Essex Rivers Healthcare
NHS Trust

BUSINESS PLAN

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1. EXECUTIVE SUMMARY

1.1 Review of business plan for 2001/02

1.1.1 The following is a summary of the objectives for 2001/2002 and how well we performed against them:

- **National Policy and priorities**
  "We will undertake a risk analysis of the national deliverables, including the NHS Plan, National Service Framework and Local Modernisation Review (LMR) targets". In partnership with the North Essex Health Authority, an action plan for achieving the targets for 2002/03 was developed which informed, in part, the Service & Financial Framework for 2002/03. This work has continued and a longer-term plan for delivering the LMR has resulted. This plan is inextricably linked with the business planning process.

- **Performance Management**
  "No-one will wait more than 26 weeks for a fist outpatient appointment or more than 15 months for surgery". This target was achieved.

  " We will reduce the number of patients waiting over 13 weeks for an outpatient appointment or more than 12 months for surgery". This target was achieved.

  "Once the decision has been made to admit a patient treated in A&E, admission to a bed will take no longer than 4 hours". We failed to achieve this target. Furthermore, the waiting time for admission grew steadily worse throughout the year as a result of significant emergency pressures. A review of emergency care is being undertaken in partnership with primary care as part of the Service Redesign process to ameliorate this situation.

  "We will ensure that patients with breast cancer, those with acute leukaemia's, testicular cancers or children with cancer, will commence treatment within 4 weeks of diagnosis" This was achieved.

- **Service Redesign**
  "As part of the £80M capital development, we will undertake a review and redesign of all services which will inform the outline business case"

  "We will continue partnership working with primary care to develop integrated care pathways and improve patient access to services"

  "We will explore future opportunities to reprovide services at primary care level rather than the traditional secondary (hospital) care"

  "We will work towards implementing best practice as outlined in the National Service Frameworks (NSFs)"

  "Outpatient and rapid assessment clinics will be developed to provide a comprehensive one-stop service"

  "Most daycases will be able to agree a mutually convenient date for admission to hospital at their outpatient consultation"

"We will continue to improve the quality of the trust's critical care services by careful monitoring of the new high dependency unit, assessing the effectiveness of the recently formed specialist nursing team which provides an outreach service for critically-ill patients"

"We will continue to work with collaborative care bodies, e.g. cardiac and cancer"

Through the development of the Clinical Policy Board - a group comprising senior clinicians and managers from across the health economy - significant progress has been made on all of these targets. This work will involve comprehensive service redesign and where appropriate, changes to service configuration will be made to improve the patient's care pathway. This work will inform the outline business case by establishing the overall strategy for which services will be provided, by which organisation, where (hospital or community) and how they will be provided in the future. Work on the detail of how services will be provided will continue through 2002/03.

- **Clinical Governance and quality**
  "We will continue to develop the trust's clinical governance framework to ensure that services are driven by a cycle of continuous quality improvements"

  "We will implement 'Modern Matrons' from September"

  "Seek to achieve Level 2 Clinical Negligence Scheme for Trusts (CNST) status"

  "Work towards implementation of the Patient Advocacy and Liaison Service (PALS)"

  Work continues towards achieving these targets.

- **Information Technology**
  "We will monitor the technical and network services provided to the trust through the North Essex Shared Services Consortia" The IM&T Steering Group, established in the autumn of 2001, is now overseeing and monitoring shared service's performance.

  "Implement the CLiniSYS clinical oncology information system". This was implemented in part. The system is to be evaluated in 2002 to ensure that it is capable of providing the level of service in line with the trust's longer-term strategy for the Electronic Patient Record (EPR).

  "Work with colleagues across North Essex to develop an outline business case for the procurement of systems to support the EPR" This is being achieved. The trust is actively involved in this development. A full time project manager post has been established to ensure successful implementation.

  "Communicate electronically with primary care" This is being achieved, with clinicians being able to gain pathology results electronically. This will be further developed in 2002/03.

- **Human Resources**
  "The trust plans to recruit, develop and retain a diverse workforce…..."

  "We will review employment policies…"

  "We will aim to provide an environment which is healthy and safe…"

  "The trust will vigorously pursue implementation of the New Deal for junior doctors…."

  "Consultant Appraisal will be carried out…".

  Significant progress and achievements have been made on all of these ongoing objectives.

- **Estates and environmental improvements**
  "We will develop an outline business case for the centralisation of acute services in Colchester on the site of the Colchester General Hospital"

  "We will make major environmental improvements to the trust's hospitals, including ongoing maintenance and upgrade to 4 wards, external redecoration to the CGH, improved entrances and improved signage"

  "Poor performance against the Patient Environment and Access Team (PEAT) standards will be addressed by September"

  "Car Parking and security will be re-tendered with the aim to improve service delivery, standards and value for money"

  "The modernisation of A&E will be complete by August"

  "An Emergency Theatre will be created"

  "We will develop and install an MRI scanner at the CGH".

  All of these targets were achieved, on time and within budget. The OBC is not scheduled for completion until the end of 2002.

- **Financial Targets and Corporate Governance Arrangements**
  "The trust aims to be in recurrent financial balance by the end of the year"

  "The trust will, through a rigorous project management approach, target specific areas of expenditure by using a combination of best practice and benchmarking to achieve major cost reductions…."

  "The trust aims to repay a significant element of its indebtedness to North Essex Health Authority from land sale proceeds"

  "The transfer of services to Tendring and Colchester PCTs has significantly reduced funds available for capital expenditure. However, frontline clinicians will be involved in determining medical equipment expenditure plans"

  All of these targets were achieved and an ongoing programme of prudent financial management is now in place.

- **Communications**
  "We will revise the Trust's communications strategy"

  "We will continue to develop good working relationships with all agencies involved in the health and social care environment"

  "The trust will actively seek to improve the quality of care by using patient/public input and by promoting user involvement in their own care as active partners with healthcare professionals"

  Communication processes within the trust is undergoing major change, including the regular production of a Chief Executive Bulletin circulated across the trust. Relationships with other care agencies is increasing in strength, particularly involving joint management of implementation of LMR and NSF targets. User involvement has been slow to gain momentum. This will be accelerated in 2002/03.

  Overall, performance against the 2001/02 objectives has been good. Strengths have been demonstrated in achieving the performance targets, developing a robust process of collaborative and collective service redesign and planning for the future, IM&T strategy, estates management and environment improvement and financial governance.

  Performance against the clinical governance, human resources and communication agenda is inevitably more difficult to demonstrate as many of the standards about the organisation's culture. However, there have been clear successes in all of these areas in 2001/2002. The trust will ensure that further measurable targets are included for 2002/03.

1.2 Business plan for 2002/2003

1.2.1 The trust has created a new directorate of Service Planning and Development to oversee all service development within the trust, including the development of a comprehensive, inclusive and timely business planning process. Although the implementation of this initiative was too late to inform the SaFF for 2002/03, an annual business planning cycle has been established and is in place in time to inform the 2003/2004 SaFF.

1.2.2 This business plan has been developed by a dual process of ascertaining the directorate's service plans and matching them with those of the commissioners' aims and objectives. Underpinning all of this is the 'must do' agenda of the NHS Plan, incorporating the Local Modernisation Review (LMR) and National Service Frameworks (NSFs).

1.2.3 Essential to the business planning process is the need for a clearly articulated strategic direction of the organisation, which reflects that of the NHS at large, the local health economy and the business objectives of the trust. This critical piece of work has not been completed in time for the 2003/2003 business plan. However, it is planned that this will be undertaken in the early part of 2002/2003 in time to inform planning for 2003/2004.

1.2.4 Shifting the Balance Of Power (StBOP); with the demise of the Eastern Regional Office and organisational and cultural transformation of the North Essex Health Authority to the Essex Strategic Health Authority, has resulted in a period of significant change in 2001/2002.

1.2.5 The business plan does, however, respond to the short-term strategic aims and objectives of both the developing Essex Strategic Health Authority and where expressed, those of the Primary Care Organisations (PCOs) and the wider changes outlined in paragraph 1.2.2

1.2.6 The main themes for the business plan for 2002/2003 are:

- Reforming Emergency Care
- Reducing waiting times and increasing capacity
- Improving access to services for the detection and treatment of cancer and improving outcomes
- Improving access and services for Coronary Heart Disease (CHD)
- Improving access and services for the Older Person
- Improving access and services for children
- Improving patient satisfaction
- Addressing the workforce development needs of the trust
- Improving the trust's Information Management &Technology capability
- Increasing and better coordinating the trust's involvement in Research and Development activity in line with national and international initiatives.

1.2.7 Underpinning these aims are two recurring themes: Modernisation and Partnership Working. The trust is committed to ensuring that everything that is does and every service that it provides must undergo an intense programme of redesign to ensure that services are fit for the Modern NHS. In doing so, clinicians and managers will work in partnership with colleagues in primary care to provide:

- ***The right service,***
- ***By the right people,***
- ***In the right location and,***
- ***At the right time***

1.2.8 By concentrating on its core function, the trust will focus on providing acute secondary healthcare, transferring those services that can and should be provided by primary care teams to primary care providers.

1.2.9 The trust will then centralise these services onto the Colchester General Hospital site into purpose built and designed accommodation that reflects best and most efficient and effective practice.

2. PURPOSE

2.1 Business plan objectives

2.1.1 The main objectives of this business plan are:

- To define the trust's strategic aims and directions within the context of both the national and local health economy's strategic aims and objectives.
- To illuminate the trust's successes and achievements over the last year.
- To set out our plans to achieve the national and local modernisation agenda for the coming year.
- To demonstrate progress in achieving the objectives of the multi-million pound centralisation PFI project.
- To set out our plans for developing the business planning process for 2002/03 and beyond.

3. STRATEGIC AIMS AND OBJECTIVES

3.1 Aims

- The trust's primary strategic aim is to concentrate on delivering high quality, effective, efficient and accessible acute, secondary health care
- To offer people fast, convenient patient-centred care delivered to a consistently high quality.
- To ensure that services are available when people require them. Tailored to their individual needs.
- To empower patients to have a greater say in their care and for local communities to have a real influence over the development of services.
- To empower frontline staff to deliver faster, more responsive, high quality services and improve performance within the context of clear strategic direction and a strong accountability framework.
- To develop new approaches to the delivery of care, breaking down traditional barriers between different professional groups and services and paving the way for innovative clinical networks and pathways across organisations.

4. NATIONAL CONTEXT

4.1 National Policy and Priorities

4.1.1 The NHS Plan represents a blueprint for radical reform of the NHS. It is both about providing continuous improvements in services and about changing the way the NHS and its partners operate in organising and delivering care.

4.1.2 Within this overarching ten-year programme of reform, the national planning framework for 2002/03 confirms three major priority areas:

- **Delivering emergency services when and where they are needed;**
- **Reducing waiting times and delays throughout the system;**
- **Improving quality of service and outcomes in the clinical priority areas of cancer, heart disease, mental health and services for older people.**

4.2 Emergency Care

4.2.1 The *Reforming Emergency Care* strategy and the national *Out of Hours* review aim to improve the organisation and delivery of emergency care services across primary care, community, social and secondary care. Patients who need emergency care should receive a prompt and appropriate response based on national clinical standards, regardless of the way in which they contact the services or the time at which they do so.

4.3 Reducing Waiting Times

The aim is twofold:

- To deliver a fast and convenient modernised primary care service for everyone, with informed patients, suitably trained and qualified professionals who provide an extended range of integrated services developed in partnership with patients and users.
- To reduce the time that patients wait before they receive NHS treatment in accordance with the NHS Plan and ensure that services will be available when people require them tailored to their individual needs.

4.4 Clinical Priorities

4.4.1 The aims in these areas are to:

- Save more lives
- Ensure people get the right professional support and care, and the best treatments, and that patients are fully involved in discussions about their own healthcare
- Build capacity for the future through investment, e.g. workforce, buildings, equipment, information technology and research.

5. HEALTH ECONOMY'S STRATEGIC DIRECTION

5.1 Essex Strategic Health Authority

5.1.1 Creating a coherent strategic framework for the development of services in consultation with stakeholders and with strong professional leadership and involvement;

5.1.2 Ensuring effective performance management by holding PCTs and NHS Trusts to account through annual performance agreements and managing the performance of programmes and networks which span organisational boundaries;

5.1.3 Building capacity and supporting performance improvement by enhancing the involvement of patients, local people and professional groups in developing services; supporting the implementation of clinical governance programmes to improve quality and consistency of care; ensuring that local PCTs and NHS Trusts are equipped to meet national standards and improve performance; and preparing and delivering cohesive strategies for capital investment, IM&T and workforce development.

Fulfilling these functions requires a style, which is:

- **Empowering** – devolving power to the frontline and to patients and the public and supporting them in improvement of the local NHS;
- **Facilitative** – sitting at the centre of a range of networks that represent a health and social care system, not as the peak of a hierarchy, and brokering solutions to resolve operational or strategic problems across those networks;
- **Developmental** – ensuring that the capacity, skills and infrastructure are in place to support local clinical teams in the redesign of services; supporting whole systems development across PCTs, NHS Trusts, public health and clinical networks and partnership arrangements;
- **Involving** – ensuring the active engagement of local people, patients and staff in decision-making and working closely with other local and national agencies;
- **Leading** – ensuring credible and effective professional and policy leadership is provided for the local health community;
- **Learning** – prepared to try new things, able to adapt and stimulating real enthusiasm for better use and sharing of information, knowledge and know-how across the health community;
- Committed to **service quality** and **patient safety**;
- **Consistent** in adhering to the values and principles of the modern NHS;

Above all, we will be **focused on delivery**, intervening if necessary to tackle poor performance where alternative courses of action fail to produce improved results.

5.2 Tendring Primary Care Trust

5.2.1 The PCT is developing its strategic objectives through its Primary Care Investment Plan. This has, however, not been available at the time of completing this business plan.

5.3 Colchester Primary Care Trust

5.3.1 The Primary Care Trust has been established to provide patient centred integrated health and social care.

5.3.2 The strategic direction of the PCT, in commissioning secondary care services, is governed by the following "Guiding Principle"

- **Guiding Principle:** The service should achieve the intended outcome and ensure the most cost effective use of resources to meet the outcome" services should be provided at appropriate times and in appropriate locations. Facilities should be clean and friendly Patients should be treated in a timely manner, with waiting times kept to a minimum and which do not compromise treatment.

5.4 Witham, Braintree & Halstead

5.4.1 The PCG is concentrating its efforts on its application for Care Trust status for October 2002. It is also developing its secondary care commissioning objectives through the Primary Care Investment Plan. These will be shared with the trust by the end of June.

5.5 Essex Rivers Healthcare NHS Trust's Strategic Direction

5.5.1 The trust's objectives will reflect the five key modernisation challenges facing the National Health Service as outlined in the NHS Plan:

- **Prevention**

Tackling health inequalities and focusing the healthcare system on its contribution to tackling the causes of avoidable ill health

- **Partnership**

Making all parts of the health and social care system work better together and ensuring the right emphasis at each level of care.

- **Patient Care**

Ensuring fast and convenient access to services and empowering patients so that they can be more involved in their care.

- **Performance**

Improving both clinical performance and health service productivity

- **Professions and the wider NHS workforce**

Increasing flexibility in training and working practices and removing demarcations in an expanding health care workforce.

5.5.2 **Prevention –** Prevention of ill health cannot be addressed by one organisation on its own. This requires a concerted, collaborative effort on the parts of all of the partner organisations in the health economy and the public. The trust will support and encourage the development of joint initiatives to

tackle such issues as coronary heart disease, stroke, obesity etc. In this way, reductions in health service demand should, and can, be achieved.

5.5.3 **Partnership –** Partnership working is not a fad; it is essential to achieving effective outcomes. The trust is committed to developing effective partnerships with partner organisations wherever possible. One such partnership is the Joint Private Public Partnership overseeing the PFI project. This involves all of the partner organisations in managing the delivery of the £80 million pound investment. An essential element of the project is the redesign of service delivery and in some cases the redistribution of elements of care from one organisation to another. The planning process too is changing in recognition that each organisation is dependant upon the other in order to plan services. To this end, a North East Essex Strategy group has been formed to jointly plan service developments and work together on managing cost pressures across the health sub-economy.

5.5.4 **Patient Care –** although third on the NHS Plan list, it is not our third priority. Everything we do must ensure that the patient's needs and interest are paramount. The local modernisation review in particular, and NHS Plan in general, prescribes far-reaching fundamental changes in the delivery of health care services, which are directed at improving patient care. The trust embraces these improvements and all of our service developments are specifically geared towards making an effective impact on improving patient care. Without such change, no investment in services will be made.

5.5.5 **Performance –** The trust has for the past two years achieved its targets on waiting times, both for inpatient treatment and outpatient consultation and treatment.

This has, however, been against a backcloth of unremitting and ever-increasing pressure on demand for services – particularly emergency care and extremely high levels of resource utilisation. Beds are being utilised at an average of 97% occupancy and operating theatres and outpatient clinics are near capacity.

This level of resource utilisation cannot be sustained in the long term. The trust is required to reduce bed utilisation over the next two years to an average 85% occupancy. To achieve this and maintain a sustained reduction in waiting times in line with government policy, the trust requires a greater compliment of acute beds. This issue will form a major part of the SaFF negotiations with the PCOs for 2003/04.

5.5.6 **Professions and the wider NHS workforce** – Significant changes in the service both in recent years and those yet to come, are being met with significant changes to the workforce. The Working Times Directive, together with the NHS Plan target for Improving Working Lives, mean that there are and will continue to be less available staff to provide the present levels of activity. Further, changes in training standards for junior medical staff require a transfer of duties and responsibilities from medical staff to others. There is a need for an integrated education and training strategy involving all professions in clinical care and across the whole health community. Again, as part of the centralisation project, much of this development will be undertaken as part of a Service Redesign Group dedicated to this subject.

5.5.7 Concentrating on acute care will involve, among other things, 'unpacking' primary care services and transferring this to primary care organisations. A

process has commenced and will be facilitated further through the service re-design process as part of the PFI project.

5.5.8 Essex Rivers Healthcare NHS Trust will also be embarking on a major centralisation project to centralise and modernise all acute services onto the one site – the Colchester General Hospital.

5.5.9 Modernisation through a process of service redesign is essential to achieving the above. The trust has embarked on a cyclical programme of service modernisation embracing the NHS Plan and national modernisation agenda. This process involves all staff and the public in the process. Further details are contained in section 4.7

5.6 Centralising Acute Hospital Services in Colchester

5.6.1 The Secretary of State approved Essex Rivers Healthcare's Strategic Outline Case titled "Centralisation of acute services in Colchester" in February 2001. A copy is available from Trust Headquarters by telephoning 01206 742648 or on the Essex Rivers Website – www.essexrivers.nhs.uk

5.6.2 The proposal is to centralise acute services in Colchester while at the same time moving other services into the community hospitals and primary care centres. This will enable Essex Rivers Healthcare NHS Trust to modernise and improve the facilities and services on one site in Colchester, and allow the Primary Care Organisations to develop appropriate services in their local areas. This is why this project is collaborative in nature between all the healthcare partners in North East Essex.

5.6.3 Essex Rivers Healthcare NHS Trust's preferred option involves the centralisation of all acute services on the Colchester General Hospital site from Essex County Hospital and Severalls Hospital. This would create an opportunity to reconfigure the Colchester General Hospital site, refurbishing some existing areas and building new facilities to create a modern hospital for the future.

5.6.4 Full details of the option appraisal is in the Strategic Outline Case 'Centralising acute services in Colchester'

5.6.5 Once the development at Colchester General Hospital is complete, the site at Essex County Hospital will close and become available for sale.

Benefits

The benefits that this proposal will bring are that it: -

- Provides the optimum configuration of Non-Surgical Oncology cancer services, enabling the Trust and the Mid Anglia Cancer Network to deliver *The Cancer Plan (September 2000)*.

- Yields significant improvements to the patient's experience of local healthcare, improvements which simply cannot be delivered by the current configuration

- Will help the Trust to deliver the standards and targets contained in the *NHS Plan (July 2000)*.

- Provides the capability and capacity to meet rapidly increasing population growth

- Creates a service configuration that is able to deliver cost-effective care and yield the maximum revenue savings.

5.6.6 Implementation of this project is in 6 distinct stages over the life of the project as outlined below:

- Stage 1 – Setting the Vision: **April to May 2002**

Most importantly at this stage, we must decide on the vision for the hospital in the future by identifying with our primary healthcare partners which services we should deliver from our acute hospital and which should be provided in the community. This process is being led by the Clinical Policy Board (Mainstream front page January 2002) chaired by Dr Sushil Jathanna.

- Stage 2 – Developing Detailed Care Pathways: **May to July 2002**

Eight service redesign groups, the chairs for which are from both the acute and primary care sector, support the Clinical Policy Board. These groups will develop more detailed care pathways, clinical output specifications and departmental level adjacencies to determine the optimum configuration of the hospital.

- Stage 3 –Working Groups: **June to Sept 2002**

This clinical review process will be further developed by a significant number of clinical user groups which will create an opportunity for as many staff as possible to provide input into the operational policies that will inform the plans for the new development. In parallel with this clinical review all the non-clinical but equally essential services supporting the hospital will also be considered and we plan to set up or use existing user groups to support this process.

Public Consultation: **May to August 2002**

In addition to the above stages we will undertake a public consultation on our proposals, which we are about to commence jointly with our primary healthcare partners. The public are being consulted around how they would prefer to access the healthcare services they need which therefore raises with them our joint proposals to transfer services from Essex County Hospital as well as the Primary Care aspirations to develop their community hospitals and primary care centres.

- Stage 4 – Final Production of the Outline Business Case (OBC): **Sept to Nov 2002**

The OBC will set out in more detail than the SOC our proposals together with the necessary supporting financial information which must be submitted to the Secretary of State for approval at the end of this year before we can proceed.

- Stage 5 – PFI Procurement: **2003**

Once our OBC is approved we can proceed with the selection of a PFI partner who will invest the £80M into the redevelopment project. The PFI procurement process involving the shortlisting of bidders and evaluation of their proposals against our plans made in the OBC is likely to take about 12 to 18 months.

- Stage 6 – Detailed Planning and Implementation: **2004 - 2007**

Our chosen PFI partner should be able to complete the detailed planning work required during 2004 with building work beginning in 2005 and the project completing in phases during 2006 and early 2007.

5.7 Modernisation agenda

5.7.1 The NHS Plan sets out a clear modernisation agenda for the NHS for the next decade. This is interpreted locally through the Local Modernisation Review (LMR) process.

5.7.2 Essex Rivers Healthcare NHS Trust is taking an active part in this process through the appointment of a Service Modernisation Manager. This postholder will facilitate a cyclical process of service modernisation throughout the entire service. The process will involve, where appropriate, process mapping, process review and re-design. It will involve input from all staff involved in the service delivery and, again where appropriate, patients.

5.7.3 The individual directorate business plans (contained in section 7) will address specific LMR/NHS Plan targets as they apply to individual patient pathway/processes/clinical teams.

5.7.4 A prerequisite of our centralisation programme is the need to review every aspect of our service. This will involve process mapping every aspect of the patient's journey from primary through secondary (and where appropriate tertiary care) back to primary care. Before investment is considered in any given service; whether it be increase in staff, equipment, facilities (or all three), this process will be undertaken and where improvements can be made to improve the process, reduce unnecessary steps and/or 'bottlenecks' these will be actively pursued. This will involve everyone involved in the process across professions, departments and organisational boundaries. It is, therefore, essential that we work in complete harmony and unison with our primary care colleagues.

5.8 Working in Partnership

5.8.1 In the early 1990's, particularly after the establishment of the individual trusts and separation from the health authority, there was little evidence of the collaborative, co-operative or joint working that hitherto existed. However, in recent months this is changing for the better. There is greater emphasis on collaborative working. This is particularly true of the centralisation of acute services project.

5.8.2 Essex Rivers Healthcare NHS Trust is committed to embracing a Whole Systems approach to developing services. This will ensure that the patient's care pathway, which transcends existing organisational boundaries, is provided in a seamless manner, unnoticed by the patient. Action to achieve the necessary changes in service organisation and/or delivery will be an integral part of the Service Redesign Groups (again, see next section and modernisation).

5.8.3 Commissioning is also undergoing major change. Hitherto, this process involved uni-organisational planning leading up to the Service and Financial Framework (SaFF) negotiations in the autumn. This process was mirrored by Essex Rivers Healthcare NHS Trust developing its programme of service developments/cost pressures and presenting them at the same forum. In recent months, a new North East Essex Strategy Group, which comprises membership, form the PCOs and ERHT. This groups meets regularly to discuss potential service developments and/or cost pressures to agree a joint way forward.

6. REVIEW OF 2001/2002

6.1 Achievements – performance

6.1.1 Month 12 Performance Position

2001/2 has been a challenging year for the Trust. Greater than expected emergency admissions have compromised our ability to deal with our elective workload. This coincided with substantial increases in our planned activity to allow us to meet the new targets in the NHS Plan.

The table below shows our achievements with regard to specific indicators.

Indicator	Actual	Target	Difference	Performance
1st Outpatients	64,345	62,071	2,274 (3.7%)	
26 week+	0	0	0	
13-25 weeks	1162	1427	265 (18.6%)	
Daycases	15,940	15,776	164 (1%)	
Elective Inpatients	7,779	8,500	-721 (-8.5%)	
Emergency Inpatients	26,470	25,639	831 (3.2%)	
Waiting List	6,428	6,238	-190 (3%)	
15 months	0	0	0	
12 months	23	25	2 (8%)	

Key		= 'Green'		= 'Amber'		= 'Red'

Cancer targets have been monitored and more stringent targets are being introduced for the coming year looking at times from diagnosis to treatment.

6.1.2 Outpatient Activity

Total outpatient activity is 1.3% or 2395 cases over target with performance on 1st attendances now 3.7% over target (2274 patients) and follow-up attendances are 0.1% over target (121 cases)

6.1.3 Outpatient Waiting Times

The use of Priority Treatment Lists (PTL) for outpatients throughout 2001/02 has been successful in enabling the achievement of the Trust's outpatient waiting times targets. The Trust achieved its target of no patients waiting more than 26 weeks for a first outpatient following referral from a GP or GDP. In addition it exceeded its plan for 13-25 week waits with 1162 patients waiting against a target of 1427 - 18.6% or 265 patients better than expected.

6.1.4 Non-Elective Activity

Emergency inpatient activity was over target in March but slightly below last year's actual level. The full year over-performance was 3.2% or 831 cases.

6.1.5 Elective activity

The over-performance in non-elective activity has compromised the Trust's ability to deal effectively with its elective workload. The Trust achieved its targets on 15 month and 12 month waiters with some assistance from the private sector. However, it under-performed on its elective targets by some

8.5% or 721 cases. This has been achieved in spite of some considerable pressure on beds.

A high level of activity in March, including outsourcing of Ophthalmology, allowed the Trust to exceed the end of year target on daycases by 1.0% or 164 cases.

6.1.6 **Elective Waiting List**

The total number of patients on the waiting list decreased by 64 cases in March and totalled 6428, which is 3% or 190 cases above the end of year target significant numbers of first outpatient attendances, has had a knock on effect on the number of patients listed for surgery. Despite not achieving the plan the Trust is still within the 5% tolerance permitted.

The use of Priority Treatment Lists (PTLs) proved extremely successful in ensuring that the Trust focused attention on the longer waiting and less urgent/routine patients.

6.1.7 **Cancer targets**

The Trust achieved the two-week wait target in 10 out of 12 months

6.2 Achievements – financial

6.2.1 In 2001/2 the Trust has succeeded in returning to financial balance. This follows a prolonged period of I&E deficits culminating in an accumulated deficit of £8.3m by the end of 2000/2001.

6.2.2 Last year, a breakeven was achieved which although supported by profit on land sales of £1.4m, indicates a return to recurrent financial balance once non-recurrent expenditure items are removed. In addition, the Trust was successful in remaining within both the agreed External Financing and Capital Resource limits and managed to reduce accumulated cash brokerage by £4m due to land sales proceeds.

6.2.3 These achievements place the Trust in a strong position to face the considerable financial challenges presented in 2002/3.

6.3 Achievements – Local Modernisation Review/NHS Plan

6.3.1 There are in excess of 500 targets contained within the NHS Plan to be achieved by 2005.

6.3.2 These far-reaching targets of reform in the NHS apply to every constituent part of the NHS; many of which require a joint effort in achieving a successful outcome. To this end, the trust has established a co-ordinated process of identifying the relevant targets with key milestones for action, by whom and when. This is undertaken in partnership with commissioners, the Strategic Health Authority and the individual directorates responsible for delivering the targets. It forms an essential part of the business planning process.

6.3.3 Below is an overall summary of the target areas for 2002/2001 and how well the trust performed. Full summaries of the targets for both 2001/02 and 2002/03 are appended.

Reducing waiting times in Secondary Care

- The trust has achieved all 8 LMR targets, including reductions in waiting times for outpatient attendance for over 13 and 26-week categories.
- No one waited over 15 months at the end of March 2002 for inpatient treatment and there was a significant reduction in over 12-month waits
- All patients with breast cancer were treated within one month of diagnosis

Expanding capacity

- Theatre utilisation is considerably in excess of the 80% utilisation target set out in the LMR

Booking

- Booking for both outpatient attendances and daycase treatments was established in a number of specialties, exceeding the LMR target.

Improving treatment

- All children with suspected cancer, those with suspected or confirmed acute leukaemia and men with suspected testicular cancer are guaranteed treatment within one month or urgent referral by their GP.

Facilities

- A new Linear Accelerator was installed, funded by the Modernisation fund, together with a replacement Treatment Simulator, in accordance with the NHS Plan target.

IM&T – Implementing Information for Health

- The target of 60% of all pathology results being transferred electronically was achieved. All internal hospital clinical departments with network PCs have access to the pathology system for retrieval of results. This is being improved in 2002/03 with a trust-wide investment in PCs for all clinical areas.

Stroke Services

- A one-stop dispensing/dispensing for discharge service was implemented ahead of the LMR target of April 2002

Improving patient and public representation

- Patient surveys have been introduced, again, ahead of the LMR target.

Clinical Governance

- The trust has developed a clinical governance strategy, including a clinical governance development plan.

Better quality environment

- Clean hospitals: the trust has recently been commended on its performance on its environment following a recent PEAT visit.

- The PEAT team gave a special commendation on the patient's food.

- Ward housekeepers are being developed, initially on a pilot basis, across the trust.

Improving Working Lives

- The trust has given a pledge to adopt this standard and gain accreditation

New ways of working

- Senior Sister/Charge nurses are in post and readily identified.

6.4 Achievements – Other service developments

6.4.1 Women and Children's services

- A sixth Paediatrician post has been established and Dr Angela Tillett has been appointed.

- Additional Staff Grade Doctor in gynaecology – helping to reduce junior doctor hours and facilitate upgrade of two existing Staff Grades to Associate Specialists

- Recruitment of a dedicated Senior Nurse for Paediatrics and Special Care Baby Unit.

- Recruitment of a dedicated Delivery Suite Co-ordinator.

- The development of Midwife Led Care within the Tendring locality as from April 2002.

- Modernisation of the maternity service. A bid for capital from the NHS Modernisation Fund was successful enabling us to achieve the following: -

    - Development of a bereavement suite at Colchester.
    - Replacement furniture for antenatal clinic in Colchester.
    - Creation of milk kitchens in the postnatal wards at Colchester.
    - Purchasing equipment for team midwifery in Colchester.
    - Develop clinical examination room for midwives at Shrub End clinic.
    - Modernisation of Clacton and Harwich maternity units.

- Developed the first Colposcopy system to be fully functioning in the Region, providing clinical, statistical and management information.

- Attained Clinical Negligence Scheme for Trusts Level One in Maternity Services.

- Transferred all Colchester-based staff to Colchester PCT.

- Transferred into Essex Rivers Healthcare all community staff based at Witham Community on behalf of Witham, Braintree and Halstead PCG. It is proposed to transfer these staff, together with resources, including Halstead Hospital, Witham and Braintree Clinics to Witham, Braintree and Halstead when they become a Care Trust (October 2002).

- Established a 'self-standing' management structure for the community in preparation for transfer next year. The teams are developing local guidelines, protocols and policies in preparation for adoption by the Care Trust – when it is approved.

6.4.2 **Pathology**

- CPA Accreditation

  All the Pathology Departments have been re-inspected by Clinical Pathology Accreditation plc in October 2001. The verbal feedback was mostly complimentary. The final reports have now been received and are being evaluated.

- A new Pathology Computer system (APEX) was installed, individual departments started to "go live" in March 2001, all departments should be live by the end of December. Work has started on the national requirement for the electronic transfer of results to GP's. The PMEP middle ware will be installed in February 2002 and the pathology system software will be installed at the end of April. To support this the pathology computer system will have to be connected to the Trust PAS system.

- An additional Consultant Haematology, Medical Secretary, Haematology Support Nurse have been appointed, and funding for a Blood Transfusion nurse has been agreed.

- There has been a successful introduction of a shift system to comply with Working Time Regulations and funding approval for the additional staff required.

- The Immunology section relocated and enlarged helping to improve working conditions.

- The ESR and Immunology analysers have been replaced.

6.4.3 Pharmacy

- The Audit Commission acknowledges the key role of the pharmacy service in its national report "A Spoonful of Sugar – Medicines Management in NHS Hospitals" published in December 2001.

- Notable enhancements to pharmaceutical care have included the creation of the first permanent Clinical Technician post, the employment of SATOs for dispensary duties, and increased pharmaceutical input into consultant-led ward rounds.

- Further developments have been the completion of the 'one-hit dispensing' system and greater involvement with Primary Care Organisations, symbolised by the setting up of the North East Essex Medicines Management Committee, chaired by the Chief Pharmacist.

- Continuing Professional Development (CPD) has been introduced satisfactorily into the department and we aim to achieve 100% involvement later in 2002. This

is no small feat, as some Trusts have not even started the process. Education is a priority for our staff and is probably one of the main reasons why we have performed so well. Indeed, 4 members of the pharmacy staff (5% of total) are presently being supported to undertake study at Masters level.

- Pharmacy staff continue their representation on Trust-wide committees and have in fact increased our involvement on working parties e.g. 'Falls Group', 'Stroke Policy', 'CHD NSF'.

- The Pharmacy Service is increasingly being seen as an exemplar compared with other Trusts. This has been demonstrated by;

    - Our National Pharmaceutical Care Award
    - Acknowledgement in the NSF for Older People
    - A favourable rating in the recently published Audit Commission Report on Medicines Management
    - The AAH Pharmacy Technician of the Year award.

6.4.4 Breast Screening Service

The Breast Screening Service is provided across Chelmsford and Colchester, and therefore encompasses split site working.

- The service has received acknowledgement of good practice. The Eastern Region QA Report makes repeated reference to the commitment of staff in the face of considerable constraints. Our Standardised Detection Rate (SDR) is 1.37 and thus is in the top ten nationally, and is described as "excellent".

- Expanded the role of the Radiographer and have one member of staff undertaking the film reading course and another embarking on training to take Image Guided Biopsies.

- The Department has been successful in obtaining funding from the New Opportunities Fund for a Multiviewer, which will be available in the coming year.

- Charitable Funds have been used to purchase valuable equipment to support image-guided biopsies.

6.4.5 North Essex Cancer Partnership

- A Cancer Services Peer Review took place in March 2001 with results published during this current year. The Chemotherapy service was commended for operating an effective service. Nurses are encouraged to undertake the ENB 234 Course (Oncology Nursing) and ENB 931 (Care of the dying) although releasing staff whilst maintaining safe staffing levels on the Wards is challenging.

- The Radiotherapy Department officially became a three LINAC department during this year with a new machine obtained from the New Opportunities Fund. It has been run full time (i.e. 9 am to 5 pm) since August 2001 but using agency staff with it's associated cost. This means however that the high specification technology is being fully utilised thus far.

- An upgrade to the TMS panning system has been granted to ensure the planning of Intensity Modulated Radiotherapy (IMRT). However, to implement this modality clinically, further investment will be required to upgrade the latest LINAC.

- Near Patient Testing has now been introduced in the Mary Barron Suite to enable patients haematological levels to be obtained quickly, avoiding time consuming transportation of samples to Colchester General Hospital. Donations and the Cancer Collaborative purchased the equipment.

- A system has been put in place to minimise risk to patients in respect of intrathecal chemotherapy. This followed the report on the recent incident in Nottingham. The limited number of medical staff who will be using this route to administer drugs, and the Nurses and Pharmacists, who will be handling and checking the drugs, must attend the relevant training session. Only those staff that appear on the Directorate's Register following attendance, will be authorised to deal with intrathecal drugs. (In line with the LMR " Improving Clinical Quality" learning from adverse events where mal-administered spinal injections are specifically targeted).

6.4.6 Clinical Radiology

- Continuous monitoring of the IR(ME)R statutory requirements including a presentation to the Directorate Managers Meeting to communicate the importance of the regulations.

- Maintained throughput of patients for IVP examinations despite total equipment failure in the IVP X-ray room.

- Worked in partnership with Alliance Medical in the on-going development and building work for the MRI unit including phased plans for installation and implementation.

- On-going comprehensive Quality Assurance programme for equipment including the establishment of film reject analysis and clinical audits resulting in improved safety and standards of radiography.

- Radiologists have co-operated by working out of hours to clear backlog nuclear medicine reporting and have also increased on-call commitment to ensure that a reporting service is always available.

- Through the wider use of the Intranet, consultants' secretaries have ready access to patients' radiology reports and appointment status, thus improving the service for requesting consultants, which directly benefit patients.

- Achieved booked appointment system in Urology Department for trans rectal biopsy appointments and for Barium enema appointments in outpatients department. The patients are being given X-ray appointments immediately after their clinic, which avoids unnecessary delays.

- Increased the number of radiographers carrying out IV injections and continued with barium enema examinations, sialography, and reporting by radiographers. This has resulted in delivering increased throughput despite the shortage of Radiologists.

- Since July 2001 we have introduced Ultrasonographer based Abdominal scan reporting service, which is assisting with waiting times.

- Effective use of voluntary helpers to assist with patients undergoing ultrasound procedures, thus increasing throughput.

- Introduced Induction Packs for new members of staff, improving orientation and to cascade and reinforce the aims of the Trust and the Radiology Department.

- Secured funding for:

    - A new IVP room including equipment, ultrasound machine and two portable X-ray machines. These are being currently installed.

    - A Teleradiology system and ISDN lines for Consultant Radiologists through the CT Body Scanner fund to be able to transmit CT Images to Radiologist Homes out of hours.

- Review and tender of film and chemistry contract including processing equipment and negotiated a new film-contrast contract that will result in substantial cost savings.

- Introduced evening ultrasound sessions that have resulted in the reduction of waiting times without additional costs.

- Introduced new software in the Radiology Information System (RIS) that has enabled faster tracking and retrieval of patients' records.

6.4.7 Quality Improvement and Nursing

- Development of Disability Discrimination Policy and undertaking of Disability Access Audit

- Recruitment and retention of Volunteers. There are currently 100 Volunteers and 50 Major Incident Volunteers.

- Delayed discharges and lost bed days have reduced over the last year and closer working relationships with the multidisciplinary teams have been fostered.

- Improved assessment and monitoring of pressure ulcers through the introduction of a standardised tool.

- New adverse staffing levels form developed, which is completed daily and therefore gaining more compliance and therefore more reliable information.

- By the end of the financial year the Trust is expected to have taken up 100% of the Post-registration education contract.

- The two leadership courses are well subscribed and beginning to generate improvements in-patient care.

- The patient information leaflets are slowly improving and increasing in number, as a result of a secondment to the Patient Information Officer post.

- Customer satisfaction surveys are increasing in demand and have made a visible impact on the delivery of patient care.

- A new property system has been instigated in the Bereavement Suite reducing the problems with lost or mislaid items.

- Continuing improvement in the quality, content and attendance at Medical Division Clinical Audi half days, including SpR clinical audit project presentations.

- The Department is piloting conciliation services to improve complaints resolution. This appears to be going well.

- The bi-annual 'Sharing Good Practice' conference has continued to gain increased support – both from speakers and attendees.

6.4.8 **Medicine and Emergency care**

- Two medical wards were upgraded and modernised

- A modernised and refurbished MAU was opened

- Ward-based hostesses were introduced on a trial basis

- NSF recommendations concerning diabetes, CHD, Reforming Emergency Care and the Older Person were implemented

- A&E was completely refurbished and modernised

- A bid to the Modernisation Fund to upgrade the CCU was approved (for implementation in 2002/03

- Layer Marney Ward was opened providing an additional 28 beds capacity

- There was a marked reduction in medical 'outliers' and delayed discharges through a number of initiatives in partnership with primary care and social services.

- All patients with suspected cancer were seen within two-weeks of referral

6.4.9 **Surgical Services**

- Details to follow

6.4.10 **Optima Directorate**

- An additional theatre to manage all emergency surgery during normal operating hours has been established this year, reducing risk to patients being treated out of hours where limited clinical support is available and reducing waiting times for surgery.

- Designed and built Endoscopic Theatre has been opened.

- Trauma Theatre has been fully refurbished.

- Development of Essex Critical Care Network to standardise care for all patients in Essex.

- Funding for fully equipped Transfer trolleys for Critical Care Patient's across Essex.

- Critical Care Outreach team has been fully established providing education for the multidisciplinary team, and proactive management of critically ill patients throughout the Trust.

- Funding secured for 2002/03 to upgrade Sterile Services to meet Government Decontamination targets.

- Approval for pilot site for implementation of Digital Hearing Aids secured for 2002/03.

- Filter clinic's set up in partnership with local Primary Care Trust's for Audiology and ENT in line with Modernisation targets. Reducing wait times for first appointments.

- Permanent funding secure for the management of patients with Acute Low Back Pain.

6.4.11 **Finance & Performance (incorporating IM&T)**

- See sections 6.1 and 6.2

6.4.12 **Service Planning & Development**

- This new directorate was established in September 2001. It is responsible for all service planning and development, Capital Planning, facilities management and overseeing the Centralisation of Acute Services Project for the trust.

- A business-planning model was developed for 2002/03, which incorporates early engagement of local PCTs and other stakeholders.

- A North East Essex Strategic Commissioning Group has been to ensure that pressures and developments are shared and actions agreed well in advance of the SaFF negotiation process.

- The Trust has now engaged the Deputy Director of Service Planning and Development to coordinate the business planning process.

- The business planning process is now becoming ingrained within the culture of the Trust. Business planning relating to the 2003/4 SaFF year has already commenced to ensure that a draft prioritised business plan is in place with the support, in principle, of PCTs and other stakeholders well in advance of SaFF negotiations.

- Essential to effective capacity and demand modelling is the need to undertake a process mapping exercise of every part of the service and where appropriate, redesign/reconfigure processes/services to ensure demand is managed and capacity is assured. The trust is committed to this principle and has recently appointed a Service Modernisation Manager to lead the trust in a cyclical process of modernisation review.

- All directorate business and operational plans are based around the modernisation agenda. An action plan to demonstrate effective delivery of the LMR is an essential component.

6.4.13 Human Resources

- Achieved 'Pledge Certificate' under the Improving Working Lives initiative.
- Achieved 'Positive about Disabled People' award from the Employment Service.
- Produced 'Policy and Procedure on Public Disclosure' (Whistleblowing Policy)
- Negotiated an agreement with trade unions to enable the re-grading of medical secretaries
- Collected ethnic group data from new and existing members of staff using the new ethnic group classifications to facilitate monitoring required by the Race Relations (Amendment) Act.
- Organised and distributed second Staff Attitude Survey
- Produced new, comprehensive information pack for candidates seeking employment with the Trust
- Organised and manned stands at numerous recruitment fairs. During the year 151 qualified nurses were recruited from external sources.
- Wrote and introduced new Parental Leave Policy and revised Carers Leave Policy to take account of changes in employment legislation.
- Took over the employment of c70 staff from Mid Essex Community and Mental Health Trust under TUPE
- Successfully transferred under TUPE significant numbers of staff to Tendring PCT, Colchester PCT and North Essex Shared Services.
- Established and developed HR services to Colchester PCT
- Established Joint Staff Council for Tendring PCT
- Provided major tutorial input to LEO programme
- Received a Commendation in the Healthcare Sector of the RoSPA Occupational Health and Safety Awards
- Accredited by the Royal Society for the Promotion of Health as a Training Centre for the Advanced Diploma and Certificate Courses in Health & Safety in the Workplace
- Advanced Diploma courses conducted in-house in October/November 2001 and February/March 2002. A total of 18 candidates attended the course
- A dedicated "heavy patient room" was opened on Nayland Ward. The room contains electronically operated overhead hoist capable of lifting 40 stone. The room also contains an extra wide electronically operated profiling bed that can withstand 48 stone of weight. To complete the room there is a heavy-duty riser chair, commode and wheel chair.

- Produced a Lone Worker Policy including guidance notes and possible control measures. The Policy is aimed particularly at Community nursing, physiotherapists and occupational therapists

- Maintained a significant commitment to staff training throughout the year in health and safety, manual handling, fire safety, aggression management

- Extended counselling services available for staff

- Reformed the Health at Work in the NHS Group and organised activities throughout European Health and Safety week

- Increased provision of help and support to staff in managing stress

6.4.14 Medical Director

- Consultant Appraisals are now in place

- A deputy Medical Director has been established and appointed

- The medical director now chairs the Management Executive of the Trust

- Three new clinical director posts have been established and appointments made

- A new forum jointly with primary care comprising the lead GPs and clinical directors has been established. This provides an opportunity to share aspirations and address issues of common concern. It also feeds into the commissioning process.

7. SERVICE AND FINANCIAL FRAMEWORK (SAFF) 2002/03

7.1 SaFF Process

7.1.1 The national SaFF requirements for the coming year have been markedly different from previous years in that the timetable has been significantly accelerated. Although this has meant that discussions have taken place in a greater level of detail at a much earlier part of the process, this has not meant that clarity has arisen from the SaFF any earlier. The major reason for this is the gap between funding available and expectation in terms of NHS Plan Targets. Relationships with Primary Care Organisations throughout this SaFF round have generally been much improved on the 2001/02 negotiations which is reflective on the need for all organisations to become more partnership focussed.

7.2 NHS Plan targets & investment

7.2.1 The NHS Plan targets for 2002/03 are extremely challenging and the funding identified above will be expected to deliver a maximum in-patient wait of 12 months and a maximum outpatient wait of 21 weeks. The Department of Health and Social Care for the Midlands and Eastern Region has asked Health Economies whether accelerated targets of 9 months for inpatients could be achieved. This will not be possible within North Essex within the existing financial envelope although the Trust will, through urgency profiling and priority treatment lists, be looking at specific areas where the accelerated targets may be met.

7.2.2 The agreement of developments has proved to be the most successful part of the SaFF negotiations. £2.5 million will allow the Trust to make significant progress towards NHS Plan targets.

7.2.3 Managing demand will prove extremely challenging given the high level of elective activity and the expected continuing increase in emergency care demand. Capacity and demand management will be jointly managed between the trust and primary care colleagues.

7.3 Cost Pressures and Cash Releasing Efficiency Savings (CRES)

7.3.1 As in previous years, despite the NHS receiving an extremely generous financial settlement for the coming year, which averages 10% in cash terms, there have also been unprecedented cost pressures identified within the system such as pay review and non-pay review body awards again being funded at higher levels than the general level of inflation and the continued and increased impact of the Junior Doctors New Deal arrangements

7.3.2 The overall impact of these cost pressures for ERHT is in the order of 7.1%. The funding, which has been identified within North East Essex, is currently 0.7% below this level. This is further compounded by a shortfall on newly introduced cost of living supplements for certain categories of NHS staff. The combined effect of these gaps on nationally determined cost pressures is equal to 1.1% of total income and will need to be funded through CRES.

7.3.3 Local cost pressures, which face the Trust, were agreed at £1.32 million. One of the most significant pressures relates to prescribing which has been

conservatively assessed at £200,000. Further risks which have been identified concern such areas as accommodation costs for Trust Staff, the continued operation of the Wheelchair Service for North East and West Essex and the new MRI scanner which will invariably lead to higher levels of demand with a service now provided on site.

7.3.4 National and Local cost pressures produce a gap to be funded of £2.4 million or 2.4% of the Trust's income base. Plans are already in place to deliver almost £2 million of savings with the balance currently being identified as a Trust wide CRES.

7.4 Risk Areas

7.4.1 There are several areas of financial risk which may impact on the Trust's ability to deliver the strategy and which could impact on financial balance. The major areas are £432k Pace of Change Funding that has been committed by Colchester and Tendring PCT's and £3 million relating to SaFF unidentified measures for the North Essex Health Economy. The latter may result in an additional CRES target if no solution is identified. The Budget setting process also identified a number of risk areas that have not been funded.

7.4.2 In view of these factors the trust has set aside a £500k contingency reserve. This will help to address any issues as they occur in year and will provide a greater level of flexibility and capacity to absorb risk.

7.4.3 Maintaining elective activity for 2002/03 will be a challenge; particularly in light of the high level of emergency activity. Close collaboration with the PCOs will be required to jointly manage capacity and demand.

7.4.4 Tackling staff shortages; particularly in areas traditionally difficult to recruit, will provide a challenge for the trust. This is particularly true in recruiting to senior medical posts both as the staffing numbers increase and junior doctor's hours reduce.

8. BUSINESS PLAN 2002/03

8.1 Emergency Care

8.1.1 ***Accident & Emergency*** – will undergo a major review this year as part of a network of A&E services in North Essex. This aims to achieve the waiting times targets within the NHS Plan and modernise and improve A&E services. This will be undertaken in partnership with others in the network including primary care and ambulance service colleagues.

8.1.2 ***Emergency medical care -*** is experiencing significant pressures, particularly in terms of capacity and demand. As previously mentioned, as part of the centralisation of acute services project, a Service Redesign Group (SRG) dedicated to emergency care has been established. This group, comprising clinicians and managers across the health sub-economy, will address the targets and issues identified within the National Emergency Care Strategy, focusing on the local priorities of access, demand and capacity. The group, co–chaired by a clinician from both primary and secondary care, will meet over the summer and produce their clinical output specification, which will inform the OBC of the centralisation project. Recommendations for change will, where possible, be implemented well in advance of any major capital investment.

8.1.3 ***Additional Staff Grade Doctors in A&E -*** Two additional posts have been approved as part of this year's SAFF

8.1.4 ***Additional nursing staff in A&E -*** Additional posts have also been funded.

8.2 Reducing Waiting Times and increasing capacity

8.2.1 ***Dermatology*** – The directorate will be assuming responsibility for the PUVA service provision by transferring it from the existing provider – The Oaks Hospital. A business case to increase equipment capacity has been submitted to the Modernisation Fund as part of the Action-On Dermatology programme.

Also, an additional consultant dermatologist has been established for 2002/03 to improve capacity and reduce waiting times.

8.2.2 ***Rheumatology*** – Access to Osteoporosis screening is being assessed as part of developing services in Rheumatology for 2002/03

8.2.3 ***Diabetes*** – It is proposed to develop a Diabetes Centre as part of the Centralisation of Acute Services Project. This capital project will centralise the existing diabetes service. It will be enhanced through additional appointments of nurse specialists and increased podiatry and dietetics.

8.2.4 ***Renal Service*** – A renal satellite service on the Colchester General Hospital site is planned. A project team comprising the health authority, Ipswich Hospital Trust and ERHT is overseeing this development.

8.2.5 ***Thoracic Medicine*** – a joint project with Colchester PCT is aiming to develop a non-invasive ventilatory service preventing unnecessary hospital admissions and effecting prompt discharge.

8.2.6 ***Neurology Service*** – This service has undergone a period of considerable instability of late. However, there is a second neurologist established and it is proposed to develop this service over the coming year.

8.2.7 ***Gastroenterology*** – A third gastroenterologist has been established to improve access and reduce waiting times. This will also include the establishment of a Lower GI nurse specialist.

8.2.8 ***Colorectal Surgeon*** – A bid to increase the surgical consultant team by the appointment of a colorectal surgeon was successful as part of the SaFF process. This post will facilitate increased capacity for reducing waiting times for elective surgery and patients with suspected or diagnosed colorectal cancer.

8.2.9 ***Orthopaedic surgical team*** – A bid to increase the team was successful. This consultant-led team will facilitate increased capacity and reduce waiting times. This service will be implemented towards the latter part of 2002.

8.2.10 ***Surgical Ward Nursing Staffing*** – A £210,000 bid to increase the nurse staffing levels within the surgical wards was successful as part of the SaFF negotiations. This increase in staffing levels will facilitate improved nursing care and maintain capacity.

8.2.11 ***Urology*** – A third urologist post has been funded this year. This new development will facilitate reduced waiting times. Also, a primary prostate clinic has been established in partnership with Colchester PCT, which is proving most effective. This will be further developed this year.

8.2.12 ***Orthodontics*** – Traditionally a major area of concern regarding waiting times. A new Staff Grade appointment has been funded this year to help reduce the long waits

8.2.13 ***Booked Appointments*** – The trust will continue to support this national initiative to roll out booked OPD appointments to all specialities.

8.2.14 ***Critical Care*** – The trust is working in partnership with 4 other trusts across Essex (Mid Essex, Southend, Basildon & Thurrock and West Essex) who have formed a critical care network to co-ordinate developments and management of ITU and HDU services. This will involve joint planning and service development on an Essex-wide basis.

8.2.15 ***Pain Services*** – A business case will be developed to improve the facilities and staffing of this service in partnership with primary care.

8.2.16 ***Additional Gynaecology Consultants*** – A business case will be developed this year for two additional posts, to provide full time supervision of the Central Delivery Suite. This will enable the trust to meet the Level 2 standards of CNST in maternity and obstetric care.

8.3 Cancer

8.3.1 ***Mobile Breast Screening Unit –*** A bid for a new unit costing £400k has been approved by the Modernisation Fund. This will be used throughout North East Essex to improve take up rates (already high) to screening.

8.3.2 ***Radiotherapy –*** waiting times for treatment continue to be of concern. This is partly due to capacity of Linear Accelerator and partly staffing (therapy radiographers). The trust will continue to maintain both capacity and staffing recruitment and retention. The NHS Modernisation Fund has expressed a desire to replace the oldest LinAcc (installed in 1982) this year. The Cancer Service Redesign Group will be exploring the possibility of installing this on the CGH site in preparation for centralisation of oncology.

8.3.3 ***Chemotherapy –*** The chemotherapy suite at Broomfield Hospital is being relocated to a new purpose-built centre (part funded by the Helen Rollinson Appeal and part by Mid Essex Hospitals). Drug costs remain of concern, particularly as the directorate is adopting the recommendations of NICE.

8.3.4 ***Medical Staffing –*** NECP are hoping to appoint a Specialist Registrar this year.

8.3.5 ***Treatment Simulation –*** An upgrade to the system within radiotherapy funded by the NHS Modernisation Fund is being implemented (April 2002). This will provide virtual simulation.

8.4 Coronary Heart Disease

8.4.1 ***Cardiology*** – An interventional Cardiologist has recently been appointed. This will enable the trust to explore many of the cardiology treatments hitherto unavailable locally. It is proposed that an Angiography Laboratory, in partnership with the Essex Angiography service will be developed in 2002/03. The trust will also be in a better position to facilitate implementation of the Coronary Heart Disease (CHD) National Service Framework (NSF).

8.4.2 ***Rapid Access Chest Pain Clinics –*** these are being developed increasing from 3 to 5 clinics per week. This will facilitate compliance with the CHD NSF.

8.5 Older people

8.5.1 ***Stroke Service*** – A dedicated Stroke Care Ward is being developed to improve the management of stroke patients. This will be a managed by a multi-disciplinary team dedicated to the care and rehabilitation of stroke patients.

8.5.2 ***Care of the Elderly*** - A working group has been established to address the recommendations of the NSF for Older people.

8.5.3 ***Consultant Physician for the Elderly*** – a new consultant post has been established to support implementation of the NSF and to help capacity issues.

8.5.4 ***Mental Health Service*** – The Medical and Emergency care directorate will take a lead on behalf of the trust to establish better links with the Mental Health Partnership to improve mental health services for people, particularly the elderly.

8.6 Children

8.6.1 ***Neonatal Hearing Screening*** - We aim to become one of the pilot sites for the introduction of Neonatal Hearing Screening. A bid has already been forwarded to the Health Authority.

8.6.2 ***Developing SCBU –*** There is a current Regional Review of neonatal services. Our SCBU is identified as a level 3 Unit, and staffed as such. However, in reality it practices at level 2, mainly because centres of excellence repatriate sick and premature babies much earlier back to local units. We will be developing the current service in line with the regional review, which will involve the development of a business case for investment.

The above will enhance and develop facilities within the paediatric (SCBU) service to support intensive care for those babies needing stabilisation and

transfer to Neonatal Intensive Care Units, and allow an outreach team from SCBU to support premature babies in the community setting (to term + 4 weeks).

8.6.3 ***Paediatric Day Care -*** We also intend to further develop and expand Day Care/GP assessment Services in line with National recommendations for Paediatric Care.

8.6.4 ***Paediatric HDU –*** It is planned to develop a designated High Dependency Unit within the acute setting to facilitate care of the acutely sick child as part of the modernisation and upgrade of the Children's Ward.

8.6.5 ***Adolescent Facilities –*** it is planned to enhance our Adolescent facilities within the acute setting in line with National recommendations for Adolescent care.

8.6.6 ***Supporting Day Surgery -*** There has been an increase in the demand from the acute paediatric ward for Sick Children's Trained Nurses to support Elmstead Day Services. Additional workforce is required to safely support Day Surgery.

8.6.7 ***Supporting Outpatients –*** A business case will be developed for an additional trained nurse to support the already very busy Paediatric Outpatients, as staff at the moment, are taken from the acute ward. Hopefully in the future to develop evening clinics to support the demand.

8.6.8 ***Palliative Care -*** A business case will be developed for 1 WTE G grade nurse supported by 1 WTE B grade support worker to develop palliative care within the community of North East Essex.

8.6.9 ***Community Paediatric Nursing -*** A business case will be developed to increase the community paediatric nursing team by 1 WTE G grade, to support increased workload for children suffering from Cystic Fibrosis, Asthma and other chronic respiratory diseases.

8.6.10 ***Paediatric Neurorehabilitation -*** A business case will be developed to develop a Neuro-disability service within the local area, and recruit an appropriate qualified Paediatric Consultant in this field, supported by 1 WTE staff grade. This work would be largely community based and would give immediate and local support to the most severely handicapped children.

8.6.11 ***Child Protection -*** Issues surrounding child protection are ever expanding in this area and make enormous demands on our current precious establishment. We intend to appropriately increase workforce to support expansion, and develop dedicated liaison teams linked with Social Services, Maternity, SCBU and Children's Ward to support these vulnerable children.

8.6.12 ***Paediatric Staffing in A&E -*** We intend to increase the paediatric presence within A & E and following the very successful introduction of a paediatric Staff Grade doctor into A & E in 2001, we wish to recruit a further 1 WTE to enable the department to be covered for a further 5 sessions per week. This doctor would also enhance the paediatric 2nd on call rota and enable us to achieve the Working Time Directives.

8.6.13 ***Diabetes Service -*** Monies have been identified for 'this year only' to establish a Paediatric Diabetic Nurse. We would look towards continuing this service and working in partnership with the Diabetes service and therefore requesting .5 WTE funding at F grade.

8.7 Patient satisfaction

8.7.1 ***Patients Panel*** - The Patients Panel is has just gone live

8.7.2 ***Patient Advice and Liaison Service (PALS) -*** PALS is a new service proposed in the July 2000 NHS Plan that will be introduced in every NHS Trust by April 2002. A formal proposal and business case has been produced outlining various options to take the service forward. Funding is required to employ a PALS Officer and Management via the complaints and litigation Department.

8.7.3 ***Patient Information Officer –*** This temporary post is providing an invaluable service, supporting clinical services and patients/carers, which is admired nationally. The trust will develop a business case to secure funding in perpetuity.

8.8 Workforce

8.8.1 ***Working Time Directive -*** The main area of concern relates to the consultant compensatory rest. The trust will need to measure the impact of the outcome of national negations and share this with commissioners.

8.8.2 ***Improving Working Lives -*** This is essentially about new, different and flexible ways of working and should, in general, be revenue neutral, including:

- Equality and diversity
- Communication and staff involvement
- Flexible working
- Healthy working
- Training & development
- Staff benefits and child care
- Staff attitude survey

There are some exceptions:

- Training & Development (particularly the requirement to ensure that all staff have an up to date PDP)
- Day Nursery – if there is need to subsidise the fees.

8.9 Information & Management Technology

8.9.1 ***24-hour Patient Administration System -*** The Trust has recognised for some time that information required for the Patient Administration System (PAS) is not entered across the full 24-hour period. This creates problems in the tracking of patient's whereabouts and the use of PAS by clinical staff for patients who enter the hospital system during hours when there is no PAS input.

The proposal is to extend the administration covered within the Medical Assessment Unit across the full 24-hour period to areas where PAS input is currently not provided. This extended service will be for all PAS input across the CGH for the duration of the extended hours to areas, which currently do not have PAS cover.

8.9.2 ***Appointment of EPR/Information Project Manager –*** In order for the trust to ensure smooth and effective implementation of the EPR project and to provide an interface between the trust and Shared Services, a project manager will be established.

8.9.3 ***Radiology Information System –*** The trust will upgrade the existing CRIS system and ensure rollout across the trust with on-line access in every clinical area.

8.9.4 ***A&E Department Patient Tracking System -*** At present, patients are tracked within the A&E Department manually and this information is used to inform the situation reports which are submitted to the Health Authority and the centre. Much of this information is based on sampling, which is not reliable, and it is therefore necessary to implement a more reliable form of data collection. The Total Care 2000 Patient Tracking System is designed to be barcode driven with the use of stand-alone and hand held bar-code readers. The system tracks patients as they arrive at Patient Charter and user-definable events and logs the date and time of arrival at the event. The system includes a patient tracking performance-monitoring report, which can be created by the user. This report can be created with various criteria and will provide an interactive means of monitoring the time taken for patients to pass through selected events. The system also includes a hospital diary facility which will allow significant events to be recorded for past dates and times which will provide a commentary against any external or internal event which may impact on hospital life. The trust will develop this initiative during 2002/03.

8.9.5 ***Tracking System for Sterile Services -*** Part of the recent government Decontamination Initiative, outlined in HSC2000/032, includes the directive that plans, should be in place for the tracking of instrument sets through the decontamination process in March 2002. Part of the recently approved Decontamination Business Plan for ERHT includes the capital cost of a tracking system for this purpose. The benefits of such a system are:

- The ability to validate decontamination of equipment;
- The ability to recall items relating to a specific 'Batch' if necessary;
- The ability to identify the specific sets used on an individual patient;
- Improved stock control and costing;
- Reducing the potential risk of litigation to the Trust;

8.9.6 ***Patient Tracking – Non-A&E***- Patient tracking is a module available on PAS to record the patient's journey throughout the Trust in real time. Implementation of this module will provide similar functionality to that already explained within the A&E department. The patient's unit number would be input followed by the event that is being recorded and again this system works primarily through the use of bar code scanners although manual input is also possible.

8.9.7 ***Pathology System -*** The major issues within pathology relate to ward based access to results and blood products tracking system. An immediate action is therefore the priority replacement of obsolete terminals with a modern alternative and this is considered as a separate investment proposal within this business plan.

8.9.8 ***Blood Product Tracking System -*** This would provide a full audit trail for the issue of blood and blood products. It is a useful adjunct to EPR and patient tracking and uses staff ID, bar coded ID badges and bar-coded patient ID's. Benefits would include the accurate automatic logging of data, instant access to blood location status information, the prevention of unauthorised access to fridges, increased safety by monitoring storage times and warning of potential errors and easy scanning and recording of data.

8.9.9 ***Storage Strategy Project -*** Implementation of this project would ensure the Trust's compliance with 'For the Record', HSC 1999/053. The key initiative of this directive is to improve the management of all NHS records. It outlines the action that each organisation should take for storage and retention of all records of all types, administrative as well as medical.

8.9.10 ***PAS Letters using Microsoft Word*** - During the last year or so a number of requirements have been raised via the User Groups and Requirement Register that concern the quality of presentation and ease of production of letters from the current PAS.

The key issues are:

- To improve the way that letters are maintained (i.e. improve on the text editor)
- To improve on the formatting that can be achieved in the PAS letters (e.g. bold, underline, italics, larger font sizes).

The above would improve the quality of letters that can be produced in line with the guidelines for improved presentation that the NHS has published. In addition to these requirements is the need to produce letters (e.g. discharge letters or clinical letters to other clinicians) that use data from PAS (e.g. demographics, clinical coding).

8.9.11 ***Theatre System*** **–** The Trust will be developing an integrated theatre IT system that will provide clinical information, including information relating to the patient journey through theatres. It may be also be possible to link the system to some of the Trust's existing systems to provide additional functions including instrument/equipment traceability.

8.10 Research & Development

8.10.1 Background

In 1998 the Trust appointed a full time R&D Co-coordinator, to conduct the day-to day management of R&D, and an R&D Steering Group, to facilitate, advise, evaluate, support, approve and monitor all research activity involving the Trust. This allowed the Trust to comply with the high quality management and information requirements for receipt of NHS R&D Support funding.

The Trust also has a number of dedicated research staff in the fields of Oncology, Breast Care and Urology. These are supported through charitable funds, income from commercial research and NHS R&D support funding.

The Trust continues to support non-commercial, commercial, and internally-funded research activities across a number of Specialities, including Accident & Emergency, Diabetic Services, General Medicine, Obstetrics & Gynaecology, Genito-Urinary Medicine, Cancer, Urology, Rheumatology, Paediatrics, Surgery, Thoracic Medicine, and Epidemiological studies.

For full details of progress in all aspects of R&D activity to March 2002, please refer to the Trust's R&D annual reports for 1998/99, 1999/00, 2000/01 and 2001/02.

8.10.2 **Actions for 2002/03**

Research Governance Framework

All research active NHS care organisations are required to produce a local "Research Governance Implementation Plan by July 2002. This will outline systems development to comply with the requirements of "*Research Governance Framework for Health and Social Care*" (Dept of Health, March 2001).

The Trust already has a number of systems in place to comply with indicators, including:

- Systems to ensure an appropriate member of staff is notified of, and has approved, all research in the care organisation
- Systems to ensure all ongoing research has ethics committee approval
- Arrangements to ensure someone acceptable is responsible for making sure that informed consent and procedures in the protocol approved by the ethics committee are being adhered to

In addition, a number of the indicators will require further systems development, including the following:

- Documented agreements with all research partners to allocate responsibilities
- Further arrangements for monitoring research projects
- Systems to ensure all research in the organisation has a nominated sponsor
- Systems to ensure all research is subject to independent expert review through accepted scientific and professional channels
- Systems to detect and deal with research misconduct and fraud
- Involvement of consumers in the development and execution of research projects, where appropriate
- Arrangements to ensure all research is appropriately disseminated
- Systems for the identification of research-based intellectual property and access to systems, where appropriate, for ownership, exploitation and income from intellectual property

PAS alert on Patient Administration system

The Breast Unit has piloted a 'research alert' on the Patient Administration System (PAS) for all patients entered on their clinical trials. This facilitates adverse event reporting for trials e.g. hospitalisations. It is planned to roll this out to other research active Specialities in the coming year.

Mid-Anglia Cancer Research Network

The Mid-Anglia Cancer Research Network (MACRN) will join the National Cancer Research Network (NCRN) from April 2002. This provides the opportunity and support to build on our current strengths and develop a co-ordinated common infrastructure of research staff able to support a full portfolio of clinical trials across all tumour sites throughout the network.

A Clinical Lead for Research and a Research Network Co-ordinator has already been appointed. In addition, NCRN funding will be used to support the appointment of new staff to support cancer research activities, including research nurses and additional pharmacy support staff, in order to meet the NCRN targets.

Training

The Trust Board has approved a 15% levy on commercial trial income. This will be used to support training in R&D methods across the Trust, for example, statistical analysis of data.

Supporting Excellence

The "Supporting Excellence" project is a joint project between Research and Development and Library Services. The project aimed to identify staff research interests staff and enable the library to offer a proactive tailored information service to the people who signed up for the project. The project currently supports 23 people with monthly Medline, Cinahl, Psychinfo and HMIC searches. Response to the project has been overwhelmingly positive, and reflected the need for a pro-active approach to evidence-based practice.

The next step is to look at the feasibility of a "Health Evidence Support Specialist" to implement best practice and support clinical governance through the careful and targeted dissemination of relevant, timely, good quality information. The purpose of this pro-active post would be to work with local NHS Staff to ensure evidence gets to frontline staff and facilitate best practice by highlighting relevant guidelines and evidence-based literature.

National Research Register

The R&D Co-ordinator will continue to send details of non-commercial studies, which the Trust supports, for inclusion in the "NHS National Research Register". This is a comprehensive register of ongoing and recently completed research projects funded by, or of interest to, the NHS, and can be accessed at http://www.doh.gov.uk/research/nrr.htm

R&D Support Funding

The Trust will receive £125,457 to support non-commercial R&D activity in 2002/03. The NHS Executive has agreed allocation of funding as given in the table below. The Trust will continue to support externally funded non-commercial trials as a priority in its allocation of R&D support funding, particularly in the field of Oncology, an NHS Executive priority area.

Agreed Activity Areas		Limits, Restrictions and Exclusions	Indicative R&D Support Funding 2002/03
1	• Externally Funded Non-commercial R&D activity • Includes £34,189 adhoc funding for 2002/03		£97,519
2	• Internally Funded R&D activity		£1,438
3	• Training & Development		£0
4	• Commercial R&D activity		£0
5	• R&D Management Costs • Includes £26,500 adhoc funding for 2002/03		£26,500
	TOTAL		**£125,457**

From April 2003, a new system of R&D Support funding will be implemented - "Support for Science" and "Priorities and Needs" Funding. In 2002/03, the R&D Steering Group will collect details on Research Active Professionals and actual numbers of patients recruited to all trials in order to comply with information requirements for the new funding system, which is based on a formulaic approach.

Monitoring of outcomes and new techniques

The R&D Steering Group will devise a framework for review of new techniques, associated training processes and improved monitoring of research outcomes in order to underpin Clinical Governance and Risk Management requirements.

8.10.3 **Proposed action for 2003/04**

- The EU Directive on Clinical Trials comes into force in May 2004, and all non-commercial research will need to fulfil the requirements of this Directive. The implications for this on trial activity will need to be addressed by the R&D Steering Group, Researchers and support departments particularly Pharmacy.

- Further Development of systems to comply with the Research Governance Framework.

9. CAPITAL INVESTMENTS 2002/03

9.1 Background

9.1.1 Over the last two years there has been a significant increase in the number of national performance targets in the form of The NHS Plan, NSFs, Controls Assurance and Clinical Governance. These targets have now begun to dominate the business planning agenda in the NHS and are placing considerable pressures on available revenue resources. This has been highlighted in our second consecutive difficult SaFF round. As a consequence of this, it is imperative that the Trust is able to confirm its ability to meet such costs before committing itself to any capital expenditure.

9.1.2 Towards the latter part of 2001, a Local Modernisation Review (LMR) framework was developed which identified those targets alluded to earlier. This framework was circulated to all directorates to assist with the development of their business plans. These business plans have been used to inform the preparation of this capital programme. Further work is required during the coming year to improve the robustness of this planning process and to develop investment proposals, which cover a wider time horizon.

9.1.3 During the course of the year, the Trust has established or redefined the function of a number of Steering Groups. Within the Terms of Reference for these groups is the responsibility for establishing and implementing the Trust's development agenda in a number of key areas. These groups are:

- Facilities Management (non-clinical operations)
- Information Management and Technology
- Service Planning and Performance
- Governance (corporate and clinical)

Proposals for investment from these groups have been incorporated in the programme. All capital investments will, in future, be supported by robust business cases, which clearly identify the benefits and costs of such proposals.

9.1.4 The Trust had access to **£5,035,000** of capital resource coverage during the period 2001/02. Expenditure for the year is projected to be **£4,535,000** with the balance being brokered (carried forward) into 2002/03.

Source of Funds:	£5,035,000
Projected Expenditure 2001/02:	£4,535,000

Balance carried forward to 2002/03:	**£ 500,000**
	=========

9.1.5 Of the projected expenditure, a sum of **£2.4m** was required to cover schemes approved/committed in 2000/01 that were carried forward into the year 2001/02. The remaining budget of **£2.135m** was set against schemes identified at the start of the year.

9.2 Available Capital Resources for 2002/2003

9.2.1 The allocation of capital is approved on an annual basis by the NHS Executive in setting the Trust's external financing limit (EFL) and capital resource limit (CRL). These limits may be subject to revision during the course of the year. There are two primary elements to that allocation:

(a) The conditional element which is approved for specific schemes and must be spent in those defined areas;

(b) The unconditional (or discretionary) element, which is assigned to the Trust on a formulae basis and is to be spent on schemes determined locally.

9.2.2 In recent years there has been a further allocation of "Capital Modernisation Funds" available to the Nursing and Medical Directors to spend on medical equipment. Additionally, the Trust has and continues to bid for additional capital resources made available to support local and/or national initiatives (e.g., Action On, Access, etc.)

9.2.3 Conditional Allocation

During 2002/03 the Trust will receive the following conditional allocations:

Treatment Planning System:	£ 177,000
Decontamination:	£ 416,000
Satellite Renal Dialysis:	£ 449,000

Total:	**£1,042,000**
	=========

Further capital resources may be available during the course of the year, subject to decisions on new and outstanding bids.

9.2.4 Unconditional Allocation

The Trust's EFL for 2002/03 provides an unconditional allocation of £2,802,000 with a further amount of £500,000 from the Local Capital Modernisation Fund. There is a further sum of £500,000, which relates to funds carried forward from 2001/02.

A summary of the available unconditional capital available for 2002/03 is illustrated below:

EFL Allocation:	£2,802,000
Capital Modernisation Fund:	£ 500,000
Funds carried forward:	£ 500,000

Total:	**£3,802,000**
	=========

9.2.5 Summary of Capital Resources for 2002/03:

Conditional Capital:	£1,042,000
Unconditional Capital:	£3,802,000

Total:	**£4,844,000**
	=========

9.3 Allocations of Capital Resources

9.3.1 Capital resources have been allocated into a number of discrete areas in an attempt to deliver a balanced investment programme. However, the first call on capital is for schemes approved and committed in 2001/02, which have not yet been completed. Schemes not yet committed are to be reconsidered with those put forward for the current year.

Allocations have been made against the following areas:

(a)	Schemes carried forward from 2001/02:	£ 700,000
(b)	IM&T:	£ 500,000
(c)	Facilities (including buildings/infrastructure):	£1,400,000
(d)	Medical Equipment:	£ 800,000
(e)	Service Developments:	£ 800,000
(f)	Others (including contingencies):	£ 644,000
	Total:	**£4,844,000**

9.3.2 Prioritisation of the above allocations has been delegated to the newly formed steering groups.

9.3.3 Although resources were not allocated in the same way in previous years, expenditure for 2001/02 has been categorised using the headings proposed for 2002/03. This is to enable a comparison to be drawn between the two. Results are shown below:

	Expenditure 2001/02 £'000	**Budget 2002/03 £'000**
Schemes carried forward	2,170	700*
IM&T Developments	204	500
Facilities	515	1,400
Medical Equipment	799	800
Service Development	847	800
Others	-	644
T O T A L	**4,535**	**4,844**

* Approximately £483k relates to Medical Equipment purchases.

9.3.4 As part of the preparatory work required to support the centralisation project, the Trust will be undertaking a detailed review of its current asset base. This will inform the preparation of a robust equipment replacement programme and estate investment strategy. Also, by extending the business-planning horizon, capital resources can be more accurately targeted in future.

10. CONTROLS ASSURANCE

10.1 Corporate Governance

10.1.1 Corporate Governance is the system by which the Trust ensures that its business activities are appropriately directed and controlled. A robust corporate governance framework will ensure that the Trust continues to meet the necessary standards of accountability and probity and should be undertaken in parallel with the Clinical Governance Framework.

10.1.2 During the 2001/02 financial year, the Trust reviewed the systems, procedures and structures it had in place to undertake corporate governance and has adopted improvements to ensure an improved synergy with the clinical governance framework and the overall controls assurance objectives. During the 2002/03 financial year, the Trust is undertaking a systematic review of the current corporate governance framework in order that it can establish the baseline and action plan required to ensure that the Trust has attained Level 3 Controls Assurance compliance by the 31st March 2003.

10.1.3 This work will be co-ordinated by the Trust Controls Assurance Steering Group. On an on-going basis the group will ensure that the Trust continues to monitor and control its performance against the corporate governance standards and framework. It will also ensure that the risks identified as part of this process feed into an overall Trust Risk Register. Finally this group will ensure that the Board receives regular information supporting the achievement of level 3 compliance and the on-going maintenance of this position.

10.2 Clinical Governance

10.2.1 The White Paper *The new NHS. Modern. Dependable (1997)* states that "The New NHS will have quality at its heart. Every patient who is treated in the NHS wants to know that they can rely on receiving high quality care when they need it. Every part of the NHS, and everyone working in it, should take responsibility for working to improve quality."

10.2.2 The NHS Plan emphasises the need to continuously work to improve the quality of services and to minimise errors. The Plan identifies a requirement for the NHS to ensure services are driven by a cycle of quality improvement and that quality should not be restricted to the clinical aspects of care, but should include a holistic perspective and the entire patient experience. The aim is that all those providing care will work to make it safer, and support a culture where we can learn from and effectively reduce mistakes. Alan Milburn qualified this in a speech in 2000, saying:

"….Health care interventions usually bring great benefits, but they can sometimes cause harm if things go wrong. The challenge is to ensure that the modern NHS is as safe a place as possible for patients."

10.2.3 The NHS has been charged with collaborating with the local health economy, the social care sector and the wider NHS to develop and work in partnership with patients, carers and their families in providing efficient and effective services. The Clinical Governance Strategy seeks to raise awareness and support these principles.

10.2.4 The aim of the clinical governance strategy is to promote and support the Trust's mission and wider NHS agenda through the delivery of these strategic aims over the next five years:

- Provide services, in collaboration with other agencies which are relevant and responsive to the needs of patients and which deliver optimal health outcomes.

- Create and foster an environment in which collaborative clinical practice and education are provided whilst striving for excellence.

- By being open and transparent in reviewing and developing clinical practice and organisational performance.

- Creating a culture of participation and empowerment within the organisation and an environment where questions flourish and their answers are heard.

- Ensuring that the patient's experience of the clinical care and service delivery is a positive one and there is active participation in the development of services and clinical quality is encouraged.

10.2.5 The elements of clinical governance against which this can be judged are:

- Clinical effectiveness
- Risk management effectiveness
- Patient experience
- Communication effectiveness
- Resource effectiveness
- Strategic effectiveness
- Learning effectiveness
- Systems awareness
- Clinical leadership
- Patient – professional partnership

10.2.6 A Clinical Governance Strategy is currently being developed. This strategy outlines the plan for the continued implementation of clinical governance at Essex Rivers Healthcare. It builds on developments outlined in the first strategy, produced in February 2000, and takes into account the development plan outlined in the Clinical Governance Annual Reports for 1999/2000 and 2001/2002.

11. PLANNING PROCESS FOR 2003/04 AND BEYOND

11.1 Process for 2002/03

11.1.1 In November 2001, a process to co-ordinate the business planning, service development and LMR processes was introduced. However, given the date of implementation, it was out of synchronisation with the SaFF process, which had all but completed the initial round. Certainly, the plans for 2002/03 were already virtually concluded.

11.1.2 However, each directorate was asked to submit their plan for 2002/03 to inform the trust business plan.

11.1.3 A series of meetings with the directorates took place during February/March to:

- review the content of the BP and how it addresses the LMR/NHS Plan targets.
- ascertain the directorate's objectives and 'deliverables' within the agreed budget for 2002/03
- ascertain any capital demands for 2002/03 – and beyond
- begin to develop the BP process for 2003/04 and 2004/05

11.2 Process for 2003/04

11.2.1 In the first quarter of 2002/3, the trust will share the prioritised business plan with the commissioners.

11.2.2 In the second quarter (July to September) we will seek agreement in principle of service developments, the detail will be developed (in the form of business cases) and these will be either taken forward or 'parked' for future consideration.

11.2.3 In the 3rd quarter (October to December), we will agree the SaFF pressures/developments where funding allows and those included will be timetabled for implementation.

11.2.4 In the fourth Quarter (January to March), the trust will continue to develop next year's business plan and finalise plans for implementation of the agreed developments for 2003/04

11.2.5 The trust wishes to move towards a 3-5 year plan rather than an annual one. The commissioners share this and the North East Essex Strategy Group will develop a longer planning process over the coming months.

APPENDIX 1

Local Modernisation Review (LMR)

Targets

Access

	REDUCING WAITING TIMES IN SECONDARY CARE: Waiting list management
	2001/2:
1	100% of Trusts reduce the numbers of over 13 week O/P waiters and implement a maximum waiting time of 26 weeks
2	100% of trusts reduce the number of 12 month I/P waiters and implement a maximum waiting time of 15 months
3	During 2001/02, Maintain the manifesto commitment to cut waiting lists by 100,000
4	100% of trusts maximum 2 week wait from urgent GP referral to O/P appointment for patients with suspected cancer
5	100% of trusts max 1 month wait from urgent GP referral to treatment for children's and testicular cancers and acute leukaemia by end of Dec 2001
6	100% trusts max 1 month wait from diagnosis to treatment for breast cancer by the end of December 2001
7	10%(3000) additional revascularisation procedures (over the two years 2000/01 and 2001/02 baseline)
8	50% of trusts adopt best practice
	2002/03:
9	100% trusts maximum O/P wait 5 months
10	100% trusts maximum I/P wait of 12 months
11	80% of trusts adopt best practice
	2003/04
12	100% trusts maximum O/P wait 4 months
13	100% trusts maximum I/P wait 9 months
14	100% trusts adopt best practice
	2004/05
15	3 month maximum waiting time for out-patient appointments by 2005
16	6 month maximum waiting time for in-patient treatments by 2005
	2005/06
17	100% trusts maximum O/P wait 3 months

18	100% trusts maximum I/P wait 5 months
19	6 months maximum wait for cardiac surgery
	Expanding capacity
20	Progress towards 80% theatre utilisation from 2001/02 onwards
21	In 2003/04, Increase in day case rate to 75%
	11.2.6
	11.2.7 Demand management
	2001/02
22	80 PCG/Ts implementing changes in capacity demand management
23	100% of PCG/Ts covered by emergency guidelines
24	100% of PCGs to have a referral advisor in place
25	100% of GPs to have access to an evaluated scoring system for hip & knee replacement and cataract extraction
26	100% of HAs to have implemented demand capacity analysis in one locality for a high volume procedure experiencing long waits
	2002/03
27	100% of HAs to have implemented demand capacity analysis in all localities for at least one high volume procedure experiencing long waits
	2003/04
28	100% of cardiac networks have redesigned systems
29	Integrated Care Pathways to be the central care mechanism for evaluating care provision
30	100% of HAs to have implemented demand capacity analysis in all specialties and emergency care
31	The No. of cataract operations will reach 250,000
32	100% of HAs will achieve a rate of 3,200 cataract operations per 100,000 older people
	Capacity planning
33	In 2001/02, Matching capacity & demand included in core services modernisation training programme for local modernisation teams
34	In 2002/03, 90%+ local modernisation teams have undertaken capacity & demand pilots
35	In 2003/04, 90%+ local health communities to have used capacity & demand planning systems in modernisation programmes
	Booking
36	In 2001/02, All Trusts with O/P waiting times >13 weeks using partial booking for 2 specialties

37	In 2001/02, Every acute Trust to be booking daycases for at least two specialties or high volume procedures
	In 2002/03:
38	All Trusts working towards 100% daycase booking
39	Increase booking from within general practice
40	Increase booking for elective admissions
41	% of NHS trusts/GP practices implementing Electronic booking systems
	In 2003/04:
42	Every patient diagnosed with cancer will benefit pre-booked care
43	2/3 of all O/P appointments pre-booked
44	2/3 of all elective I/P admissions pre-booked
45	% of NHS trusts/GP practices implementing Electronic booking systems
46	A national standard appointment booking facility on every GP desktop; linked to booking and scheduling systems in every NHS Trust
	Dec 2005:
47	100% of all O/P appointments pre-booked; part of the target for booking of appointments for patient treatment by December 2005
48	100% of all I/P appointments pre-booked, part of the target for booking of appointments for patient treatment by December 2005
49	Capability for 100% of NHS trusts/GP practices to implement Electronic booking systems
	Primary Care Access and Services
50	Reduce GP workloads and improve access to local services
51	All patients to see GP within 48 hours and other Primary Care professionals within 24 hours by 2004 (60% of patients to see GP within 48 hrs and other PC professional with 24 hrs by March 2002)
52	Provide tests in primary care centres by 2004
53	1000 specialist GPs taking referrals from colleagues by 2004
54	By 2002, all PCT/Gs to have agreed with main providers plans to deliver outpatient consultations in primary/community care settings by 2004
55	Approximately 4 million new out-patient consultations in primary care and community settings by 2004
56	By April 2002 we expect nearly a third of all GPs to be working in PMS contracts.

57	100% GPs connected to NHSnet by March 2002
58	Access to high quality NHS dentistry by September 2001
	Avoiding cancelled operations
59	Operations cancelled on day for non-clinical reasons: new date within 28 days or patient choice of date/hospital, by 2002

	Emergency and Acute Service Access
60	By 2004, no one to wait more than 4 hours in A&E from arrival to admission, transfer or discharge and average waiting times to fall to 75 minutes.
61	Inappropriate waits for admission to be eliminated – All patients to be found a bed without undue delay once a decision to admit has been made (within 1 hour of the decision to admit) by 2004.
62	All relevant organisations must ensure prompt and effective emergency care is available 24 hours a day 365 days a year and must have in place robust local planning arrangements for winter. A consistent improvement in standards of these services is necessary
63	30% increase in adult critical care capacity over 3 years (to 2003/4)

	Medicines and extended roles
64	PCG/T medicines management schemes so people get more help from pharmacists by 2004
65	HAs to put forward proposals for first PMS-type Local Pharmaceutical Services pilots to operate from 2002
66	Repeat dispensing schemes to be in place nationwide by 2004 making it easier for patients to obtain the right medicines

Cancer

	Improving screening
67	By 2001, all PCG/Ts to review screening coverage rates and draw up plans to improve the accessibility of screening for women in socially excluded and minority groups.
68	By 2001, all women to receive results of smear tests in writing
69	By 2002, Cancer networks to review equipment and facilities for breast screening to maintain or increase screening uptake rates and prepare for extension of the programme.
	Improving cancer services in the community
70	By 2001, PCOs to be represented on network management groups
71	By 2001, PCOs appoint lead cancer clinician

72	By 2001, new support and training initiatives in palliative care for community nurses
73	By 2001, maximum one month wait from urgent GP referral to treatment guaranteed for children's and testicular cancers and acute leukaemia
74	By 2001, maximum one month wait from diagnosis to treatment for breast cancer
75	By 2001, All cancer networks to participate in second phase of Cancer Services Collaborative and to: - Set local improvement targets; begin booking arrangements; and - implement national waiting times targets
76	By 2002, maximum two month wait from urgent GP referral to treatment for breast cancer.
77	By 2004, every patient diagnosed with cancer to benefit from pre-planned and pre-booked care.
78	By 2005, maximum one month wait from diagnosis to treatment for all cancers.
79	By 2005, maximum two month wait from urgent GP referral to treatment.
	Improving treatment
80	By 2001, ensure all patients receive the clinically-proven and cost effective drugs they need, taking full account of NICE appraisals of 13 chemotherapy treatments to be published in summer 2001
81	By 2001, improve quality of treatment patients receive by beginning to implement the Improving outcomes guidance on gynaecological, upper gastrointestinal, urological and haematological cancers.
82	By 2001, Trusts assess local services against national standards as basis for peer review visits.
83	By the end of 2001, cancer networks will develop and begin implementing costed strategic service delivery plans to cover all aspects of cancer services including workforce, education and training requirements
84	Cancer networks should take account of the views of patients and carers when planning services.
	Improving care
85	By 2001, all cancer networks to develop costed strategic plans for palliative care in partnership with voluntary organisations to begin implementation in 2001.
86	By 2001, all cancer networks to undertake a review of specialist palliative care provision and NHS and voluntary sector investment in preparation for drawing up and agreeing strategies for palliative care provision
	Investing in staff
87	From 2001 onwards, Cancer networks develop costed workforce plans (including education and training) to support cancer

	SDP.
88	From 2001 onwards, Cancer networks develop timescales for the delivery of the standard of care that all patients with cancer should have their care reviewed by a specialist team.
	Facilities
89	By 2001, all regions to develop cancer facilities strategies for equipment to keep the stock of equipment up to date and to work towards a fair distribution of equipment. The regional strategies must ensure in aggregate their plans make sufficient progress towards the NHS plan targets that by 2004 there will be 50 new MRI cancer scanners, 200 new CT cancer scanners, 80 new liquid cytology units and 45 new linear accelerators.
90	By 2001, Networks undertake audit of cancer diagnostic and treatment facilities.
	Improving outcomes
91	Reduce mortality rates from cancer by 20% in people under 75 by 2010
	Research and Development
92	By 2003, Participate in the NHS Cancer Research network as it is rolled out.

Capital & Capacity

	Beds
96	30% increase in adult critical care beds by 2003
97	2,100 extra beds in general and acute wards by 2004
98	5,000 extra intermediate care beds by 2004, of which, 1500 extra to be delivered by March 2002
	Estates
99	Every major hospital has bedside televisions and telephones by 2004
100	Clear maintenance backlog of £3.1bn by at least 25%, by 2004
101	Nationally, 100 hospitals with on-site nurseries by 2010; all hospitals must consider whether to provide on-site nursery with RO
102	Improve decontamination in NHS hospitals by 2003
	Equipment

103	Increase haemodialysis stations by 450 to achieve an acceptance rate of 120 pmp by 2004 and improve kidney transplantation rates to 50 pmp by 2005. An NSF for renal services is due to be published in 2002 and will set milestones for future years
104	By March 2003, develop a plan approved at regional level for modernising pathology services
105	By March 2004, complete an accreditation inspection visit for all pathology services
106	By March 2003, develop a plan to achieve full accreditation for pathology services.
	Primary Care premises
107	Up to £1bn investment in primary care facilities, including NHS LIFT, by 2004
108	Up to 3,000 GP premises to be refurbished or replaced by 2004
109	500 One-stop primary care centres established by 2004
	Information Management and Technology- Implementing Information for Health
110	100% of GP Practices to be computerised by March 2002
111	All GP practices connected to NHSnet by 2002
112	100% of Practices with LANs connected to NHSnet (e.g. desktop access) by March 2002
113	50% Primary & Community Trust hospitals and 75% acute Trust hospitals have electronic patient records by 2004; leading to 100% by 2005
114	All patients have access to electronic personal medical records by 2004
115	By March 2005, all bookings from GPs to outpatients or from outpatients to day-case or inpatients to be made electronically
116	By March 2002, 60% of all biochemistry haematology and microbiology test results to be transferred electronically
117	By March 2003, electronic transfer of all radiology reports and discharge summaries between hospital and GPs
118	All local health services have facilities for telemedicine by 2005

Children

119	Reduce smoking among children from 13% to 9% or less by 2010 with a fall to 11% by 2005
120	Reduce the percentage of women who smoke during pregnancy from 23% to 15% by 2010 with a fall to 18% by 2005
121	By 2003 70% of 5-year-old children should have had no dental caries experience and, on average, 5-year-old children should have no more than one decayed, missing or filled primary tooth.
122	To reduce the death rate from accidents by at least 20% and to reduce the rate of serious injury by at least 10% by 2010

123	By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the level of inequality in rates between the worst fifth of wards and the average by at least a quarter
	Children's Health
124	Increased numbers of community palliative care teams by 2004
125	Review of Neonatal Services completed and implementation of Strategy for Improvement by 2004
126	New screening programme for haemoglobinopathies by 2005 (infrastructure by 2002)
127	Pilots followed by national roll-out of universal neonatal hearing screening. Roll-out to begin 2003
	Child and Adolescent Mental Health services
128	Support for carers (all ages) by 2004 (led by Mental Health Taskforce)
129	Continue CAMHS development strategies in line with previous national priority guidance and Audit Commission recommendations (Children In Mind 1999). Including local service mapping in preparation for the Children's NSF (currently being piloted guidance to follow.)
130	50 early intervention teams in psychosis for young people (aged 14 to 35) by 2004. Lead is with Local Implementation Teams (Adult Mental Health) but a key role for CAMHS.
	Working in Partnership
131	Effective cross agency working to deliver services for children including work relating to children's Fund, YOTs, healthy schools and planning for Connexions service.
132	One third of children under 4 years covered by Sure Start projects (250 by 2002) by 2004

CHD

	Change clinical practices
133	75% of category A calls to be responded to within eight minutes by April 2002
134	75% of eligible patients to receive thrombolysis within 30 minutes of arrival in hospital by April 2002.
135	75% of eligible patients to receive thrombolysis within 20 minutes of arrival in hospital by April 2003.
136	National roll out of paramedic thrombolysis by 2004.
137	80% to 90% of patients discharged after heart attack to receive appropriate medication: aspirin, statins and beta-blockers. The number and proportion of people aged 35-74 years with recognised CHD whose records document advice about use of aspirin
138	National roll-out of rapid access chest pain clinics to every acute trust in the country by 2003

139	National roll out of 3,000 automated defibrillators in public places
140	Develop and expand heart failure services.
141	Develop and expand cardiac rehabilitation services.
	Expand clinical services
142	Maximum 15 months waiting time for revascularisation by March 2002
143	Maximum six months waiting time for revascularisation by 2005
144	An additional 6,000 revascularisations over 1999/00 baseline by March 2003.
	Workforce
145	An end to single-handed cardiologists in 2004.
	Primary care
146	All practices to have disease management registers with clinical audit data in place, actively managing patients at risk of CHD by 2003.
	Improving outcomes
147	Reduce mortality rate from heart disease and related disease in people, under 75 by 40% by 2010.

Inequalities & Public Health

148	Reduce the proportion of people under the age of 25 reporting use of Class A drugs by 25% by 2005 and 50% by 2008.
149	All local DAT agencies to have implemented prevention programmes agreed through their local DAT and consistent with national best practice guidance. This includes ensuring that by March 2004 all HAs, PCTs and SSDs will be routinely commissioning a) primary prevention activity for the general populations; and b) primary and secondary prevention activity for all young people identified as at risk; in accordance with DH guidelines. NHS and social services drug prevention guidance to be written by March 2001 and implemented in revised format if necessary by March 2002. All Health Authority and Social Services anti-drug activities will be compliant with this and other interdepartmentally agreed best practice guidance.
	To enable people with drug problems to overcome them and live healthy and crime-free lives
150	Increase the number of problem drug users in drug treatment programmes by 66% by 2005 and by 100% by 2008
151	Develop services so that 15% more problem drug misusers (excluding those from the criminal justice system) per health authority and 10% more for local authorities receiving a specific grant, are accessing drug misuse treatment services by March 2002
152	By March 2002, we will have determined four key treatment performance indicators for each of the main types of treatment, and by March 2004 we will have in each raised the standards of all to the level of the top 25%.

153	All DATs to set maximum waiting times for each type of treatment to achieve the performance of the top 25% by 2002.
154	At least 30% of GPs to be offering services through a shared care scheme by 31 March 2003
155	Levels of drug misuse related deaths to have fallen by 20% by 31 March 2004.
156	By March 2002 a baseline for monitoring all drug misuse related deaths will have been established and a baseline for monitoring numbers in treatment who reduce injecting and sharing by 2001/02. An action plan to reduce drug misuse related deaths will have been implemented by 31 March 2002 and levels of drug related deaths to have fallen by 20% by 31 March 2004.
	Reduce conception rates among under 18s and reduce teenage parents' risk of social exclusion
157	By achieving agreed local conception reduction targets, to reduce the national under 18 conception rate by 15% by 2004 and 50% by 2010, while reducing the level of inequality in rates between the worst fifth of wards and the average by at least a quarter.
	Increase the range and scope of smoking cessation services, including the provision of pharmacotherapies, targeting especially manual groups.
158	To reduce the proportion of women who smoke during pregnancy from 23 to 15 per cent by 2010 (55,000 fewer), with a fall to 18% by 2005
159	To reduce prevalence of smoking among adults from 28 to 24 per cent by 2010, with a fall to 26% by 2005
160	To reduce inequalities by reducing prevalence of smoking among manual groups from 32 to 26 per cent by 2010
161	Further expansion of high quality smoking cessation services to deliver at least 60,000 smokers quitting at the four week stage (in 2002/03)
162	Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy (in 2002/03 and beyond)
163	Develop services to target and meet the needs of smokers from manual socio-economic groups (in 2002/03 and beyond
164	By 2002, Trained healthcare professionals in every PCT to support smokers wishing to quit.
	Improve NHS access for all by placing health inequalities in the main stream of the service
165	Introduce 200 more Personal Medical Schemes in disadvantaged communities by 2004
	Address root causes of inequalities by fostering new partnerships across Government
166	Establish a Healthy Communities Collaborative by 2002
167	NHS playing a full part in DETR-led National Strategy for Neighbourhood Renewal by developing Local Strategic Partnerships (including HAZs) in the medium term by 2003

168	Extend expert patients programme by 2004
	Reduce levels of obesity and increase physical activity, especially amongst the less well off.
169	Local actions to tackle obesity and physical inactivity, focused on obese and inactive in disadvantaged communities, by 2004
170	Develop local HA/PCT level programme of effective policies on promoting healthy eating, increasing physical activity and reducing overweight and obesity by 2001 with quantitative data by 2002
171	Agree local targets to increase physical activity levels and reduce obesity/overweight levels by 2004 Local initiatives implemented across agencies to increase activity and reduce overweight/obesity levels by 2004
	Increase fruit and vegetable consumption
172	Promote uptake of National School Fruit Scheme in all potential applicant schools by 2004
173	Agree local targets to increase fruit and vegetable consumption: Five a day community initiatives implemented in all HAs/PCTs by 2004
174	Agree local action to increase support for breastfeeding by 2004: Promote local programmes to support breastfeeding by 2004
	Improve access to screening
175	Part of screening programmes for women and children, by 2004 (lead Children's Task Force)
	Improve the health of the nation and reduce inequalities
176	Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole.
177	Starting with HAs, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole.
178	To reduce the death rate from accidents by at least 20% and to reduce the rate of serious injury by at least 10% by 2010
179	By 2003 70% of 5 year old children should have had no dental caries experience and, on average, 5 year-old children should have no more than one decayed, missing or filled primary tooth
180	Implement Sexual health and HIV strategy (when published) by 2004

Mental Health

181	From 2000, Health Improvement Programmes should demonstrate linkages between NHS organisations and partners to promote mental health and to combat discrimination and social exclusion of people with mental health problems.

182	By March 2002, the written care plan for those people on enhanced CPA must show plans to secure and/or sustain suitable employment or other occupational activity, adequate housing and their appropriate entitlement to welfare benefits.
183	By March 2002, develop & agree evidence-based mental health promotion strategy based on local needs assessment
184	By March 2002, build into local mental health promotion strategies action to reduce discrimination
185	By March 2002, Implement strategy to promote employment of people with MH problems within health & social services
186	By April 2004, ensure all people on CPA have housing, employment, welfare needs regularly reviewed.
187	All mental health services must be planned and implemented in partnership with local communities, including the specific needs of local black and minority ethnic communities, and involve service users and carers.
	Primary Care and Access **Any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed; and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.** **Any individual with a common mental health problem should be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care and be able to use NHS direct**
188	By March 2004, 1,000 new graduate primary care mental health workers, trained in brief therapy techniques of proven effectiveness, employed to help GPs manage and treat common mental health problems in all age groups, including children.
189	By March 2004, 500 more community mental health staff employed to work with general practitioners and primary care teams, with NHS Direct, and with each A&E department to respond to people who need immediate help.
190	By 2004, 300,000 people to receive extra help from the new primary care mental health workers, and around 500,000 people will benefit from additional mental health staff working in frontline settings.
191	By December 2001, Prescribing rates of antidepressants, antipsychotics and benzodiazepines monitored and reviewed within local clinical audit programme.
192	Timely access to specialist assessment and treatment; and action implemented to tackle delays
193	Protocols on emergency access agreed and implemented across local health and social care communities within health improvement programmes
194	A&E departments have liaison arrangements - specialist nurse or other evidence-based approach
195	NHS Direct contacts reported directly to corresponding CPA information system
196	Duty doctor, Section 12 approved, and approved social worker always available for mental health emergencies
197	By March 2002, Protocols between primary care and specialist mental health services for the management of: depression and post-natal depression; anxiety disorders; schizophrenia; those requiring psychological therapies; and drug and alcohol dependence, are agreed, implemented, and reviewed to ensure they are being used and operating effectively.

198	By March 2002, Information about treatment and services is available for all people presenting in primary care with mental health problems, including information about access to local self-help groups and support services such as housing and employment.
199	By April 2004, develop training in mental health for all primary care staff
200	By October 2004, support development of mental illness registers in primary care
201	All services should be sensitive to cultural needs, including the needs of people from black and minority ethnic communities.
	Effective Services for people with severe mental illness. **All mental health service users on CPA should receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk; have a copy of a written care plan which includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator, advises their GP how they should respond if the service user needs additional help and is regularly reviewed by their care co-ordinator; and is regularly reviewed by their care co-ordinator.** **Each service user who is assessed as requiring a period of care away from their home should have timely access to an appropriate hospital bed or alternative bed or place, which is in the least restrictive environment consistent with the need to protect them and the public and as close to home as possible, and copy of a written after care.**
202	By April 2000, Local health and social care communities need to ensure that care management and CPA are integrated and implemented systematically for all individuals in contact with specialist health and social care services
203	Mental health services should ensure timely access to an effective place of safety, such as an acute hospital or alternative bed or place, which is in the least restrictive environment, and is as close to home as possible, if care away from home is needed when a crisis occurs.
204	By 2003, Assertive outreach services available to the estimated 20,000 people who need it.
205	By 2004, all people in contact with specialist mental health services will be able to access crisis resolution services at any time.
206	By 2004, all prisoners with severe mental illness must be in receipt of treatment, and no prisoners with serious mental illness must leave prison without a care plan and a care co-ordinator.
207	By 2004, up to 400 patients moved from high secure hospitals to more appropriate accommodation.
208	By December 2003, 50 assertive outreach teams established, in addition to the 170 teams already in place.
209	300 staff employed to provide prison in-reach services, 60 of which to be employed by March 2002.
210	By March 2004, 50 early intervention teams established to provide treatment and active support in the community to young people with psychosis and their families.
211	By March 2004, All young people who experience a first episode of psychosis, such as schizophrenia, must receive the early and intensive support they need. This will benefit 7,500 young people each year.

212	By March 2004, 335 crisis resolution teams established to respond quickly to people in crisis at any time.
213	By March 2004, 400 additional community staff to provide intensive support when patients in high secure hospitals are eventually discharged.
214	By March 2004, An additional 140 new secure places and 75 specialist rehabilitation hostel places will have been provided for people with severe personality disorder, employing almost 400 extra staff.
215	By March 2004, 200 more long-term secure beds to allow patients to move on from high secure hospitals, 40 of which to be provided by March 2002.
216	An annual review is conducted of the appropriateness of bed use and recommendations are implemented.
217	Full integration of health and social services into a single management CMHT structure.
218	All service users assessed as requiring rehabilitation receive access to education, training, occupational and social care support, including supported accommodation.
219	Arrangements in place for assessment and access to services for those coming into contact with the criminal justice system
220	Waiting times monitored for referral for psychological therapies and action implemented to tackle delays
221	Using clinical guidelines, all service users should be assessed for and receive new antipsychotics where indicated.
222	Using the framework of the National Bed Inquiry, local communities have reviewed the shortfalls and pressures across local beds and places, including the independent sector: use of high secure beds; use of medium secure beds; availability of intensive care places; local acute beds; crisis and refuge places; 24 hour staffed places; and hostel places and other supported residential places and prioritised investment to overcome service shortfalls.
223	Local health and social care communities achieving more effective use of mental health beds and places, including reducing bed occupancy rates where these exceed 95%
224	By 2004, steady reduction of inappropriate out of area treatments to zero.
225	By March 2002, reduce the national emergency psychiatric readmission rate to 12.3%.
226	By March 2002, all specialist mental health service users on CPA should have a written care plan, available to staff providing care to users at the time and place required to provide appropriate and effective care, which includes: the action to be taken in a crisis by the service user, the carer and the care co-ordinator; advises the GP of the response required if the service user needs additional help; is regularly reviewed by the care co-ordinator; and informs the service user how to access services 24 hours a day, 365 days a year.
227	Care co-ordinators need to ensure that care plans are reviewed at a frequency which reflects assessments made of the risks identified for individuals.
228	By March 2002, all patients discharged from inpatient care have a written care plan at the time of discharge.
229	By March 2002, each health authority must have identified all clients who require the assertive outreach approach, and prepared plans for a further 50 assertive outreach teams to ensure that all clients who need this approach will be in receipt

	of such services by 2003.
230	By March 2004, women-only services available in all health authorities.
	Caring about Carers. **All individuals who provide regular and substantial care for a person on CPA should have an assessment of their caring, physical and mental health needs and should have their own written care plan which is given to them and implemented in discussion with them.**
231	By March 2004, 700 more staff employed to increase the breaks available for carers, and to strengthen carer support networks, such that around 165,000 carers will be receiving they need to continue to provide care.
232	By April 2002, Carers and users involved in development of Mental Health Local Implementation Plans (MHLIPs).
233	By April 2004, Carers have seen and had explained to them the care plan of the person for whom they provide care, and understand the nature of their illness.
234	By March 2002, all regular carers of people on enhanced CPA have their own written care plan which addresses their caring, physical and own mental health needs. This includes children caring for mentally ill parents.
235	By 2002, strategies and arrangements agreed with local child protection agencies to support child carers.
	Preventing Suicides. Local health and social care communities should prevent suicides by promoting mental health for all, working with individuals and communities; delivering high quality primary mental health care; ensuring anyone with a mental health problem can contact local services via the primary care team, a helpline or an A&E department; ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services around the clock; providing safe hospital accommodation for individuals who need it; enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care. In addition, support local prison staff in preventing suicides among prisoners; ensure that staff are competent to assess.
236	Local health and social care communities should establish a network of specialist mental health helplines and other services, in time linked to NHS Direct, to provide round the clock advice and help for those in mental health distress.
237	Mental health services should develop and implement protocols to ensure that people who have self-harmed receive a specialised psychological assessment prior to discharge from A&E.
238	By March 2002, support local prison staff in preventing suicide among prisoners.
239	By 2010, reduce the mortality rate for suicide and undetermined injury by at least 20%.
240	By March 2002, review physical environment in inpatient settings and make necessary changes to reduce access to means of suicide.

241	Maternity services working with health visitors develop and implement protocols for assessment and management of mental health during pregnancy and after delivery.
242	Care plans to provide point of access for carers in a crisis.
243	A&E Departments develop and implement protocols for those who present with self-harm.
244	Local health and social care communities, working with their consortia, meet the training and educational needs for risk assessment and management in relevant staff groups including primary care, A&E midwives, as well as the mental health teams.
245	By March 2002, develop local systems for suicide audit to learn lessons and take any necessary action.
246	By March 2002, all patients with a current or recent history of severe under the Mental Health mental illness and/or deliberate self-harm, and in particular those who at some time during their admission were detained Act because of a high risk of suicide, must be followed up by a face to face contact with a mental health professional within 7 days of discharge from inpatient hospital care.
247	By March 2002, every health authority and local council must have multi-agency protocols agreed and operational for the sharing of information relevant to reducing risk of serious harm to self or others. **Underpinning Programmes**
248	To ensure that mental health and social care provision can be properly integrated locally, statutory powers will be taken to permit the establishment of combined mental health and social care trusts.
249	All relevant agencies must have in place computerised information systems for CPA and Care Management as set out in Effective Care Co-ordination in Severe Mental Illness, available to staff providing care to users at the time and place required to provide appropriate and effective care.
250	All NHS Trusts providing specialist mental health services should have a project plan for implementation of the MHMDS in place and registered with the Department of Health MHMDS implementation team, with plans for assembly of the data set to achieve full implementation as required by April 2003.
251	Clinical governance development plans and annual reports should be produced as set out in guidance HSC 99/065
252	By November 2001, a review of local workforce issues to identify pressures and priorities, including the action needed to match workforce to local community.
253	By November 2001, a retention strategy including measures to tackle stress and improve working conditions, and provide proper supervision and appraisal
254	By November 2001, an education and training plan which encompasses recruitment to training grades, continuing professional development, clinical skill acquisition, lifelong learning and team development

255	To achieve a whole systems approach, all relevant agencies must ensure arrangements for both of the following are adequate and effective: transition of service users' care between child and adolescent services and adult services; and transition of service users' care between adult services and services for older people.
256	By November 2001, each LIT must have signed off by the relevant NHS and Social Care Regional Office their Stage 3 plan for implementing the MHNSF, and the mental health targets in the NHS Plan. Each health authority must reflect the LIT plans in their planning for 2002/03 and beyond.

Older People

	Assure standards of care
257	By 2007, eliminate arbitrary policies based on age; audit of all age related policies complete by 2002, councils to have reviewed eligibility criteria to ensure no ageism by 2003 (NSF)
258	Single assessment process across Health and Social Care introduced by 2002
259	Analysis of levels and patterns of key intervention will have been carried out to establish best practice benchmarks by Oct 2002; from 03/04 health systems can demonstrate year on year improvements towards benchmarked intervention rates
260	Skills profile of staff caring for older people completed, and plans to address gaps by 2004
261	Strategic and operational plans will include the development of an integrated mental health service for older people by April 2005
262	GPs following agreed protocols to diagnose, treat and care for older people who are suffering from dementia by April 2005
263	Systems to explore user and care experience in PCTs by April 2004
	Stroke services
264	Every general hospital which cares for people with Stroke, will have plans to introduce a specialist stroke unit by from 2004, and clinical audit systems to ensure delivery of the RCP clinical guidelines for stroke care by 2004
265	GP practices using agreed protocols will be identifying, treating and managing patients at risk of stroke, and also patients who have had a stroke by April 2004
266	All hospitals will have a "one stop dispensing/dispensing for discharge" schemes by April 2002
267	GP practices will be using agreed protocols for rapid referral of patients with TIAs to local specialist services by April 2004
268	GP practices will have established clinical audit systems for Stroke by April 2004
	Extend access to services
269	PCTs will have in place schemes so that older people get more help from pharmacists in using their medicines by April 2005
270	Establish Care Direct Service for older people

	Promote independence
271	Strategic and operational plans will include the development of an integrated continence service by March 2004
272	1,700 extra supported intermediate care places. NHS and social services work together to ensure:
273	By March 2002, 1500 additional intermediate care beds compared with 99/00 baseline; and 5000 (& 1700 additional non-residential intermediate care place) by March 2004
274	By March 2002, 40000 additional people receiving rehab intermediate care services, and 20000 receiving preventative intermediate care services, as compared to 99/00 baseline; and a total of 150000 additional people benefiting by March 2004
275	70000 additional people receiving intermediate care to prevent unnecessary hospital admission by 2004
276	50,000 more people living independently at home, by 2004
	Reduce preventable hospitalisation of older people
277	Keep the year on year growth in emergency admission of people over 75 to under 2%; as part of the target to provide high quality pre-admission and rehabilitation care to older people to help them live as independently as possible by reducing preventable hospitalisation and ensuring year-on-year reductions in delays in moving people over 75 on from hospital
278	Ensure every patient has a discharge plan by 2004
279	End widespread bed blocking, by 2004
280	Year-on-year, reduce delays in moving people over 75 on from hospital, as part of the Public Service Agreement target to provide high quality pre-admission and rehabilitation care to older people to help them live as independently as possible by reducing preventable hospitalisation and ensuring year-on-year reductions in delays in moving people over 75 on from hospital.
281	Risk management procedures in place for all providers of health and social care to reduce risk of older people falling by 2004, and integrated strategic and operational plans in place from 2004, and integrated falls services by April 2005
	Help older people to stay healthy
282	People 75 and over will have an annual review of medicine and those with 4 or more medicines will be reviewed 6 monthly by April 2002
283	Local Health systems can demonstrate year on year improvement in health and well-being of older people; strategic and operational plans in place to promote healthy ageing, by 2004
	Develop links between health and social services
284	Systems in place in NHS/PSS exploring user/carer experience, including systems to analyse complaints by 2004
285	Single integrated community equipment services in place by April 2004
286	Integrated continence services will be in place by April 2004
287	Protocols in place across Health and Social Care systems for the care and management of older people with mental health

	problems by April 2005
288	Every health authority and local council must continue to work with their local independent sector providers to determine what nursing and residential beds are needed in the future, subject to securing the right levels of quality and value for money

Quality & Patient Satisfaction

	Improving patient and public representation
289	Patient Surveys - to be carried out in line with forthcoming guidance in NHS trusts (2001-2), and PCTs (2002-3). All NHS and primary care trusts to publish the action taken in response to patients' views in a Patient Prospectus during 2002-3.
290	Patients represented throughout NHS - through Independent Local Advisory Forum (ILAF) by March 2003 (Health Authorities to set up ILAFs by 2002)
291	Patient Advice and Liaison Service (PALS) - by April 2002 every NHS and primary care trust to set up a local Patient Advice and Liaison Service (PALS)
292	Overview and Scrutiny Committees - all NHS organisations to provide information about their activities to local authority Overview and Scrutiny Committees, in accordance with forthcoming regulations.
	Improving clinical quality across primary and secondary care
293	Each NHS organisation to fulfill its statutory duty of quality, by putting and keeping in place arrangements for continuously monitoring and improving the quality of health care it provides.
294	Clinical Governance - all NHS organisations to complete, implement and update clinical governance development plans, and report on clinical governance within Annual Reports, as set out in HSC 1999/065 for previous year.
295	Clinical Governance - service modernisation sessions ("protected time") - clinical governance development plans to include systems and programmes to ensure staff participation in clinical governance.
296	NICE guidance - NHS organisations to demonstrate implementation of guidance issued by National Institute for Clinical Excellence - see http://www.nice.nhs.uk
297	Mental Health National Service Framework - implement milestones set out in the NSF and NHS Plans plan (as listed in the Mental Health section of LMR targets) to demonstrate that services are effective, dependable and safe.
298	Coronary Heart Disease National Service Framework - implement milestones set out in the NSF (as listed in the CHD section of LMR targets) to demonstrate that services are effective, dependable and safe.
299	Older People National Service Framework - implement milestones set out in the NSF (as in Older People section of LMR targets) to demonstrate that services are effective, dependable and safe.

300	NHS Cancer Plan - implement milestones set out in the NHS Cancer Plan (as in Cancer section of LMR targets) to demonstrate that services are effective, dependable and safe.
301	Forthcoming National Service Frameworks - once published, implement milestones set out in forthcoming NSFs, including those for Diabetes, Children and Renal services to demonstrate that services are effective, dependable and safe.
302	Commission for Health Improvement (CHI) - all NHS organisations which have been the subject of a CHI clinical governance review or investigation to be implementing an action plan agreed with the CHI and the Regional Office.
303	Consent - all PCTs have implemented a consent policy in line with guidance contained within HSC 2001/023.
304	Learning from adverse events - to implement "An organisation with a memory" and "Building a safer NHS for patients": 60% of NHS trusts to be in a position to provide information to the national adverse event reporting system; all NHS trusts to be working towards this goal; by December 2001. All NHS trusts and a significant proportion of primary care to provide information to the system, with levels of reporting doubled by December 2002
305	Deliver the four specific targets identified in "An organisation with a memory" :(i) reduce to zero the number of patients dying or being paralysed by maladministered spinal injections; by end 2001 - guidance on intrathecal injections to be released later in 2001; (ii) reduce to zero the number of suicides by mental health inpatients as a result of hanging from non-collapsible bed or shower curtain rails on wards; by March 2002; (iii) reduce by 25% the number of instances of negligent harm in the field of obstetrics and gynaecology which result in litigation; by end 2005; and (iv) reduce by 40% the number of errors in the use of prescribed drugs; by end 2005
306	Research Governance - ensure that the Research Governance Framework is applied according to the Implementation Plan; NHS organisations must ensure that a senior manager is aware of all current research going on in their organisation, that all active research has received ethics committee approval where necessary and that procedures are in place to obtain informed consent from patients who take part in research; by May 2001 **Improve patient satisfaction**
307	To secure year-on-year improvements in patient satisfaction, including standards of cleanliness and food, as measured by independently audited local surveys
	Better quality environment
308	Clean hospitals - there will be no "red" hospitals by Autumn 2001. From 2002 onwards, the target is to achieve improvements as measured by independently audited surveys.
309	Better quality food - hospitals will have introduced the new NHS menu (including the use of the menu format, the introduction of leading chefs' dishes, and a 24 hour service); by December 2001 From 2002, we are setting targets for further improvements in hospital food including the introduction of hot meals throughout the 24-hour period, and the further use of leading chefs' dishes and the national dish selector. We will also be

	looking to see continued improvements in patient satisfaction, as with cleaning.
310	Ward Housekeepers - all hospitals will have a plan, supported by sufficient resources, to introduce ward housekeepers by June 2001, with hospitals having introduced services by December 2004. From 2002 onwards, we will be developing the housekeeper service further. This will include setting interim targets for introducing the service.
311	Single sex accommodation - 95% of NHS trusts to have eliminated mixed sex accommodation; by December 2002
	More and better information for patients
312	Letters copied to patients - all trusts will have made progress towards letters between clinicians about an individual patient's care being copied to the patient as of right

Workforce

	Increasing staff numbers
313	20,000 more nurses by 2004
314	2,000 more general practitioners by 2004
315	7,500 more consultants by 2004
316	1,000 more specialist registrars being trained by 2004
317	550 extra GP registrars by 2004
318	6,500 more AHPs by 2004
319	5,500 extra nursing training places by 2004
320	4,450 extra AHP training places by 2004
	Improving working lives
321	NHS employers accredited for new Improving Working Lives standard by 2003 (Pledge by 2001) and assessed on performance targets
322	Increasing availability of affordable accommodation in London, South East and surrounding areas with high property values within 3 years
323	Improved childcare provision, on-site staff subsidised nurseries in around 100 hospitals, by 2004. Childcare co-ordinator available to all parents by 2003. All new NHS hospitals to build on-site nursery and child care facilities into their new plans
324	Extension of Occupational Health Services to GPs and their staff (£6m in 2001/02, £8m in 2003/04), by 2004

	Modernising pay, contracts and pay-related incentives
325	Bonus payments from the National Performance Fund from 2001
326	Expansion of Personal Medical Services contract to one third of GPs by 2002
327	Consultant Appraisals linked to 5 yearly revalidation
328	Working Time Directive for Junior Doctors
329	Shared Services on HR and Payroll system implementation
	Modernising education, training and development
330	All staff who do not have a professional qualification to have access to Individual Learning Accounts/NVQ's by 2003
331	Review systems for continuing professional development (CPD), and target extra investment
	New ways of working
332	Assistant practitioners in radiography: diagnostic radiography from 2002
333	Every hospital to have 'senior sisters and charge nurses' who are easily identifiable to patients and who will be accountable for a group of wards, by 2002
334	Specialist GPs - 1000 in place by 2004
335	1,000 additional nurse consultants by 2004
336	Majority of NHS staff working under agreed protocols by 2004
337	Midwives to work with doctors and nurses in developing maternity and child health services

APPENDIX 2

Clinical Governance Strategy

Action Plan

9.2 Objectives

		POSITION AT 31.4.02	2002/2003 OBJECTIVES	2003 ONWARDS	LEAD
9.2	**TECHNICAL COMPONENT**				
9.2.1	**Consultation and public involvement**	• Trust has begun to formalise patient consultation and involvement through: • Formation of Patients' Panel • Basic PALS • Patient surveys	• More fully develop the Patients' Panel. • Develop more robust consultation methods for those patients/carers who are disadvantaged, for example through disability or race. • Develop fully the PALS service and provide training for staff • Have a systematic approach to the use of patient satisfaction surveys for the development and monitoring of services.	• Develop a consultation process for service development as a result of the SOC • Produce a Patient Prospectus • Ensure clinical policies, procedures and guidelines are developed with patient involvement	Denise Hagel
9.2.2	**Clinical risk management**	• Clinical Incident Reporting procedures in place • A new Clinical Risk Committee has been constituted which will monitor clinical incident reporting, receiving exception reports from the Directorates.	• Undertake Trust-wide clinical risk assessment as a baseline to action plan and prioritise • Monitor the reporting of incidents and near misses to identify trends. • Improve its method of exception reporting to the Clinical Risk Committee	• Review clinical incidents and adherence to policies and procedures • Encourage and demonstrate a "no fault" culture • Improve clinical incident reporting for near misses by 10% year on year	Paul Kitchen
9.2.3	**Clinical audit**	• Clinical audit department has	• Reconstitute the Clinical Audit Committee	• Provide clinical audit training for	Paul Kitchen

		POSITION AT 31.4.02	2002/2003 OBJECTIVES	2003 ONWARDS	LEAD
		produced a prioritised programme of clinical audit. • This remains reactive to local audit activity. • Some robust mechanisms for sharing learning from clinical audit, through clinical audit half days.	• Audit compliance with policies, procedures and guidelines (including national guidance and National Service Frameworks)	multidisciplinary teams • Monitor clinical audit activity and participation and take remedial action where necessary	
9.2.4	**Research and effectiveness**	• Robust research and development system in place. • Clinical effectiveness systems require development. • Multidisciplinary team working requires further development • Communication and involvement of front line staff in Trust business decisions needs further development	• Develop robust and co-ordinated systems to review, identify implications and implementation of national guidelines, accreditation and external body reports • Develop a mechanism for reporting and monitoring clinical effectiveness • Identify 5 areas for development of integrated care pathways • Identify the blocks to good communication with staff and benchmark other areas	• Ensure clinical data is accurate, fit for purpose and accessible to clinicians • Provide IT hardware and link clinical data systems; provide training for staff regarding its use and inputting data • Quality standards are benchmarked • Develop close working relationships with PCO to improve the patient journey • Develop multidisciplinary integrated care pathways for 5 high risk areas • Develop robust communication systems	Bill Shields,and Paul Kitchen Denise Hagel David Walsh David Walsh Mike Pollard
9.2.5	**Use of information about the patients' experience**	• The Trust has a Customer Satisfaction Co-ordinator who does some	• More co-ordinated approach is necessary with inception of Trustwide continuous	• Benchmark against other Trusts, eg using Essence of Care • Develop a programme	Denise Hagel

		POSITION AT 31.4.02	2002/2003 OBJECTIVES	2003 ONWARDS	LEAD
		satisfaction exercises which develop and change practice, but this is not co-ordinated and part of a managed programme	patient feedback after admission • Develop the PALS. • Further develop Patients' Panel • Ensure feedback loop for learning from complaints and action taken	with other departments, such as clinical audit • Ensure that this is integral to all service developments	
9.2.6	**Staffing and staff management**	• The Trust suffers some recruitment and retention problems in certain areas of the Trust • Not all staff have appraisals	• All staff to have annual appraisals and personal development plan • Ensure that all staff work as a team within their areas, regardless of their employer • External contractors awareness/compliance to Trust's philosophy monitored	• Monitor areas of poor recruitment and retention and ensure that leavers are interviewed in areas where retention is poor • To be proactive in recruitment and retention methods	John Kitson David Walsh
9.2.7	**Education, training and continuing personal and professional development**	• Staff are encouraged to undertake further education but there are anomalies to access at present • Frontline staff do not have easy access to the internet and learning sites	• Developed a system to monitor the equity of access to education and training • Ensure there is hardware and software support to all wards/departments allowing access to the intranet and internet.	• There is a robust education and training register within the Trust to which Managers have access	John Kitson
9.3	**ORGANISATIONAL COMPONENTS**				
9.3.1	**Organisational leadership**	• Senior Management objectives aligned with performance targets, but these have not been quantified in	• Clear quality performance objectives to be set for senior managers	• All staff will have quality objectives within their appraisals • Promote and adhere to the principles of	Chief Executive, and Executive Directors

		POSITION AT 31.4.02	2002/2003 OBJECTIVES	2003 ONWARDS	LEAD
		quality terms, as yet • Empowerment and leadership courses have been provided across the Trust at middle management level		empowerment	
9.3.2	**Direction and planning**	• The Trust has not had an inclusive business planning process to inform SAFF negotiations	• Business planning to be undertaken in sufficient time to allow information to be utilised to inform SAFF process	• Appraisal objectives should reflect corporate objectives identified in the business planning process	David Walsh
9.3.3	**Performance review**	• Performance review focuses primarily on activity and finance. Quality assessment sporadic • Not all staff have any appraisals/performance review. There are pockets of good practice and some supervision in clinical areas but it is not a Trust-wide system.	• Quality performance data to be added to Trust Board reports. • All staff to be fully aware of how to identify and inform management if practice falls below acceptable standards • Benchmark data to be used to identify areas of good and poor practice and action plans to be developed	• Refine clinical/quality reporting suite to Trust Board • All staff to have annual appraisals	Paul Kitchen & Denise Hagel John Kitson Denise Hagel & Paul Kitchen
9.3.4	**Patient and public partnership**	• See section 9.2.1 and 9.2.5	• See section 9.2.1 and 9.2.5	• See section 9.2.1 and 9.2.5	Denise Hagel
9.4	**DIMENSIONS OF PATIENTS' EXPERIENCE**				
9.4.1	**Clinical effectiveness**	• See section 9.2.4	• See section 9.2.4	• See section 9.2.4	Denise Hagel & Paul Kitchen
9.4.2	**Access to services**	• The Trust has had to cancel a number of elective admissions	• To identify the primary causes for the high usage and manage the	• To reduce the number of cancelled appointments aiming for only one	Denise Hagel

		POSITION AT 31.4.02	2002/2003 OBJECTIVES	2003 ONWARDS	LEAD
		due to high level of emergency activity	services accordingly	cancellation if necessary	
9.4.3	**Organisation of care**	• Audits of patient records have demonstrated that record keeping skills are of variable quality. • Clear care plans are not being developed for all patients.	• Ensure that all clinicians keep detailed, accurate and timely patient records • Encourage multidisciplinary care planning	• Develop a remedial training package for those clinicians who do not keep detailed and accurate patient records and monitor progress	Denise Hagel & Paul Kitchen
9.4.4	**Humanity of care**	• Most practitioners involve patients and users in the planning and delivery of the care provided, but this is not the case across the Trust • Services are still not patient centered in all areas • Audit of patient leaflets and database being compiled • Patients dietetic needs are not always met • Throughout the Trust there are varying levels of compliance with adherence to confidentiality	• Communication and customer care skills training to be given to ancillary and administrative staff • Patient information leaflets to be audited and a database compiled • Recruitment of a Patient Information Officer to assist with development of leaflets and patient information • Patients and carers to be involved in development of leaflets and information. • Ensure that specific dietetic requirements are met in a timely manner • Some of the bathrooms in wards are being used as storage areas – these	• Communication and customer care skills to be core at induction for all staff and training to be given to all existing staff • All main procedures undertaken will have a patient information leaflet identifying benefits, risks and alternatives to treatment. • Ensure systems in place to maintain patient's confidentiality • Freedom for Information Act is adhered to and staff have had training about it's implications	Denise Hagel Bill Shields David Walsh

		POSITION AT 31.4.02	2002/2003 OBJECTIVES	2003 ONWARDS	LEAD
			should revert to their original purpose and other storage facilities provided		
9.4.5	**Environment**	• The hospital environment has improved and the patients have given more positive feedback in surveys, eg National Patient Survey. • Not all staff feel that the Hospital environment is their area of concern	• Develop a system to ensure consistently high standard of hotel and support services • Ensure that clinical practice and the environment conform to infection control standards and H & S requirements	• Develop an ethos of belonging for all staff so that they tackle environmental issues where possible and report exceptions to standards at the earliest opportunity	David Walsh, Paul Kitchen & John Kitson

APPENDIX 3

IM&T Strategy

Action Plan

IIM&T Strategy - ACTION PLAN

Source	Action	Responsibility	Timescales
Support			
Programme Support • Programme Mgt • IM&T Resources • Staff IM&T Training • Comms. Plan	Set up Programme Support arrangements	IM&T Steering Group	Complete by 31st August 2002
NHS Plan			
Cancer NSF	Review "Towards a Cancer Information Strategy' and work of ERDIP Demonstrator (Camden & Islington/Wirral)	Directorate Manager LIS Co-ordinator	30th Sept 2002
CHD NSF	Review ' Coronary Heart Disease Information Strategy' and work of ERDIP Demonstrator (S&W Devon) and produce action plan for ER elements of LIS project	Directorate Manager LIS Co-ordinator	30th Sept 2002
Older people NSF	Review ' Information Strategy for Older People in England' and work of ERDIP Demonstrator (West Surrey) and produce action plan for ER elements of LIS project	Directorate Manager LIS Co-ordinator	30th Sept 2002
Diabetes NSF	Review 'Diabetes Information Strategy' and work of ERDIP Demonstrator (Cornwall) and produce action plan for ER elements of LIS project	Directorate Manager LIS Co-ordinator	30th Sept 2002
Projects			
Infrastructure development (Clinician Connect)	Provide all clinicians with connection to NHSnet according to LIS targets. Implement Trust Hardware improvements	ESSA F&P Directorate	March 2003 July 2002
Communications (Website/Intranet)	• Produce Feasibility Report, Project Brief and PID	F&P Directorate Library Services Communications	FR - Sept 2002 PB - Nov 2002 PID - Mar 2003

Document Management (Storage Strategy Project)	Produce feasibility report, Project Brief and PID	Library Services IM&T Steering Group	FR - Sept 2002 PB - Nov 2002 PID - Mar 2003
Knowledge Mobilisation	Produce feasibility report, Project Brief and PID	Library Services	FR - Sept 2002 PB - Nov 2002 PID - Mar 2003
Process & Information Requirements Analysis	Produce feasibility report, Project Brief and PID	F&P Directorate	Dependent upon Service Re-Design
EPR	Appoint Project Manager	F&P Directorate	August 2002
24 Hour PAS	Appoint Personnel	Medicine Directorate	June 2002
Patient Tracking - Non A&E	Target major A&E recipients for Barcode readers and Network points Roll out in all other wards	Medicine Directorate All Directorates	October 2002 June 2003
PAS letters	Upgrade of software system, rewrite of PAS letters and training for relevant staff	F&P Directorate	December 2002
Radiology Information System	Purchase and install system	Radiology Dept	March 2003
A&E Dept Patient Tracking System	Upgrade of A&E software system and training for relevant staff	Medicine Directorate	October 2002
Tracking System for Sterile Services	Full roll out of hardware, software and training	OPTIMA Directorate	October 2002
Pathology System	Full roll out of hardware, software PAS interfaces and training	Pathology Manager	March 2003
Blood Product Tracking System	Full roll out of hardware, software and training	Pathology Manager	March 2003
Theatre System	Full roll out of hardware, software and training	OPTIMA Directorate	March 2003

APPENDIX 4

Supplies Strategy Review

2002/2003

SUPPLY STRATEGY REVIEW – 2002/3

1.0 INTRODUCTION

This paper reviews the existing Supply Strategy Document of Essex Rivers Healthcare Trust (ERHT), and identifies those areas that require improvement and commitment at all levels within the Trust to ensure that expenditure on goods, services and capital equipment is subject to best procurement practice, value for money and procured via an efficient supply chain.

2.0 BACKGROUND

The Supply Strategy Document was produced by Mr David Herd and presented to the Board and approved on 3rd April 2000. This strategy followed a template of core objectives established from the Audit Commission's Report *Goods for your Health*; and the HSC 1999/143, *Review of NHS Procurement*.

3.0 SUPPLIES STRATEGY

The initial agenda within the Supply Strategy identified 6 key supply chain areas and action points within those areas. This review summarises progress to date on the action points and also highlights additional areas that need to be addressed.

4.0 SUPPLY CHAIN AREAS

4.1 SELECTION – choosing the right goods.

The planning and evaluation of major items and contracts needs to be improved. The existing system is sufficiently robust to ensure compliance with SFIs and public procurement regulations. Procedures need to be established and introduced to ensure that full financial, technical and clinical evaluations are carried out and recorded accurately and that each tender exercise and contract renewal is carried out in a timely manner to ensure adequate time and resources can be allocated to the project. It is recommended that as part of the financial evaluation existing costs be taken into consideration to identify any savings that can be achieved from the exercise.

The EBME department keeps records of all major medical equipment within ERHT and has highlighted equipment that is in need of replacement. An equipment replacement policy is not in place and should be considered.

The standardisation and rationalisation of consumables and equipment is an ongoing exercise with considerable input from the Clinical Products Review Group and the EBME department. ERHT has recently awarded a contract for laboratory consumables which demonstrates how contracts can be standardised, is in the process of awarding a contract that will rationalise the type and range of stationery and printer consumables available, and is also looking at the range of uniform supplies available. The appointment of the Supplies Project Manager has helped to identify additional areas for consideration.

The Trust is aware of the environmental impact its actions may have and where relevant asks contractors to ensure adherence to NHS Environmental policies. All purchases placed via NHS Logistics or using the NHS Purchasing and Supply Agency (PASA) contracts are done so in the knowledge that these suppliers and products are compliant with regard to environmental issues. The Trust is currently working with

NHS Logistics to replace cardboard packaging and introduce re-useable plastic tote boxes instead as well as switching from original to compatible printer consumables, which is not only more environmentally friendly but also more cost effective. The Trust could improve the impact it has on the environment by working closer with our partners who provide out sourced services and ensure that every cost effective opportunity is taken to minimise the environmental impact of purchasing decisions made.

4.2 **PROCUREMENT** – ensuring that the goods are ordered, received and paid for in the most efficient way possible

On Line Requisitioning (OLR) continues to be rolled out to suitable areas within the Trust, this system reduces paper work and leads to a more efficient procurement process. In excess of fifty requisitioning points/cost centres are now live, with additional departments being added weekly.

The supplies department has established and maintains an electronic catalogue, which consists of over 3000 items and includes most theatre consumables and orthopaedic items. Laboratory consumables having been recently added to the system. Once items are catalogued the ordering process is simplified for the on line requisitioner. North Essex Shared Services (NESS) is currently investigating options that will provide the required functionality to enable electronic uploading of supplier catalogues into the McKeowns Integra system.

The auto faxing module within the character based McKeowns system was unworkable and with the implementation of the new McKeowns Integra system across North Essex from 1st April 2001, the auto faxing module has now been installed and the Trust is seeking access to enable a trial to commence.

Purchasing cards have been introduced within the supplies department to help address the issue of low value orders. These cards are also used to place orders over the internet and to reduce the number of cheques that need to be raised. Although the Trust continues to rationalise the supplier base wherever possible, we are currently at a level that will make continued reductions difficult.

The location of receipt points within the Trust has been reviewed with additional delivery points being established to accommodate deliveries from NHS Logistics to Gainsborough, Constable and Elmstead, this has helped to reduce the movement of goods within the Colchester General Hospital site.

The consolidation of deliveries has been addressed with delivery days being agreed with major suppliers to improve efficiency within the receipting points. The potential of all deliveries via a single carrier is being explored centrally by NHS Logistics who already deliver to the majority of health care establishments.

It is felt that the introduction of the shared services McKeowns Integra windows based system has slowed the payment process. There are however compensating benefits: For example, the new system has highlighted the need to review the existing payment procedures.

4.3 **PRICES** – achieving best possible prices for goods and services

The Trust has on line access to, and makes full use of, the NHS PASA contracts where it is cost effective to do so. Contract details are also made available to key departments and our out-sourced partners.

The existing procurement process ensures that purchases not covered by existing contracts are subject to competition in line with the Trust's SFIs.

The Trust is continuing to aggregate demand for products as demonstrated in the recent laboratory consumables tender exercise and is also working with other Trust's within North Essex to help achieve economies of scale.

The length of contracts is discussed and considered by directorates and set at a level to ensure that the Trust benefits from commitment, but retains safeguards against the complacency of contractors who have longer-term contracts.

The review of payment procedures and goods receipting procedures should help to maximise early payment discounts, the roll out of OLR and the goods receipting access at department level should also help to improve the payment cycle.

4.4 STOCK – ensuring reliable supply while minimising stock levels

All departments need to ensure that stock levels are reviewed and set at an economical level. The stock holding within materials management areas needs to be reviewed, and full use made of the stock management reports and information within the NHS Logistics Resus system. A materials management procedure needs to be established that incorporates stock reviews.

Improvements in delivery frequencies and facilities for suppliers to hold stock for calling off as and when required have been implemented. The Trust continues to explore areas where just in time services will help reduce stock holding without impacting on service provision.

Additional funding has been approved for the Pharmacy department to increase staffing levels to enable the continued roll out of materials management across the Trust.

The Trust is currently testing the stock control module within the McKeowns Integra system; this module will improve processing efficiency and help to reduce stock levels.

The roll out of the stock control module will provide the necessary reporting facilities to enable stock levels to be reviewed and monitored.

All departments must continue to review local security arrangements with regard to stock and storage areas. Advice should be sought from the Trust's security advisor to ensure risks are kept to a minimum.

4.5 USAGE – using the right amount of goods and ensuring that there is no waste

Many of the high value and high usage consumables within the Trust have been identified and been the subject of discussion by the Clinical Products Review Group. Looking at quality and cost which has resulted in standardising many products across the Trust. Other such items have been tendered or are in the process of being tendered; the appointment of the Supplies Project Manager has provided the resource to investigate high volume and high usage items in depth.

The variation of usage within the Trust has not been investigated. This area is on the agenda for the Supplies Project Manager who will report on progress to the Non Pay Review Group.

The Trust continues to share usage information with Trust's within Essex and the Eastern Region and also provides information to the Purchasing and Supply Agency for contracting purposes.

Progress on the analysis of variation will be reported to the Non Pay Review Group and relevant areas will be discussed by the Clinical Products Review Group.

Guidelines on the use of consumables and equipment needs to be reviewed. Policies and procedures produced by groups and directorates within the Trust will be pooled and assessed to identify best practice and areas that need addressing.

The equipment library continues to provide an effective pooling system for the efficient utilisation of equipment.

4.6 CONTROL - ensuring the maximum proportion of expenditure is influenced by supplies professionals

The procurement procedures within the Trust require that all goods and services should be ordered against an official order. Since the implementation of the McKeowns system official orders are only available via the Supplies Department, Pharmacy Support Unit and Orthotics Department. The SFIs require tenders for goods and services over £20,000. All tenders are registered within the Supplies Department which is increasing its input into tender exercises therefore increasing the influence that the supplies department has over non pay expenditure.

The Supplies Department staff are making full use of training provided by PASA; access to this training for Pharmacy procurement staff is being pursued.

5.0 PROPOSED ACTION AGAINST EXISTING SUPPLY CHAIN AREAS

- A formal tender process and evaluation procedure to be produced.
- An equipment replacement policy to be considered.
- Closer links with partners to ensure environmental concerns are addressed.

- Auto faxing of orders to be implemented.

- Existing payment and goods receipting procedures to be reviewed.

- Existing procurement procedures to be reviewed.

- Material management procedure to be established.

- The roll out of materials management to be completed.
- The stock control module within McKeowns to be implemented in suitable areas.

- All departments to review stock security arrangements.

- High volume and high value consumables to be reviewed and reported on.

- Variation of usage to be investigated and reported on.

- Guidance, policies and procedures, which effect the use of consumables, should be reviewed and the details made available to all users.

6.0 ADDITIONAL ACTION – Savings

It is proposed that the Trust sets a target of savings from non pay expenditure of £200,000 per annum. This target will require the full support of directorates and it must be recognised that changes to customs and practices may be required to achieve significant savings in some areas. It is vital that full co-operation is given to enable any investigation and implementation to be carried out. The approval and support of the Non Pay Review Group, Clinical Products Review Group and any other relevant group within the Trust will also be essential.

7.0 FUTURE ACTION

It is proposed that the action points identified together with on going procurement issues within the Trust identified from the recent data collection exercise completed by the audit commission and the controls assurance exercise are incorporated within a Trust procurement work plan which clearly identifies responsibilities and reporting arrangements.

APPENDIX 5

Facilities Management

Action Plan

2002/2003

FACILITIES MANAGEMENT ACTION LIST

STRATEGIC DIRECTION	OBJECTIVE	COST PRESSURES	LEAD	TARGET DATE
NHS PLAN INITIATIVES				
Cleanliness in hospitals	· Implement & maintain National Standards.	Cost pressure	ES + Carillion	
	· Implement recommendations from PEAT inspections.	Cost pressure	ES	
	· Establish regular auditing of cleaning environment.	Nil	ES	
	· Complete cleaning strategy.	Nil	ES + Carillion	
	· Implement painting programme.	Cost pressure	Carillion	
Ward Housekeeper	· Develop Ward Housekeeper role and extend to other areas of the hospital (LMR target).	Cost pressure	ES + DH	
Better Hospital Food	· Develop catering strategy	Nil	ES + Sodexho	
	· Complete implementation of snack provisions, snack boxes and chef dishes.			
	· Establish proposals for 24hr catering.			
	· Review and extend hostess services to Gainsborough Wing.	Cost pressure £50k		
	· Review and standardise ward meal times. (LMR target)	Cost pressure £50k		
	· Develop NHS menu for Patient Communication System.	Nil	ES + Sodexho	Short term charges to current menu – April 02 PCS Dec 02
	· Review beverage trolley service.	Minimal	ES + Sodexho	In Year
Patient Power	· Implement patient bedside communications systems, to include 'In House' video with information on Facilities Services.	Nil	ES + Carillion + Sodexho + Hospital Radio	April 02-March 03

STRATEGIC DIRECTION	OBJECTIVE	COST PRESSURES	LEAD	TARGET DATE
CORPORATE INITIATIVES				
Linen Services	· Review provision of linen services.		ES	
	· Address quality of product with contractor.		ES	
	· Consider delivery options from laundry to ward/department.	Cost pressure	ES + Sodexho	
	· Review and implement efficient system of stock levels in ward/department.	Cost pressure	ES + Sodexho	
	· Consider combined management of service with catering.			
Restaurant	· Draw up refurbishment proposals for restaurant facility. - Visitors/patients - Staff - Smoking areas.	Cost pressure	ES	
	· Review restaurant opening times.	Nil	ES + Sodexho	
	· Address quality & choice of food products, including branded products.	Nil	ES + Sodexho	
	- Review Jnr Drs Catering arrangements			
Car Parking	· Review visitor car parking charging.	Improved income	ES + FMG	
	· Review of car parking on ECH site.	Nil	ES	
	· Oversee allocation of car parking spaces wards 6/7 site.	Identified capital spend Short-term cost of St Mary's.	ES	
	· Provide support to Car Parking Group.	Nil	ES	
	· Provide secure bike sheds/staff changing facilities i.e. showers.	Cost pressure	ES	
	· Facilitate production of Travel Plan for ECH & CGH.		ES + DH with Capital Planning Department	
FACILITIES INITIATIVES				
Best Value Review	· Implement recommendations of BVR where appropriate.	Cost pressure	ES + Service Providers	
Accommodation	· Assist with implementing accommodation policy (Hospital Housing).	Nil	ES	
	· Rationalisation of Office Accommodation/ - Union Office.	Nil	ES + JP	

STRATEGIC DIRECTION	OBJECTIVE	COST PRESSURES	LEAD	TARGET DATE
Contract Monitoring	· Implement procedure for auditing of Facilities Management Service Contracts.	Nil	ES + Contractors & Trust staff	
	· Develop audit tools and implement auditing in line with Control of Infection Systems. - Cleaning - Catering - Linen Services	Nil	ES + Heather Dakin	
	· Establish performance indicators across all services.	Nil	ES + Contractors	
	· Address controls assurance requirements on services.			
	· Carry out organisational review of Facilities Structure and implement proposals. - General Office - Facilities Structure	Cost of posts in Facilities Structure	ES	
	· Review Service Level Agreements across all outsourced services.	Nil	ES + Contractors	
	- 2 -			
	· Advise users of services by localised service agreements.	Nil	ES + Contractors	
	· Identify service gaps across services/	cost savings		
	· Review of transport services.			
	· Finalise external signage CGH & ECH (Wayfinder Scheme) - Information leaflets for patients/visitors.		JP	
	· Ensure robust financial controls are in place for all services managed.	Nil		