BACKGROUND

NOTES

FOR THE

FFAEM

MANAGEMENT

VIVA

CONTENTS

INTRODUCTION.

This series of notes aims to provide a brief overview of the structure (processes and organisations) of the NHS that may be useful in the Management Viva of the FFAEM exam. It is not intended to be a thorough treatise on the NHS nor a complete preparation for the viva. There are numerous resources that teach medico-legal issues (consent, confidentiality, the complaints procedure, etc) but the topics covered here have been condensed from larger official documents.

They have been organised in the following format.

1. Background Documents – Government publications, such as the 1997 White Paper ('The New NHS: Modern, Dependable') and the Consultation Document ('A First Class Service: Quality in the NHS') were formative in the development of the NHS Plan (2000). They introduced concepts such as clinical governance, and although details of these documents are not needed for the exam, they provide an insight into the parliamentary procedures that affect our working lives.

2. Processes – systems that influence or monitor the provision of healthcare are summarised in this section. Topics include processes that aim to improve quality of healthcare provision, such as National Service Frameworks, clinical governance, the NHS Performance Assessment Framework, star ratings, the Clinical Negligence Scheme for Trusts, and appraisal and revalidation. Finally, workplace legislation such as the European Working Time Directive and Zero Tolerance procedures are included.

3. Organisations – institutions that have an influence on healthcare provision are summarised in this section: the National Institute of Clinical Excellence, Commission for Health Improvement, the Modernisation Agency, and Healthcare and Audit Commissions are covered.

4. Emergency Medicine specific issues – Reforming Emergency Care introduced a number of strategies to try to improve a number of identified problems; processes such as 'see & treat' and 'streaming' were introduced in this document.

5. Miscellaneous issues – the Victoria Climbie and Bristol inquiries are included here, with a summary of the recommendations made.

It is intended to add to this series as further, relevant documents are published and documents that become out of date will be archived. Any ideas for further topics to cover will be welcome; even better, completed summaries will be gratefully received!

SECTION 1.

BACKGROUND

GOVERNMENT

DOCUMENTS.

DEFINITIONS:

Green Paper: a preliminary report on Government proposals which is published to stimulate discussion.

White Paper: a Government report which gives information about a proposal.

Consultation Document: a Government document which seeks information and advice about a proposal from interested parties.

WHITE PAPER
'THE NEW NHS: MODERN, DEPENDABLE'
(1997)

Introduction
A White Paper is a document that is published by the Government setting out details of future policy, which allows the Government the opportunity to gather feedback before it formally presents the policy as a Bill. This paper was the fore-runner of the NHS Plan, 2000.

Principles
The aim was to implement this plan over 10 years.

1. better access to services;
2. reduced variation in practice;
3. reduced bureaucracy;
4. patient-centred practice applying national standards to local needs.

1. Accessibility
a. <u>fast advice for people at home.</u>
NHS Direct (by 2000).
Health education (TV/internet).

b. <u>rapid access to community services.</u>
NHS Net (test results, OPA booking).
Electronic records.

c. <u>prompt access to specialist services.</u>
Suspected Ca seen within 2/52 of GP referral.
Telemedicine.

2. Reduced Variation in Practice
a. <u>National Initiatives.</u>
National Service Frameworks (NSFs): consistent access to services and quality of care.

National Institute of Clinical Excellence (NICE): give lead on clinical-/ cost-effectiveness.

b. <u>Local Initiatives.</u>
Primary Care Groups (PCGs): community teams with local knowledge. Devolved responsibility for single, unified budget.

Commission for Health Improvement (CHI): support and oversee quality of services at a local level and tackle short-comings. Secretary of State has powers to intervene.

Service Agreements: between Health Authorities (HA)/ PCGs/ Trusts. Local agreements reflecting national standards.

Clinical Governance: system to ensure clinical standards are met, processes are in place to ensure continuous improvement and backed by a statutory duty for quality in Trusts.

3. Increased Efficiency/ Reduced Bureaucracy.

a. Budgets:
- unified at HA/PCG level;
- management costs capped;
- 'reference costs';
  - -itemise individual treatment costs across NHS
  - -Trusts benchmarked against these
- incentives and sanctions.
  - -extra cash if performing well
  - -HAs can withdraw freedoms from PCGs
  - -PCGs have powers to demand standards from Trusts and change provider if necessary
  - -NHS Exec can directly intervene at any level

b. Commissioning Groups:
- reduced from >3500 to 500.

c. Local Authorities:
- remove boundaries between local and health authorities.

4. Locally-Driven, Patient-Centred Care.

a. Health Action Zones:
-1998
-roughly HA size
-up to 10 zones – bring together organizations within and outside NHS → develop local strategies to improve health of local people.

b. NHS Charter:
-replace old patient charter
-standard of treatment/ care that patients can expect
-states patients' responsibilities

Different Groups

1. Health Authorities
a. Oversee effectiveness of NHS locally; in time, the plan is to relinquish direct commissioning to PCGs.
b. Take lead in drawing up 3-year Health Improvement Programmes with LAs, PCGs, and Trusts.
c. Allocate funds to PCGs and hold them to account.
d. Forge stronger links with social services.

2. Primary Care Groups
a. All GPs and community nurses.
b. Commission services for local community
c. Have freedom to decide how to provide services within the framework of Health Improvement Programme.
d. Accountable to HA.
e. Over time, have opportunity to become free-standing Primary Care Trusts.

3. NHS Trusts
a. Provide patient services in hospitals and community.
b. They are party to Health Improvement Programmes and they have a statutory duty for quality.
c. Agree long-term service agreements with PCGs:
-linked to NSFs
-agreements organized around particular care groups (eg children) and diseases (eg heart).

4. Department of Health/ NHS Executive
a. Responsible for action needed at national level.
b. Integrate health and social services policy.
c. Develop NSFs (with clinical professions).
d. Secretary of State has powers to intervene locally where HAs, PCGs, Trusts fail.
e. Regional Offices are responsible to ensure that HAs + PCGs work together to commission specialist health services at regional level. Also have a role in ensuring local links between NHS + Local Authorities.

Specific Features

1. Clinical Governance.

- quality improvement processes eg clinical audit
- leadership skills developed at clinical team level
- evidence-based practice used
- dissemination of examples of good practice within and outside organization
- clinical risk reduction programmes
- adverse events detected and openly investigated so that lessons can be learned
- complaints – lessons learned
- clinical performance
    - poor performance recognized and dealt with, to protect patients
    - professional development programmes reflect principles of clinical governance
- high quality of data collected

It is the responsibility of Trusts – lead by Chief Executive but devolved to either committee or named senior clinician/nurse.

2. Failing Trusts.

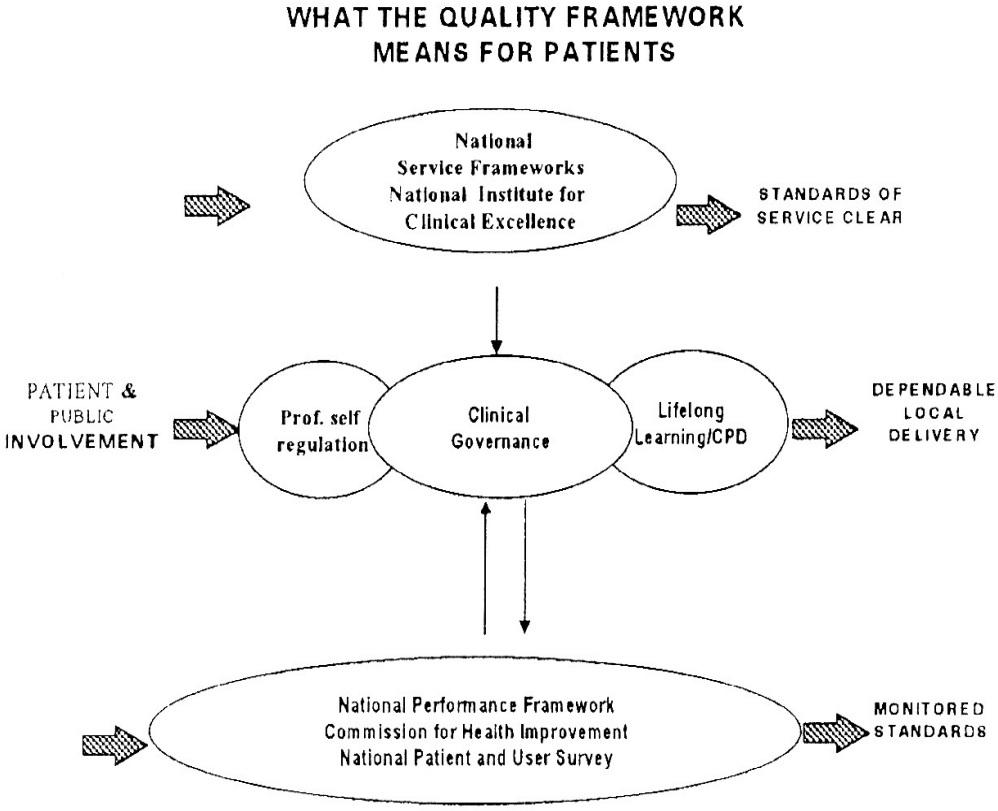
- HAs call in Regional Offices if Trusts not delivering against Health Improvement Programmes
- Regional Offices investigate if not complying with statutory duties
- CHI can investigate and report
- PCGs can change the local service agreement
- Secretary of State can remove NHS Trust board

3. NSFs.

- improve consistency (availability and quality) of services nationally
- leave patients clear about what to expect

CONSULTATION DOCUMENT
'A FIRST CLASS SERVICE: QUALITY IN THE NEW NHS'
(1998)

It added detail to the 1997 White Paper (New NHS: Modern, Dependable) and aimed to improve quality of healthcare provision and to standardise care nationally. The following diagram was produced to summarise the key elements:



It gave more details about:

1. how standards would be set nationally by NICE and NSF;

2. how standards were to be delivered locally using the system of clinical governance, principles of lifelong learning among NHS staff, and a system of professional self-regulation;

3. how standards were to be monitored using CHI (now the Healthcare Commission), National Framework for Assessing Performance, and annual National Survey of Patient and User Experience.

Websites

Original Consultation Document
www.dh.gov.uk/assetRoot/04/04/48/91/04044891.pdf (forward)
www.dh.gov.uk/assetRoot/04/04/49/41/04044941.pdf (introduction)
www.dh.gov.uk/assetRoot/04/04/50/37/04045037.pdf (setting standards)
www.dh.gov.uk/assetRoot/04/04/51/52/04045152.pdf (delivering standards)
www.dh.gov.uk/assetRoot/04/04/51/76/04045176.pdf (monitoring standards)
www.dh.gov.uk/assetRoot/04/04/51/86/04045186.pdf (action plans)

Feedback on Consultations (HSC 1999/033)
www.dh.gov.uk/assetRoot/04/01/20/25/04012025.pdf

THE NHS PLAN: A PLAN FOR INVESTMENT, A PLAN FOR REFORM (2000)

Problems Identified

1. Inadequate funding.
2. Out-dated working patterns:
    a. Lack of national standards.
    b. Old-fashioned demarcation between staff and barriers between services
    c. Lack of clear incentives to improve performance.
    d. Over-centralisation and disempowered patients.

Solutions Proposed

1. Funding

1. Facilities
    a. 7000 extra beds (hospital & intermediate care).
    b. 100 new hospitals & 500 new one-stop primary care centres by 2010.
    c. 3000 GP practices modernised.
    d. 250 new scanners.
    e. Clean wards overseen by 'modern matrons'.
    f. Better hospital food.
    g. Modern IT (all GP surgeries & hospitals).

2. Staff
    a. more staff (7500 consultants, 2000 GPs, 20000 nurses, 6500 therapists)
    b. 1000 more medical school places.
    c. 100 on-site nurseries to improve child-care support for NHS staff.

2. Reform

Overall aim, to produce a more patient-centred NHS.

1. Relationship between central administration and local services.
    a. Nationally
        DoH set national standards
        CHI regularly inspect all local health bodies
        NICE determine cost-effectiveness of drugs to reduce local variation in prescribing
        Modernisation Agency set up to spread best practice
    b. Locally
        Organisations that perform well will get more freedom to run their own affairs, but Government will intervene more quickly in those that fail.

2. Relationship between NHS & Social Services.
    New agreements will be made between these services to pool resources and new Care Trusts will be developed whose role will be to commission health and social care in a single organisation.

3. Relationship between NHS and Private Healthcare Providers.
   New agreements made with the Private Sector to allow the NHS to use facilities if necessary, as long as it provides value for money, maintains standards of care, and remains free at the point of delivery.

4. Staff contracts & roles.
   a. New contracts will be developed for hospital doctors and GPs.
   b. Extended roles for other professionals (over ½ nurses able to prescribe by 2004, over 1000 nurse consultants, and introduce consultant therapists.

5. Leadership Centre.
   This is to be set up to develop managerial and clinical leads.

6. Patients' influence.
   a. Copies of letters to be sent to patients.
   b. Better information provided to help them choose a GP.
   c. Patient advisers/advocates set up in hospitals (PALS)
   d. Patients given proper redress when operations cancelled.
   e. Patients' surveys and forums used to improve local services.

7. Reduced waiting times.
   a. A&E 4 hour target.
   b. GP appointments in <48 hours.
   c. Out-patient and in-patient waits reduced.

8. Specific areas of care.
   Miscellaneous improvements in services for the elderly and patients with cancer, heart disease, and mental illness. Also improvements to Primary Care such as in deprived areas, screening services, and health promotion.

Website
www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf

SECTION 2.

NHS

PROCESSES

NATIONAL SERVICE FRAMEWORKS
(NSFs)

Aims

1. Set national standards and define service models for defined service/care groups.
2. Put in place strategies for their implementation and delivery.
3. Establish performance measures against which progress can be monitored over an agreed time-scale

Development

1. External Reference Group
    - professional groups
    - service users and carers
    - health service managers
    - partner agencies
    - 'other advocates'
2. Department of Health
    - overall co-ordination and management

Time-Scale

1. Rolling programme from April 1998
    - cancer
    - paediatric ITU
    - mental health
    - coronary heart disease
    - national cancer plan
    - older people
    - diabetes care
    - in preparation (renal services, children's services, chronic conditions [especially neurological])
2. Agreement with Association of British Pharmaceutical Industries
    - trying to get them to agree and co-operate with NSFs at all stages (development, implementation, and delivery).
3. Benchmarking tool developed 2002.

EXAMPLES OF NSFs

The NSR for coronary heart disease will be presented in some detail because it has direct relevance to Emergency Medicine. In addition, the NSFs for Older People and Diabetes are mentioned because they are aim to improving general medical practice which includes but is not exclusive to Emergency Medicine.

1. NSF for Coronary Heart Disease
There are 12 standards covering different clinical areas:

Public Health
Reducing risk factors in the general population.

Primary Care
Primary and secondary preventative strategies.
Reducing ambulance response times (see box below).

Standard five: People with symptoms of a possible heart attack should receive help from an individual equipped with and appropriately trained in the use of a defibrillator within 8 minutes of calling for help, to maximise the benefits of resuscitation should it be necessary.

Secondary & Tertiary Care
Reducing waiting times for out patient investigations (ie provision of Rapid Access Chest Pain Clinics).
Increased provision of interventional procedures.
Appropriate investigation and treatment of heart failure.
Adequate provision of cardiac rehabilitation programmes.

Standards with Direct Relevance to Emergency Medicine

Standard six: People thought to be suffering from a heart attack should be assessed professionally and, if indicated, receive aspirin. Thrombolysis should be given within 60 minutes of calling for professional help.

Standard seven: NHS Trusts should put in place agreed protocols/ systems of care so that people admitted to hospital with proven heart attack are appropriately assessed and offered treatments of proven clinical- and cost-effectiveness to reduce their risk of disability and death.

Standard ten: NHS Trusts should put in place hospital-wide systems of care so that patients with suspected or confirmed coronary heart disease receive timely and appropriate investigation and treatment to relieve their symptoms and reduce their risk of subsequent coronary events.

In practical terms, these standards have a number of clinical implications:

1. Hospital-wide protocols for managing patients must be developed, so that treatment is standardised irrespective of the grade of doctor assessing the patient.

2. Mandatory treatments for acute MI:
    - Aspirin 300mg
    - Oxygen
    - Pain relief +/- antiemetics
    - Thrombolytic therapy within 1 hour of onset of symptoms
    - Beta-blockers (continued for at least 1 year)
    - ACE inhibitors (review after 4-6/52 if clinical/ echo evidence of failure)
    - Meticulous glycaemic control
    - Continuing care (post A&E): statins, smoking cessation advice, tight BP control (<150/90), assess need for revascularisation, arrange individualised rehabilitation programme.

3. Treatment of non-infarct ACS:
    - Risk assessment: if has rest angina >20 mins, ST depression >2 leads, pulmonary oedema/ hypotension/ tachycardia, MI <2/52, elevated troponin, then should be referred to a cardiologist.
    - Treatment: bed rest, oxygen, cardiac monitoring, aspirin and heparin, nitrates, beta-blockers/ calcium channel blockers, reassess after 12 hours.

Time-scale

1. Call-to-needle time (for thrombolysis) reduced:
    - 75% category A ambulance calls responded in <8 mins – April 2001
    - 75% eligible patients thrombolysed <30 mins of reaching hospital – April 2001
    - 75% eligible patients thrombolysed <20 mins of reaching hospital – April 2002

2. Every acute hospital should have hospital-wide protocols for managing ACS – April 2001.

3. Every acute hospital should have clinical audit data on the following by April 2002:
    - % thrombolysed within 20 mins of arrival in hospital
    - % thrombolysed within 1 hour of call for help
    - % patients post MI discharged from hospital on aspirin, beta-blockers, ACE inhibitors, statin.

Full details of the Coronary Heart Disease NSF can be found at:
www.nelh.nhs.uk/nsf/chd/nsf/main/mainreport.htm

2. NSF for Older People

1. rooting out age discrimination – care given is based on clinical grounds
2. person-centred care – treat each person as an individual
3. intermediate care – independence in the community
4. general hospital care – appropriate specialist care (includes emergency care)
5. stroke – prevention and specialist stroke services
6. falls – prevention
7. mental health – integrated care
8. promoting active healthy life

3. NSF for Diabetes

1. prevention of type 2 diabetes
2. identification of people with sub clinical diabetes
3. empowering people with diabetes
4. clinical care of adults and children with diabetes
5. management of diabetic emergencies – should be dealt with by suitably trained staff
6. adequate diabetic control during hospital admission
7. diabetes and pregnancy
8. detection & management of long-term complications

Websites

Department of Health: www.dh.gov.uk

National Electronic Library for Health: www.nelh.nhs.uk

CLINICAL GOVERNANCE

Definitions

A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. *Health Services Circular 1999(065.)* (www.dh.gov.uk/assetRoot/04/01/20/43/04012043.pdf)

The system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care. *Commission for Health Improvement.*

Background

It was a system that was adapted from industry and presented in the NHS White Paper: a First Class Service. It was a core principle running through the paper and aimed to ensure the local delivery of high quality clinical services:

National Standards provided by:
NSFs
NICE

Dependable Local Delivery improved by:
Professional self-regulation
Clinical governance
Lifelong learning

Monitoring Standards undertaken by:
CHI (superseded by Healthcare Commission since April 2004),
National Performance Framework,
National Patient & User Survey.

Aspects of Clinical Governance

Different organisations stress different aspects of clinical governance, which is why it often seems confusing to clinicians. The following two are examples: the first (by the World Health Organisation) is simple and captures the essence of clinical governance in 4 headings; the second is the system that is used to assess Trusts.

1. Four aspects of quality have been defined by WHO (Sally & Donaldson. BMJ. 1998; 317; 61-65):

1. Professional performance (technical quality).
2. Resource use (efficiency).
3. Risk management (risk of injury or illness associated with service provided).
4. Patients' satisfaction with the service provided.

2. Seven aspects of quality are formally assessed (by the Healthcare Commission). These are the so-called 'seven pillars of clinical governance':

1. Patient/ public involvement (patient experience, access to services, quality of care).
2. Risk management (risk assessment and learning from mistakes and complaints – an 'organisation with memory').
3. Clinical audit (what is audited – in particular use of national audits – how are they audited, and what is done about the results?)
4. Clinical effectiveness (includes use of evidence based guidelines)
5. Staffing levels and management (includes staff development, performance and appraisal).
6. Education, training, and continuous personal/ professional development (trust induction, supervision of staff, and mandatory training).
7. Use of information (how IT is used and how patients are involved to identify needs).

Roles of Different Organisations

Trusts

Chief executives are responsible to ensure that clinical governance principles, processes and systems are in place within all areas of the trust; the practical aspects of this role is usually delegated to another member of the Executive team. The aim is to ensure the local delivery of safe, high quality care and implementation of national initiatives (NICE guidance, NSF standards, and National Patient Safety Agency reporting).

The important issues that concern trusts are:

1. Clinical audit/ review of clinical services.
2. Assessing performance.
3. Identifying training needs.
4. Open culture of reporting incidents and learning lessons.
5. Effective risk management processes.

Trusts have to produce an annual report on their clinical governance activities to the Strategic Health Authority. See the NHS Trust Reporting Framework (below) for the aspects that must be assessed when Trusts prepare their annual reports.

Strategic Health Authorities

They are responsible for improving the patient's experience and health care outcomes for their local health community.

The important issues that concern Strategic Health Authorities are:

1. Prioritise service improvement across the sector.
2. Ensure different local organisations work together.
3. Support trusts as necessary to achieve effective clinical governance.
4. Collaborate with the Healthcare Commission (formerly CHI) with review schedules and agreeing/ monitoring action plans.

Strategic Health Authorities have to report directly to the Department of Health about its clinical governance activities.

Department of Health

The DH has a number of roles:

1. Set national priorities.
2. Set national standards via National Service Frameworks (NSFs).
3. Commission national guidance from the National Institute of Clinical Excellence (NICE).
4. Co-ordinate policy between health and social care systems.

The Department of Health reports to the public using the star rating system and Healthcare Commission reports.

Healthcare Commission

The Healthcare Commission:

1. Reviews the clinical governance arrangements and the implementation of National Service Frameworks in all NHS organisations.
2. It also rapidly investigates any areas of concern and, if necessary, has the power to intervene when serious or persistent problems are identified.
3. It can commission national audits and patient/ staff surveys.

It produces reports on clinical governance activities and publishes the star ratings to help the Department of Health inform the public.

Modernisation Agency

The Clinical Governance Support Team (CGST) is part of the Modernisation Agency which supports the NHS in its clinical governance activities.

1. It supports the NHS and its staff to implement effective clinical governance locally and improve patient care.
2. It works with Strategic Health Authorities to develop local networks.
3. It helps to create, capture and spread best practice.

NHS Trust Reporting Framework

The annual report produced by Trusts must assess each of the following areas of clinical governance:

1. Patient experience – planning/ organisation of care
   environment of care

2. Use of information – to assist patients' experience
   monitor outcomes of care
   determine utilisation of resources and processes.

3. Quality improvement processes – risk management
   clinical audit
   evidence based practice
   clinical effectiveness programmes

4. Staff focus – staffing levels and management
   training/ continuing professional development
   multidisciplinary team working

5. Leadership/ strategy/ planning – consultation/ patient involvement
   organisation/ clinical leadership
   service planning
   organisation's performance review
   health-community partnerships

Websites
Useful information can be found by following the 'clinical governance' links on these websites:

1. Department of Health: www.dh.gov.uk
2. BMA: www.org.uk
3. GMC: www.gmc-uk.org
4. Clinical Governance Support Team: www.cgsupport.nhs.uk
5. NHS Information Authority: www.nhsia.nhs.uk

Introduction
This is the mechanism by which the NHS Executive can monitor the effects of the NHS Plan on achieving improvements in healthcare at a local level. Annual reports are produced at regional level and sent to the NHS Executive.

Healthcare Areas Assessed
Six aspects of healthcare are assessed, which approximate to different aspects of clinical governance:

1. Health improvement of the population
2. Fair access to healthcare
3. Effective delivery of appropriate healthcare
4. Efficiency of healthcare provision
5. Patient/ carer experience
6. Healthcare outcomes of NHS care

High Level Indicator Sets (HLIS)
Each of the above areas is subdivided into a number of specific measures (High Level Indicator Sets). These are chosen annually. Examples of HLIS from 1999-2000 are follows:

1. Health Improvement
   - death rates (all causes) – ages 15-64 & 65-74
   - cancer registrations
   - suicide rates
2. Fair Access
   - surgery rates
   - in-patient waiting lists
   - number of people registered with an NHS dentist
3. Effective delivery
   - disease prevention/ health promotion
   - acute care management
   - chronic care management
4. Efficiency
   - day case rate
   - length of stay in hospital (case-mix adjusted)
   - generic prescribing
5. Patient/ carer Experience
   - number of patients waiting <2 hours for emergency admission (via A&E)
   - delayed discharge (>75 year olds)
   - % on waiting lists >12/12
6. Healthcare Outcomes
   - dental disease in <5 year olds)
   - infant mortality rates
   - survival rates from breast & cervical cancer

NHS PERFORMANCE RATINGS

Introduction
These were first published in September 2001. The aim is to provide the public with information about the performance of their local health services. An annual assessment is performed by Healthcare Commission (taken over role from CHI) and the assessment criteria fall into two groups:

1. 9 key targets
2. Larger number of indicators – 'balanced scorecard'

Performance is expressed in terms of stars (0-3).

Key targets
Different criteria determined each year (check on the Department of Health and Healthcare Commission's websites)

Balanced scorecard
Range of indicators grouped into 3 areas:

1. clinical focus eg readmission rate; deaths within 30 days of surgery; risk of clinical negligence.
2. patient focus eg waits for outpatient and inpatient treatment, patient surveys, delayed discharges
3. capacity & capability focus eg quality of data measured, compliance with doctors' hours, sickness/absence rates, compliance with confidentiality/ information governance targets

Formula used to calculate contribution of individual scores to the overall score

Websites
Department of Health: www.doh.gov.uk

Healthcare Commission: www.healthcarecommission.org.uk

THE CLINICAL NEGLIGENCE SCHEME FOR TRUSTS (CNST)

Introduction
This is an indemnity scheme, which covers trusts and their employees in respect of clinical negligence claims arising after 1st April 1995. It is administered by the NHS Litigation Authority (which is a Special Health Authority).

Its Role
It provides indemnity to clinical negligence claims made against clinicians whilst undertaking duties as part of their employment for the trust; it does not cover private practice, Schedule 2 work (insurance medicals etc) and 'good Samaritan' acts which are covered by medical defence organisations.

The NHS Litigation Authority has a panel of specialist solicitors and in the event of a claim being made, will allocate one of them to represent the trust, its employee and the Authority.

In addition to the CNST, the NHS Litigation Authority is responsible for administering a number of other indemnity schemes:

1. Existing Liabilities Scheme (ELS): covers clinical negligence claims prior to April 1995.
2. Liabilities to Third Parties Scheme (LTPS).
3. Property Expenses Scheme (PES). LTPS & PES cover non-clinical risks.

Funding
The CNST is funded by contributions from the member trusts; the annual fee can be reduced if the individual trusts meet certain criteria ('Risk Management Discount'); these standards are developed by the NHS Litigation Authority:

Level I Criteria
75% total score available in every standard.

Level II Criteria
90% for level I in every standard
75% for level II in every standard

Level III Criteria
90% for level I…
90% for level II…
100% for level III…
…in every standard

Discounts
For compliance at each level:
Level I – 10%
Level II – 20%
Level III – 30%

Website
NHS Litigation Authority web-site: www.nhsla.com
Follow 'document' link.

APPRAISAL AND REVALIDATION

Appraisal

A professional process which aims to give NHS doctors regular feedback on past performance and continuing progress and to identify educational/ developmental needs. It aims to:

1. set out needs;
2. set aims for their achievement;
3. consider doctor's contribution to local healthcare services and optimise their skills to this end;
4. give the opportunity for doctors to seek support for their participation in activities and identify resource requirements.

Introduced as part of clinical governance 1998 ('A First Class Service – Quality in the New NHS').

Information to be collected from April 2003.

Revalidation

All doctors must demonstrate regularly to the GMC that they are up to date and fit for practice. There are 3 stages:

1. Annual Appraisal: information should be collected which relates to 7 areas that have been stipulated by the GMC:
   a. good clinical care;
   b. maintaining good medical practice;
   c. teaching and training, appraising and assessing;
   d. relationship with patients;
   e. working with colleagues;
   f. probity;
   g. health.

2. 5 Year Assessment: evidence should be provided by each individual doctor, and both colleagues and members of the public will be part of the process.

3. GMC Decision: there are 3 possible outcomes:
   a. continuing licence to practice;
   b. conditions on the licence to practice;
   c. suspension.

Source/ Websites
GMC documents

Further information can be obtained from:

1. the GMC website (www.gmc-uk.org.uk/revalidation/index.htm)
2. the DoH website (www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/LearningAndPersonalDevelopment/Appraisals/fs/en)

EUROPEAN WORKING TIME DIRECTIVE

This is Health and Safety legislation and, like other laws, it has to be implemented, unlike the New Deal, which was a contractual arrangement.

Overall Average Weekly Working Hours
August 2004 – 58 hours
August 2007 – 56 hours
August 2009 – 48 hours (but could be extended to 2012)

Rest Provisions from August 2004
11 hours of continuous rest in every 24 hour period
Minimum 20 min break when shift >6 hours
Minimum 24 hours rest in every 7 days or 48 hours rest in every 14 days
Minimum 4 weeks annual leave
Maximum 8 hours work for night workers (if applicable)

1. <u>SiMAP Ruling</u>
   This is a recent ruling in the European Court of Justice stated that 'time spent on call by doctors…must be regarded in its entirety as working time …if they are to be present at the health centre'. In other words, if a doctor is required to be resident on call, then he/she is considered to be continuously at work even if he/she is resting/asleep.

2. UK is making changes to the rest provisions by allowing compensating rest where it is not possible to provide the full period of continuous rest.

Suggested Changes
1. Reduced numbers of resident rotas, leaving fewer (but more intensive) rotas supported from on-call cover from home.
   a. Multidisciplinary teams: using non-medical practitioners to take over many of the PRHO/SHO duties, thereby decreasing the tiers of cover.
   b. Cross-cover between specialities
2. Changing work patterns of SpRs and consultants
3. Use of IT (eg imaging links, near patient testing) reducing the need for resident medical care.
4. Some expansion of numbers.
5. Assessing service delivery models, such as determining the appropriate type and seniority of doctor suitable for different tasks and determining ways of minimising out-of-hours work.
6. Training issues:
   a. training must be more focussed with clear goals (Individual Learning Plans)
   b. Greater use of simulators/ web-based material.

Pilot Trusts
Different strategies can be tested at certain, nominated trusts and are assessed bimonthly and reported on the DoH website.

Strategic Change Fund
£7M committed up to 2004.

1. develop non-medical roles and training.
2. develop new models of service delivery/working patterns (eg emergency teams) and facilitate their implementation
3. other initiatives.

Workforce Development Confederations

1. Support Strategic Health Authorities in implementing the EWTD.
2. Address training implications (eg for non-medical practitioners).

Websites
www.doh.gov.uk/workingtime/
details of guidance.
updated information from the pilot sites.
updated information on examples of good practice from other trusts.

www.bma.org.uk
use search engine to locate updated articles on the implementation of the EWTD

ZERO TOLERANCE POLICY

Aim

To get over to the public and staff that violence against staff is not acceptable

Facts

- > 84000 reported incidents 2000-1
- government aim to decrease this by 30% by 2003-4 (monitored by Regional Offices (part of Human Resources Performance Framework)
- costs in terms of physical and psychological pain to staff and financial burden to NHS (sick pay/locums/legal fees/loss of trained staff)

Legal Basis

- Health and Safety Legislation
  - 'Safer Working in the Community' (RCN/NHS Exec) 1998
- Crime and Disorder Act, 1998
  - Crime and Disorder Reduction Partnerships (CDRPs) between police and local authorities.
  - amended 2002 (Police Reform Act)
    - police/fire authorities responsible agents
    - provision for PCTs to be included as responsible agents
    - statutory requirement for PCTs/HAs to co-operate

Preventing Violence

- Risk assessment (environment, training, communication)
- Improving Working Lives (IWL) Standard (central locking ambulances, personal alarms, safety training, CCTV, swipe-card access)

Reporting Incidents

- robust, uncomplicated system
- aid risk assessment
- aid police in charging offenders
- keep record of incidents
- nominate member of staff to act as Police Liaison Officer

Procedures for Dealing with Incidents

- how help summoned
- record of who goes to help
- help for victim – manager's responsibility
- correct reporting
- ?report to Health and Safety Executive
- assess/update safety systems
- ?help with CICA/NHS Injury Benefit Scheme

With-holding Treatment from Violent Patients

Local policies developed by Trusts

- independent legal advice
- national guidelines ('Withholding Treatment' DoH Guidelines)
- include views of staff and patient representatives

- define unacceptable behaviours (verbal abuse, threatened/actual violence, drug abuse in hospital, damage to property)
- notify other NHS service providers of patients who are subject to this procedure
- inform press of prosecutions

Minimum requirements of local policy

- review each case individually (protect staff vs. health care needs of individual)
- determine action needed for less serious/'one-off' offences
- explanation of sanctions:
    1. verbal explanation by staff +/- leaflet
    2. YELLOW CARD: formal written warning (from senior staff) – copy to GP
    3. RED CARD: letter from Chief Executive, including period of ban – copy to GP
- exceptional circumstances – immediate withholding of treatment
- decision to withhold treatment based on clinical assessment and advice from patient's consultant or a senior member of the medical team
- withholding treatment time-limited (max 12/12)
- make clear links to other relevant procedures/policies (eg consent; clinical procedures for dealing with patients with mental health/ learning difficulties)
- clear lines of responsibility
- mechanism for review (eg local complaints procedure)
- other procedures
    - for patients on non-urgent W/L
    - not withholding treatment of patients as a result of behaviour of person accompanying them
    - file in patient's notes, trust office
    - flag up on PAS system
- communication of policy to staff and patients

Website

Zero tolerance web-site: www.nhs.uk/zerotolerance/intro.htm

SECTION 3.

NHS

ORGANISATIONS

NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE (NICE)

Introduction

NICE is an independent organisation within the NHS (a 'Special Health Authority') that provides national guidance on therapies and care for people using the NHS in England and Wales.

It aims to promote:

1. clinical excellence;
2. effective use of resources.

The Areas Covered by NICE Guidelines

Currently NICE produces guidance in three areas of health:

1. Technology appraisals - guidance on the use of new and existing medicines and treatments within the NHS in England and Wales.
2. Clinical guidelines - guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS in England and Wales.
3. Interventional procedures - guidance on whether interventional procedures used for diagnosis or treatment are safe enough and work well enough for routine use in England, Wales and Scotland.

Organisational Structure

Permanent Staff

They support different aspects of the work

There is also a Senior Management Team who meet weekly to co-ordinate NICE's work, and some of whom form the Guidance Executive.

Partners Council

Members are drawn from key organisations with a special interest in the work of NICE:

1. patients' groups;
2. health professionals and NHS managers;
3. quality assurance organisations;
4. trade unions;
5. industry.

They provide advice and a forum for exchange of ideas, and they review the Annual Report.

Citizens' Council

15 men and 15 women drawn from all walks of life (recruited by an independent organisation) to reflect public opinion on the published guidance. They meet twice a year for 3/7 each meeting.

Independent Advisory Committees
They develop the guidance using healthcare professionals and people familiar with the relevant issues. There are a number of different committees:

1. technology appraisal committee;
2. guideline review panel;
3. interventional procedures advisory committee;
4. research and development advisory committee;
5. confidential enquiries advisory committee.

Patient Involvement Unit
This works to promote patient and carer involvement in NICE's work.

Website
www.nice.org.uk

HEALTHCARE COMMISSION
(Full title = Commission for Healthcare Audit and Inspection)

Introduction
It was formed on the 1st April, 2004 and has a central role in monitoring quality and promoting improvement of healthcare provision in England and Wales. Before this date, this role was undertaken by a number of agencies:

1. Commission for Health Improvement (CHI) – monitoring quality of healthcare provision in the NHS

2. National Care Standards Commission – monitoring private and voluntary healthcare

3. Audit Commission – monitoring efficiency/ effectiveness/ economy of healthcare (ie checking that the public get value for money from the taxes spent on healthcare)

Aim
The aim of the Commission is to promote improvement in quality of healthcare in England and Wales. In England only, it also covers private healthcare sector – in Wales this is covered by the Care Standards Inspectorate for Wales.

In future, it is planned that the Commission will integrate some of the functions of the Mental Health Commission.

Functions and Powers
1. Independently assess performance of health services from patients' point of view and using Department of Health standards.

2. Co-ordinate NHS inspections with other healthcare organisations to minimise disruption to healthcare staff.

3. Assess whether public funds are being spent effectively.

4. Publish regular ratings of NHS trusts and an annual report on healthcare in England and Wales.

5. Develop independent second stage of complaints procedure, when the local resolution process has been unsuccessful.

6. Investigate serious failures in healthcare services.

Website
www.healthcarecommission.org.uk

THE AUDIT COMMISSION

Overview

Set up in 1983 to appoint and regulate external auditors of Local Authorities; their role was extended to the NHS in 1990.

The aim is to:

1. ensure proper stewardship of public finances;
2. help public services become more economic, effective and efficient.

Relevance to Emergency Medicine

1. 1996 Report ('By Accident or Design')
   It highlighted:
   a. long waits;
   b. poor provision for vulnerable patients, such as children;
   c. poor supervision of juniors;
   d. poor provision and use of I.T.

2. 1998 Report ('Accident and Emergency Services Follow Up')
   It noted that the waits were even longer.

3. 2000 Report ('Accident and Emergency' – part of Audit Commission's Acute Hospital Portfolio)
   Data collected during July 2000
   It involved nearly all trusts with A&E Departments.
   It focussed on:
   a. waiting times
   b. efficient and effective use of staff;
   c. high quality service;
   d. good management information.

The 2000 Report

1. Waiting Times
   Measured: i. time from arrival in department to seeing nurse/doctor;
   ii. time from arrival in department to admission.
   It did not measure times from arrival to triage or from decision to admit to admission (as had been previously used by the Patient's Charter).
   It noted that the waiting times were still getting longer, worse in larger, urban hospitals.
   It also noted: i. lack of space & staff;
   ii. organisational/ management factors;
   iii. lack of hospital beds;
   iv. delays in XR/pathology.

The times used in the NHS Plan were those measured by the Audit Commission:

i. 75% should be discharged/admitted in <4 hours by March 2002 (average 75 mins.);
ii. 100% should be discharged/admitted in <4 hours by 2004.

2. Staffing Issues

Noted 1% increase in patients/year since 1990s, but a 10% increase in staff since 1998 (especially non consultant career grade doctors)

Suggested developing the nurse practitioner role.

3. Quality Issues

i. speed of thrombolysis

75% eligible patients thrombolysed in <30 mins. – April 2002.
75% eligible patients thrombolysed in <30 mins. – April 2003.

ii. availability of experienced doctors

~50% of departments had doctors with >6/12 A&E experience available 24hrs.

iii. Paediatric-trained nurses

17 departments had 24 hour cover with paediatric-trained nurses compared with 7 departments in 1998; the overall average was 60 hours/week compared with 37 hours/week in 1998.

4. Information

There was improved data available on waiting times.

86% of departments had a computerised information system, but there was wide variation in type.

Website

www.audit-commission.gov.uk

MODERNISATION AGENCY

Introduction
Set up in April 2001, the Modernisation Agency supports the NHS to modernise services and improve experiences and outcomes for patients.

It has 3 main principles and 5 rules underpinning their work:

3 Rs
1. Renewal – more modern buildings & facilities, new equipment & IT, and more, better-trained staff.
2. Redesign – service delivery with greater use of clinical networks to co-ordinate services around the patient.
3. Respect – promote a culture of mutual respect between NHS-politicians; NHS-patients; different staff groups.

5 Rules
1. See things through patients' eyes.
2. Find better ways of doing things.
3. Look at the whole picture.
4. Give frontline staff the time & tools to tackle problems.
5. Take small steps as well as big leaps.

Teams
The work of the Modernisation Agency is divided into a number of teams; some of these cover all NHS organisations (1-5 below), and some working with particular areas (6 below), such as primary care or mental health services.

1. NHS Leadership Centre
   Works with NHS leaders at all levels to ensure that they can lead and deliver real changes for patients.

2. New Ways of Working Group
   Aims to ensure that there are sufficient numbers of appropriately trained, motivated staff who are able to deliver improved patient services through better skills utilisation.

3. Clinical Governance Support Team
   Works with the NHS to help to implement clinical governance.

4. Innovation and Improvement in Knowledge Team
   Identifying and developing initiatives that impact across the whole system and support local teams to implement them.

5. Health Technologies and IT Team
   Works with Strategic Health Authorities to develop changes needed for the National Programme for IT and e-booking.

6. Specialist Teams
   National Institute for Mental Health in England (NIMHE)
   National Primary Care Development Team (NPDT)
   National Primary and Care Trust Development Team (NatPaCT)
   Service Improvement Team – improved access to secondary care
   Partnership Development Group – promote integration of the Agency with its partner agencies (eg Strategic Health Authorities, DH, NICE etc).

Website
www.modern.nhs.uk

SECTION 4.

EMERGENCY

MEDICINE

SPECIFIC

TOPICS

REFORMING EMERGENCY CARE

Overall Problem
Patients wait too long:
- for ambulances
- all stages in ED
- seeing primary care team
- discharge out of ED (social services/ hospital beds)

Targets
2002 – ambulances – 75% calls to life-threatening emergencies < 8 mins.
2003 – thrombolysis – 75% MI patients receive thrombolysis < 20 mins.
2003 – ED waits – 90% < 4 hours
2004 – GPs – patients able to see < 48 hrs (< 24 hrs for other primary care staff)
2004 – ED waits – all patients < 4 hours (average 75 mins)

Problems and Solutions

Specific Problem	**Proposed Solution**
ED staff capacity too stretched	183 extra consultants by 2004 600 extra nurses by 2003
Hospital capacity insufficient	Aim to reduce bed occupancy from >90% to 82% (eg use private beds for W?L patients)
Delayed discharge from hospital	1. extra money to social services → 1000 extra hospital beds by 2002. 2. extra intermediate care /RH/ NH beds 3. Delivering standards in NSF for Older People (preventative/ domiciliary care → reduced admissions
Competition between elective and emergency work	Separate into different paths (different, dedicated resources; free staff with emergency responsibilities from routine work eg 600 extra physicians)
Diagnostic/other services not available 24 hours	1. Use private sector 2. 'Near patient' testing 3. extending skill mix in breast-screening service to other roles 4. longer term, recruit radiog/radiol staff
Single queue in ED	Streaming See and treat suitable walk in patients
Demarcation of working practices	1. nurse practitioners 2. GPs in EDs 3. paramedics assessing patients for GPs 4. nurse triage for GPs 5. early senior input 6. emergency medicine networks (A&E, GP, anaesthetics, critical care, medicine, surgery)

Streaming
Patients attending the ED are allocated to different flows according to their need; teams of doctors and nurses are dedicated to each stream.

The different streams will be as follows:

1. self care
2. primary care
3. ambulatory care (minor injuries and moderate illness)
4. clinical assessment (majors)
5. resuscitation

See and Treat
"A system of care designed to reduce waits and improve the patient's experience in Accident and Emergency Departments."

It involves assessing and treating patients with relatively minor conditions as soon as they arrive rather than asking them to wait.

Principles:
1. on arrival, patients are seen, treated and referred/discharged by one clinician
2. more seriously ill patients or those requiring more investigation are streamed to another area.
3. triage of minor patients is unnecessary when see and treat is in operation
4. staff undertaking see and treat sessions should have no other commitments during these sessions
5. enough staff should be allocated to see and treat to prevent a queue from forming (1 doc + 1 nurse for an arrival rate of 10 walk-in patients/ hour.

Websites
www.doh.gov.uk/capacityplanning/reform.htm

www.modern.nhs.uk/emergency

THE WAY AHEAD
Final Draft October 2004

Introduction

This is a wide-ranging document produced by both FAEM & BAEM which reviews the recent changes undertaken by Emergency Medicine and discusses the future direction of the speciality.

It is currently at the discussion stage and the final document is due to be published in January 2005.

Topics Discussed

1. Core services
2. Recommendations for the future configuration of Emergency Services
3. Recent initiatives in Emergency Care
4. Workforce issues
5. Non-career grade doctors
6. Specialist registrars
7. Modernising medical careers (the proposed PRHO/SHO Foundation Years Programme)
8. Nursing issues
9. Quality and standards in Emergency Departments
10. Teaching and research
11. The relationship between Emergency Medicine and Primary Care
12. Paediatric issues
13. Pre-hospital care
14. Accident prevention
15. Secretarial support
16. Management support
17. European Working Time Directive

Websites

www.baem.org.uk
www.faem.org.uk

SECTION 4.

MISCELLANEOUS

TOPICS

THE BRISTOL INQUIRY

Background
Concern was expressed about the excess mortality in children <1 year old undergoing cardiac surgery at the Bristol Royal Infirmary between 1984 and 1995; at times the mortality rate doubled the national average.

Adult cardiac surgeons were performing procedures on children; the ICU had a mixture of adult and paediatric patients with conflicting treatment recommendations; initially there was inadequate monitoring of outcomes and latterly, when concerns were recognised, there was inertia in the system to affect change.

A Public Inquiry was undertaken between October 1998 and July 2001 and was presented to Parliament in July 2001.

The problems identified by the Inquiry and the recommendations made are summarised in the table below.

Website
www.bristol-inquiry.org.uk

Summary of Problems Identified and Recommendations Made by the Inquiry

Problems	Recommendations
Variable quality of care	Needs standardisation of care using current knowledge. Welcomed the introduction of NICE (developing guidelines) and CHI (monitoring quality)
Lack of insight into problems • Poor monitoring of quality • Lack of openness	Recognises need for change of culture in the NHS: • Openness when things go wrong • Learning lessons • Safety as a priority • Welcomed formation of the National Patients Safety Authority
Inadequate competence	Stressed need for continuing professional development and regular appraisal/ revalidation. Proper training/ supervision when performing invasive procedures and permission from local research/ ethics committee before undertaking new techniques. Codes of conduct for poor performance/ misconduct
Poor leadership/ poor teamwork/ resistance to change	Change of culture needed in the hospital
Not a child-centred approach • Staff training • Adequate facilities	Welcomed introduction of children's NSF More integrated children's healthcare services • Children's hospitals close to acute general hospitals • Specialist care in limited number of centres with suitably skilled staff More patient involvement in healthcare policy and local provision
Poor communication • Staff-patient • Staff-staff	All staff suitably skilled in communication with children & parents. Change of culture to breakdown barriers between professional groups

Overall Problems

1. Multiple agencies involved
    - 3 Housing Authorities
    - 4 Social Service Depts
    - 2 police Child Protection Teams
    - 1 NSPCC-run specialised centre
    - 2 hospitals (Victoria was admitted via EDs on 2 occasions, because of suspicions of abuse)

2. Failings in procedures in all agencies

3. Poor communication
    - intra-/interagency

4. Poor management
    - poor supervision
    - poor accountability (lots of passing the buck)
    - lack of clear understanding about their managerial responsibilities

Overall Lessons

1. draw up clear lines of responsibility/accountability (top ←→ bottom) in all agencies.

2. agencies should become more 'people-centred' rather than 'bureaucratic activity centred'.

3. reorganization of child-protection services at national and local level.
    - National Agency for Children and Families
    - Child and Family Board (chaired by a minister of cabinet rank)
    - Local committees under the auspices of Local Authorities

4. improve communication between agencies, although there may be potential with confidentiality/data protection/human rights legislation

Medical Problems + Solutions

Problem	Solutions
Note taking	Clinical details, phone calls, conversations and hand-overs must be recorded contemporaneously
Inter-/intra-departmental communication	Written statements from doctors to social services re concerns
Lack of overall responsibility	Named consultant who agrees actions that need to be taken and ensures that they are undertaken
Discharge sanctioned by junior doctors	Must be by doctor more senior than SHO, preferably by consultant. (Chief Executive responsible to ensure that the relevant systems are in place)
Poor follow up arrangements	There must be a documented plan of action before discharge. (Again Chief Executive is responsible to ensure that such a system is in place and to monitor its compliance)
Poor training	Recommendations re training/revalidation of consultant paediatricians with an interest/expertise in child protection.
Variations in primary care procedures	1. GP registering systems should include social info (housing/school attendance) 2. Multidisciplinary training - recognition and management of deliberate harm 3. Procedures in place of who to contact and when. 4. training and audit of liaison health visitors.

SECTION 5.

ARCHIVE

COMMISSION FOR HEALTH IMPROVEMENT (CHI)

This was set up to be a link between national initiatives and local care providers, but ceased operating on the 31st March, 2004 when its role was taken over by the Healthcare Commission.

Website
www.chi.nhs.uk
The site is kept as an archive of CHIs activities, but is not updated.

The Healthcare Commission has a website: www.healthcarecommission.org.uk