



*Raising Standards Across
the NHS*

A Programme of Rewards and
Support for all NHS Trusts

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1. This document codifies the support that all parts of the NHS will get to improve the performance of local health services. Our aim is to raise standards everywhere.

The 1948 Model

2. For the first 50 years of the NHS there was no transparent and robust system for measuring the performance of local health services and driving up standards. Patients had little information on how their local hospital compared with other local providers, and indeed with providers up and down the country. There were no effective incentives for good performers. The reality was an NHS of many tiers, with precious few incentives for improving performance and little support to those who wanted or needed to improve. This was exacerbated by the internal market changes of the early 1990s. The approach was “sink or swim”.

The New Model

3. Our ambition is to raise standards in every part of the NHS so that wherever patients are treated, they get high quality care. To do this we have put in place:
 - A framework of clear national standards – national service frameworks for cancer, coronary heart disease, mental health, older people and diabetes have been published with others covering children, renal services and people with long-term conditions in preparation – and an independent system of inspection through the Commission for Health Improvement.
 - Open reporting on performance – a rigorous performance assessment framework and an annual system of star ratings which assess the individual performance of local health services.
 - A programme of action to improve performance – the NHS Plan set out how actions would follow assessment so that those local health services doing well earn greater freedom and those doing less well get help, support and, where necessary, intervention.
4. The concept of “earned autonomy” established in the NHS Plan provides for rewards going to those NHS organisations who perform well. The rewards act as an incentive for others to improve. The more performance improves, the greater autonomy will be earned across the whole NHS. The new system of financial flows we are introducing into the NHS will strengthen these incentives by giving more resources to those NHS hospitals who can treat more NHS patients more quickly.
5. We now aim to strengthen, too, the support available to all NHS Trusts to improve their performance so that none are left behind – and so that standards are improving in every part of the NHS. The remainder of this document sets out the range of support available to help all NHS trusts to raise their game.
6. Through the Modernisation Agency best practice is being spread across the NHS. The Modernisation Agency provides a range of “core” programmes for all acute trusts, such as the Booking programme; the Critical Care programme; the Clinical Governance Board programme; the Cancer Services

Collaborative; the Coronary Heart Disease Collaborative; the Emergency Services programme; and the Action On programme. It also targets help at those trusts which perform less well. This support is supplemented by a comprehensive menu of other programmes for those who need and want them (see Annex A for further details).

Raising standards in all NHS Trusts

7. Different NHS Trusts have different starting points – some are performing well, others less well, and a few are persistently under-performing. Different action is needed to reduce these variations in performance and to raise standards, depending on the starting position of individual NHS Trusts.
8. *Three-Star NHS Trusts* are organisations which demonstrate the highest level of performance. They will receive a package of rewards on the principle of “earned autonomy” (see Annex B for a complete list). For example:
 - (i) **More resources**, including automatic access in 2002–03 to up to £1m additional capital, depending on the size of the trust; higher delegated limits for approval of capital investments; freedom to retain more of the proceeds of local land sales; and access to additional Local Capital Modernisation Funds;
 - (ii) **More autonomy** – central reporting requirements are reduced, there are fewer and better co-ordinated inspections and greater freedom to set up “spin-off” companies;
 - (iii) **More influence** – three-star Trusts are used as pilot sites for new initiatives, their Chief Executives contribute to developing the policy on earned autonomy and their staff support modernisation work (for which the trust can apply to be reimbursed);
 - (iv) **More opportunities** – three-star trusts can apply for NHS Foundation Trust status and automatically go on the NHS Franchising Register of Expertise, giving them the opportunity to bid for franchises of failing Trusts.
9. *Two-Star NHS Trusts* are organisations which are already performing well overall across the range of indicators, but which need to improve in particular areas. They are subject to the normal reporting arrangements. We have decided that they too should share in at least some of the “earned autonomy” freedoms, namely higher delegated limits for approval of capital investments and the freedom to retain more of the proceeds of local land sales and additional freedom when establishing “spin out” companies. We shall also be discussing with the Shadow Chair of the Commission for Healthcare Audit and Inspection (CHAI), the Shadow Chief Executive once appointed and the CHAI Implementation Team how CHAI’s new inspection regime will be proportionate to risk, thereby lightening the burden on both three-star and, in principle, two-star trusts. This mirrors the Government’s policy on inspection in local government. The details are set out at Annex B.
10. These trusts have a clear incentive to improve in order to gain access to the other rewards of earned autonomy and can access support to tackle areas of relative weakness through the Modernisation Agency’s programmes.
11. *One-Star NHS Trusts* are organisations which are giving some cause for concern against particular key targets. Reflecting their needs we will ensure that there is a much closer oversight by the relevant Strategic Health Authority (SHA). The Trust will be supported by the SHA in developing plans to improve the Trust’s position. On occasion key personnel will be seconded in, for example at Chief Executive level, to drive forward improvements. The Modernisation Agency will be closely involved.

12. The Modernisation Agency is currently piloting a whole-hospital improvement programme called the Hospital Improvement Partnership programme (HIP), which is aimed at achieving better care without delay along whole hospital pathways. The HIP will contribute substantially to reductions in waiting times by supporting service redesign. The Agency will work with participating SHAs and Trusts to develop a locally customised improvement strategy, drawing on the full range of Agency expertise. All one-star acute trusts will be expected to participate in this programme as it is rolled-out in 2003–4. This will ensure that they are given the support they need to improve. It will be worth the equivalent of £200,000 per Trust. Further financial help will also be available where needed.
13. *Zero-Star NHS Trusts* are organisations showing the poorest levels of performance against key targets. They are required to produce Performance Improvement Plans within 3 months to demonstrate how they intend to turn the organisation around. The most hard-pressed health communities, including where appropriate zero-star trusts, are able to access support from the NHS Bank, a centrally-managed £100m Special Assistance Fund, to facilitate service improvements.
14. Zero-Star Trusts also benefit from a targeted programme delivered by two teams in the Modernisation Agency, the Performance Improvement Team (where a Trust has failed key access targets) and the Clinical Governance Team (where the cause of the zero star rating is an adverse review by the Commission for Health Improvement (CHI)). In 2002–3 the average zero-star trust is receiving free of charge at least £250,000 of high quality consultancy advice and support from the Modernisation Agency to help turn it around. Support of at least this level will continue to be available to zero-star trusts in the future.
15. The last resort for failing trusts is to franchise the management. Where the SHA considers that there is insufficient capacity within the Trust to deliver the necessary improvements they consult Ministers on whether to franchise the trust's management. In 2001 six of the then zero-star trusts had their management franchised to experienced NHS managers with a proven track record for delivery. Already we are seeing the results: four of the six improved their ranking in this year's ratings. Three NHS trusts, Medway, Brighton Healthcare and Epsom and St Helier received no stars in the first set of ratings but received two stars in this year's exercise.
16. Annex C sets out the sort of support given to struggling trusts and the improvements for patients secured, whilst the table attached at Annex D describes this incentive, support and intervention structure in summary form.

Conclusion

17. Patients everywhere need local health services that are able to guarantee improvements in services. Since different NHS Trusts have different starting points, different forms of action are needed to bring that about. A mix of incentives, support and intervention is needed. No part of the NHS will be left to sink or swim. Every part of the NHS will be helped to raise its game.

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Annex A

Modernisation Agency Programmes

A range of programmes is available from the Modernisation Agency to help all trusts and all health communities, and to provide particular support to those who need it most.

Dedicated customised support for zero star Trusts is provided by two teams in the Agency who work very closely together, the Performance Improvement Team (where a Trust has failed key access targets), and the Clinical Governance Rapid Response Unit (where the cause of zero star status is an adverse CHI review). These two teams work in partnership with the local Strategic Health Authority as well as the Trust and its key partner organisations, with oversight from the Department.

The Agency also provides tailored support to trusts to tackle particular problems early. This can be particularly helpful for one-star trusts and some two-star trusts.

The following six “core” programmes have been rolled-out across all acute trusts:

- Booking – the aim of this programme is to support trusts in redesigning their booking systems so as to allow patients to choose and pre-book their appointments at a time and place of their choice. By 2005 all appointments will be pre-booked
- Critical Care – this programme involves every hospital in England which provides critical care. Each hospital is organised into one of 29 networks and each network has responsibility for the planning and implementation of service improvement projects in the partner hospitals. The aim is to improve access, experience and outcomes for patients with potential or actual need for critical care
- Cancer Services Collaborative – this covers all 34 cancer networks in England and supports local clinical multidisciplinary teams analyse and redesign their services for the benefit of patients
- CHD Collaborative – launched in October 2000, this programme covers all CHD networks. Drawing on the National Service Framework for Coronary Heart Disease it aims to redesign the systems for prevention, diagnosis, treatment and care
- Emergency Services – this programme provides training and development to staff to help them apply the key lessons from “Improving the Flow of Emergency Admissions” (Modernisation Agency 2001) and thereby achieve the 4 hour maximum waiting time in A&E
- Action On – the Agency runs Action On programmes in specialties where there is a high level of demand, long waiting times for treatment and variations in the level of service provided and the ease with which patients can access them. There are Action On programmes for cataracts, dermatology, ENT, orthopaedics and dentistry.

In addition, a new whole systems programme, the Hospital Improvement Partnership (HIP) is in development and will be in place in the next financial year. HIP is a new initiative aimed at achieving better care without delay along whole hospital pathways. It will contribute substantially to reductions in waiting times by supporting service redesign. The Agency will work with participating SHAs and Trusts to develop a locally customised improvement strategy, drawing on the full range of Agency expertise.

There are a wide range of other programmes to help hospital trusts tackle key performance issues, such as the Day Surgery programme, aimed at driving up day surgery rates, a key performance requirement if trusts are to meet Access targets; the Operating Theatre and Pre-operative Assessment programme, which works with hospitals to help them reduce the number of cancelled operations; and the Endoscopy programme, which is streamlining and redesigning endoscopy services. In addition, the Agency runs organisational development programmes focusing on, for example, leadership for different professions and patient and public involvement, highlights and supports innovation, for example through the Beacons programme, and spreads good practice.

Making a Difference – Some Examples

Theatres and Pre-Operative Assessment programme – Southern Derbyshire Acute Hospitals NHS Trust

All new breast cancer outpatient referrals are pooled and the three breast surgeons have adopted a flexible weekly timetable in order to cover all theatre and outpatient commitments irrespective of consultant leave. This greatly increases the flexibility to cover the workload. Over a 12 week period the team only cancelled two outpatient clinics and one theatre session (101 sessions ran out of a potential 102). If no cross-cover had been possible, ten elective theatre sessions would have been lost during this time period.

National Booking programme – Gastroscopy Services in Peterborough

Work on redesigning the booking system in a Peterborough hospital has led to a drop in waiting times for GP direct access gastroscopy from 10 months to eight weeks. Peterborough District Hospital serves a population of 280,000 and 60 GP surgeries use the direct access gastroscopy clinic. When the redesign process began waiting times were high and there was a large number of did not attends (DNAs) and cancellations at short notice. This meant that the clinic's capacity was underused even though the waiting list was so long. Systems were redesigned to reduce variation incorporating protocols and clinical guidelines supported by the lead clinician in gastroenterology. As well as the reduction in waiting times, cancellations and DNAs there has been an increase in patient satisfaction, and an increase in administrative support for the unit. A new, purpose-built endoscopy unit has recently been opened. This has two theatres with the capacity for a third. GPs have been given training opportunities, and further developments are planned for colonoscopy.

Emergency Services Programme – Barnet and Chase Farm NHS Trust

The Agency has been using the “See and Treat” programme in the A&E Department. “See and Treat” involves putting clinical decision-makers (eg A&E consultants, GPs working in A&E, emergency nurse practitioners) into A&E to treat patients straightaway, removing the wait for triage. Since April the number of patients waiting less than 4 hours in A&E has increased 10% and is currently around 85%. The trust has noticed increase in patient satisfaction and knock-on benefits for A&E staff.

Endoscopy – North Cumbria Acute Hospitals NHS Trust

The “third wave” booking project of North Cumbria Acute Hospitals NHS Trust demonstrates how process mapping and redesign has been used to spread booking across two hospital sites. The project ran from November 2001 until March 2002. By employing extra secretaries and reorganising working practices waiting times have been reduced from anything up to six months to four–six weeks. The rate of Do Not Attends (DNAs) has been reduced from 25 per cent to less than four per cent and patient satisfaction has increased.

ANNEX B

Earned autonomy freedoms for Three- and Two-Star Trusts

Direct Allocation of Additional Capital

Three-star trusts received this year an additional one-off capital sum according to turnover as follows:

Trust Turnover	Additional Funds
£100m or more	£1m
£50 – 99.9m	£0.5m
Less than £50m	£0.25m

Higher Delegated Limits for the approval of capital investments.

Three-star trusts have revised delegated limits relative to their turnover. The largest three-star trusts have a £10m delegated limit, with smaller trusts getting £8m and £6m.

Trust Turnover	Additional Authority
A Trust with a turnover of less than £30m	Will require approval for business cases with a total cost of more than £6m.
A trust with a turnover of between £30m and £80m	Will require approval for business cases with a total cost of more than £8m.
A Trust with a turnover of more than £80m	Will require approval for business cases with a total cost of more than £10m.

Two-star trusts will have slightly lower delegated limits:

Trust Turnover	Approving Authority
A two-star Trust with a turnover of less than £30m	Will require approval for business cases with a total cost of more than £3m
A trust with a turnover of between £30m and £80m	Will require approval for business cases with a total cost of more than £6m
A Trust with a turnover of more than £80m	Will require approval for business cases with a total cost of more than £8m

These limits apply to capital but not to IM&T projects.

Retention of more of the proceeds of local land sales for re-investment in local services.

From July 2002, the amount a three-star Trust can retain from the disposal of its assets was increased to the levels shown in the table below.

Trust Turnover	Value of proceeds that can be retained
A Trust with a turnover of less than £30m	Can retain up to £6m of the proceeds from the sale of an individual asset.
A Trust with a turnover between £30m and £80m	Can retain up to £8m of the proceeds from the sale of an individual asset.
A Trust with a turnover of more than £80m	Can retain up to £10m of the proceeds from the sale of an individual asset.

For two-star trusts the proposed position is as follows:

Trust Turnover	Value of proceeds that can be retained
A two-star Trust with a turnover of less than £30m	Can retain up to £3m of the proceeds from the sale of an individual asset.
A two-star Trust with a turnover between £30m and £80m	Can retain up to £6m of the proceeds from the sale of an individual asset.
A two-star Trust with a turnover of more than £80m	Can retain up to £8m of the proceeds from the sale of an individual asset.

Additional funds from the 2003/04 Local Capital Modernisation Fund

The Local Capital Modernisation Fund (LCMF) provides funding for investment projects initiated by clinical teams at acute trusts. Trusts receive £1m, £675k, £500k, or £100k depending upon size.

The LCMF allocation for 2002/03 distributed an additional £2.5million between 3 star trusts only.

Opportunity to shape national policy

Chief Executives from the three-star Trusts have been invited to join learning sets that consider how the Earned Autonomy package could be developed for next year and what additional freedoms could benefit their organisations. Similar events held with Chief Executives of acute NHS Trusts that were awarded three stars in the 2001 ratings have generated many useful ideas about how the Earned Autonomy system can be improved

Less Frequent Monitoring from the Centre

The burden of producing Service and Financial Framework (SaFFR) monitoring data is reduced somewhat for three-star trusts. The quarterly programme of returns from Trusts to the Department of Health are, for three-star trusts, reduced so that returns are only required at Q2 and Q4/outturn. If Trusts retain three-star status in next year's rating then these reduced monitoring arrangements will continue, otherwise a full SaFFR monitoring regime will be reinstated.

Whilst these returns will not be required by the Department, it is our expectation that Trusts will continue to collate this information for their own use. The requirement for other returns will continue including amongst others: waiting and booking, A&E, cancelled operations, and Situation Reports (SITREPs). Further, three-star trusts will be required to supply data to enable PCTs to provide their SaFFR and other returns to the Department.

NHS Trusts that hold a three-star rating are not expected to respond to unplanned requests for information from the centre. All information requests from the Department of Health must be notified and agreed at least one month in advance. However, application of this freedom in no way undermines the right of Parliament to scrutinise the activity of the NHS and does not absolve Trusts of their responsibilities under the *Code of Practice on Openness in the NHS*. In addition, this freedom in no way undermines the reporting arrangements that are agreed between Trusts and Strategic Health Authorities.

Removal of management cost limits

The Department of Health no longer imposes any limit on management costs for three-star Trusts. As such three-star Trusts now have the freedom to set their own management cost limits without being routinely monitored. Management costs continue to be reported within end of year accounts.

This arrangement will be preserved until the end of 2003/04 and will then continue subject to the Trust retaining three-star status.

Fewer and better co-ordinated inspections

High performing trusts will, in future, be subject to levels of monitoring and inspection proportionate to risk. There will of course still need to be appropriate safeguards in place to assess performance and to reassure patients and the public that national standards of service and quality continue to be met wherever care is provided. In future responsibility for inspection will be given to the Commission for Healthcare Audit and Inspection (CHAI) which will operate independently of government. In developing its inspection methodology CHAI will consider how best it can limit the demands placed on higher-starred trusts, and indeed on all NHS organisations.

CHAI will lead the inspection of health care, including co-ordination of inspection visits and requests for information. This will ensure that burdens placed on front-line staff by other inspectorate bodies will be kept to a minimum.

Work will begin on streamlining inspections later this year. The Department has asked the component bodies of CHAI to consider how they can best co-ordinate their inspections in the run-up to the establishment of the new body. In addition, the Department is also working in conjunction with the Public Sector Team of the Cabinet Office's Regulatory Impact Unit (RIU) to review other inspection and audit burdens placed upon the NHS.

Automatic entry on to The NHS Franchising Register of Expertise

Three-star Trusts are automatically entered on to the Register without the need to submit an application.

Direct access to 'fair shares' of 2003/04 central budgets without the need to bid

Three-star Trusts only need to submit an expression of interest for 2003/04 central revenue funding rather than a full application and will not have to undergo a full scrutiny. They will be eligible for their share of the funds as long as the budget holder's basic criteria are met (e.g. if the budget is for children's services then the Trust concerned will need to provide children's services in order to be eligible)

Additional freedom when establishing 'spin-out' companies

The Health and Social Care Act 2012 (the Act) enables the Secretary of State to authorise Trusts to form or participate in the formation of companies and to invest in companies established to exploit Intellectual Property Rights. Guidance for NHS Trusts that wish to consider establishing such companies can be found in *A Framework and Guidance on the Management of Intellectual Property in the NHS*. The guidance was published on 6 September and is available from the Department of Health website: http://www.innovations.nhs.uk/nhs_ip_guidance.htm

NHS Trusts that intend to establish 'spin out' companies are required to submit a business case for approval by the Private Finance Unit on behalf of the Secretary of State. Earned Autonomy allows a three-star or two-star Trust which has had one business case for such a company approved by the Private Finance Unit to participate in further spin-out activity without express approval by the Unit whilst it retains its star status.

They will be used as the pilot sites for new initiatives eg Agenda for Change implementer sites

Where appropriate, three-star Trusts will be considered in the first instance as pilot sites for new initiatives. The Department of Health will be in contact with three-star Trusts as new initiatives arise.

As an example, in the selection of early implementer sites for *Agenda for Change* the Department will look for Trusts that have a good track-record on performance across a range of areas and have a clear vision for how the new pay system will deliver benefits. These Trusts will need to demonstrate top-level commitment to deliver change and to work in partnership with staff organisations. Clearly three-star trusts will be well placed for selection as early implementers.

Additional funding for sabbaticals to support the Trust in contributing to the work of the Department of Health and the Modernisation Agency

Three-star Trusts are increasingly asked to release key staff in order to support the work of the Department of Health and Modernisation Agency. The Department very much hopes that this will continue given the valuable contribution that three-star Trusts can make through such arrangements. That is why the Department is making additional funding for sabbaticals available to support three-star Trusts in recognition of the additional demand on resources.

Eligibility to apply for NHS Foundation Trust status

Three-star acute and specialist NHS Trusts are eligible to apply to become NHS Foundation Trusts. On 25 July, the Department published *NHS Foundation Trusts eligibility criteria and timetable*. A guide to NHS Foundation Trusts is to be published shortly, after which preliminary applications will be invited.

Support for Challenged Trusts

There is a wide range of interventions to help challenged trusts turn themselves around, including a comprehensive range of interventions available from the Modernisation Agency (see Annex A above), financial support where necessary, tight performance management from the Strategic Health Authority and franchising of management.

There are a number of examples of where focused interventions with struggling trusts have resulted in significant improvements. Thus of the six zero-star Trusts franchised as a result of the 2001 performance ratings, all but two improved in 2002 ratings, moving up to one-star. The following are some examples of how support has been made available to struggling NHS trusts.

Ashford & St Peters NHS Trust

The trust was given zero stars after failing several key targets, namely reducing out-patient waits, cancelled operations, two week waits for cancer and hospital cleanliness. Through the franchising arrangements the trust had the leadership of a highly experienced three-star Chief Executive who has worked in the trust for a year alongside the Chief Executive designate to ensure that improved systems and management arrangements were put in place. The trust has benefited from a number of Modernisation Agency initiatives, including:

- waves 2, 3 and 4 of the Booking programme
- two Action On programmes (cataracts and dermatology)
- a theatre project
- a Clinical Governance development programme
- Five Cancer Collaborative initiatives.

The trust received £320,000 from central funds to support modernisation initiatives.

The trust also received £9.5m from the NHS Bank to help with financial recovery.

The Trust has been working hard to address recruitment and retention issues which have affected overall performance. The Trust recently received an award from the Government of the Philippines for being a good employer. The award by the Philippines Overseas Employment Agency is made to overseas employers who have made special efforts to make Filipino staff welcome.

About 280 Filipino nurses and other staff work for the Trust, making up 10 per cent of the overall workforce and 16 per cent of its nursing staff. They work in areas such as surgery, theatres, orthopaedics, adult and neonatal intensive care, and accident & emergency.

The SHA is now developing a Programme Board to ensure that all key stakeholders in the local health economy work effectively together to deliver targets.

The trust received one star in this year's rankings.

Medway NHS Trust

The Medway NHS Trust received a zero star rating in the 2000/2001 published performance tables, when it scored poorly on financial balance, outpatient waits and two week cancer waits. The Medway Health Economy Performance Improvement Plan was published in March 2001 and subsequently updated in August 2001. The Plan incorporated measures to introduce better demand management, improve waiting list performance and achieve financial balance. The Health Authority allocated a project manager to work with the trust to address performance issues. Around £8m additional funds were provided. WEST and NPAT (now part of the MA) advised on systems reform. The trust also secured money to participate in three Action On programmes, Dermatology, ENT and Orthopaedics.

Key areas of improved performance include:

- **Breast Cancer Waits** – these moved from 70% compliance to 95% compliance by successfully appointing an additional consultant
- **Finance** – the Trust has broken even for every month since January 2001 and at month 6 was slightly underspent
- **Waiting Lists** – the position has considerably improved for both Outpatients and In-patients. The Trust has fully implemented Primary Targeted Listing (cohort management), using the computer software “CHECKLIST”.
- **Demand management** – the trust has worked in partnership with primary care to develop demand management initiatives.

The Trust achieved all Access and Finance targets for the year 2001/2002 and received a two-star rating in the 2001/2002 published performance tables.

Dartford and Gravesham NHS Trust

The Trust received a zero rating having had financial problems and significantly underachieving on twenty six-week outpatient waits. They were also underachieving in cancelled operation rates and two week Cancer waits.

West Kent Health Authority put in place a whole system Performance Improvement Programme, working with Dartford, Gravesham and Swanley PCT. The management was franchised in late 2001. The Trust has been concentrating on reducing over 21 week waiters and by the end of October the target figure of 37 had been surpassed and stood at 13. The Trust is also confident that the number of 13 week waiters will be no more than 350 by the year-end.

Since May 2002 no patient with suspected cancer has waited over 2 weeks for an appointment. The Trust has consistently achieved the 1-month to treatment targets for specified cancers and these will be maintained.

The Trust has agreed a recovery plan, which includes improving productivity and refinancing the Private Finance Initiative. The Trust is confident that it will achieve the agreed end of year position.

Cancelled operations have been significantly reduced and there is currently a Modernisation Agency Programme underway to reduce this still further.

The Trust received £300,000 from the Winter Emergency Services Team and £100,000 for tackling cancelled operations.

The Trust has the following support from the Modernisation Agency:

- Cancelled operation programme
- Booking Programme
- Clinical Leaders Programme
- First and Fast Modernisation Programme for Orthopaedics
- Endoscopy Capacity and Demand Project
- Change Agent Team for Delayed Discharges.

As part of the Franchise arrangement staff from Basildon and Thurrock have been working alongside staff in the Trust to share best practice. Members of staff from Dartford & Gravesham have also visited Basildon & Thurrock. In addition staff are working between the Trust's sharing ideas and focusing on improving ways of working in their own departments.

Both the DHSC and SHA have been actively supporting the Trust in achieving key targets.

The Service Improvement Manager from the SHA is working closely with the Trust to improve access to outpatient services.

University Hospitals of Coventry and Warwickshire (Formerly Walsgrave Hospital)

Following the award of teaching status, the Walsgrave Trust was renamed UHCW on 1st April 2002. The trust was franchised, largely in response to an adverse CHI Review which identified a number of problems, including:

- Poor relationships between senior managers and some consultant staff
- Higher than national average death rates for non-emergency admissions
- Lack of strategic planning
- The practice of putting a fifth bed in four-bed bays, and
- a split site A & E service

The Modernisation Agency has provided intensive support through its Clinical Governance Rapid Response Unit and the Performance Improvement Team. CHI reviewed progress in January 2002 and found that satisfactory progress had been made on the issues around high death rates, the practice of putting five beds in four-bedded bays and strategic planning, and that some progress had been made on the other two areas.

UHCW received one star in the latest round. The SHA is working closely with the new Trust management team to implement its Performance Improvement Plan. Intensive Support has been provided by the SHA to formulate actions to deliver improvements in the Trust's star-rating.

Brighton Healthcare NHS Trust

Brighton received zero stars in the 2000–1 rankings having failed to achieve several key targets, namely, outpatient waits, two week cancer waits and over 12 hour trolley waits. The trust has since merged with Mid-Sussex. Following the zero star rating the SHA and PCT put in place a modernisation team to work with the trust.

The trust has benefited from a number of Modernisation Agency initiatives, including:

- a Change Agent team which has recently started working jointly with Social Services to reduce delayed discharges
- the Emergency Services programme
- Waves 3 and 4 of the Booking programme
- Four Action On programmes – Cataracts, Dermatology, ENT and Orthopaedics
- An endoscopy theatre project
- Two Cancer Services Collaborative projects
- A Clinical Governance development programme.

The trust has received more than £1.25m in central funds to support modernisation and £4m this year from the NHS Bank.

The trust received two stars in the 2001–02 rankings.

Annex D

Trusts: Incentives, Support and Interventions

Star-rating	Incentives: Rewards and Sanctions	Intervention and Support
NHS Foundation Trust	Legally-independent bodies, able to innovate through extra freedoms	Potential provider of consultancy support to others. Able to access core and other MA programmes if they wish
3	“Earned autonomy” freedoms (see Annex B)	Potential provider of consultancy support to others. Access core MA programmes and other MA programmes if they wish
2	Limited number of earned autonomy freedoms (see Annex B). Clear incentive to gain earned autonomy freedoms	Access core MA programmes and can use other MA programmes to target areas of relative weakness
1	Clear incentive to improve so as to access freedoms for two-star and three-star trusts. Threat of possible zero-star status if weaknesses not addressed	Expected to participate in the new Hospital Improvement Partnership programme when available (equivalent to £200,000 of consultancy support and advice). Expected to use MA programmes to target areas of relative weakness
0	Threat of franchising	3 months to produce action plan; up to a year to demonstrate improvement; franchising of management as last resort. Targeted MA programmes to drive forward improvements (equivalent to at least £250,000 worth of free high quality support and advice)



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