

Topic Update – August 2009

Social Work Task Force Interim Report - 29 July 2009

The Government has published a report setting out the interim findings and recommendations of the Social Work Taskforce. The Taskforce has been working with frontline social workers, social work leaders, families and academics to support and develop the long-term reform of the social work profession, including training, recruitment and day-to-day practice. Recommendations from the report include:

- The creation of a national college for social work
- Greater partnership between employers and educators for the improvement of social work education
- Clearer career and progression structure
- A much more sophisticated understanding of supply and demand
- Securing the resources social workers need to be effective

The issue of a national college of social workers is raised in the report. The Social Work Task Force will now bring forward the recommendations for the college, which will have a key role in driving learning and best practice in social work and will provide a strong voice which speaks to the media about the profession.

For the full report from the Task Force, please see: www.dcsf.gov.uk/swtf

The Government has also launched a new peer support programme for middle managers of social care functions in local authorities. The programme will help managers to explore and tackle the challenges of leading and managing workforce change to improve services and outcomes. This work builds on the Government's response to Lord Laming's recent progress report on the protection of children in England. Previous steps announced in May include a £58 million plan to transform the recruitment, retention and development of the social work profession. This included:

- sponsoring 200 university places from September
- starting a new recruitment campaign specifically targeting social workers who may have left the profession to give the current workforce a boost
- rolling out the successful Newly Qualified Social Workers (NQSW) pilots to all new children and families' social workers joining statutory and voluntary services from this September
- funding a practice-based Masters in social work to start in early 2011 so that all social workers can continue to develop further their knowledge, skills and expertise
- introducing a new Advanced Social Work Professional Status programme to create senior practice-focused roles to keep excellent and experienced social workers in children's services
- coaching and development for frontline social worker managers to boost leadership and management skills.

More information: <http://publications.dcsf.gov.uk/eOrderingDownload/DCSF-00753-2009.pdf>

Improving access to Child and Adolescent Mental Health Services (CAMHS)

Children and young people in need of more specialised help from child and adolescent mental health services (CAMHS) should have clearly signposted routes to specialist help and timely access to this, with help available during any wait. There are concerns that swift access to services is not always being achieved in practice:

- Some children and young people still have to wait too long to be seen by services and there is geographic variation in access.
- Some families find the procedures for accessing services confusing.

Findings such as these led the National CAMHS Review (2008) to make the following key recommendation:

'improve the quality of CAMHS experienced by children, young people and families by reducing waiting times from referral to treatment.'

The Review's vision for accessible services states that children, young people and their families should have:

- clearly signposted routes to specialist help
- an 'open door' into a system of joined-up support
- timely access to this.

This joint guide from the Department of Health and the Department for Children, Schools and Families explains the rules on the 18 weeks referral to treatment (RTT) standard, as set out in the NHS Operating Framework for 2009/10 (Department of Health, 2008) and how these apply to non-emergency consultant-led CAMHS services and pathways. It does not set any new standards or targets.

Good practice examples show how these rules can be achieved in practice. It sets out key strategic and operational steps for both implementing mandatory waiting time standards and supporting the delivery of low wait, accessible, multi-disciplinary CAMHS.

The guide describes four service improvement models that can be used alone or creatively combined:

- 10 High Impact Changes
- the Choice and Partnership Approach
- Lean Thinking
- New Ways of Working.

These overviews are supported by local case studies which illustrate how the service improvement models have been applied to improve access to local services. Advice is provided for both commissioners and providers of CAMHS and web links are used to signpost readers to a range of implementation tools and supporting resources.

To view the full guide please visit

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103651

Care Quality Commission - Managing money belonging to people who use services

What is this checklist about?

People who use care services should be able to use and manage their money as and when they choose. Some people may need support with managing their finances but this should not override their right to access their money and to decide how they wish to spend it.

Managers and staff of homecare services and care homes should ensure any support they provide:

- respects people's right to control their finances and personal property
- handles people's finances and valuables appropriately and in confidence
- minimises any risk of criminal activity or financial abuse.

Checklist

1. Support people to manage their finances independently

- Work with the person to develop their financial profile as part of their overall support plan. This profile will include what the person needs to pay for, how money and valuables are made secure and a risk assessment of their money management skills
- Provide information to help people make decisions about managing their money and keeping it safe; ensure information is available in easy-read formats and involve independent advocates to help people consider their choices
- Always consult with people about their money and ensure it is spent as they wish

2. Make support arrangements clear, safe and accountable

- Provide people with a copy of the 'service user guide' and written contract that clearly outlines what is included in the fee for the care service and any extra charges
- Ensure people understand the terms and conditions of the service
- Use the single test set out in the Mental Capacity Act 2005 when assessing people's capacity to take a particular decision and adopt 'best interest' principles where a decision has to be made on a person's behalf
- Where a person lacks the capacity to express their needs, work with people making financial decisions on their behalf to ensure any personal funds enhance people's quality of life
- Assess whether a person is able to manage their own finances and manage any risks; and avoid drifting into making decisions on someone's behalf because it is the easy option
- Ensure there is an appointed person to manage a person's financial affairs, rather than a member of staff, if there are legally recognised responsibilities that need to be taken on
- Train staff in managing finances

3. Make all transactions transparent

- Keep receipts for all financial transactions

4. Balance accessibility and security

- Do not withhold money
- Seek signatures from a witness where workers handle a person's money and the person is unable to sign
- Do not share PIN numbers
- Provide safe storage in people's rooms (in care homes)

5. Make procedures more than a piece of paper

- Ensure and check that staff understand the written procedures
- Make sure procedures cover all eventualities (for example, when care workers go out with residents, gifts are offered)
- Ensure everyone understands and knows how to make a complaint and what to do if they suspect abuse

6. Practise sound financial management (in care homes)

- Practise sound financial management so that any money that needs to be held or managed on a person's behalf is safe and within their control
- Keep money and records separately for each resident
- Corporate appointees should put safeguards in place and the account established to manage people's financial affairs must be separate from the main business account
- Be cautious about establishing a resident's fund; as a general principle a person's money and property should be within their control and not seen as belonging to everyone
- Ensure any resident with a lot of money is supported to open an account and not too much cash is held on the premises

Department of Health (DH) partner and stakeholder perceptions surveys

Since 2004 the Department of Health has been working to improve the quality of its engagements and relationships with partner and stakeholder organisations. In January 2009, Jigsaw Research was commissioned to explore partner and stakeholder perceptions of DH. Jigsaw concluded that "... overall, DH's partner relationships are improving against a complex and often difficult backdrop ... Most (52%) of those interviewed felt that their organisation's relationship with the Department had improved over the last two years ..." The quantitative data from the research support Jigsaw's conclusion with 57% of respondents agreeing that DH is "... good to do business with" (up from 36% in 2007).

Jigsaw's research confirms that the relationship management arrangement that was recently implemented with some key stakeholders is the right approach. These arrangements will now be further developed and rolled out to include other key stakeholders, including other Government departments. But, whilst the overall findings are encouraging, there remain clear opportunities for further improvement. In October 2009, the Department's Corporate Management Board will consider their full response to Jigsaw's recommendations alongside emerging plans for continuous organisational improvement, partly informed by the results of the recent Cabinet Office Capability re-Review.

For summary of report please visit

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103644

Towards a strategy to support volunteering in health and social care: Response to the consultation

This response to the 'Towards a strategy to support volunteering in health and social care' consultation sets out the messages that were heard during the Department of Health's consultation process through nine regional workshops held around England, an on-line questionnaire; and detailed written responses received by the Department of Health. This document sets out the key themes identified, an analysis of the feedback received, and outlines how the work will be taken forward to develop a substantive strategy on volunteering in health and social care.

The consultation document is said to have described a more coherent vision to the value volunteering activities bring to the health, well-being and social care system. It was said that establishing a coherent vision would: raise the esteem and profile of volunteering; improve management and support of volunteers; allow more coherent investment; and support evaluation of outcomes and benefits. It was also said that to achieve this, the vision for volunteering in health and social care needs:

- support for Individual volunteers;
- effective management within organisations
- commissioning environment and infrastructure
- promoting partnership; and
- leadership.

The response to the consultation broadly supported the approach that was set out to achieve this vision. Some debate and discussions were raised around specific questions, which will need to be considered when developing the substantive volunteering strategy.

The overall outcome of the review and consultation process is the creation of a volunteering strategy in health and social care.

For further information you can contact the Third Sector Partnership Team by emailing volunteeringstrategy@dh.gov.uk or by telephoning 0113 2546259.

GP Extended Opening Hours - July 2009

	Number of Practices	Number of practices offering extended hours	Percentage of practices offering extended hours	Number of PCTs having 75% or more of practices offering extended hours	Number of PCTs having 100% of practices offering extended hours	Percentage of PCTs having 100% of practices offering extended hours.	Percentage of PCTs having 75% or more of practices offering extended hours.
England Total	8279	6384	77.1%	81	3	2.0%	53.3%
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East Midlands	632	454	71.8%	3	0	0.0%	33.3%
East of England	795	602	75.7%	8	0	0.0%	57.1%
London	1527	1205	78.9%	19	1	3.2%	61.3%
North East	397	331	83.4%	9	1	8.3%	75.0%
North West	1267	904	71.3%	8	0	0.0%	33.3%
South Central	503	412	81.9%	7	0	0.0%	77.8%
South East Coast	641	502	78.3%	3	0	0.0%	37.5%
South West	732	634	86.6%	11	1	7.1%	78.6%
West Midlands	976	718	73.6%	7	0	0.0%	41.2%
Yorkshire and Humber	809	622	76.9%	6	0	0.0%	42.9%

PCT name	Total number of practices	Number of practices offering extended opening hours	%
TAMESIDE AND GLOSSOP PCT	40	20	50.0%

Tameside and Glossop PCT, along with Cumbria and Knowsley PCT's, has the lowest percentage of practices offering extended opening hours in the North West, and the second lowest percentage in the country (only Shropshire PCT is lower).

The NHS Operating Framework sets out the Government's key priority for improving routine access to GP services in evenings and at weekends, requiring primary care trusts to ensure that at least half of their practices are offering extended opening hours to patients.

More information

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_104001.xls

New service hands more power to the patient

A new online service that allows patients to rate and compare hospitals on issues such as car parking and waiting times was launched on 11 August 2009 by Health Secretary Andy Burnham.

As patients now have the right to choose when and where they receive hospital treatment, a new web-based scorecard is now available at www.nhs.uk to give people all the information they need to make the right choice of hospital for them.

The scorecard, which works in a similar way to internet comparison websites, means patients will no longer have to search multiple sources to find key information about where to receive treatment. Instead, for the first time, patients will be able to compare a range of hospitals and their ratings in one place, as well as read reviews on:

- Mortality rates;
- Infection rates, including MRSA and Clostridium difficile;
- Cleanliness;
- Staff performance;
- Quality of food;
- If patients felt they were involved in decisions around their care; and

- If they would recommend the hospital to friends and family.

Later this year, a similar service is being launched to allow patients to rate and compare GP Practices.

For further information please visit

<http://nds.coi.gov.uk/Content/Detail.aspx?NewsAreaId=2&ReleaseID=405758&SubjectId=2>

Swine Flu Vaccination programme

Accepting advice from independent expert committees, including the Joint Committee for Vaccination and Immunisation (JCVI) and the Scientific Advisory Group for Emergencies (SAGE), Health Secretary Andy Burnham has announced the priority groups for vaccination against swine flu:

- individuals aged six months and up to 65 years in the current seasonal flu vaccine clinical at-risk groups
- all pregnant women, subject to licensing considerations on trimesters
- household contacts of immunocompromised individuals
- people aged 65 and over in the current seasonal flu vaccine clinical at-risk groups

These groups have been identified because they are at highest risk of severe illness should they contract the swine flu virus. They should be prioritised for vaccination in order, once the vaccine has been licensed. Frontline health and social care workers will be offered the vaccine at the same time as the first clinical risk group as they are at increased risk of infection and of transmitting that infection to vulnerable patients. Those staff eligible for seasonal flu vaccine, as set out in the Green Book, will be eligible for swine flu vaccination. This includes staff who have regular clinical contact with patients and who are directly involved in patient care.

Further operational guidance to the NHS on the roll out of the programme will be made available in the next few weeks. The Department of Health is working with the BMA and NHS organisations to reach a comprehensive swine flu vaccine implementation plan for this first stage of the programme.

Preparations continue to be made to extend the programme beyond these initial priority groups and JCVI will consider this matter further and report back in due course.

For further information please visit www.nhs.uk/news/2009/04April/Pages/Swineflulatest.aspx

A&E Attendances 2009-10 April to June (Q1)

Name	Total attendances
Tameside Hospital NHS Foundation Trust	19,852
Oldham Primary Care Trust	11,524

For further information please visit:

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_104301.xls

Development of Tier 4 Child and Adult Mental Health Services (CAMHS)

Ever since the tiered framework for CAMHS was first used, Tier 4 was seen essentially as an inpatient service which was felt to be the necessary environment for sorting out and treating young people with the most complex needs.

Tier 4 has more recently come to be understood as multi-faceted with multi-agency services that can include inreach, outreach, intensive and crisis community initiatives, day provision, therapeutic fostering and other services that may be described as 'wrap around'. Over the past few years there have been innovative approaches in assessment and treatment of this most complex group of young people and the development of new intensive community focussed services.

Children with Tier 4 needs frequently suffer from two or more disorders, as well as a number of factors known to increase the risk for mental health problems. Risk conditions often occur simultaneously and the number rather than the type is predictive of outcome. Groups of children known to be at particularly high risk are shown in the box below:

Groups at higher risk than their peers for mental health problems

- Young offenders and children from a criminal background
- Children who are being looked after by local authorities or who have recently ended a period of public care
- Children with learning difficulties
- Children with emotional and behavioural difficulties
- Children who have been sexually, physically or emotionally abused
- Children with a chronic physical illness
- Children with a physical disability
- Children with sensory impairments
- Children of parents with mental illness
- Children of parents with a substance abuse problem
- Children who have experienced or witnessed sudden and extreme trauma
- Children who are refugees.

Thus, Tier 4 must deal not only with a diagnosis of mental health disorder but also with children who, in real life, more often than not, have two or more comorbid conditions, such as learning disability and mental health disorder, or depression and a conduct disorder, as well as a number of risk factors.

The needs for CAMHS at Tier 4 were:

- according to the type of care required by the needs of the young person, a range of types of care were described, with considerable variation in individual reviews, including emergency or acute care, intensive care, care over the medium to long term, inpatient and day patient, community based care, which includes outreach, home treatment, post-discharge and 'wrap around' services and low, medium and high secure services
- a service can be described according to the type of condition it manages, such as eating disorder, learning disability, dual diagnosis, conduct disorders, autistic spectrum disorder
- according to age group. For younger children, for older adolescents, and transition services for those about to be classified as 'adult'
- according to legal status for young offenders and those sectioned under the Mental Health Act 1983 (and 2007 amendments).

For further information please visit

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103444

High Quality Care for All: Our Journey so far

One year on from the publication of High Quality Care for All, Lord Darzi has reviewed the progress made to put quality at the heart of the NHS.

In his report, *High Quality Care for All: our journey so far*, he says that across each dimension of quality – patient experience, clinical effectiveness and patient safety – real improvements have been made.

Most patients with long-term conditions now have personalised care plans, over 75 percent of GP surgeries are now open for longer hours, the NHS has met targets to dramatically reduce *C.difficile* and MRSA infections and no one is waiting more than 18 weeks from referral to treatment.

The second part of the report looks at progress towards the overarching goal of putting quality at the heart of everything we do in the NHS, from defining and measuring quality through to innovating for the future.

Our journey so far finishes by focusing on NHS staff and improvements to their education and training and investment in leadership. This, Lord Darzi suggests, is the way to win hearts and minds and achieve the ambition of putting quality at the heart of the NHS.

The year ahead

While the past year has seen progress in leaps and bounds, Lord Darzi recognises that more needs to be done to further empower clinicians to take the lead on improving the quality of care patients receive.

‘We need to keep the momentum going by encouraging a bottom-up approach and giving frontline staff more power to drive the changes forward,’ he says.

In primary care, this shift has been under way for some time with practice-based commissioning offering GPs and practice staff the opportunity to take more control over NHS commissioning expenditure to achieve better outcomes for the local population.

The report also includes proposals to give greater freedom to the NHS by reducing unnecessary data collection and removing obsolete targets and commitments. The 13-week outpatient and 26-week inpatient performance targets have been removed and a review of data collections across the board will soon take place.

In the next few years, the NHS is expected to face a serious funding shortage and Lord Darzi stresses that a partnership between innovation and quality will become even more important if the NHS is to continue to make progress with less money in the pot.

‘Quality and cost are inseparable: if you do things well, they cost less,’ he says. ‘The financial crisis has helped to refocus our attentions on innovating to provide the same, if not better, services more cost efficiently.’

Key Highlights

- Waiting times in the NHS dramatically reduced, with the time from referral by GPs to treatment down to a maximum of 18 weeks, from 18 months just ten years ago.
- Improving patient experience by substantially increasing access to primary care services, including 50 new GP-led health centres now open, 65 new GP practices in areas that previously did not have enough doctors and more than three-quarters of GPs offering extended opening hours.
- Improving patient safety through substantial reductions in healthcare associated infections, including a 35% reduction in *C. difficile* and a 38% reduction in MRSA rates over the last year alone.
- Improvements and investment in NICE to ensure faster access for patients to new drugs and treatments.
- Five Academic Health Science Centres, bringing together our top academic and healthcare organisations to form world-leading institutions for innovation and research.
- Major progress on the new Quality Framework to support local organisations and frontline staff in putting quality at the heart of services, for example through the new Indicators for Quality Improvement, the development of Quality Accounts and the new National Quality Board.
- The first NHS Constitution was launched setting out the purpose and values that underpin the NHS and the rights and responsibilities of patients and staff.

To see the full report please visit www.ournhs.nhs.uk/wp-content/uploads/2009/06/next-stage-review_low-res.pdf

Join the Big Care Debate

The Government is offering everybody the chance to have their say on the reform of adult care and support in England. This is the *Big Care Debate*. The vision is to create a National Care Service that is fair, simple and affordable. To set this process in motion, they have published a public consultation document, or Green Paper, called *Shaping the Future of Care Together*.

In it they spell out the options for reform – how a new system could be organised and paid for. They are asking everybody what they think of these options and which ones they would like to see adopted.

The consultation closes on **13 November**.

All information about the Green Paper consultation can be found at www.careandsupport.direct.gov.uk

A Junior Doctor's Guide to the NHS

Launched on 1 June 2009, the guide was written by two junior doctors on secondment in Bruce Keogh's Medical Directorate in the Department of Health. The aim is to help junior doctors understand the way the NHS works. The guide contains information explaining how the DH, SHAs, Parliament and the NHS work together. Bruce says of the guide: 'It is an accessible way for junior doctors to understand the NHS and the policies that affect them. Junior doctors are tomorrow's clinical leaders so it is vital that we engage them in the organisation they work for.' Initial feedback

has been positive, and the guide has already been incorporated into some junior doctor training programmes.

To view the guide please visit

<http://group.bmj.com/group/affinity-and-society-publishing/NHS%20Guide.pdf/view?searchterm= junior%20doctor%20guide%20to%20the%20NHS>

Prevention is key to new ageing strategy

New health checks for people between 40 and 70 will be introduced next year to identify those at risk of heart disease, stroke, kidney disease or diabetes and help people stay healthy in old age. This announcement is part of *Building a society for all ages*, the Government's strategy for our ageing society. With falls responsible for over two million hospital bed days and 40 percent of admissions to nursing homes – costing £1.7 billion a year – the strategy recognises that more needs to be done to improve public services and prevent hospital admissions for our ageing population.

To view the strategy please visit www.hmg.gov.uk/media/33830/fullreport.pdf

Perinatal mortality rates published

Stillbirth and neonatal death rates in the UK have improved according to the Confidential Enquiry into Maternal and Child Health (CEMACH) *Perinatal Mortality Surveillance Report 2007*, published on 24 June.

For more information please visit

www.cmace.org.uk/Publications/CEMACH-Publications/Maternal-and-Perinatal-Health.aspx

NHS Choices: most common operations data

The NHS Choices website presents indicators to the public for 35 of the most common operations. From the end of July, this information will be displayed according to the hospital site(s) that carry out the procedures instead of under the heading of the NHS trust that carries out the procedure. The nominated lead in each trust has been asked to check all of their sites' information is included in the data set and correct any omissions using the monthly NHS Choices preview application. If site codes have not been allocated for a particular procedure the hospital will not be displayed on NHS Choices. Please visit www.nhs.uk

Guidance on NHS patients who wish to pay for additional private care

Following a 12 week consultation, from 4 November 2008 to 27 January 2009, the Department of Health has now published final guidance on NHS patients wishing to pay for additional private care, alongside a Government response to the consultation.

This follows the publication on 4 November 2008 of Professor Mike Richards's report Improving access to medicines for NHS patients, and the Secretary of State's announcement of a package of measures in response, designed to make more drugs available to NHS patients free of charge on the NHS.

These measures, such as the National Institute for Health and Clinical Excellence's introduction of greater flexibility into its appraisal of more expensive drugs for end of life conditions, should minimise the number of patients who will ever want to pay for additional private care.

For those few patients who may still wish to pay for additional private care, the Department published guidance for consultation which made clear that NHS patients should not lose their entitlement to NHS care, as a result of choosing to buy additional private care, and that any private care must be delivered separately from NHS care.

The Department received 146 consultation responses on this guidance, and was pleased to note the broad support for Professor Richards' recommendations and the aims of the guidance. In response to specific issues raised in consultation, the final version of the guidance includes a number of changes which are explained in the Government response.

To view the guidance please visit

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096576.pdf

MRSA deaths reduced

Figures from the Office of National Statistics show that, between 2007 and 2008, deaths due to MRSA in England dropped by more than 50 percent to 200. In the same period, deaths due to C.difficile dropped by more than 40 percent to 2,298, the first fall since reporting began in 1999.

For further information please visit:

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_104535.pdf

Health services responding to tragedy of Shipman with better monitoring of controlled drugs

The Care Quality Commission (CQC) has published a report detailing significant progress in implementing regulations introduced in response to the Shipman Inquiry, to monitor controlled drugs.

The Shipman Inquiry found that ineffective monitoring had allowed Dr Harold Shipman to obtain large quantities of diamorphine, which he used to kill at least 15 and possibly up to 200 patients.

The Controlled Drugs (Supervision of Management and Use) Regulations 2006 were introduced in January 2007. This is the second report on implementation of the regulations and covers progress made during 2008.

CQC said that the majority of healthcare organisations comply with the regulations and that many of the problems experienced during the first year of the new system have been resolved. It said

healthcare workers are now better trained to deal with concerns about controlled drugs and to identify problems sooner.

But CQC said there are still important parts of the system that need to be improved. It cautioned healthcare providers not to lose the substantial gains, but to build on them and to ensure they continue to embed the practices into routine activity.

The CQC made the following recommendations:

- *Organisations should have mechanisms to replace accountable officers immediately when vacancies arise and to notify CQC of the change.* Almost all relevant health organisations now have accountable officers in place who are responsible for monitoring controlled drugs. However, there has been significant turnover of accountable officers, particularly in PCTs where 41% changed their accountable officer at least once between January 2007 and December 2008.
- *That a more robust method to ensure that 72-hour fentanyl patches, which are used to manage chronic pain, are applied at appropriate intervals is explored.* Fentanyl patches are applied to relieve pain and last for 72 hours. They are often used in palliative care situations both in care homes and where care is provided by visiting carers in a person's home. The former adult social care regulator, the Commission for Social Care Inspection, advised that it in some cases it was difficult to manage and monitor the use of the three-day patches as the days to change the patches are different each week. This could mean that patches are changed too late, leaving the patient in pain.
- *Organisations should ensure there are enough "authorised witnesses" for destroying obsolete drugs.* Organisations must appoint authorised witnesses to be present when obsolete drugs are destroyed. The Royal Pharmaceutical Society of Great Britain advised that earlier problems relating to accumulation of obsolete controlled drugs had improved as more authorised witnesses were appointed. However, it said that some organisations need to both appoint additional witnesses and recognise existing witnesses in order to prevent accumulation of drugs, which could create a risk to security.
- *Local intelligence networks must make sure they inform relevant bodies about their formation and leadership and that they know where to submit reports.* The Royal Pharmaceutical Society of Great Britain reports that effectiveness of local intelligence networks is variable and information sharing between organisations and the networks requires further development. During 2008, some PCTs changed the set-up of their local intelligence networks, sometimes establishing networks that cover more than one PCT. This created uncertainty about leadership and reporting. While these issues have now been resolved, it is important that local intelligence networks are clear about their remit and responsibilities.

The regulations require relevant healthcare organisations to have an accountable officer who is responsible for monitoring controlled drugs. They also require providers, regulatory bodies and agencies to share information and investigate serious concerns.

To view the report please visit

www.cqc.org.uk/_db/_documents/The_safer_management_of_controlled_drugs_Annual_report_2008.pdf

Employer loophole could leave social care users at risk

People who use social care services could be put at risk by a loophole which would mean local authorities and employment agencies would not be required to run the necessary checks on social workers, according to the General Social Care Council (GSCC).

Responding to the Care Quality Commission's (CQC) consultation on the criteria for compliance with the Health and Social Care Act 2008, the GSCC welcomed the inclusion of the Code of Practice for Employers of Social Care Workers in the proposed regulations. This follows the recommendation from Lord Laming that the code becomes mandatory which was accepted by government.

As a result, CQC registered agencies will be required to carry out checks into workers' background and ensure they are suitably registered for their role. They would also be compelled to follow the code including informing the GSCC of misconduct and helping workers abide by the Code of Practice for Social Care Workers.

However, whilst this would catch most care workers, it would miss the majority of social workers as the regulations do not cover local authorities or employment agencies which are the major employers of social workers.

Local authorities are inspected through a Comprehensive Area Assessment, led by the Audit Commission, which assesses broadly how well local public services are delivered but will not assess detail such as whether checks have been made on staff. Inspections by Ofsted, which contribute to the Comprehensive Area Assessment, will cover children and families social workers and the GSCC will be in discussion with Ofsted to explore how inspections can support compliance with the code of practice for employers.

The exclusion of employment agencies is of particular concern as the government is also planning to relax other requirements overseen by the Department for Business, Innovation and Skills (DBIS) that require agencies to vet workers before supplying them.

Last year, the GSCC highlighted the case of Christopher Nwokoro – a social worker who gained employment via agencies in three local authorities despite not being registered and supplying false references.

For more information please visit www.gsc.org.uk/News+and+events/Media+releases/

Summer holiday boozing

Drinkers in England drank an average eight alcoholic drinks every day during their summer holiday this year, a new survey from the Know Your Limits campaign revealed.

With the typical summer break lasting ten days, that's 80 alcoholic drinks over one holiday; 80 pints of beer is equivalent to 227 units, whilst 80 large glasses of white wine is 240 units. The NHS recommends women should not regularly drink more than 2-3 units a day (around one large glass of wine) and men should not regularly drink more than 3-4 units a day (two pints of beer)[1].

More than a quarter of holidaymakers (27%) admitted to the Know Your Limits campaign that they drank three times or more than usual whilst away this summer.

Though many drinkers chop and change their drinks on a night out on holiday, beer lovers consumed an average of five pints a day. Wine drinkers lapped up four standard glasses of wine each day, while spirit drinkers admitted to having five mixer drinks, such as vodka and coke, each day. Drinkers also admitted to downing four other alcoholic drinks, such as strong cocktails or shots each day.

As a result, September is looking like the new January across England, with holidaymakers vowing to cut back on their return this month:

- one in five people (19%) surveyed in the ICM poll pledged to take two days off drinking a week;
- 16% planned to stop drinking altogether between Monday and Thursday;
- one in five people (22%) are generally going out less;
- 12% are having a completely dry month.

The Know Your Limits campaign has created some top tips for those holidaymakers wishing to leave their holiday boozing behind and get into the habit of drinking less:

- *Have at least two alcohol-free days each week:* not drinking at all on certain days is often easier than promising yourself you won't have quite as many in the pub. Many people find Monday and Tuesday are the easiest days of the week to cut back. As time goes by and you've proved you've got the willpower, try adding Wednesdays as well.
- *Alternate with soft drinks:* there's nothing like an exotic pineapple juice or a fizzy orange drink to remind you of your holidays, so alternate your alcoholic drinks with a soft one to help you stay in control and cut back your overall intake.
- *Clock your starting time:* if you regularly begin drinking early in the afternoon, it's likely that you're drinking too much. If you're at home when you reach for your first drink, limit the amount of alcohol you have in the cupboards.
- *Focus on next year's swimsuit!* For those of you who came back vowing to look better on the beach next summer, cutting back on your alcohol intake is an easy way to cut out 'empty calories' from your diet. You'll also be less tempted to reach for the snacks if you're not drinking wine in front of the TV most evenings.
- *Cut down with a friend/partner:* If there is one particular person you always drink with or only ever meet in the pub, suggest that you both cut down together and find alternatives to drinking for each other. Many people find this helps their own willpower and removes unnecessary temptation.

Over ten million adults in England regularly exceed the recommended daily limits, affecting their general day to day health, but also increasing their risk of serious illnesses such as heart disease, stroke, liver disease and various cancers.

Regular drinkers keen to cut back on their intake and keep an eye on their drinking after the holidays should visit www.nhs.uk/units, where an interactive units calculator can help you keep track of how much you're really drinking.

Consultation on the Future of NHS Inpatient and Outpatient Waiting Times Statistics publications produced by the Department of Health

The Department of Health currently publishes, on a monthly basis, National Statistics on NHS Inpatient and Outpatient Waiting Times in England. These figures have been published for a number of years (since 1987 for inpatients and 1994 for outpatients), and have been used to measure the waiting times for the first outpatient and inpatient stages of a patient's treatment pathway. However, the Department of Health now publishes monthly data on NHS Referral to Treatment (RTT) Waiting Times, which measures the total waiting time from GP referral to treatment. This information has been published since June 2007, and is now the main source of information on NHS waiting times.

Now that this information is routinely published, the inpatient and outpatient waiting times could be viewed as a duplication of data collection resulting in undue burden to the NHS.

The current burden of this collection on the NHS is an estimated 750 person days per year nationally. This cost only reflects the burden of completing the return, and does not include the cost of keeping systems in place to monitor periods of medical suspension that are not required for RTT.

The proposal is therefore that the Inpatient and Outpatient Waiting Times publication should be dropped from April 2010, and this consultation invites comments on the proposal.

As identified above, the Referral to Treatment figures now reflect the whole patient pathway and are therefore more representative of the overall time waited by the patient before being treated.

However, if users have a requirement to look at the inpatient or outpatient element of the pathway, then data (particularly mean and median waits) will be available via Hospital Episode Statistics (HES), published by the NHS Information Centre. HES can be used as an alternative timeseries for users wishing to continue look at the inpatient and outpatient part of the pathway. However, it should be emphasised that RTT is now the predominant measure for NHS waiting times.

Subject to the results of this consultation, the last monthly publication will be for March 2010, scheduled for Friday 30th April. Interested parties are invited to comment on this proposal by Friday 23rd October 2009. A summary of responses will be published on this webpage in November 2009.

Consultation document is available at

www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_104419.doc