EDUCATION AND HEALTH STANDING COMMITTEE

THE ROLE AND INTERACTION OF HEALTH PROFESSIONALS IN THE WESTERN AUSTRALIAN PUBLIC HEALTH SYSTEM

REPORT ON INTERNATIONAL TRAVEL

Report No. 5

2003

Published by the Legislative Assembly, Parliament of Western Australia, Perth, September 2003.

Printed by the Government Printer, State Law Publisher, Western Australia.

Education and Health Standing Committee

The Role and Interaction of Health Professionals in the Western Australian Public Health System

ISBN: 1 920830 14 6

(Series: Western Australia. Parliament. Legislative Assembly. Committees.
Education and Health Standing Committee. Report 5)

328.365

Copies available from: State Law Publisher
10 William Street
PERTH WA 6000

Telephone: (08) 9321 7688
Facsimile: (08) 9321 7536

Email: sales@mpc.wa.gov.au

Copies available on-line: www.parliament.wa.gov.au

EDUCATION AND HEALTH STANDING COMMITTEE

THE ROLE AND INTERACTION OF HEALTH PROFESSIONALS IN THE WESTERN AUSTRALIAN PUBLIC HEALTH SYSTEM

REPORT ON INTERNATIONAL TRAVEL

Report No. 5

Presented by:
Mrs C.A. Martin, MLA
Laid on the Table of the Legislative Assembly
on 25 September 2003

COMMITTEE MEMBERS

Chair	Mrs C.A. Martin, MLA Member for Kimberley
Deputy Chair	Mr M.F. Board, MLA Member for Murdoch
Members	Mr R.A. Ainsworth, MLA Member for Roe
	Mr P.W. Andrews, MLA Member for Southern River
	Mr S.R. Hill, MLA Member for Geraldton

COMMITTEE STAFF

Principal Research Officer	Dr Karen Hall, BSc (Hons), PhD
Research Officer	Mr Peter Frantom, BA
Research Officer	Ms Liz Kerr, BA

COMMITTEE ADDRESS

Education and Health Standing Committee
Legislative Assembly
Parliament House
Harvest Terrace
PERTH WA 6000

Tel: (08) 9222 7494
Fax: (08) 9222 7804
Email: laehsc@parliament.wa.gov.au
Website: www.parliament.wa.gov.au

TABLE OF CONTENTS

COMMITTEE MEMBERS I
COMMITTEE STAFF I
COMMITTEE ADDRESS I
COMMITTEE'S FUNCTIONS AND POWERS V
TERMS OF REFERENCE VII
CHAIR'S FOREWORD IX

CHAPTER 1 DETAILS OF MEETINGS 1

1.1 BACKGROUND 1
1.2 CANADA 2
(a) Vancouver 2
(b) Ottawa 3
(c) Halifax 4
1.3 UNITED KINGDOM 5
(a) London 5
(b) Peterborough 7
(c) Kettering 9
(d) Manchester 9
(e) Liverpool 10
(f) Wookey Hole 10
(g) Southampton 11
(h) Eastbourne 12
(i) Ashford 13

APPENDIX ONE 15
SUMMARY OF BRIEFINGS 15

COMMITTEE'S FUNCTIONS AND POWERS

The functions of the Committee are to review and report to the Assembly on:

(a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;

(b) annual reports of government departments laid on the Table of the House;

(c) the adequacy of legislation and regulations within its jurisdiction; and

(d) any matters referred to it by the Assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. Annual report of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and joint committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

TERMS OF REFERENCE

At a meeting of 26 June 2002 the Standing Committee resolved to conduct an inquiry into '*The Role and Interaction of Health Professionals in the Western Australian Public Health System*'. On 26 June 2002 the Standing Committee also resolved to adopt the following Terms of Reference:

That the Standing Committee examine and report on:

- emerging models of health care delivery;
- the adequacy of current training methods;
- the availability of defined career paths for health professionals; and
- any other matters deemed relevant by the Standing Committee.

CHAIR'S FOREWORD

This is the fifth report of the Education and Health Standing Committee. It provides an overview of the Committee's recent investigative tour to Canada and the United Kingdom, undertaken to gather evidence for the Committee's current inquiry into *The Role and Interaction of Health Professionals in the Western Australian Public Health System*.

Canada and the United Kingdom were identified as being of particular relevance to the Committee's inquiry, first because of the similarities between their health systems and our own, and second because of the innovative ways in which they are exploring health professional roles. In Canada, a number of organisations were identified through their involvement with the Health Transition Fund (HTF), a joint initiative of federal, provincial and territorial governments, created in 1997 from federal funding to '*encourage and support evidence-based decision making in health care reform*'. The HTF offered competitive funding for 141 pilot projects ranging from small, local to national level projects. The results of some projects were so impressive, they have since been extended or expanded beyond the life of the HTF. At the other end of the spectrum, the National Health Service (NHS) reforms represent a massive system-wide overhaul of public health care in the United Kingdom. Whilst the reform process is in its infancy, a number of organisations were identified for the innovative approaches they have developed.

Three of the five Committee members were able to participate in the investigative tour: the member for Murdoch and the member for Geraldton undertook the Canadian leg of the tour and, by scheduling the tour to coincide with the Commonwealth Parliamentary Association conference in London, the member for Southern River was able to join the other members on the United Kingdom leg of the tour.

The meeting schedule was ambitious, but with meticulous planning, the members were able to meet with some 28 organisations in 12 locations in a short period of time. In Canada, the Committee travelled from coast to coast, meeting with representatives from eight organisations. These briefings focussed mainly on Primary Health Care, an area that is increasingly becoming the main focus of the Canadian Health System. For the most part, the Canadian briefings were with policy-makers, both provincial and federal.

In the United Kingdom, the Committee had an invaluable opportunity to visit health professionals in the field, as well as meeting with professional associations and policy-makers. The range of issues covered in briefings traversed the entire health system, from education to career development, from primary through to tertiary care, from policy to practice. The Committee particularly appreciated the opportunity to meet with professionals in the field and to 'follow the patient journey'.

Despite the gruelling schedule, the investigative tour was an enjoyable, highly enlightening experience. The Committee returned to Western Australia with a fuller appreciation of the innovative ways in which health professionals can work together.

I would like to thank my fellow Committee members for their participation in this investigative tour and for their contributions to this report. I would also like to thank Mr Peter Frantom, who played an integral part in pre-tour arrangements, and Dr Karen Hall, who accompanied the members on tour.

MRS C.A. MARTIN, MLA
CHAIR

CHAPTER 1 DETAILS OF MEETINGS

1.1 Background

At a meeting of 26 June 2002 the Education and Health Standing Committee resolved to conduct an inquiry into '*The Role and Interaction of Health Professionals in the Western Australian Public Health System*'. The Committee received 61 written submissions, heard evidence from 33 organisations and received a further 30 supplementary submissions. Whilst this evidence provided useful insight into some of the issues surrounding the role and interaction of health professionals in Western Australia, it became clear that the Committee would need to look further afield for innovative ways to address these issues.

Through extensive background research, the United Kingdom and Canada were identified, both because of their similarities to our own health system, and because of the innovative practices in which they have recently engaged. The process of health reform has been approached in a very different manner in the two countries. In Canada, the approach has been somewhat evolutionary. Small, carefully targeted changes have been piloted across the country, with an expectation that reform will ultimately reach 'critical mass', at which point the momentum for reform will be sufficient to drive universal change. The Health Transition Fund ($150 million) was established in 1997 to support pilot projects to explore innovative models of health care delivery. This was followed in 2001 by the Primary Health Care Transition Fund ($800 million) and more recently by a multi-billion dollar federal commitment to ongoing Primary Health Care reform. A number of exciting projects exploring role development, which are particularly relevant to the Committee's inquiry, were identified as part of the original HTF program.

In the United Kingdom the approach has been more revolutionary in nature. The current government has committed to a substantial increase in spending over the next five years to 'modernise' the National Health Service (NHS). Changes are being driven both from a policy level and from a clinical level. With regard to role development, a number of programs, supported at national level, are operating. The *Changing Workforce Programme*, the *European Working Time Directive* and the *Skills Escalator* are just a few of the national level programs facilitating new ways of working for NHS health professionals. Independent of these national programs, innovation is also happening at a local level, where it is largely driven by the vision of health professionals in the field.

In all, the Committee met with 28 organisations. The following provides a brief description of the information gathered in briefings with these organisations.

1.2 Canada

(a) Vancouver

(i) Alex Berland, Strategic Resource Group

Mr Berland discussed his experiences with health reform both in Canada and in the United Kingdom. He indicated that a 'sledge hammer' approach had been used in the United Kingdom, whereby public unhappiness with the quality of health care was exploited to establish publicly managed regulatory and disciplinary bodies and to counter the medical profession's resistance to change. By contrast, the Canadian governments have adopted a more conciliatory approach, preferring to facilitate incremental changes, rather than to impose universal change. Mr Berland also advised the Committee of differences between walk-in centres in Canada and walk-in clinics in the United Kingdom.

(ii) Megan Loeb, British Columbia Ministry of Health

Ms Loeb informed the Committee that Primary Health Care is now seen as the cornerstone of the Canadian Health System, and that there is a firm belief that good Primary Health Care can relieve pressures on the acute sector. The Committee was also briefed on the goals and progress of the *Primary Health Care Transition Fund* (*PHCTF*), a federal initiative designed to facilitate the development of multi-disciplinary Primary Health Care Organisations (PHCOs). PHCOs are characterised by increased access to services; emphasis on health promotion and disease prevention; health care delivered by multi-disciplinary teams; and alternative physician funding (blended capitation, rather than the current fee-for-service model). There has been considerable resistance to Primary Care reform from the British Columbia Medical Association, but it is hoped that by the end of the *PHCTF* program, the momentum for change will come from patients, who will demand that Primary Health Care be delivered by PHCOs.

(iii) Laurie Gould, Fraser Health Authority

Ms Gould reiterated the importance of Primary Health Care to relieve pressures on the acute sector and described how the *PHCTF* would be implemented in the Fraser Health Authority, one of the five health authorities in British Columbia. The Committee was also advised about Fraser Health Authority's future strategies in the area of chronic care, whereby early intervention at a primary care level is expected to generate significant long-term benefits, particularly in elderly people.

(b) Ottawa

(i) Nancy Swainson, Lucy Falastein, Jacquie Lemaire, Health Canada

Ms Swainson and colleagues advised the Committee that the current fee-for-service model of physician remuneration is a major obstacle in the move toward a comprehensive primary care model, as fee-for-service promotes high turnover, acute, episodic care. It is particularly difficult to create the right incentive for continuing care of high needs patients or for 'keeping healthy patients healthy' in a fee-for-service environment. Collaboration is also challenging in a fee-for-service environment, as funding follows the physician episode. There is a progressive increase in the number of physicians interested in alternative payment plans, consistent with the number of new physicians entering the workforce.

(ii) Clive Shepherd, Ontario Family Health Networks

Mr Shepherd briefed the Committee on the history, progress and expected outcomes of the Ontario Family Health Networks (FHNs). The primary aim of the program is to improve access to primary care by providing incentives for family physicians to offer after hours care. While doctors must be geographically co-located, they do not need to operate within the same practice. Payment is based on blended capitation, whereby an annual age/sex adjusted capitation payment per patient is paid for 'core' services (accounting for 60-70% of total remuneration) and the remaining non-core services continue to attract a fee for service. On average, FHN physicians are expected to earn 20 percent more than straight fee-for-service physicians. For those physicians not prepared to join Family Health Networks, there is the option to join a Family Health Group, which sits between the FHN and the current style of practice. The Ontario Medical Association was initially opposed to FHNs, but ultimately agreed to co-sponsor the program, provided certain criteria were met. It is hoped that FHNs will cover fifty percent of Ontarians by 2008.

(iii) Dr Daniel Way, University of Ottawa

Dr Way briefed the Committee on the outcomes of the *Health Transition Fund (HTF)* project *'Improving the Effectiveness of Primary Health Care Through Nurse Practitioner / Family Physician Structured Collaborative Practice'*. The project identified two pilot sites in which a model of active, supportive collaboration between nurse practitioners (NPs) and family physicians (FPs) was established, and two pilot sites in which NPs and FPs worked without any intervention by the project team. In the active sites, physicians began to allow nurse practitioners to do what they were trained to do, job satisfaction increased for both NPs and FPs, physicians were able to achieve more by delegating to NPs and a sense of mutual respect and trust began to develop. By contrast, there was little evidence of effective collaboration in the non-intervention sites. Dr Way advised that a further 117 NPs will be supported in collaborative practice as part of the *Primary Health Care Transition Fund*.

(c) Halifax

(i) Dr David Gass, Tracey Martin, Nova Scotia Department of Health

Dr Gass and Ms Martin provided a historical perspective on Primary Health Care reform in Nova Scotia and on the outcomes of the *Health Transition Fund* project *'Strengthening Primary Care in Nova Scotia'*. The project had three aims: to introduce nurse practitioners into primary care settings, to explore alternative physician funding models and to introduce information technology to support practice. The Committee learned that nurse practitioners are seen as a new provider that will be incorporated into primary care on a long-term basis. There is currently a pool of dedicated money for NPs, but District Health Authorities will ultimately be expected to incorporate NPs into their business plans.

Nova Scotia is currently considering alternatives to the fee-for-service model of physician funding, as fee-for-service funding is considered to provide an incentive for short, low-intensity visits. As with other provinces, blended capitation is being explored.

The issue of medical indemnity was discussed in relation to nurse practitioners. The Committee was advised that NPs are not employed or supervised by physicians, therefore physicians are not vicariously liable for NP actions. This differs in Ontario, where physicians employ NPs and are therefore liable as employers.

(ii) Mary Jane Hampton, Stylus Consulting; Dr David Gass, Nova Scotia Department of Health

Ms Hampton provided the Committee with information in relation to the *Health Transition Fund* project *'Eskasoni Primary Care Project'*. The purpose of the project was to design, implement and evaluate a holistic model of health service delivery in the Eskasoni First Nation community. The Eskasoni community comprises 3200 permanent residents and is characterised by high rates of substance abuse, diabetes, heart disease and respiratory disease. The project devolved responsibility of health care from the federal government to the local Band (community government); redesigned physician services from a solo, part-time, fee-for-service medical service to a multi-doctor, multi-disciplinary clinic with alternative funding; constructed a new health complex; and integrated primary care and community health.

Outcomes included: a 40 percent decrease in visits by Eskasoni residents to outpatient and accident and emergency departments at the regional hospital; 96 percent of pregnancies followed from prenatal care through delivery and postnatal care; reduction in the number of visits to a family physician from 11 to four per patient per annum; and an 850 percent increase in the number of referrals from family physicians to nutritionists. Dr Gass advised the Committee that although federal funding ceased with the end of the *HTF*, the project had been so successful, the provincial government had stepped in to provide stopgap funding until further federal funding is available.

1.3 United Kingdom

(a) London

(i) Marc Seale, Greg Ross-Sampson, Health Professions Council

Mr Seale advised the Committee that the Health Professions Council (HPC) regulates around 150,000 health professionals. The Council currently regulates 12 allied health professions and a further 20 professional groups have applied to be regulated. For those professional groups awaiting approval, there is a perception that being regulated at a national level by the HPC increases their credibility. By contrast, those professional groups covered by the *Health Professions Order 2001* (the original enabling legislation), there was initial resistance, as the professional bodies believed that they should be able to regulate themselves.

The HPC is self-funding - health professionals pay for their regulation. This is an area of conflict with professional bodies, as they too are self-funding and must compete with the HPC. The HPC sets standards of professional conduct; sets educational standards; maintains a register; and undertakes disciplinary action for the professions it regulates.

(ii) Barbara Edmonds, College of Health; Simon Williams, The Patients' Association

The Committee was advised that *The NHS Plan* is a 10-year plan and is still in its infancy. Access to general practitioners (GPs) has traditionally been problematic, with waits of two weeks or more not unheard of. One of the targets of the current round of NHS reforms is to ensure that patients are able to see a GP within 48 hours, although this target has not yet been met. The rate of GPs in the United Kingdom is one per 3-6000 people, considerably lower than in Australia, where the rate is approximately one per 1000 people.

There is now considerable pressure on NHS Trusts to meet their waiting list targets. The Trusts are under scrutiny from oversight bodies, and where targets are not met, the Chief Executive may lose his/her post. With regard to elective surgery, if a Trust cannot provide a service within 6 months, the patient can choose to go elsewhere - another NHS Trust, a private facility, overseas - at the Trust's expense.

(iii) Sheelagh Richards, Beryl Steeden, College of Occupational Therapists

The Committee learned that the NHS reforms have provided an exciting opportunity for occupational therapists (OTs). Historically, OTs have been largely employed in a social care setting, but with a shift toward closer integration between health and social care, OTs are increasingly taking on new roles in intermediate care, accident and emergency departments and outpatient clinics.

(iv) Geraldine Cunningham, Royal College of Nursing

Ms Cunningham briefed the Committee on the Royal College of Nursing (RCN) *Clinical Leadership Programme*. The aim of the program is to assist healthcare practitioners and their teams to develop patient-centred and evidence-based leadership strategies within the context of their day to day practice, their organisational climate and the policy agenda. The emphasis of the program is on developing a culture where patient-centred leadership can thrive. The program began as the *Ward Nursing Leadership Project* in 1994, which was trialed across four NHS Trusts. Since that time, it has been extended across the United Kingdom and, recently, into other countries, including Australia.

(v) Rachel Haynes, Chartered Society of Physiotherapy

Ms Haynes briefed the Committee on the changing roles of physiotherapists in the NHS. There is a high vacancy rate in the NHS due to the large disparity in pay scales between the public and private sectors. Physiotherapy is the most popular degree course in the United Kingdom. Despite an almost doubling of student placements in the last five years, there are 14 applications per placement.

Traditionally patients have been referred to physiotherapists through their GPs, although they have been able to self-refer since the 1970s. In a GP practice with 5 GPs it is estimated that one month of consulting time per annum can be saved by not seeing a physiotherapist through GP referral. In recognition of this inefficiency, physiotherapists are increasingly practicing in GP surgeries.

(vi) Robert Rose, NHS Modernisation Agency

Mr Rose briefed the Committee on the history and function of the *Changing Workforce Programme (CWP)*, which comes under the auspices of the New Ways of Working Directorate in the NHS Modernisation Agency. The *CWP* is a national program, the goals of which are to improve service to patients and to improve work experience for staff. The program was launched in 2001 with 13 pilot sites, each dedicated to exploring new roles in a different specialty area. A Workforce Designer, whose role is to assist local organisations to redesign health professional roles that they have identified, oversees each pilot. Roles can be redesigned by moving tasks up or down a uni-disciplinary ladder, by expanding the breadth of roles and/or by increasing the depth of roles. The process of role redesign involves mapping services, testing the role, measuring benefits to patients/staff, assessing education/training requirements, creating a job description and set of competencies and ultimately preparing a business case to be considered by the Board of Management. The *CWP* not only facilitates change at a local level, but also provides a mechanism for dissemination of information on a national level through the *Role Redesign Database.*

(vii) Phillip Masterton-Smith, Royal College of Physicians; Professor Roy Pounder, University College London

The Committee was briefed on how NHS reforms were affecting the roles of physicians. The issue of pressure in accident and emergency (A&E) departments was discussed, Professor Pounder advising that GPs placed in A&E departments could be a very cost-effective means of managing non-emergency patients, as GPs are less likely than junior doctors to order myriad diagnostic tests.

The Committee also discussed the *European Working Time Directive (EWTD)*, a directive of the Council of the European Union that lays down minimum health and safety requirements for the organisation of working time. The *EWTD* currently applies to all health and social care workers with the exception of doctors in training. The extension of the *EWTD* to doctors in training in August 2004 will present a major challenge to the NHS. Historically, doctors in training have worked long hours and provided much of the out of hours medical cover. Across the country, Trusts are developing new healthcare practitioner roles to take on the work currently carried out by junior doctors. The Royal College of Physicians have two major concerns about the *EWTD* - first, that some 80 percent of hospitals do not have sufficient doctors to meet *EWTD* objectives, and second, if doctors in training work fewer hours per week, they will not acquire sufficient training.

(viii) Judith Ellis, Hillary Cass, Maggie Barker, Cheryl Unthank, Great Ormond Street Hospital for Children NHS Trust

The Committee was provided with information on Clinical Site Practitioners (CSPs), a new role developed to relieve some of the workload of junior doctors, particularly at night, in accordance with *EWTD*. The role was also established to provide support for junior nursing staff. A team of six nurses who came from senior pediatric intensive care backgrounds were originally appointed as CSPs in April 2001. There are now 11 CSPs, who run a joint night team with their medical colleagues. Whilst doctors lead in terms of primary specialty responsibility, the senior clinician on site is the CSP. The establishment of CSPs would not have been possible without a cultural change of respect for nursing.

(b) Peterborough

(i) Randle Milne, Peterborough Hospitals NHS Trust

Mr Milne briefed the Committee on the history and purpose of extended role radiographers in the United Kingdom. A major driving force for the extension of radiographers' roles was the shortage of doctors and, as a direct consequence, the unacceptable waiting lists for patients. Because doctors are not paid on a fee-for-service basis, extended role radiographers were not seen as a threat to their livelihood. Radiographers and other extended role health practitioners act as a triage point for patients - only the most complex cases are referred to doctors, the more routine

patients being assessed and treated by extended role practitioners.

The Committee was also briefed on the four-tier system of career development for allied health professionals. The system is currently being developed at a national level by government and professional groups. The first tier is the assistant practitioner, who has vocational training; the second tier is the practitioner, who is generally degree qualified; the third tier is the advanced practitioner, who has considerable experience; and the fourth tier is the consultant practitioner, who operates at the most senior level with a considerable degree of autonomy. One of the underlying principles of the four-tier system is that it is competency based. In theory, a person can work their way from assistant to consultant practitioner through experience alone, without necessarily satisfying certain academic requirements. In practice this will likely happen in very few cases, but the pathway is open to all.

(ii) Sylvia Few, Ruth Emmins, Gill Dawson, Peterborough Hospitals NHS Trust

Ms Few and associates briefed the Committee on the Peterborough Rapid Response Team (RRT). The team was established four years ago and comprises senior nurse practitioners. Patients are referred by GPs, A&E departments and walk-in centres for acute, non-life threatening events (such as falls or infections). The RRT responds within two hours, attending the patient's home and providing care for up to 72 hours (intermediate care). The RRT vehicle is equipped with standard nursing equipment and can provide care for a wide range of situations. The RRT general charter is to keep patients out of hospital, and it is able to do so in around 70 percent of cases. Prior to the establishment of the RRT, all patients would have occupied acute hospital beds.

(iii) Sue Drake, Celia Kendrick, Peterborough Hospitals NHS Trust

The Committee was advised that Emergency Nurse Practitioners (ENPs) undertake a minor injury role in A&E departments. They are able to deal with sprains, lacerations, wounds, minor injuries and foreign bodies, patients that would normally be dealt with by a senior house officer (SHO, junior doctor in training). Ms Drake advised that ENPs have been guiding SHOs over the years and are now receiving recognition for doing so. There are some limitations to their scope of practice, for example, they cannot prescribe medication for patients to take home (although they can administer medication within A&E), they are able to refer patients but do not have admission rights to hospital and in some hospitals they are unable to interpret x-rays.

(iv) Kay Ruggiero, Allison Dickinson, Peterborough Hospitals NHS Trust

Ms Ruggiero briefed the Committee on her experiences as an Orthopaedic Nurse Practitioner (ONP) at Edith Cavell Hospital in Peterborough. When she was first appointed, only one of ten consultant orthopaedic surgeons was willing to work with her, the others being ambivalent or even opposed to her involvement. Six months into the post, Ms Ruggiero had cleared the waiting list of the first surgeon and approached a second surgeon to establish a working partnership. Two years into the post, Ms

Ruggiero now works with eight of the ten consultants (she specialises in lower limb orthopaedics, the remaining two surgeons are upper limb surgeons). A second ONP was recently appointed at Edith Cavell, to work with upper limb surgeons, attesting to the success of the program. The ONPs are able to greatly relieve the workload of the surgeons in two ways: first, by 'screening' new patients and referring only those who require surgery to the consultant; and second, by undertaking follow-up (post surgery) visits for the majority of patients.

(c) Kettering

(i) Dr Angela Dancocks, Marisa Shrimpling, Geraint Martin, Kettering General Hospital NHS Trust

Dr Dancocks and colleagues briefed the Committee on the *'Greet and Treat'* program at Kettering General Hospital, an Emergency Services Collaborative initiative. The Committee was advised that the transit time for 'minors' patients (non-urgent patients who account for 70-80 percent of all cases) in A&E has been greatly decreased by eliminating delays and duplications. Patients are assessed, treated and discharged by the same health professional - a senior doctor or an experienced emergency nurse practitioner - where previously a number of health professionals (eg a triage nurse, a junior doctor, a senior doctor and a nurse) were involved at various points along the patient pathway. Since introducing the program, the number of patients seen within one hour has increased from 52 to 75 percent, and 93 percent of patients have a transit time (assessment, treatment, discharge) of less than four hours. Wait times for patients with more urgent conditions have decreased significantly as a flow-on effect of the *Greet and Treat* approach for minors patients.

(d) Manchester

(i) Denise Houghton, Nicola Nicholls, Chris Appleby, Pennine Acute Hospitals NHS Trust

Ms Houghton and colleagues briefed the Committee on their experiences with Magnet accreditation at Rochdale hospital, one of the four hospitals within the Pennine Acute Hospitals NHS Trust. Magnet accreditation began in the United States as an accreditation model for nurses. It is governed by principles of shared governance, which in practice means, participation of staff in decision making around practice, responsibility for managing nursing and an expectation that along with responsibility comes the authority to make decisions. Improved clinical capability and improved patient outcome are well-documented flow-on effects of Magnet.

Rochdale was the first pilot site to test the hypothesis that the Magnet framework can be transferred outside the US. In the two to three years preceding the 18-month pilot, a major investment was made in leadership development and cultural change. The Rochdale program differed to the US framework in that it was extended beyond

nursing to all clinical staff. Whilst medical staff were initially reluctant to become involved, they later joined the program, encouraged by the changing attitudes of nursing staff and the improvement in patient outcomes. Ms Houghton indicated that establishing 'clinical champions' to liaise between project managers and staff at ward level was a vital ingredient to the success of the project.

(e) Liverpool

(i) Jackie Novak, Ann Campbell, Joan Kirby, Dr Veronica Abernethy, St Helens and Knowsley Hospital NHS Trust

The Committee was briefed on the operation and experiences of the nurse-led rheumatology (Foxton) ward at St Helens Hospital. In contrast to the traditional doctor-led rheumatology unit, where allied health professionals are often not a part of the core team of carers, the Foxton ward is staffed by a multi-disciplinary team of nurse practitioners, consultants, an occupational therapist and a physiotherapist. The nurse practitioners case manage care of patients from original assessment to 6-week follow-up, coordinate and participate in pre-assessment clinics and arrange patient admission. For patients with newly diagnosed disease, several days on the ward with a multi-disciplinary team facilitates continual education and support.

(f) Wookey Hole

(i) Cheryl White, Sharon Lomas, NHS Modernisation Agency

Ms White and Ms Lomas briefed the Committee on the Primary Care pilot operating in the Mendip Primary Care Trust as part of the *Changing Workforce Programme*. As well as providing an overview of the *CWP*, Ms White provided some examples of role redesign in the Mendip region. For example, a Discharge Facilitator is a ward clerk who calls patients 48 hours after discharge from hospital. The role was developed in response to concerns about patients being readmitted to hospital after experiencing problems with medication following their initial discharge. Some 20 percent of patients fell into this category. By extending the ward clerk's existing role, patients' medication problems were dealt with. The role has been so successful it will now be rolled out across all community hospitals in Mendip.

The Committee was also briefed on the *Accelerated Development Programme (ADP)*. The program provides a fast track approach on a number of key health roles, including radiographers, medical secretaries, emergency care workers and intermediate care workers. The *ADP* will establish ten Trusts on a rolling program in three phases to explore new roles. It will take 10 months, compared to the regular 18-month *CWP* pilots.

(g) Southampton

(i) Dr Mike Hall, Helen Creedon, Southampton University Hospitals NHS Trust

Dr Hall and Ms Creedon briefed the Committee on the role of Advanced Neonatal Nurse Practitioners (ANNPs) and how they were established. Toward the end of the 1980s, junior doctors were working long hours (100 hours per week). Rotations through neonatal units were rapid (6 monthly) and, as a consequence, during a considerable proportion of time, relatively inexperienced doctors were providing high level first line care, and babies were receiving less than optimal care. The regional health authority began to examine alternatives for care and neonatal nurses, with their considerable experience and keen intuition, were seen as an attractive alternative.

One hundred and twenty ANNPs have now been trained at Southampton and are employed throughout the country. ANNPs assess babies who are unwell, initiate treatment and play a prominent role in subsequent management. The level at which ANNPs operate varies from unit to unit, in some cases functioning up to what would be regarded as a middle grade doctor.

(ii) Katherine Fenton, Southampton University Hospitals NHS Trust

Ms Fenton briefed the Committee on the re-introduction of matrons into the NHS as part of the modernisation program. At Southampton General Hospital the senior sister has assumed the role of modern matron, whilst at other hospitals, a new tier has been created for the modern matron role. A ward secretary and housekeeper, who assist with administrative duties, support the new role. It also comes with a new job description, a new set of competencies and a new development program. The matron role is one of leadership, rather than a clinical role - the modern matron is expected to spend much of his/her time on one-to-one education with junior staff, or in a clinical area working one-to-one as part of the team. The modern matron is also expected to be instantly recognisable to patients (by the distinct uniform), dealing with patient problems and concerns at ward level.

Ms Fenton also provided the Committee with a brief overview of nursing in the United Kingdom. The majority of nursing staff are diploma qualified. There are perverse incentives in the United Kingdom not to undertake a nursing degree. Diploma students receive a salary of around £14,000 pa during training, while degree students receive a bursary of around £6,000. Upon graduation, diploma and degree qualified nurses earn the same salary and yearly increments do not differ. Research indicates that degree educated nurses become more effective practitioners within a shorter period of time, but they are also less likely to stay in nursing.

(iii) Allan Jolly, Martin Barkley, West Hampshire NHS Trust; Steve Tee, University of Southampton

Mr Jolly and colleagues briefed the Committee on the *(Associate) Mental Health Practitioner Project* at West Hampshire NHS Trust. A major impetus for the project was the *European Working Time Directive*. The project developed a new role in mental health with the aim of improving quality of patient care, addressing recruitment issues in the Trust and preparing practitioners for the "modern NHS". After extensive consultation with local Trusts, to ascertain which skills the new practitioner should possess, a curriculum was designed. The (A)MHP course is a two-year postgraduate diploma with a first degree minimum entry. Students are fully employed by the Trust for the duration of the course, spending four days per week in supervised placements and one day per week at University. There has been some resistance from other professional groups in relation to a number of issues including: delineation of roles, regulation, payment for training, administration of medication and supervision. The first intake of students will commence in September 2003. The majority of candidates have completed undergraduate psychology degrees.

(iv) Dr Debra Humphris, Professor Jill Macleod Clark, University of Southampton

The Committee received a briefing on the *New Generation Project* and the concept of inter-professional learning (IPL). In the health sector, IPL involves two or more professions learning from and about each other to improve collaboration and, ultimately, quality of patient care. The project is based on the premise that one of the most effective ways to foster an understanding about respect for various professional roles and the value of multi-professional teams is to expose students to shared education and training. There is a strong belief that once professional groups have undergone 'professional socialisation' it is difficult to breakdown the negative stereotypes and prejudices towards other professions and to foster a collaborative work culture.

The Universities of Southampton and Portsmouth have come together to form the largest of four national *New Generation* pilots. The pilot will develop and deliver an integrated inter-professional *Common Learning Programme*, across 10 professional programs - medicine, nursing, midwifery, physiotherapy, occupational therapy, podiatry, pharmacy, diagnostic radiography, therapeutic radiography and social work. The first cohort of 1500 students will begin the new program in October 2003.

(h) Eastbourne

(i) Mr Paul Rowe, East Sussex Hospitals NHS Trust

Mr Rowe briefed the Committee on the establishment and operation of the Surgical Assessment Unit at Eastbourne General Hospital. Emergencies account for up to half of all surgical admissions and represent 60-70 percent of the surgical workload at Eastbourne General Hospital. In a recent audit, it was estimated that around 20 percent

of emergency surgical admissions could be avoided. Twelve surgical beds were closed so that a short stay Surgical Assessment Unit (SAU) could be established. The SAU can house patients for up to 48 hours, but the target is to have patients assessed and discharged in less than 24 hours. A dedicated registrar in the SAU takes all phonecalls (from GP and A&E), provides advice without follow-up, provides advice and refers to outpatient clinic for follow-up, or admits to SAU. Previously, patients were referred to a junior doctor, who was often not experienced enough to make a decision on course of action, leading to many unnecessary admissions to surgical wards. The registrar has the confidence and experience to make clinical decisions without ordering unnecessary investigations or awaiting a second opinion from a more senior doctor. Since establishing the SAU, there has been a 34 percent reduction in admission rates to the main surgical wards.

(i) Ashford

(i) Mr Jalal Maryosh, Lesley White, Sue Travis, Sarah Maycock, East Kent Hospitals NHS Trust

The Committee was given the opportunity to 'follow the patient journey' through the Accident and Emergency Department at William Harvey Hospital. Mr Maryosh walked through each stage of the patient journey from entry into the A&E department, through assessment, treatment and discharge or admission. Ms White briefed the Committee on William Harvey's involvement in the *Emergency Services Collaborative*, a national initiative aimed at improving delivery of emergency care. Ms Travis briefed the Committee on the Bed Bureau, a system wide bed management program that covers the three major hospitals in the East Kent Trust. The Bureau coordinates beds on a daily basis, determining where both elective and emergency patients will go. Three times daily, bed state information is mapped and disseminated to all community service managers, hospital managers, ambulance service and local primary care trusts. Downstream, a discharge coordinator educates staff at ward level to use beds more efficiently and liaises with social and rehabilitative services to ensure that acute beds are used for patients who need acute care.

APPENDIX ONE

SUMMARY OF BRIEFINGS

CANADA

Date	Name	Position	Organisation
Sun 22 June	Mr Alex Berland	Partner	Strategic Resource Group
Mon 23 June	Ms Megan Loeb	Consultant, Stakeholder Liaison, Education and Evaluation, Primary Health Care	British Columbia Ministry of Health
	Ms Laurie Gould	Director, Planning and Development, Primary Care and Chronic Disease	Fraser Health Authority
Tues 24 June	Nancy Swainson Lucy Falastein Jacquie Lemaire	Acting Director Policy Analyst Senior Program Officer	Health Policy and Communications Branch, Primary Health Care Division, Health Canada
	Mr Clive Shepherd	Site Co-ordinator	Ontario Family Health Networks
	Dr Daniel Way	Director of Postgraduate Education	Faculty of Medicine, University of Ottawa
Wed 25 June	Dr David Gass Ms Tracey Martin	Director, Primary Health Care Primary Health Care Co-ordinator	Nova Scotia Department of Health
	Dr David Gass Ms Mary Jane Hampton	Director, Primary Health Care Director	Nova Scotia Department of Health Stylus Consulting

UNITED KINGDOM

Date	Name	Position	Organisation
Fri 27 June	Mr Marc Seale Greg Ross-Sampson	Chief Executive Project Manager	Health Professions Council
	Ms Barbara Edmonds Mr Simon Williams	Director of Public and Patient Involvement Director of Policy	College of Health The Patients Association
	Ms Sheelagh Richards Ms Beryl Steeden	Chief Executive Group Head, Membership and External Affairs	Council of Occupational Therapists
	Ms Geraldine Cunningham	Director, Clinical Leadership Programme	Royal College of Nursing
	Mr Robert Rose	Workforce Designer, Changing Workforce Programme	NHS Modernisation Agency
	Mr Phillip Masterton-Smith Professor Roy Pounder	Chief Executive Professor of Medicine	Royal College of Physicians University College London
	Ms Cheryl Unthank Ms Judith Ellis Dr Hillary Cass Dr Maggie Barker	Senior Clinical Site Practitioner Chief Nurse Director of Postgraduate Medical Education Associate Medical Director, Public Health	Great Ormond St Hospital for Children NHS Trust
Mon 30 June	Mr Chris Wilkinson Sandra Betterton	Director of Nursing Head of Nursing	Peterborough Hospitals NHS Trust Norfolk, Suffolk and Cambridgeshire Strategic Health Authority

Date	Name	Position	Organisation
Mon 30 June (cont.)	Mr Randle Milne	Radiology Services Manager	Peterborough Hospitals NHS Trust
	Ms Sylvia Few	Intermediate Care Lead	Peterborough Hospitals NHS Trust
	Ms Ruth Emmins	Senior Nurse	Peterborough Rapid Response Team
	Ms Gill Dawson	Senior Nurse	Peterborough Rapid Response Team
	Ms Sue Drake	Emergency Nurse Practitioner	Peterborough General Hospital, Peterborough Hospitals NHS Trust
	Ms Celia Kendrick	Lead Nurse, Accident and Emergency	
	Ms Kay Ruggiero	Orthopaedic Nurse Practitioner	Edith Cavell Hospital, Peterborough Hospitals NHS Trust
	Ms Allison Dickinson	Orthopaedic Nurse Practitioner	
	Dr Angela Dancocks	Consultant, Accident and Emergency	Kettering General Hospital NHS Trust
	Ms Marisa Shrimpling	Emergency Nurse Practitioner	
	Mr Geraint Martin	Chief Executive	
Tues 01 July	Ms Denise Houghton	Director of Nursing	Pennine Acute Hospitals NHS Trust
	Ms Nicola Nicholls	Magnet Project Manager	
	Mr Chris Appleby	Chief Executive	
	Ms Jackie Novak	Rheumatology Nurse Practitioner	St Helens and Knowsley Hospital NHS Trust
	Ms Ann Campbell	Physiotherapist	
	Ms Joan Kirby	Ward Manager	
	Dr Veronica Abernethy	Consultant, Rheumatology	

Date	Name	Position	Organisation
Wed 02 July	Ms Cheryl White Ms Sharon Lomas	Workforce Designer, Changing Workforce Programme Project Manager, Changing Workforce Programme	NHS Modernisation Agency, Mendip Primary Care Trust Pilot
	Dr Mike Hall Ms Helen Creedon	Consultant, Neonatal Medicine Neonatal Nurse Educator	Princess Anne Hospital, Southampton University Hospital NHS Trust
Thurs 03 July	Ms Katherine Fenton	Director of Nursing and Patient Services	Southampton General Hospital, Southampton University Hospital NHS Trust
	Mr Allan Jolly Mr Steve Tee Mr Martin Barkley	Project Manager, Mental Health Practitioner Project Head of Mental Health Division Chief Executive	West Hampshire NHS Trust University of Southampton West Hampshire NHS Trust
	Professor Debra Humphris Professor Jill Macleod Clark	Director, New Generation Project Head of School of Nursing and Midwifery, Deputy Dean, Faculty of Medicine, Health and Biological Sciences	University of Southampton
Fri 04 July	Mr Paul Rowe	Clinical Director, Surgical Services	Eastbourne General District Hospital, East Sussex Hospitals NHS Trust

Date	Name	Position	Organisation
Fri 04 July (cont.)	Mr Jalal Maryosh	Consultant, Accident and Emergency	William Harvey Hospital, East Kent Hospitals NHS Trust
	Ms Lesley White	Business Manager and Deputy Emergency Services Collaborative Programme Manager	
	Ms Sarah Maycock	Acting Assistant Hospital Manager	
	Ms Sue Travis	Bed Bureau Manager	