dental care services (within 2 to 4 weeks) in Aberdeen City.

There are currently no patients on a waiting list for dental services in Aberdeen City. We now feel therefore, that we are getting close to sufficient numbers of dentists in Aberdeen City, although there may still be issues of location and access for groups such as the homeless which we will aim to address. However as we move further north in Grampian we still have considerable challenges.

Aberdeen Dental School has opened and has delivered its first 13 new dental graduates in 2012. This was achieved within 5 years of concept. 10 of these graduates are now working in the north of Scotland. A further 20 are expected to graduate next year to fill vacancies such as those arising from retirements etc in Grampian and complement the other 2 dental schools in Glasgow and

Dundee. This will ensure a permanent solution to the dental workforce throughout the North of Scotland by 2014/15.

**Question:** Why do GPs 'lose control' when patients are taken into hospital? We would like to see more integration between GPs and hospitals.

**Our Answer:** It is regrettable if GPs sometimes feel this way when their patients are admitted to hospital. You can be assured that integration is one of our priorities and we are working hard to remove unnecessary barriers between people and organisations. Our 2020 Vision includes a section on how we expect primary care groups to organise care on a local basis, integrate community health and social care, and integrate primary and acute care on a Grampian basis. We have already begun this process with the development of GP cluster areas.

**Question:** While prevention of Healthcare Associated Infections, (HAI), must indeed be a priority for NHS Grampian, are some Clinician's obsession with Infection Control Targets and Falls Targets, and their reluctance to record these on occasion for fear of failing to meet targets, jeopardising patient, staff, and visitor safety and well-being?

**Our Answer:** We do not believe that staff are reluctant to report adverse incidents in an effort to meet targets. We continually remind staff of the need to report such incidents using the Datix reporting. An example of this was our September 2012 Team Brief (which goes to all staff). The following message was included:-

*'NHS Grampian is committed to ensuring that when an adverse or critical event occurs the event will be managed effectively to ensure that:*

- the patient and their family are safe and supported;*
- staff members are safe and supported;*
- the organisation appropriately reviews what happened in an open, fair and thorough way, within defined timelines and having due regard for patient and staff confidentiality*
- we learn from the event and implement any required improvements.*

*The most important first step is that Datix is used on each and every occasion. This ensures that we investigate all incidents in a way that is:*

- fair and thorough;*
- compassionate;*
- transparent;*
- timely and consistent;*

*while all the time being focused on the needs of the patient, their family and staff. Usage of Datix is very good in NHS Grampian. Please ensure that this continues and that if you have any difficulties in access or with the system itself you let us know so that these can be resolved.'*

**Question:** How much are patient outcomes influenced – and even potentially jeopardised - when they present at Primary Care venues with 'Suspicion of Cancer' by the wording and grading of the GP referral? Are GP's being



discouraged from assigning high risk gradings to their referral requests, to tie in with 62 day criteria?

**Our Answer:** There is an electronic system for GP referrals within Grampian, which uses guideline checklists (based on Scottish Referral Guidelines for Suspected Cancer 2009) and letter templates to guide referral wording and grading. The principle adopted by us for the Detect Cancer Early programme is 'clinically appropriate' thresholds for diagnostic investigations and referral to secondary care. Support for GP clinical suspicion and clinical judgement is necessary, and potential barriers to further diagnostic investigation or referral should be avoided. It is however recognised that a proportion of cancer cases will not present with guideline 'checklist' symptoms and signs.

GPs are not discouraged from assigning high risk gradings to their referral requests to tie in with the 62 day criteria. Referral decisions are based on interpretation of clinical features and clinical judgement. Such decisions are complex with many uncertainties.

**Question:** I understand there are an increasing number of refusals for x-rays and scans being given for patients referred for these procedures by their GPs and that GPs are being 'reprimanded' for some of these requests. GPs are making patients aware of their dissatisfaction, frustration and anger at this, which does not bode well for relationships between health care providers. What is the current criteria for GP referrals for such investigations, and how can you keep GPs 'on side', while still understandably vetting procedure requests in some fashion?

**Our Answer:** GP requests are vetted either by a radiographer or radiologist. If a request is deemed to be inappropriate, then this is returned to the GP with an explanation. This should not be considered as a reprimand. The system of returning referrals hasn't altered for some time and the service is unaware of an increase in the number of such returns or any GP dissatisfaction with current processes.

**Question:** There is a major shortage of Clinical Oncologists within NHS Grampian, due to retirement, etc. This is going to have a massive impact on Oncology provision, causing lengthier waiting times for consultations and treatment, potentially jeopardising cancer patient outcomes. What is being done to address this shortage of vital oncology clinicians?

**Our Answer:** The establishment of oncologists has risen over the past 3 years from 6.5 to 8.6 whole time equivalents (wte). Prior to the summer we had 1 wte retiral but have successfully re-appointed to this position with the individual starting at the beginning of September. We do have a consultant on long term sick leave and will recruit to that position once it is clear whether he is returning to work or not. There is also a new post being advertised presently and we are optimistic of recruiting to this.

We have been working within the regional cancer network to provide some additional cover (Neuro-oncology) via a consultant in NHS Tayside and this

has worked very well. The caseload is very small and the service has an excellent regional multi-disciplinary team to support it. The consultant support has been very short term but has emphasised the benefits to patients and service continuity of working within teams across the region.

Throughout the period there have been no 62 day or 31 day breaches in radiotherapy or chemotherapy treatment times. The increase in overall consultant establishment has enabled us to cover the retirement period and the sick leave without any performance implications.

**Question:** With the roll-out of the new Parking Management Scheme since July, I understand from the General Manager Facilities and Estates that Car Park and Barrier Attendants have been instructed to be 'rigorous' in their approach to dealing with those accessing the ARI site. Is this an acceptable instruction to use such a 'heavy-handed' approach to those who require to visit ARI, bearing in mind many of these people may be unwell themselves, transporting others who are unwell, visiting ill relatives, and already anxious and stressed?

**Our Answer:** In this context the term rigorous means that we are seeking to apply a fair and consistent approach in line with agreed policy to all vehicles entering the site. This has not been 'heavy handed' but differs from the previous 'open to anyone' approach. This approach is essential if we are to avoid the congestion we had previously. Feedback from patients has been positive and in line with what we expected and hoped.

**Question:** By March 2013 a target of 90% of all patients admitted to hospital with a diagnosis of stroke should be admitted to a stroke unit on the day of admission or the following day. On this, 88.9% was delivered in July 2011, but performance then dipped, before rising to 97.0% in March 2012. As a figure is not give, how much did this performance dip between July 2011 and March 2012?

**Our Answer:** Performance dipped over the winter months to 65.9% in November, 64.8% in December, 77.4% in January, 66% in February. Performance in March, April and May was above the 90% target.

**Question:** In relation to the 'Older People in Acute Care' initiative, can NHS Grampian take steps to address the issue of identifying and caring for those patients with severe sight-impairment/blindness? Could a scheme similar to the 'Butterfly Scheme', which uses a butterfly symbol to identify those suffering Dementia or Cognitive Impairment, be introduced?

**Our Answer:** A system for this is currently being piloted and if this is successful it will be rolled out.

**Question:** In relation to 'Shifting the Balance of Care towards Health and Social Care Integration' it is stated that, "within Grampian there is a strong history of effective joint working between health and social care services". My

experiences do not always reflect this – how can effective joined-up care be experienced by everyone going forward?

**Our Answer:** In order to meet the challenges associated with a growing elderly population we have no alternative but to work in an integrated way with local authority partners and the third sector to make best use of the financial and workforce resources we have. The Change Fund introduced last year has provided the means of doing this more extensively but in the future joint working, joint care plans and joint budgets will keep this going. The integration of Health and Social Care is a priority for Scottish Government and we have contributed to the consultation on this. We await the detail on implementation.

**Question:** By March 2013 no one will wait longer than 26 weeks from referral to treatment for Specialist Child and Adolescent Mental Health Services (CAMHS). Half a year wait for vulnerable patients of this age group appears unacceptable, given the nature of their health issues and attached risks. Do NHS Grampian not feel that a 6 month wait is particularly undesirable and extremely detrimental to patient care and well-being, especially given their involvement in the 'Patient Safety in Mental Health' programme?

**Our Answer:** The maximum 26 week wait is the current NHS Scotland target and we are working towards delivering this by March 2013. This is the first target that has been introduced for this service and based on experience with other targets it will be reviewed by NHS Scotland to make further improvement. Within Grampian we have integrated the child and adolescent services and increased capacity so that more people are being seen and quicker than before. You can be assured that those most in need are seen first. We are confident the target will be delivered and then improved upon.

**Question:** While I commend NHS Grampian on continually taking steps to involve users, and obtain feedback and patient experience information, I believe what useful and important data is received by various methods is only from a very small percentage of NHS Grampian service users. What steps can be taken to encourage far more feedback, in particular from users who may not consider submitting information, either due to not believing they are au fait enough with medical terminology, or because they fear jeopardising their care, or that of a relative?

**Our Answer:** The involvement and engagement of service users and the wider population is very important to us and we want to do everything we can to make this involvement as meaningful, relevant and comprehensive as possible.

Our experience has been that this is most successful when we target our efforts on a particular service or sector of the community. For example we engaged very comprehensively with parents of children with complex needs and recently with users of maternity services. We find it much more effective to meet and talk with service users in their community – for example at ante-natal classes and mother and toddler groups for maternity service users.

We have a responsibility to engage with people in a way that is meaningful to them. We should not be using medical terminology, abbreviations or jargon. Everyone's views are important, expressed in whatever way is easiest for them. Similarly we should use communication tools that are appropriate – for example, we are increasingly using social networking to engage with young people. Recently we have trained lay representatives to undertake patient interviews and record patient stories which we think will be very useful.

Finally, we would hope that no one feels that by giving us feedback and talking about their experiences this would in any way affect their care or that of a relative. It is only by receiving feedback that we can improve the services we provide. The only comments expressed by our staff is that the patient or their family did not raise any concerns or give feedback at the time so that issues could have been sorted out more quickly.

**Question:** From my observations as a patient, I am very concerned about the amount of waste generated within the NHS. Why is it that drugs and paraphernalia such as packed syringes which are returned to a local chemist, get destroyed by them? Why cannot sealed syringes, other paraphernalia and drugs in their original and sealed packaging be reused?

**Our Answer:** We are likewise concerned about the waste associated with unused medicines and the cost of this to NHS Grampian has been assessed at around £9m per year. Unfortunately it is not possible to use returned medicines and paraphernalia even if it appears to be in its original and sealed packaging as it has been outwith a controlled environment and a guarantee of safety cannot be given.

It follows that we must take action to reduce the amount of unused medicines. In 2011 we undertook a campaign which included television and radio advertisements, posters in pharmacies, GP practices and care homes. The key messages were:-

- Make better use of your medication
- Unused medicines are a safety risk and should be returned to the pharmacy for safe disposal
- Have medicine reviews with your GP or pharmacist on a regular basis
- If you need to go into hospital, take your medicines with you

An evaluation of the campaign showed that people did take action following the campaign. We will be running another campaign in early 2013

**Question:** I am concerned that bureaucracy and administrative processes occasionally get in the way of the welfare and needs of patients. I understand that the NHS needs to protect itself against inappropriate and time-consuming litigation but I feel this is becoming detrimental to the welfare of patients. Examples include waiting on the ward for one tablet which needed to be authorised by the neurologist who was off duty only to be told by the duty Doctor that he was not a specialist in Parkinson's disease forgetting that the

patient (i.e. me) with Parkinson's for 12 years, was the specialist! Do you think this ever increasing risk-adverse culture is getting in the way of providing timely and appropriate healthcare?

**Our Answer:** We agree that more needs to be done to involve patients more in the management and decision making relating to their illness because as you say, years of experience are invaluable. We are working with our clinicians to recognise and make more use of patient experience and self management in the future.

We do not believe that the culture of the NHS is becoming more risk adverse. We strive for the appropriate balance without compromising patient safety. The increasing use of new technology such as the electronic patient record will help streamline processes by giving ready access to up to date patient information to assist in risk assessment and decision making.