WMW931

R22/4

Lewisham and North Southwark Health Authority

Guy's Hospital

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CC51/EMC

18 April 1988

Mr P Gray
10 Downing Street
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Dear Mr Gray

Thank you for your letter of the 29th March.

I am sorry for the delay in my reply but I have been in Malaysia examining over the last two weeks.

I enclose with this letter a paper that I have written for the King's Fund College which discusses the Guy's experience. Section 3.3 and 4.3 relates to management budgeting.

I also enclose some notes on the National Health Service that I wrote following a meeting with the Centre for Policy Studies earlier this year. The section on management on page 2 deals with the management structure. I would particularly like to draw attention to the comments that I have made regarding the district health authority, as this is the level of which I have most experience.

Yours sincerely

PROFESSOR C CHANTLER MA MD FRCP LIHSM
CONSULTANT PAEDIATRIC NEPHROLOGIST

Enc

NOTES ON THE NATIONAL HEALTH SERVICE

PROFESSOR C. CHANTLER
CHAIRMAN
GUY'S MANAGEMENT BOARD

JANUARY 1988

GENERAL ORGANISATION

The first question and by far the most important for the service at the present time is whether or not we wish to continue with a health service funded out of taxation. We can either abolish the present service or else develop it. Before abolishing it we should reflect that whilst no other country has adopted it there are problems with all other systems in the developed world and it has proved better than all the competition in restricting expenditure on health care. Indeed a cynic might argue that the main advantage of the national health service has been to restrict expenditure to an extent which is now the envy of governments throughout the western world. In spite of claims to the contrary international comparisons concerning the quantity of care delivered and the quality of care and the ability to provide for all the population show that it is as effective as any other system that has been tried.

A fundamental change to a health insurance system, would be a massive undertaking and there is little evidence that the British people wish it, and certainly plenty of evidence that it would be less cost effective. One alternative that might be considered is to fund the NHS out of a state based insurance system funded as a separate tax, presumably progressive, and collected as part of the income tax. Thus it would be apparent what each individual was paying for health care and the level of this tax could be determined by parliament on a yearly basis with the hope that this might to some extent lead to a more rational debate about resources both in the country and in parliament.

It has to be recognised that a major defect of the national health service is that it does not provide choice for the customer and there are few internal pressures for efficiency. If as I believe a centrally funded service should continue then an expansion of the private sector is not only appropriate it is desirable as long as it is controlled. ?

FINANCE

The national health service is underfunded, this is a complex statement because it presupposes that overspending is not the reason for the deficits that many health authorities now have. The government's policies during the last few years have done much to increase the efficiency of the service and much remains to be done, however, again international comparisons suggest that the health service is no worse in terms of efficiency than other health care systems. The success of the service in introducing advances in medical technology and the improving health of the population have lead to rapidly increasing demands which have not been met by increased government expenditure. The gap however is not wide and a modest increase in government expenditure would do much to deal with present difficulties. The argument that it is a bottomless pit which emanates from Mr. Enoch Powell's tenure as Minister of Health is irrelevant. Many areas of expenditure particularly goverment expenditure could be so

described. This argument should not be used as an excuse for not spending enough. It is not possible to define sufficiency but it can be determined by comparisons with other systems and indeed that is the way the normality of most human activities is determined. On this basis an extra 1% of the gross domestic product spent on health care would bring us up to the regression line that determines the relationship between the size of the gross domestic product and the proportion spent on health.

MANAGEMENT

There have been considerable improvements in the management at the bottom end of the service following the Griffiths initiative. This has lead to increased efficiency which is apparent from most health service statistics and from the analysis of the cost improvement programmes. Those of us who work at the bottom end of the service do not feel that much has been achieved above. The lines of communication to the central management are too long and the awareness of central management to the management issues at the point of delivery of the service seems insufficient. There is a confusion at the District Health Authority level between representation and governorship and one propostion that should be examined is re-constituting Health Authorities' with executive directors, who would be the district officers, and non-executive directors chosen from outside because of their particular skills and interest. The Community Health Councils could be strengthened and two representatives say the chairman and secretary would sit on the newly constituted District Health Authorities with a purely representative role. At the centre consideration should be given to the NHS Management Board assuming a more involved management role using the corporate holding company model. Whilst accepting the need for a link at regional level again the regional directors should be partly the regional officers and partly non-executive directors chosen because of their interest but without representational responsibilities. According to this format the Ministry of Health would maintain a central directorate to advise the minister and to audit the activities of the NHS Management Board but many of the functions currently undertaken by the DHSS would be transferred to the NHS Management Board.

The efficiency of hospitals has improved with the Griffiths initiative but more needs to be done to involve professionals particularly doctors and nurses in management. The recognition that clinical freedom far from being compromised is actually enhanced by involvement in management and the importance of separating management accountability and professional responsibility and accountability in the management structure should lead to greater involvement of doctors in hospital management. Improved management is essential if outdated working practices are to be altered and efficiency increased. The involvement of the private sector and inter-hospital cost comparisons should continue to be promoted to stimulate efficiency.

An internal market in the health service is absolutely essential. It would be possible to introduce a simple scheme immediately and then to refine it as case-mix costing becomes more sophisticated. Such an arrangement between different

hospitals already exists in Sweden. Regular provision of information on waiting lists and waiting times to general practitioners and other hospitals could occur now.

Income generation for NHS hospitals has to be considered realistically. There is little point in hospital managers trying to set up businesses which they do not have the skills to create or manage. On the other hand actions such as the creation of amenity beds within NHS hospitals have much to commend them.

THE PRIVATE SECTOR

The private hospitals are necessarily more expensive than NHS hospitals (or at least should be) but their existence provides ideas for the health service and necessary competion. They provide an essential element of choice and it is realistic to suppose that further expansion in expenditure on private health will occur. Their contribution however is likely to be in relatively simple procedures particularly cold surgery rather than complex multi-system failure or the problems of old age. It is important that their expansion is controlled realistically so that for instance they are not able to attract essential staff from the NHS by financial inducements when NHS salaries are strictly controlled. It is also important to monitor and control any tendency for health service personnel to abuse their national health service contracts by working in the private sector during NHS time. The vast majority of clinicians work many hours of unpaid overtime in the national health service and even those with extensive private practices rarely fail to fulfill their NHS commitment. However some formal monitoring system of this is essential if public confidence is to be maintained. Adequate disciplinary procedures for those who abuse their privileges already exist and must be used.

The pay of low paid staff in the national health service, particularly nurses, therapists, secretarial and ancillary staff must be dealt with and the extra cost to the nation must be accepted. As far as nurses are concerned there is an immediate need to increase London weighting and to provide an extension of the salary scale for clinical nurses at sister level. An extension of the present salary scale from 5 years to 15 years with the eventual attainment of a salary equivalent to that of a senior registrar after 15 or 20 years service would do much to improve morale, keep people in the service, and attract back those who have left. A salary lead should be paid to those nurses with post basic qualifications at least while they are undertaking work where those qualifications are required. These three measures rather than a substantial overall increase in nurse salaries are recommended and would be less expensive.

CONCLUSION

The current problems of the NHS were predictable given the increasing prosperity of the country, the peoples increasing expectations, the changing age structure and medical advances. The problems are soluble and it is suggested that they should be dealt with not by changing the fundamental structure which by national comparisons has much to commend it. A modest

increase in resources to the health service, an expansion of the private sector, an improvement in management organisation, and the creation of competition within the service itself, are now required.

CC/JAG
25.1.88.

KING'S FUND COLLEGE INTERNATIONAL FELLOWSHIP

GUY'S HOSPITAL 1985 - 1988, A CASE STUDY

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1 INTRODUCTION

This case study analyses the experience at a major London teaching hospital over a three-year period, during which major management changes were introduced. It analyses the reasons the changes were thought to be necessary, the philosophy behind the changes proposed, and describes the results to date, in order to provide a basis for a preliminary examination of the lessons that have been learned.

1.1 Guy's Hospital - A Brief History

Guy's Hospital opened in 1726 in Southwark, a densely populated area of south London near to London Bridge. Southwark was then, and is now, an area of considerable inner city deprivation, and the first purpose of the hospital is to serve the local population.

Guy's Hospital, however, is a major London teaching hospital qualifying over one hundred doctors each year, about ninety dentists, a large number of nurses and people in allied health care professions. The hospital is situated next to London Bridge railway station, which is one of the busiest commuter stations in London and the centre of a network which extends out to the south coast providing public transport facilities into London to a population of over 3.5 million people. Thus, it is apparent that as well as providing hospital services to the local population, the catchment population of Guy's is much larger, and the hospital has an important role in the provision of tertiary referral services as well as for post-graduate teaching and research.

1.2 Guy's Hospital 1948 - 1974

The hospital was incorporated into the National Health Service in 1948. The board of governors had overall responsibility for the management of the hospital reporting via their chairman to the minister of health. The board of governors was serviced by the clerk to the governors who, with his staff, took overall responsibility for the administration of the hospital. The post of clerk to the governors was considered one of the most senior posts in hospital administration in the country.

The day-to-day responsibility for running the hospital was vested in the superintendent, who was always a clinician, and was responsible to the board. In effect, he, along with the clerk and the matron, shared this total responsibility.

In retrospect, the years 1948 to 1974 were "the years of plenty" and a steady expansion in the services provided by Guy's occurred over these years. The NHS was responsible for providing the money to run the hospital but the board of governors had access to the trust funds of Thomas Guy, which were used to fund new developments. Although the hospital endeavoured to stay within its financial allocation, it was not, in effect, cash limited, and thus legitimate demands for increased services could always be funded with the allocation adjusted at the end of each year, so the Government took over responsibility for items funded by the governors from trust funds in the previous year. In 1948, the board of governors assumed responsibility for the Evelina Children's Hospital situated about a quarter of a mile away from the main hospital and containing one hundred childrens' beds. Later, they assumed responsibility for St. Olave's Hospital and New Cross Hospital, both about two miles from Guy's. Thus by 1974 the Guy's Group of hospitals had access to about 887 beds on the main site, one hundred childrens' beds in the Evelina, the 234 beds in St. Olave's and the beds at New Cross making a total of 1,557 beds.

1.3 Guy's Hospital 1974 - 1982

In 1974 the board of governors were abolished. The community health services (not the family doctor services) and the hospital services were joined into the Guy's health district. This was joined with the St. Thomas' health district, the King's health district and Lewisham health district to form one Area Health Authority. The post of superintendent was abolished and the District Management Team was set up. The District Management Team worked by consensus between its various members and comprised: The chairman of the medical and dental staff committee at Guy's, a general practitioner, district treasurer, district administrator and district nursing officer. The two most significant changes as they affected Guy's were that the post of district administrator was far less senior in health service career terms than the previous post of clerk to the governors had been, the consensus management model was totally different from the old responsibilities held by individuals such as the superintendent, and finally, instead of Guy's Hospital reporting directly to the Minister, the reporting structure was through area to region to the DHSS.

In 1976 the then labour government introduced the concept of cash limits on public expenditure and these were applied strictly by the incoming conservative government of 1978. Cash limits laid an obligation on the Area Health Authority not to overspend, thus expense in the health service, having been to some extent demand led became strictly limited by the cash allocation irrespective of demand. It was, perhaps, inevitable that this change would lead to overspending and both the Guy's district and indeed the Area Health Authority's financial position rapidly deteriorated.

In 1978 considerable cutbacks in clinical services were proposed with an overall reduction at Guy's Hospital of 30%. These changes were resisted by the clinicians, who produced an alternative plan to close St. Olave's Hospital, and to accept a 10% reduction in clinical services as a result. This policy was eventually adopted but only after the government had replaced the Area Health Authority with commissioners. The final result, however, of the closure of St. Olave's Hospital was that the financial savings necessary were made.

1.4 Guy Hospital 1982 - 1985

A further reorganisation of the National Health Service took place in 1982 with the abolition of the Area Health Authorities. The Guy's health district and the Lewisham health district were joined as the Lewisham and North Southwark Health Authority reporting to the South East Thames Regional Health Authority. The District was broken into three separate units of management, namely, Guy's Hospital, Lewisham Hospital, and the Priority Care Community Care Services.

The overall responsibility for the district was held by the District Management Team reporting to the District Health Authority who were comprised of individuals representing various interests in the local community and headed by a chairman appointed by the secretary of state.

The new health authority decided on a radical plan to improve the provision of health care in the community and, in particular, the closure of long-stay large hospitals for mental handicap with the re-location of patients in small groups in the community. They determined to obtain the money for this plan by reducing expenditure in the two acute hospitals, i.e. Lewisham and Guy's Hospitals. In addition to these cuts, the South East Thames Regional Health Authority decided to reduce the allocation to Lewisham and North Southwark Health Authority by £12m per annum at current prices over a ten-year period (10% of allocation). To this reduction in allocation, other cuts have been added such as inflation shortfall, planned efficiency savings, etc., so that between 1982/83 and 1987/88 the District has suffered a loss of £12,430,000 per annum. The combination of Guy's share of this deficit and the re-distribution to the community has reduced the Guy's Hospital's budget by £10,235,000 in the five years 1982/87 leaving a budget of about £50m per annum.

The reductions at Guy's commenced in 1982/83 but the scale increased in 1983/84 and 1984/85. In January 1984 it was apparent that the hospital was going to overspend its allocation substantially, and the then District Management Team decided to close over one hundred beds to save money though a number of clinicians suggested at the time that the effect would not be as foreseen. During the two months following closure, throughput in the hospital increased to a level higher than in the same two months the previous year, and Guy's thus had the dubious distinction of being the first London hospital to spend more money by closing beds.

At this time the Griffiths' report was published and indeed clinicians and others at Guy's had discussions previously with the Griffiths' team suggesting that clinicians should be involved in the management of the hospital with their own budgets related to the clinical service provided and with a decentralisation of services, as far as practical.

The combination of increased demand for our services along with a reduction in our allocation and the imposed reduction in beds and other clinical services led to a crisis of management within the institution. Relationships deteriorated rapidly between different professional groups, not least between the clinicians and the administrators. The administrators felt the advice they were receiving from the medical advisory committee (based on a divisional "Cogwheel" representational system), was irresponsible because it took no account of the financial problems of the institution whereas the clinicians felt the administrators had lost their vision of the aims of the hospital to care for the sick.

Tensions were apparent at all levels of the institution, on the wards when doctors wished to admit patients to beds which were under-nursed because of reductions in the nursing service, within the nursing hierarchy itself, with their long line of communication imposed by the Salmon structure, and between different professional groups who sought to protect their particular service at a time of radical reductions in the provision of care. This then was the background to the debate which then took place concerning a new management structure which is discussed below.

2 ROLE OF CLINICIANS IN THE MANAGEMENT OF HOSPITALS

2.1 The Clinician's Perspective

It is often argued ('Lancet' PP 1398, June 23rd 1984) that clinicians should not actively participate in hospital management because a conflict of interest may arise between the allocation of resources and the needs of their own patients. It is important to recognise this dilemma; failure to do so may compromise the primary duty of a doctor to his patient or lead to resource allocations which are unfair to individuals whose needs are less acute or who are represented by less persuasive doctors.

However, clinical freedom is obviously restrained by lack of resource, and if clinical freedom is to be maximised, then it is important that clinicians have a voice in the debate on allocation of resources. The medical advisory committee system worked well in the days when the service was expanding and not cash limited, and works well in the private hospital where, in effect, the doctors are customers of the institution because they are the ones who introduce the patient who, in turn, pays the bills. In a cash limited system the position is different and no authority charged with maintaining financial stability will transfer responsibility for expenditure to any other group, such as clinicians, unless that group accepts the financial constraints within which they have to operate.

Clinicians in Britain guard their clinical freedom and all consultants in the NHS have equal status. The possibility that any individual clinician should have authority over others is properly resisted. Clinicians contemplating involvement in hospital management are also concerned about the time they will have to make available for the task, and fear that this will limit their clinical activities.

2.2 Service Perspective

Professional Health Service Administrators and Managers tend to have mixed feelings about the desirability of clinicians being involved in hospital management.

They are concerned that it is the clinicians who commit the resources but this is often without regard for the financial or organisational consequencies of decisions and it is they, the administrators, who have to cope with these consequences. They also feel that many clinicians have little knowledge of the complexity of the delivery of health care, the organisation of the hospital service, and of the National Health Service, and therefore tend to make irrational and uninformed decisions.

On the other hand, they recognise the clinicians are directly involved with the customer, that they tend to be semi-permanent in the organisation whereas the administrative staff move frequently as their career progresses, that clinicians are intelligent and have stamina, and that they tend to be responsible for many of the innovations in the Service (See Initiative and Inertia : Case Studies in the NHS by Barbara Stocking, Nuffield Provincial Hospitals Trust, 1985).

I believe that the balance of the argument is in favour of involving clinicians; both from the clinicians point of view because it helps to maximise their clinical freedom and, it is frustrating to be working in a service where one's capacity to influence it is limited. From the Service's point of view it is sensible to involve the most powerful professional group in the management of Hospitals in order to increase the efficiency of the organisation, However, certain principles and systems are necessary to avoid the conflict or confusion that may result.

3 PRINCIPLES AND SYSTEMS REQUIRED

3.1 Professional and Management Accountability

It is important to distinguish between professional accountability and management accountability. A clinician is professionally accountable to his patient and this accountability is audited in various ways, by the traditions of Hypocrates, by the various professional bodies, such as the Royal Colleges, by the General Medical Council, and by the law.

Although the remuneration of a clinician in the NHS comes from central government, it can be legitimately represented as coming from the patient from whom it is raised by taxation.

Hospitals are unusual in that they are staffed by professionals in a number of different fields, each of which has their own well-developed professional structure, for instance, in addition to doctors, there are nurses, engineers, physicists, medical scientific officers, etc. Management accountability can legitimately be separated from professional accountability and each individual in a hospital, irrespective of the job done, has management accountability to the health authority for the quantity and quality of service delivered and for the efficiency of the work carried out. Any management structure must take account of the difference between professional and management accountability and separate lines of accountability, not only serve to maintain professional freedom but also can act as a useful check or balance to the unrestrained use of authority. (See below).

3.2 Responsibility and Authority

Responsibility and authority must be co-terminus and commensurate. If the responsibility to provide a clinical service is to be taken by a group of clinicians with a clinical director, then the authority commensurate with the responsibility must be transferred to this individual. The dangers of authority without responsibility or responsibility without authority have already been referred to (section 1.4 & 2.1) but it is necessary to recognise the apprehension some clinicians will have about assuming responsibility for provision of service as opposed to individual patient care and the resistance that the administration will provide against the transfer of authority.

3.3 Management Budgeting

Traditionally, the National Health Service hospital service has operated on a functional budgeting system and whereas this works well in the Hotel and Support Services, it has little relevance in the clinical service where it is clearly impossible for one individual, such as the Director of Nursing, to be responsible for the day-to-day nursing expenditure in widely different areas throughout the hospital.

The result of the cumbersome functional budgeting system is that there is little commitment accounting, little knowledge of day-to-day expenditure, and little management control of the expenditure. The actual amount spent in the service is only known accurately at the end of each financial year, and it is hardly surprising that quite frequently an unforeseen over-expenditure is found when the final accounts are made. Only after they have been completed is it possible to determine exactly where the money was spent. This process is usually complete by mid-summer when the institution is well into the next financial year, so it is hardly surprising that hospital cuts tend to occur in the autumn year by year.

It is fundamentally important, in my view, that the National Health Service adopts management budgeting throughout the service, so that all expenditure is under the control of named individuals who receive their budgets in advance and can check expenditure at regular intervals taking action where necessary to adjust their programmes. Commitment accounting is an important component of such a system.

A decentralised clinical management structure needs to be served by a management (clinical) accountancy system. It is pointless to introduce clinical budgeting without a clinically based management structure because there is no point in having a budget if there is no one who accepts responsibility for it.

3.4 Part-Time Clinical Managers

If clinicians are to be involved in management, then they must be allowed to fulfil this reponsibility on a part-time basis. If it is a requirement that they devote a great deal of time to their management function, then they will cease to be clinicians and their unique perspective as clinicians will no longer be available to the hospital they serve.

If they are to fulfil their responsibilities on a part-time basis, then it should be recognised that their responsibility is for management and not administration. They need to be supported by able business managers, who may be drawn from the hospital administrative service, or other professional groups. They need to recognise that professional administrative skills are important and must be rewarded by paying attention to opinions expressed.

The emphasis is on a team approach and the basic team comprises the clinician, the business manager and the nurse manager working together. The other important component in allowing part-time clinicians to play a full part in management is that the organisation must be split up or decentralised so that the work can be shared amongst a number of clinicians, each of whom can commit a certain amount of time but not be overwhelmed by the management responsibilities.

4 GUY'S HOSPITAL 1985 - 1988

The historical review, the discussion on the role of clinicians in management and the necessary prerequisites for such arrangements dealt with in sections 1 - 3 were debated at Guy's in 1984-85. In the autumn of 1984, the medical and dental committee comprising all the consultants at Guy's voted to take part in an experiment based on these principles. A new hospital management board (board of directors) was formed and assumed responsiblity for the running of Guy's Hospital in April 1985.

4.1 Management Structure

The management structure introduced is shown as appendix 1. The chairman of the hospital management board is finally responsible for the performance of the hospital and reports directly to the district general manager and the District Health Authority.

He works closely with the chief executive, who is responsible for all the general management and overall objectives of the hospital. He also works closely with the director of nursing, and these three individuals carry the central responsibility for the performance of the hospital. They are assisted by a central team of the clinical superintendent, who is responsible for medical staffing, hospital development (we are planning a major capital development costing over £30m over the next five years), and who also chairs the quality committee, which reports directly to the Hospital Management Board. The central team also comprises the director of operations, who is responsible for the hotel and support services, the hospital finance director and his staff, and the personnel director and his staff.

Thirteen clinical directorates were established, each headed by a clinician assisted by a nurse manager and a business manager. The business managers were mainly chosen from professional hospital administrators but the business manager in one directorate is a nurse and in another a scientific officer. Obviously, arrangements differ in different directorates in that some directorates share a business manager, and for the laboratories the responsibility is shared between the director, the chief technician and a junior administrator/secretary.

It is fundamentally important to appreciate that management accountability is separate from professional accountability, so that the nurse-manager in a directorate reports directly to the director of nursing on professional matters, physicists report to the chief physicist etc. Although these professional lines of accountability have not had to be invoked because of serious management difficulties, they nonetheless exist for use, if required.

The chairman of the board is appointed by the district general manager but on advice from colleagues from within the Institution. It is obviously important that such an individual is acceptable to the authority and to his or her colleagues. It is also clear that if that individual lost the support of his board or of the medical and dental committee at Guy's, which represents all consultants, then he or she would have little choice but to resign irrespective of standing with the authority. Similar considerations have governed the appointment of clinical directors, who are not elected but appointed - again, however, on advice from colleagues and with regard to their management capabilities as seen by the chairman of the board and the district general manager.

4.2 Decentralisation

Having established the structure, it was then important to decentralise responsibility and staff to the directorates. Three years' later 1,838 out of a total staffing of 2,916 individuals in the hospital report within the decentralised directorates. These comprise doctors, nurses, clerical staff. scientific staff, etc. Centralised Outpatient appointing and management arrangements have been dismantled, and these responsibilities are now assumed in their entirety by their individual directorate for clinical firms. Similarly, admissions and the management of waiting lists have been largely decentralised to directorates. Bed allocations have been given to directorates with as few individual clinical teams as possible working out of any one ward. Rules for bed borrowing have been established and only the director of admissions, who is also the director of the accident and emergency department has the power to commandeer a bed. The authority of the ward sister or charge nurse over her or his ward has been re-established, and ward budgets, of which they are the budget holder, introduced.

4.3 Management Budgeting and Finance

A management budgeting system based on the Arthur Young model has been introduced and applied to clinical budgeting. We are now able to capture expenditure on staffing costs, radiology, pharmacy, and these are contained within the budget negotiated each year with each directorate. During the next financial year, we will add pathology costs, medical/surgical supplies and CSSD to these budgets. Performance by directorates is monitored at monthly intervals. Budgets are negotiated each year over the period October to December and then form an important component of the unit business plan presented in March to the board and the authority. (Appendix II).

This budget review process is an important component of our system in that it provides management appraisal where expenditure, quantity and quality of activity is formally examined. In the budget reviews just completed savings of £1.909,000 were extracted, and £1,122,000 of this saving was then re-applied to new developments out of a total budget for 1988/89 of £51.574m.

The board inherited a deficit from 1984/85 of £1.2m and an inherent overspend in 1985/86 of over £300,000 per month. In August 1985 it was apparent that the unit was heading for an overspend in that financial year of over £5m or over 10% of budget. In order to contain this overspend, it was decided to concentrate on staff costs rather than directly reducing clinical services as had been done previously. A strict manpower control system was introduced (previous to this, only very loose control had been exercised and, indeed, it was difficult to tell month-to-month exactly how many people were employed in the hospital).

By the autumn, the total staffing at Guy's had been determined, and individual managers, to whom the totality of staff reported, had been identified. It was determined to reduce the number of posts by 300 (about 10% by the end of the financial year, 1985/86 and this task was accomplished and at the end of the year the unit was overspent by £1.7m.

By the end of the financial year 1986/87 this deficit had been cleared and the unit was financially breaking even. This position has been maintained in the year 1987/88. The severity of the cuts is apparent in that since the beginning of 1984 the Guy's Unit has lost 28% of its beds (340). Manpower has been reduced by 17% (575 posts) and expenditure by £7.8m per annum, (15%).

4.4 Patient Services

The massive bed closures and financial reductions outlined above inevitably were associated with a fall in patient activity but inpatient throughput this year is only 6% less than the maximum achieved in 1982, and this year will number over 36,000 inpatient admissions. This represents an increase on last year of about 5%, and it is projected that it will rise another 5% next year. There has been a considerable increase in efficiency with length of stay and turnover interval declining sharply.

We have established an observation ward associated with the accident and emergency department to take the pressure off beds, and a five-day ward and a day surgery unit. Waiting lists rose inexorably between 1982 and mid-1987 but have now started to decline quite sharply in most areas.

The ranking of Guy's amongst London teaching hospitals has changed from being the most expensive on patient related cost per case in 1985/86 to being eighth out of eleven in 1986/87. With the increase in activity this year and the reduction expenditure, it is expected that the 1987/88 figures will show further improvements. In 1986/87 we saw 69,754 new Outpatients and the cost per patient for Outpatients was the lowest of the three teaching hospitals in our area of London.

Obviously, the quality of care is an important issue and we have not yet developed satisfactory outcome measures for this though we are concerned to do so. We do know that our re-admission rate has not increased and we have introduced a new system for planned discharges for the elderly or chronically disabled to the community with a reporting system to judge inappropriate discharges. As far as we can judge from these systems, the quality of care we are delivering has not deteriorated.

4.5 Quality Issues

It is an urgent priority for our institution to introduce clinical audit throughout the hospital and to look at outcome measures as discussed above. In the meantime, the quality committee has introduced codes of practice for customer relations such as outpatient waiting time, and these are being monitored.

An important issue in quality is the state of our buildings and medical and surgical equipment inventory. The works officer estimated in 1984 that there was a backlog of £12m on essential maintenance and we have begun to deal with this. In the last three years we have instituted a major lift refurbishment programme costing £370,000 over three years and this will continue in the future. We have spent £350,000 on replacing theatre cooling and air conditioning systems, £397,000 on a new incinerator, re-located and refurnished the blood transfusion unit, created an observation ward, and begun to improve the decorative state of the hospital - the roads and pavements in the hospital and major structural repairs to our buildings.

Much still remains to be done but the board has managed in the last three years to protect the works department budget and increase it. Similarly, with regard to medical and surgical equipment, we have established an electrical and mechanical services unit and managed to increase the budget for replacement of equipment. Other initiatives being developed by the quality committee and the board with the clinical directors include the introduction of management appraisal, definite guidelines for directorate responsibilities, a five-year plan for objectives for the hospital, and new standards for communication, particularly with discharge summaries etc.

4.6 Personnel Issues

The massive reduction in employment obviously led to difficult personnel issues but most of the redundancies were dealt with by natural wastage and only 42 compulsory redundancies were required out of a total of 576 posts lost. Whilst the majority of these posts came from the ancillary services, no group was spared and the number of doctors and nurses employed had to be reduced. Further changes will be required in the future, and we are introducing a new system of private management for our domestic and portering staff though the individuals concerned will stay as employees at Guy's.

Perhaps the most important positive change that has come from our decentralised system has been the improvement in staff morale. Communications between different professional groups have improved with much more widespread appreciation of the essential contribution made by everyone concerned to the quantity and quality of health care. This has been particularly important with the decentralisation of the records department staff to work with individual clinical teams where recruitment has improved and turnover drastically reduced.

The improvement in quality is apparent in that it is relatively uncommon for a patient to attend without the notes and X-Rays being available whereas three or four years ago as many as one third of attendances were complicated in this way. We have worked hard at improving our communications and introduced a briefing system based on the monthly board meeting followed by a newsletter to all managers to discuss with their staff telling them of developments that are taking place in the hospital and problems that we are confronting.

4.7 Resource Management

The introduction of a management budgeting system has already been discussed. Guy's has been appointed a second generation "resource management" site as part of the experiment being conducted throughout the country by the NHS management board. As well as continuing to progress with our clinical budgeting system, we are also piloting the introduction of a new personnel system, and a nurse and theatre management system, all linked to a new patient administration system. We shall be looking to develop case-mix analysis and the production of average cost per case data over the next two years.

5 CONCLUSION

The experience at Guy's over the last three years has been positive and we believe that our approach to clinical management, certainly as far as this hospital is concerned, has much to commend it, and confirms the success of a similar system in the Johns Hopkins Hospital, Baltimore, USA (New England Journal of Medicine 310,1477, 1984). The extent to which a similar system would be advantageous to other hospitals is a matter for discussion and we would accept that an exact facsimile of our model probably would not be widely applicable but there are, however, certain principles which we would wish to insist on and they particularly relate to the proper involvement of clinicians in management, the decentralisation of authority and responsibility, and the development of team work between different professionals. This paper has necessarily concentrated on the role of clinicians but this should not be over-emphasised, and we believe that the development of the management skills of the administrative group (business managers and particularly the nurse managers) has been an important part of our success to date.

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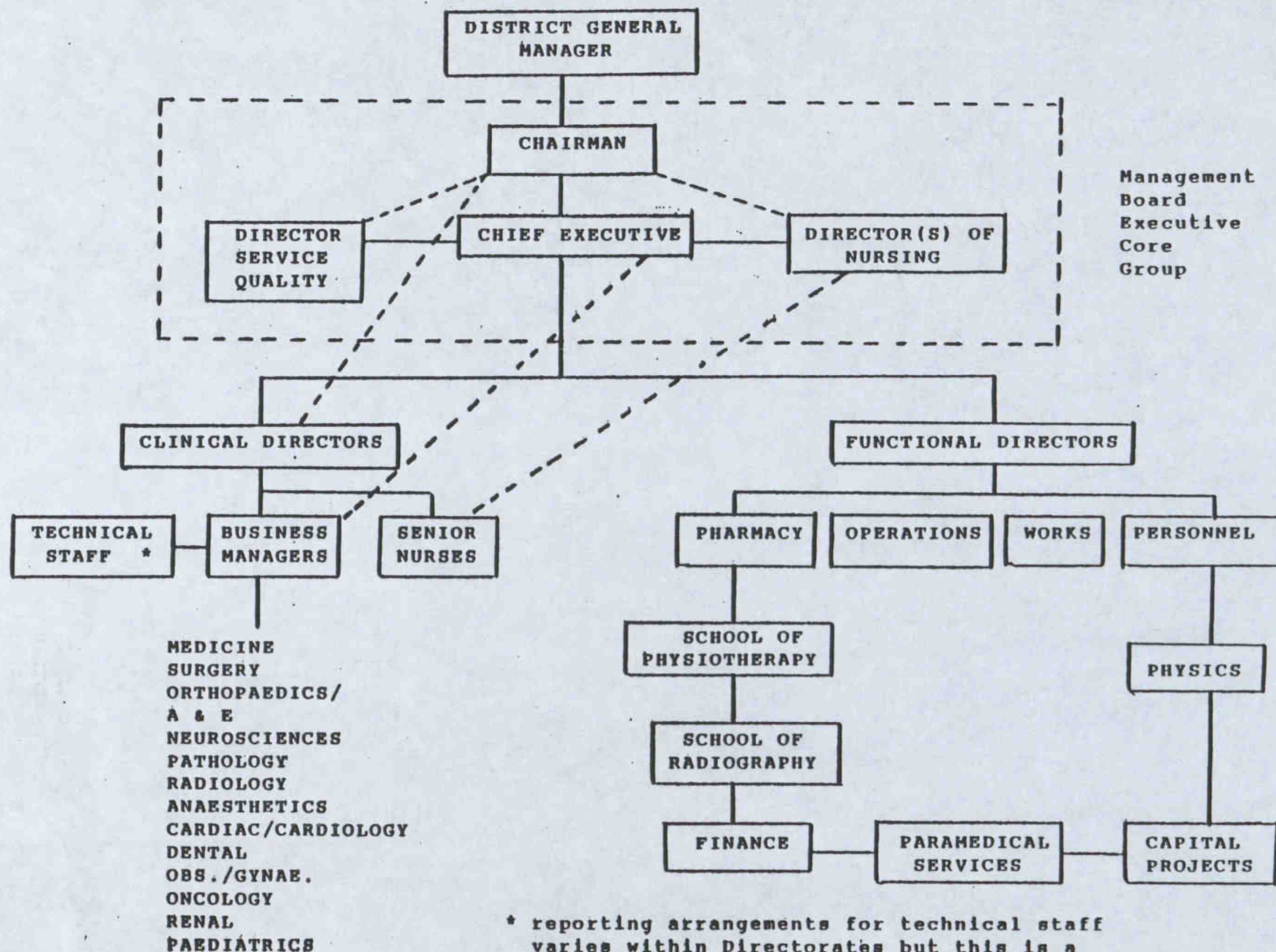
APPENDIX I

GUY'S HOSPITAL - MANAGEMENT STRUCTURE



* reporting arrangements for technical staff varies within Directorates but this is a typical arrangement.

APPENDIX II

LEWISHAM AND NORTH SOUTHWARK HEALTH AUTHORITY

GUY'S HOSPITAL

BUSINESS PROGRAMME 1988/89

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1. FOREWORD

This is the third Business Programme that we have produced for Guy's Hospital. The purpose of this is to set out our programme and budgets for the next year. These are based on the aims and objectives previously described in the Short Term Programme that we were required to produce in the summer for the Regional Health Authority. But we have set out in rather more detail what our budgets will actually be and how the resources available will be distributed within the hospital.

Each year we try to express our objectives in a more specific way so that we can keep these under review during the year and decide whether they are being achieved. This year for the first time much hard work and thought has gone into producing a statement of five year aims and objectives for Guy's. A statement of these is included in Section 10 of this Programme, and we have tried to reflect these in our proposals for next year. In some areas, for example, reducing waiting time in Outpatients and reducing cancelled admissions specific targets have already been set. In others, work is just beginning and we will need to give careful thought to work out the targets we set for future Business Programmes.

The present time is a very exciting and challenging one for Guy's Hospital. Much has been achieved over the last three years, and this is apparent from the way that Guy's goes about its business day to day. Our aim for 1988/89 and subsequent years is to build on the work that has already been done. We hope that the future will be less dominated by financial concerns so that we can devote more time and attention to the quality of service the hospital provides to the local community.

Increased Workload

During the last year we aimed to increase our workload to 35,204 admissions.

The latest available figures show that during the first nine months of the year we treated 26,922 patients compared with 26,577 for the same period in 1986/87. If these figures are projected forward for the entire year it seems likely that our caseload will be in the region of 35,896 cases, which is greater than the target.

Reaching our target represents a considerable achievement in view of the difficulties that have been encountered in recruiting nurses. Increasing the number of patients we treat was also dependent on making more sensible use of space and beds in the hospital and during the last year we have been able to:

(a) open the A & E Observation Ward.

(b) fund an additional paediatric intensive care cot in the Special Care Baby Unit.

(c) provide additional surgical beds on Patience Ward.

(d) provide additional beds for Renal patients in Astley Cooper Ward which was re-opened following a major upgrading in October 1987.

(e) open the Day Care Surgical Unit in June.

(f) carry out the closure of New Cross Hospital and the relocation of those services at Guy's Hospital, Lewisham Hospital and in the Community.

Greater Efficiency

For the second year in succession Guy's will have balanced its books. This represents a considerable increase in efficiency. Over the last five years Guy's has had its revenue allocation reduced by more than £7m per year. This represents a 14.5% reduction in expenditure. During the same period Guy's reduced its beds by 25%, its staff by 10%, but its caseload by only 6-7%, and there are signs this year that it is beginning to increase again. The cost accounts for London Teaching Hospitals for 1986/87 (the most recent available) show that Guy's has improved 8 places from being the most expensive teaching hospital in 1985 to one of the cheapest in 1987. As this year was one in which our case load was reduced because of the Theatre closures in the summer, it is likely that our cost per case will be even better in 1987 and 1988.

Nurse Recruitment

Nurse recruitment difficulties have affected most London Hospitals over the last year. There has been a shortage of specialist nurses at Guy's in care of the elderly, paediatrics, intensive care and theatres. But there are signs that Guy's is coping with this better than its neighbours. Our vacancy level (13.5%) is still too high, but it is one of the lowest in London and there is progress towards almost full recruitment in key areas such as the theatres. This is a tribute to the energy and determination of nurses at all levels throughout the hospital, but we will need to continue to pay attention to this and specific action is planned for 1988/89 which we believe will enable us to improve our recruitment of nurses.

Financial Prospects for 1988/89

Current revenue projections for the Guy's Acute Unit indicate that a "break-even" position will be achieved by the end of the current (1987/88) financial year and the Unit will, therefore, be able to plan for the 1988/89 Business Programme on the basis that there will be no recurring overspending, carried forward.

However, this position has only been achieved because of the following factors:-

(a) the DHA agreed non-recurring support of £215,000 which the Unit will need to call upon.

(b) the delay in opening the Observation Ward saved the Unit £150,000.

(c) the Ministerial announcement on cash limits in December will result in an additional £353,000 allocation, non-recurring.

(d) staff vacancy levels were higher than expected.

(e) whole wards were closed and on others there was a reduction in available beds due to short-term recruitment difficulties.

(f) British Telecom refund £138,000.

and despite the fact that the following reductions were made to the Guy's budget compared with the expenditure agreed in the Business Programme 1987/88:

	£000's
- Multi-District Specialties Cost Improvement Programme.	35
- Reduction in allocation to Renal Directorate	122
- Shortfall in Learner Nurse allocation	570

None of the advantages listed as (a) to (f) above can be expected to re-occur in the coming financial year and must therefore be excluded when drawing up the 1988/9 Business Programme.

Budget Review

During the last three months considerable work has been undertaken within the Guy's Unit to review each individual budget in order that a realistic revenue budget can be arrived at for 1988/89.

This exercise has resulted in an internal redistribution of revenue to support underfunded services and thereby maintain the current level of service provided by the Unit.

Key Issues for 1988/89

The total running costs of Guy's Hospital for 1988/89 at March 1988 price levels has been costed at £51.574m as compared with £51.7m for 1987/88.

It must be emphasized that this costing allows for no growth whatsoever and has only been arrived at after the most rigorous examination of all current expenditure.

During our Budget Review Meetings we were frequently asked by Directorates and Departments alike to provide additional funds

for much needed projects. None of these have been included in our Business Programme for 1988/89. In our view none of the proposals submitted was frivolous or proposed anything other than sensible developments which the hospital will have to consider at some time or another. The total value of the bids that we did not include exceed £2.0m and for convenience a summary of these unmet needs are included elsewhere in the Business Programme.

Broadly, our Business Programme aims to:

(a) begin to achieve the aims and objectives of our 5 year plan (included later on) particularly in paying more attention the relationships between quantity and quality and the crucial need for all staff to be fully motivated to be more efficient.

(b) maintain caseload at least at 1987/88 levels with some increase in quality.

(c) live within budget.

(d) enable the re-opening of Charles Symonds Ward which is temporarily closed at present.

(e) enable the continuation of the Observation Ward and Day Care Surgery, for which full funding has not been received from the RHA.

The net recurring allocation for Guy's Hospital notified by the District is £49.879m for 1988/89, which after adjustment for learner nurse shortfall, the allocation agreed by the NHS Management Board for the Resource Management Project, and other adjustments, amounts to £51.466m. This compares with an expenditure forecast of £51.574m which leaves a marginal deficit of £108,000 which the hospital will address in discussion with members of the District Management Board during the year.

Phase III

The hospital has previously made a commitment to raise £2m towards the cost of the Phase III redevelopment. This would require a saving of roughly £350,000 a year which would transfer to our capital account. It has not been possible to allow for this in our 1988/89 budgets because to do so would have required a reduction in the services provided by Guy's Hospital.

Lewisham Hospital

The financial situation at Lewisham Hospital has been a cause of great concern to all the staff at Guy's. The plans set out in the Lewisham Unit Business Programme show that the hospital will have dealt with its recurrent overspending problems within the next two years. This will undoubtedly be a time of great stress for Lewisham, and Guy's has offered to do whatever it can to help. In particular there will be a joint approach to medical emergencies and it is suggested that the recent improvement in surgical waiting lists at Guy's might enable some more work to be done at Guy's, thus easing the pressure on Lewisham.

Pay Awards

It would not be possible for the hospital to absorb an underfunding for pay awards without reducing services. If we were required to fund the 1% shortfall (approximately £350,000 in 1988/89) this would be achieved by a reduction of 35 w.t.e. staff for a full year. This in turn would require the closure of 1.5 wards for all or part of the year.

Finally

The next year provides an opportunity for us to build on our past successes and to make progress on our aims and objectives for the next five years. This is very much dependent on continued financial stability and freedom from the ill effects of drastic centrally ordered changes to our financial baseline which come during the course of the year. Whilst 1988/89 remains a difficult one for Guy's Hospital we believe that with that stability we will be able to tackle the challenges with increasing confidence and success.

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2. FINANCE AND MANPOWER STATEMENT

This section sets out in more detail the financial situation for 1988/89 described in the foreword.

Details of the source of funds statement and proposed budgets for 1988/9 are shown on the attached Appendices 1 and 2.

Source of Funds

Using the latest issued draft allocation figure of £49,879,000. Appendix 1 identifies the anticipated additional allocation adjustments including the Evelina Appeal funding for nursing posts in the Paediatric Directorate. The total level of funding within which the budget setting process has taken place is £51,466,000. As part of the process, estimates have been made on the level of student nurse availability and the cost of replacement of any shortfall with trained staff. This exercise revealed a total requirement of £1.4m compared with an agreed funding level of £850,000. An additional £150,000 has therefore been included as a non-recurring addition but subject to confirmation of actual student numbers and additional expenditure incurred. The remaining balance of £400,000 has been found through internal redistribution.

1988/89 Budgets

An analysis of the Directorate and Residual Functional Budgets for 1988/89 are shown in Appendix 2. These total £51,574,000 and represents an overcommitment of £108,000 compared with the estimated available funding. In addition to providing for the full year effect of changes to the 1987/88 budgets these start figures incorporate £1,122,000 for new developments as detailed elsewhere in the plan, and further savings of £1,909,000 which have been extracted, as part of the budget reviews.

Manpower

The total manpower level within the hospital is planned to reduce during 1988/89 from 2915.99 w.t.e. to 2908.39 w.t.e. a reduction of 7.60 w.t.e. Details of the various movement between budgets and the actual 1987/88 and 1988/89 total manpower figures are shown in Appendix 3.

Vacancy Factor

A vacancy target of £385,000 has been set. As in 1987/88 fortuitous savings (i.e. normal turnover) accrued from vacancies will be deducted from Directorate and Departmental budgets.

Nuffield House

The provisional budgets set out at Appendix 2 do not take account of the income targets set by the District Health Authority, or the accumulated debt of £1.8m. Our proposals for dealing with this issue are described in Section 6, "Income Generation".

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3. UNMET NEED

During the Budget Reviews for this Business Programme the Unit noted a number of bids, for which it accepted the need, but was unable to fund in the coming financial year. Shown below is a summary by Directorate and Department of these bids. These only represent the tip of an ever growing iceberg, as a number of bids were not put forward by the respective managers as they knew there were no funds available to allow them to proceed.

The outstanding bids are summarised below. Staff, where requested have been identified separately, but the total value of the outstanding bids shown in the right hand column also includes requests for additional non-recurring funds.

None of the requests could be regarded as unreasonable. For example, the additional staff for paediatrics are nursing staff who are needed to support our present caseload and whose salaries are currently paid for by the Evelina Childrens Fund.

	W.T.E.	£
Directorate of Surgery	9.43	124,048
Directorate of A/E & Orthopaedics	6.50	85,600
Directorate of Medicine	6.00	130,400
Directorate of Neurosciences	1.00	38,800
Directorate of Paediatrics	30.05	369,000
Directorate of Obstetrics & Gynae	8.00	88,000
Directorate of Renal Services	2.00	107,000
Directorate of Cardiac Services	9.00	100,900
Directorate of Oncology	1.50	55,000
Directorate of Anaesthetics		30,000
Directorate of Radiological Sciences	0.39	23,300
M.S.S.E.		100,000
Drugs		100,000
Estate Management		7,500
Non Capital Programme		150,000
Maintenance and replacement Medical Equipment		500,000
	73.87	2,009,548

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4. DIRECTORATE PLANS

Introduction

The Directorate Plans for 1988/9 have been compiled as a result of an exhaustive programme of budget reviews which have been undertaken over the past three months. It was made clear to directorates that the 1988/9 budgets would be constructed on a zero based forecast and that any additional developments would have to be funded by savings and internal redistribution. As a result over 1% of revenue was identified for internal redistribution within the Unit and the Directorate Plans reflect this.

Surgical Directorate

(a) 1988/9 will see a full year's operation of the Day Surgical Unit and it is hoped that 1500-1800 cases will be treated.

(b) The Directorate is concerned with the increased growth of the waiting list and has therefore bid to the central waiting list fund to provide an additional 12 beds which would allow the treatment of an extra 840 cases in a full year at a cost of £288,000.

(c) The Directorate has reached an agreement with the London Bridge Hospital to use their Lithotripter for NHS patients. This will enable the Directorate to enclose the balcony on Martha Ward to gain an extra 4 beds. For this purpose and to enjoy a cash income the cross charging of other Districts has been agreed in principle with the RHA and will be introduced in 1988/9.

Accident and Emergency and Orthopaedics Directorate

(a) Although the RHA is only providing a proportion of the cost the Observation Ward will be funded at a full year cost of £274,570 in 1988/9 and it is hoped that in 1988/9 4,000 bed days on other wards will be saved. A recalculation of the original submission for transitional funding has been done but early indications are that the RHA will only provide funds at the level of the first submission. The discrepancy was a direct result of the very limited time allowed for the submission of bids.

(b) It has been possible to reinstate the Saturday mornings clerical cover in the A & E Department by the re-application of internal savings.

(c) A computerised A & E register will be established in 1988/9 at a non-recurring cost of £20,000.

(d) With the introduction of the ICL Patient Administration System it is intended that the decentralisation of admissions to individual Directorates will be completed.

(e) The management of the Hospital's Transport Department will be transferred to the Directorate.

(f) A bid to the central waiting list fund has been made for the enclosure of the two balconies on the orthopaedic wards creating an additional 8 beds. This bid should allow the treatment of an additional 300 orthopaedic and 250 plastic surgery cases in a full year, will reduce the waiting lists considerably and keep them at manageable levels. A total of £200,000 revenue and £90,000 capital has been requested.

(g) Joint Finance has been applied for in respect of the appointment of a Discharge Liaison Officer.

Medicine Directorate

(a) Following the considerable upheaval which accompanied the New Cross transfer, it is expected that 1988/9 will see a year of consolidation for the Medicine Directorate with caseload maintained at 1987/8 levels.

(b) A GP Direct Referral Service will be established in which special times are reserved to see patients on an out-patient basis. A direct line will allow GP's to discuss patients' symptoms and the service will hopefully reduce both out-patient waiting times and pressure on the A & E Department.

(c) It is hoped that recent recruitment initiatives will result in the re-opening of the Geriatric beds on Charles Symonds Ward.

(d) An SHO rotational scheme with Lewisham and Hither Green Hospitals will be implemented.

(e) A review of Dermatology out-patient scheduling will result in an increase in the number of new patients seen with a consequent reduction in both follow-up attendances and the waiting time for a first appointment which currently stands at 19 weeks.

(f) Conversion work on William Gull Ward has been funded by RHA AIDS money which will provide single room facilities for the possible treatment of AIDS patients. A further bid has been made to the District for 5 wte nurses to run this service. Notification of the 1988/9 Regional AIDS money is awaited.

(g) A bid has been made to the Strategy Group for the Provision of Services for the Elderly for pump-priming money to enable the appointment of a Discharge Liaison Oficer.

(h) Following a Consultant retirement, a bid has also been made to the RHA for the appointment of a Consultant Physician with an interest in Diabetes.

(i) It is anticipated that the recently completed refurbishment of the Lloyd Clinic will facilitate a general increase in activity in Genito-Urinary Medicine.

Neurosciences Directorate

(a) The appointment of a Senior Lecturer in Neurology and Rehabilitation has taken place and 2 NHS sessions will be funded by the Directorate.

(b) The Ward Receptionist on Bright Ward will be made up to full-time (+ 18 hours) thus improving admission and discharge arrangements.

(c) Discussions are at a preliminary stage on the possible transfer of the Pain Relief Service to this Directorate in 1988/9.

(d) Some additional funds were received in 1987/88, and a further application has been made to Region for increased funding for Plasma Exchange Services.

Paediatrics Directorate

(a) A complete review of the current nursing establishment has been undertaken but the increases recommended cannot be funded within the Unit's budget. The Evelina Appeal Fund will continue to fund 17.5 wte nursing posts within the Directorate.

(b) It is anticipated that there will not be an increase in workload during 1988/9 although the Directorate will be monitoring the effects of increased foetal cardiac work and changes in legislation.

(c) Bid for central waiting list funds have been submitted in respect of:

- an additional 400 paediatric surgical cases per annum with the re-opening of 4 beds on Ronnie MacKeith for 5 day operation and 2 beds on Borough for day cases at a cost of £181,000 per annum.

- an additional 96 paediatric cardiac cases on Russell Brock at a cost of £262,200 per annum.

(d) ENB approval has been given for the establishment of a post-registration nursing course in Paediatric Intensive Care in 1988/9.

Obstetrics and Gynaecology Directorate

(a) The creation of the private Nuffield Ward in the Tower will result in considerable ward movements for the Directorate involving Braxton Hicks, Lever and Blundell. There will be no significant reduction in NHS beds during the process although it will provide an opportunity for a review of bed usage.

(b) It is hoped that the regional standard obstetric computer system (Euroking) will be installed in 1988/9 if Regional funding is made available.

(c) The recently opened Day Surgery Unit will now accommodate the majority of TOPS work, thus reducing the reliance on fully staffed beds.

(d) The Directorate will continue to develop fertility services for District and Regional patients including IVF and GIFT.

(e) It is felt more appropriate to transfer the Cervical Cytology budget to the Directorate of Pathology (Histopathology). This will include £9,000 for the maintenance of the Radius Computer System.

(f) A waiting list bid has been submitted to the Region to address the increasing problem of patients needing urgent gynaecology treatment, particularly colposcopy. An additional 200 colposcopy and 50 gynaecology patients would be treated at a cost of £60,500 per annum.

(g) Additional space for colposcopy clinics will be made available at a cost of £2,000 for minor conversion work.

Oncology Directorate

(a) To comply with the Ionising Regulations 1985, lead shielding will be installed on the 8th floor of New Guy's House at a cost of £9,000.

(b) An increase of 2 wte staff nurses on Samaritan Ward will take place to reflect the increased level of workload.

(c) The possibility of recharging other Health Authorities for patients referred for Irridium treatment, will be investigated.

(d) Planning and enabling works will continue in 1988/9 in respect of the Radiotherapy Bunker with a view to commissioning the new LINAC at the end of 1988/9 and the consequential upgrading of the remainder of the Department.

Dental Directorate

Unlike the relationship between Guy's Unit and the Medical School, there is a totally different functional necessity between the Dental Hospital and School. This difference needs to be explained when considering dentistry in the Business Programme or with objectives outlined in forward planning.

Over 95% of the workload recorded for the Dental Hospital's 201,000 attendances in 1987 was carried out for patients by students in training. These patients could just as easily receive that treatment in a general dental practice outside the hospital. This contrasts sharply with the treatment for which patients are perforce referred to hospital by doctors. If treatment efficiency alone is the criterion, this would be dramatically improved by substituting the resource cost of students by a smaller cohort of qualified staff dentists.

- The priorities for provision of care in the Dental Hospital need clearer definition in the future if understanding of its apparent costliness for consumables be judged in comparison with other directorates. There are three major considerations. First, there is a service commitment for the treatment of trauma and relief of pain for those without immediate access to a general dental practitioner. The Primary Treatment Unit exists to satisfy this important demand. Secondly, a specialist referral service must be provided for dental treatment and/or advice for residents of the District. Thirdly, by virtue of the £2.84m funding from the Region for Service Increment for Teaching (SIFT) there is a clear duty to make facilities accessible for training clinical undergraduate dentists. While training they will carry out routine dental procedures on suitable patients. Whether any of these service priorities constitutes a multi-district specialty for Lewisham and North Southwark Health Authority has not been confirmed.

If we are to remain the most prestigious Dental School in the UK, as well as the biggest, our aspirations to remain viable when the closure of further Dental Schools is considered, will depend upon our ability to continue producing adequately trained dentists. Sufficient resources to do this will be determined by manpower demands, which may well change. It is hoped to safeguard the likelihood of our survival as the Dental Teaching Hospital in the South by maintaining an expanded programme of post-graduate education which provides advanced forms of treatment.

Finally, there will be a high benefit to cost ratio for any support the hospital may give to the many research programmes continuously underway in the Dental Hospital and School.

The funding allocated to Dental Hospitals by the DHSS directly through Regional Supplies is essential for the maintenance of major dental equipment. Any Regional cuts in this funding would result in further financial burden upon the District.

(a) The Health Care Registration module of the ICL PAS system will be installed and the Directorate will be investigating additional computer applications such as chair booking, diaries and the coding and tracing of notes.

(b) The successful implementation of decentralised non-admin budgets to sub-specialties will continue in 1988/9.

(c) The policy of flexible admin and clerical gradings within total budget will be continued in 1988/9.

(d) The increased cost of consumables has been recognised by a £89,000 increase in the Directorate's non-pay budget transferred from savings in staffing.

Anaesthetics Directorate

(a) An additional Consultant Anaesthetist will be appointed in 1988/9 with 7 sessions at Guy's and 4 at Lewisham.

(b) A Consultant for the Intensive Therapy Unit will be appointed in 1988/9 and further discussions will take place on whether a separate ITU Directorate should be established.

(c) Development funds of £30,000 have been provided for equipment replacement.

Radiological Sciences Directorate

(a) A key objective for the Directorate is to make the new digital imaging installation in the link theatre fully operational and to introduce an efficient vascular service, responding to the increased level of demand expected from the District and other parts of the Region. In order to maximise the use of this equipment a proposal is under consideration to offer sessional use to selected Radiologists from other Districts on a fee basis.

(b) It is hoped to expand the computerised reporting system into out-patients and wards to reduce the time patients wait for results.

(c) No changes to the Directorate's budget or manpower figures will take place.

Pathology Directorate

(a) An additional Consultant Histopathologist will be appointed with the Hospital providing half of the revenue costs, (£16,500 p.a.) from savings on Medical Staffing within the Directorate. This sum has already been top-sliced by the District.

(b) An additional w.t.e Technician will be appointed in Histopathology from savings in junior medical staffing.

(c) The Directorate will investigate the feasibility of taking over the Pathology services required by the Drug Trials Unit which is a potential source of income.

(d) The budget for the phlebotomy service has been withdrawn and the Outpatient Phlebotomy Service will not be reinstated.

Renal Directorate

(a) Essential maintenance will take place in Bostock House to comply with Health and Safety regulations and the possibility of creating a waiting area/counselling room will be investigated.

(b) The Directorate has made a bid to the Region for £155,000 to purchase an additional dialysis machine and £5,500 for an extension to the existing computer system.

(c) 2 wte Ward Receptionists will be appointed for Bostock House and Astley Cooper Ward to ease pressure on the nursing staff and to aid recruitment.

(d) Negotiations will continue with the British Kidney Patients Association for the funding of a half-time Welfare Officer for an initial two year period.

(e) It is anticipated that the number of patients on the End Stage Renal Failure Programme will increase by 25-30 in 1988/9.

(f) An additional Consultant will be appointed in 1988/9 to meet the increased patient activity which is being funded by the Region.

Cardiac Directorate

(a) 2 wte Ward Receptionists will be appointed on the Medical and Surgical Intensive Care Wards to ease the pressure on nursing staff.

(b) Cross-charging will be introduced (on 1st April 1988) for open-heart surgery and angioplasties which will enable the increased level of patient activity to be maintained.

Central Services Directorate

Central Services provide a vital service to the hospital and it is essential that all who work in them feel part of the team and are aware of the objectives of Guy's Hospital and their potential contribution.

We intend to clarify our management arrangements by setting up a Central Services Directorate. It is intended that the Directorate should meet regularly and be similar to a Clinical Directorate in its relationship to its constituent specialties. It is also intended that the Directorate be represented on the Board and that some of the Managers of the larger Departments should be invited to attend Board meetings regularly.

The next year will be a challenging and exciting time for the Central Services Departments.

Our proposals include:

(a) Clinical Physics

It is proposed to transfer the management of Clinical Physics to the Medical School from April 1st 1988. This change will be accompanied by a separation of the maintenance work previously undertaken by Physics which will be transferred to the EBME service set up in 1987 as part of the Works Department. As a result a number of posts in Clinical Physics are under review.

(b) Works

The improved appearance of the hospital site and its buildings is one of the main features of our five year objectives. In the next year we will aim to identify an increased annual percentage to be spent on works and maintenance.
This in turn will enable a more extensive painting programme than is possible at the moment. We will also consider ways of strengthening works middle management so as to achieve this.

(c) Catering

It has been agreed with the Medical School that the hospital catering service should take over their responsibilities and provide a rationalised catering service for the whole site. This change will take effect from the new academic year in 1988.

A takeaway food outlet will open on the site of the present bakers shop in Spring 1988.

The programme developed in 1987 and as a consequence of the removal of crown immunity is now being implemented and this will continue throughout 1988.

d) Porters and Domestic Services

In accordance with the Health Authority's policy we are preparing specifications to submit the Domestic Department at Guy's Hospital to competitive tendering in accordance with Circular No. HC 83(18). We are also considering an alternative proposal which would involve contracting with a commercial organisation to take on the management of both the Domestic and Portering Departments at Guy's Hospital. Under this arrangement the management of the staff would be undertaken on contract with the private sector but the workforce in the Portering and Domestic Departments would retain their Lewisham and North Southwark contracts of employment. The successful Company will be required to demonstrate that specific standards can be achieved for a given cost, and that higher standards and efficiency savings through cost improvements can be attained. The emphasis of this contract is to define a standard, and performance will be measured against that standard which the contracting company will be expected to guarantee in both quality and cost terms.

It is anticipated that this contract will improve standards by approximately 5%, for example undertaking bed cleaning and remaking, thereby freeing nursing staff to concentrate more time in patient care.

(e) CSSD

This service transfers to the management of the District Headquarters on 1st April 1988. As far as Guy's Hospital is concerned the highest priority is the introduction of a formulary for equipment provided by the CSSD, which we believe will enable significant savings to be met in this area.

(f) Medical and Surgical Supplies

Supplies management transfers to the District on 1st April 1988. Like CSSD our priority for 1988/89 is the production of a formulary for Medical and Surgical Equipment.

(g) Telephones

The target date for the installation of the new Guy's Hospital switchboard is February 1989. An up-to-date directory will be published at the same time.

(h) Reception Staff

One of our most important aims is to set higher standards for the way that the public are welcomed to Guy's Hospital. Part of this approach involves refurbishing the public parts of the hospital. In addition we will be providing specialist training and support for all staff on reception duties to help them achieve this objective.

(i) Crown Immunity and Fire Precautions

The Guy's Unit is aware that the removal of Crown Immunity has widespread implications throughout the Unit, and all Departments are required to review their departmental health and safety policy and to conduct a health and safety audit. It is anticipated that the result of this audit may identify recurring and non-recurring expenditure that will require funding in the year 1988/89 and for this reason it has been necessary to allocate some minor block capital to address this problem, despite the growing problems of background maintenance.

The Unit attaches considerable importance to this issue and we have already appointed a Hygiene Control Officer to the Catering Department who will assist Catering Managers throughout the Authority to set quality standards which will be closely monitored. In order to support this we are committed to a high level of hygiene training for food handling staff.

It is our objective to improve the standard of fire prevention and we have agreed to appoint an Assistant to the Fire Prevention Officer which will be joint funded with Priority Care, and this will enable more staff to be trained in fire prevention and closer monitoring of fire prevention procedures, e.g. ensuring fire doors are closed, and ensuring fire escape routes are kept free of rubbish and discarded furniture or equipment.

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5. KEY OBJECTIVES

Introduction

The following section outlines the way Guy's Hospital will approach the set of objectives laid down by the District for 1988/9. For ease of reference the numbering system relates to that used throughout the District's guidelines for the Business Programme. Much work has already been completed on the production of objectives for Guy's Hospital over the next 5 years. See Section 10.

(a) Objectives Relating to Planning for the future

Objective 1.1 - "To Progress Guy's Phase III to Budget Cost Submission"

The Projects Directorate will continue to progress the Phase III project during 1988/9 and are aiming towards a target of October 1988 for the formal Budget Cost Submission. Project Managers (CONSPECTUS) have been appointed by the Regional Health Authority and the Design Team of relevant building professionals has been established. Regular Project Team and Design Team meetings will be held during 1988/9 and smaller sub-groups will continue to look at capital costings and cash flow, revenue costs and manpower and enabling works. The Unit is achieving a very high programme for the preparation of briefing information.

(b) The Delivery of Services to our Patients and our Local Population - Acute Services

Objective 2.1 - "To identify the volume of activity which can be maintained without detriment to service quality"

Objective 2.4 - "To maintain the 1987/8 levels of caseload and patient activity"

These two objectives are taken together as they ae so inter-related.

The budget reviews that have taken place with each Directorate have been undertaken on the basis of zero growth of both revenue and caseload. It is, therefore, planned that the Guy's Hospital Unit caseload target will be 35,896 which is the current projection for 1987/89. Any additional caseload will be the result of successful bids for additional funding such as waiting list monies. If the Unit does not receive the revenue needed to run the Unit at this level or if there is an underfunding of pay awards then the contingency arrangements outlined in Section 2 of the Guy's Business Programme will greatly effect the caseload figures. In line with the development of resource management, with its emphasis on the integration of financial, manpower and activity at Directorate level, activity reporting on 1988/9 will be split by Directorate.

Objective 2.2. - "To identify specific quality targets for service provision"

The Quality Assurance Committee at Guy's will be building on the work carried out during 1987/8 and will be monitoring caseload levels and aspects of care such as the number of cancelled admissions, waiting times and waiting lists. In addition the Committee will be concentrating on improving the quality of service given to patients by our reception staff.

Objective 2.3 - "To maintain as first priority services to District residents"

For District Acute Specialties the Hospital now records waiting lists separately for District and Non-District patients and precedence is given to District patients whenever the minimum waiting time of 8 weeks for an out-patient appointment is exceeded.

Objective 2.5 - "To increase day case activity"

1988/9 will see a full year's running of the Day Case Unit, established using transitional funds in 1987/8. It is anticipated that 1500-1800 cases will be treated per annum in this Unit and will include TOPS cases previously dealt with through staffed beds.

Objective 2.6 - "To reduce the numbers of cancelled admissions"

The policy of decentralisation of admission procedures to Directorates, linked to the installation of the ICL Patient Administration System, should be completed in 1988/9 and will make the whole process more efficient and flexible. The Quality Assurance Committee will continue to monitor the number of cancelled admissions although it is difficult to foresee any marked reduction when bed occupancy across the Unit remains at such a high level.

Objective 2.7 - "To improve systems for planned discharges"

The major problems associated with this objective lie in the lack of notification to Community Services or insufficient notice of discharge. The Hospital has clarified responsibilities on the Wards and the creation of Ward Receptionist posts (continuing in 1988/9) will provide for better procedures and notification. Guidelines have been issued to medical staff from the Quality Assurance Committee and seminars held to stress the importance of planning discharges. A bid has been made to the Strategy Review Group for a Discharge Liaison Officer in Geriatric Medicine and to Joint Finance for a post in Orthopaedics where 24% of beds are blocked by non-acute cases. Monitoring will continue by the Quality Assurance Committee. If plans to reduce Hospital Social Work support are implemented by the London Boroughs of Southwark and Lambeth then the situation will get worse.

Objective 2.8 - "To reduce waiting times for first out-patient appointments"

The waiting times are monitored regularly by specialty, and Directorates are asked for explanations of high figures. Proposals for 1988/9 which will have an effect on waiting times include the review of Dermatology out-patient scheduling with greater concentration on new attendances within existing sessions and the GP telephone referral service in Medicine. The decentralisation of out-patient scheduling will improve the efficiency of the service and the Quality Assurance Committee has issued guidelines on good practice. New guidelines will be issued to all local GP's in 1988/9 and will not only include basic information on how to arrange appointments and the list of clinics, but will also give them waiting times for routine first out-patient visits and in-patient treatment split by District and Non-District patients.

Objective 2.9 - "To reduce waiting times in Out-patients and A & E"

Guidelines stipulate that 75% of patients should be seen within 30 minutes of their Out-patient appointment and no more than 3% should wait for more than one hour. The introduction of computers and the decentralisation of out-patient management, linked to realistic appointment scheduling should assist in keeping to these recommendations. Regular monitoring will be undertaken by the Quality Assurance Committee. In A & E it has been agreed that no patient for admission should wait for longer than 30 minutes. The introduction of a computerised register should assist in the monitoring process.

Objective 2.10 - "To improve the accuracy of recording hospital activity"

The forthcoming installation of the ICL PAS should greatly increase the accuracy of recording activity as should the A & E computer, obstetric system and the decentralisation of management of admissions and out-patients. The completion of discharge summaries, from which Korner data is compiled, are to be rigorously monitored and a suggested target of accuracy has been set at 85%.

Diagnostic Coding Backlog

To catch up on the backlog of coding resulting from staff shortages and turnover, the following steps have been taken to improve the situation:

- staffing establishment is now up to 4 w.t.e. and a bid for a 5th person has been made (the original staffing level was 5 w.t.e.).

- in order to cut turnover staffing grades have been assessed and have been increased from CO to HCO grade (this is the standard grade throughout the Region for coding posts).

- extra staff have been engaged on additional contracts to deal with the backlog.

Discharge Summary/Letter

A new Discharge Summary/Letter is being tried out by Renal, Gynaecology and part of Medicine for a two month period. This is to be reviewed in April and if successful should be extended across the Unit. The aims of this new form are as follows:

- These forms should contain sufficient information in order to code the discharge and thereby eliminate the need for the Diagnostic Coding Unit (DCU) to retrieve the casenotes. Retrieval of casenotes has been identified as both time consuming and ineffective in cases where the clinician retains the casenotes for follow-up treatment. There are instances when DCU are coding discharges which are 3 years old.

- The introduction of this form should bring about standardisation of the required information for coding purposes and thus quicken the coding process.

- We are also considering splitting the coding work in order that each member of the coding staff may gain an expertise in set specialties.

District Information System (DIS)

As far as Guy's Unit is concerned this has caused many problems. Firstly it is a duplication of the work already done by the Admissions Department and secondly access to the system has been plagued by downtime. All of this has therefore resulted in a backlog of work. Objectives relating to DIS are as follows:

- to deal with accrued backlog using extra staff in 1C where possible.

- once the ICL Inpatient Module is installed at Guy's, the DIS will be integrated so that Inpatient Activity is automatically transferred.

- Diagnostic Coding will be transferred from PRIME to DIS. This has been delayed in view of their backlog and the problems encountered with access to this system.

Data Capture

There are a number of areas (particularly Day Case Units such as Bostock House) which need to be brought in line and this should coincide with the implementation of the new PAS. They are being taken into account in procedures being drawn up but do pose a certain manpower problem where this will cause extra work for areas with little or no clerical support.

Operating Theatres

Information about activity within the theatres should improve with the introduction of FIP. It is not yet possible to say whether there will be any manpower implications of this.

(c) Multi-District Specialties

Objective 2.11

The Hospital was disappointed that Paediatric End Stage Renal failure was transferred from a Supra-Regional to a Multi-District specialty for 1988/9.

Although the specialties where de-classification has been accepted will continue at current levels of activity, these levels will be monitored and the Hospital will be agreeing with the Directorates concerned, longer term proposals which may include cross-charging. From 1st April 1988 cross-charging will definitely be inroduced for open-heart surgery and angioplasties.

The Hospital is awaiting the RHA's decision on those specialties where a case has been made for the retention of Multi-District status, i.e. paediatric surgery, paediatric burns and paediatric assessment.

In addition the Hospital will be pushing for Regional recognition of the Neonatology service at Guy's.

(d) Terminal Care Services

Objective 2.19 - "To maintain the existing level of Terminal Care Services and to provide secretarial support to the Consultant"

The Unit will be appointing a Secretary for the Consultant in Terminal Care and will be recruiting to vacant nursing posts in the Symptom Control Team. Continued emphasis will be put on communications with referring Clinicians and on enhancement of the teaching programme.

(e) AIDS

Objective 2.22 - "To provide appropriate services to AIDS patients"

HIV testing facilities and the counselling service, established in 1987/8 from Regional AIDS funding, will continue in 1988/9 in the recently refurbished Lloyd Clinic. In addition an upgrading programme of 5 single rooms is underway on William Gull Ward which will accommodate the in-patient treatment of AIDS patients if necessary. Capital has been provided from the RHA's AIDS fund and the Unit is waiting to hear if the 1988/9 allocation will enable the Unit to be staffed.

(f) Breast Cancer Screening

Objective 2.23 - "To implement, as appropriate to the District, the Forrest Report proposals on Breast Cancer Screening"

As part of the South East London Breast Screening service it is proposed that Guy's will provide an Assessment and Biopsy Unit for women who have had abnormal breast cancer screening tests. The cost of providing this service on the Hedley Atkins Unit is assessed at £55,899 per annum with £102,900 equipment and building works start-up costs. However, it is unlikely that the Region's plan will involve setting up this Unit before 1989/90.

(g) Cervical Cytology Call and Recall

Objectives 2.24, 2.25, 2.26 and 2.27

The Guy's Hospital cytology laboratory will be providing part of the smear testing service to assist with the implementation of a full call/recall system for 4 community patches in 1988/9. An additional Consultant and Technician will be appointed in Histopathology (half the cost of the Consultant will be funded by the Unit) and the cost of the maintenance contract on the Radius Computer (£9,000) has been included in the budgets.

(h) Health Promotion

Objective 2.28 - "To implement across the District the Authority's agreed Health Promotion policies"

The Unit has implemented the Authority's policies on No Smoking, Healthy Eating and Sensible Drinking and will be continuing to monitor their success in 1988/9.

(i) Services for Adults with Physical Disabilities

Objective 2.29 - "To develop an integrated District-wide plan for the provision of services to adults with physical disabilities"

he appointment of a Consultant Neurologist (Senior Lecturer) with an interest in this field will provide a much needed co-ordination of rehabilitation services including the in-patient rovision at Dunoran. The Guy's Unit will be funding 2 sessions of this post.

(j) Improving the Organisation

Revenue

Please see Section 2.

Staff

<u>Objective 3.2</u> - "To identify and implement measures which are reasonably within the control of the Health Authority to increase levels of recruitment and retention of staff"

The Guy's Unit is currently experiencing serious difficulty in recruiting to posts in various professional groups including Psychiatric, Geriatric, Paediatric and ITU Nurses, MLSO's, OT's Speech Therapists, Pharmacists and Works Officers. In addition medical and general secretaries are difficult to attract because of the low levels of pay when compared to other employers in the vicinity.

In 1988/9 the Unit will be aiming to improve on its recruitment performance for these groups and to increase retention rates by:

- reviewing the Unit's advertising policy.
- the introduction of performance review.
- the introduction of a YTS scheme for clerical staff.
- introducing a rolling "Customer Relations Training Programme".
- improving links with local schools and colleges.
- expanding the joint management development initiative with the King's Fund.
- Developing within the workforce a common sense of purpose and identification with Guy's.

Particular attention will be paid to nurse recruitment by:

- the appointment of a nurse recruitment officer.
- the provision of additional clerical support on the wards to reduce the level of routine paperwork carried out by nurses.
- giving accommodation priority to nurses in "hard to recruit" areas.
- implementing parking concessions.
- increasing the ward work undertaken by ancillary staff, e.g. bed making.

Objective 3.3. - "To implement the management development programme District-wide"

Substantial progress was made in management development during 1987/8 with the establishment of the King's Fund College link and the appointment of a Field Fellow under the auspices of the Resource Management Project. It is hoped that in 1988/9 the programme will be extended to cover the Executive and Heads of Department. A detailed implementation programme for 1988/9 is now available.

A system of individual performance review will begin to be implemented in 1988/9. This will include:

- Chairman/Chief Executive and Central staff
- Clinical Directors
- Business Managers
- Senior Nurses
- Heads of Departments

The programme will take two years to implement fully, but it is anticipated that substantial progress on clarifying roles and setting objectives for the above groups of staff will have been made by the end of 1988/89.

Objective 3.5 - "To finalise the District's Equal Opportunities Policy and implement its recommendations"

Guy's Hospital will consider how best to implement the Authority's policy on Equal Opportunities when this has been agreed by the Authority.

Objective 3.6. - "To Implement Cashless Pay"

Although the lead role in the achievement of this objective will be taken by the District Payroll Department, the Unit will be assisting in the implementation of cashless pay. The Unit's allocation has already been "top-sliced" to provide for the incentives being offered to staff and it is hoped that the savings that accrue from the scheme will also be allocated to the Unit's at a later date.

(k) Capital Resources

Please see separate section.

(1) Information Systems

<u>Objective 3.19</u> - "To implement the PAS system through installation of ward based terminals"

Guy's Hospital plan to install ward terminals by the end of March 1989. However, this will depend on resources being made available and obtaining the commitment of ward staff. It is also being considered that terminals should be provided in Bostock House for the recording of Day Case patients and in the Maternity Unit in order to deal with healthy babies.

<u>Objective 3.21</u> - "To introduce the IPS system for staffing and manpower"

Detailed procedures for the collection of the data for IPS are currently being worked up and training of the "end-users" will take place before the system goes live in June 1988. The final stage of implementation will be completed when a direct link to the payroll computer is established. This will enable managers to input pay details on a weekly/monthly basis and will also provide financial information downloaded from the payroll to IPS. All Business Managers and Heads of Department will have access to a terminal and after the system goes live they will be responsible for maintaining the records of their staff and for inputing data on starters and leavers.

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6. INCOME GENERATION

Each year Guy's Hospital has a proportion of its allocation expressed as an income target. For 1988/89 this will be £1.36m. Of the total target of £1.36m approximately £360,000 will be accounted for by way of income that we will earn from receipts for road traffic accidents, prescription charges, and rents from the Guy's aerial farm.

It may be possible to earn additional income in 1988/89 by introducing more revenue generating schemes such as contracting out our incineration services to other organisations, greater sales to the private sector, and increased charges for the aerial farm. But these are unlikely to produce more than £100,000 and will thus have only a marginal effect on the hospital's target.

It is therefore proposed to re-introduce Section 65 private practice to the Guy's site.

This will be undertaken in two stages.

(a) Nuffield Ward

The creation of additional beds on the 16th floor of the Guy's Tower to provide a self-contained private unit of 12 beds. This will be achieved with no significant loss of beds elsewhere in Guy's by carrying out enabling alterations on 14th and 15th floors of the Guy's Tower. The total cost of all the necessary work has been offset against the likely income to be earned, and after paying for the conversions will generate a profit of approximately £100,000 clear in 1988/89.

In addition to the income the hospital will also gain the advantage of having refurbished wards on the 14th, 15th and 16th floors paid for from private patient income,and ultimately additional beds for the NHS when Nuffield House re-opens.

(b) Refurbishment of Nuffield House

It is proposed that the hospital should take over the project for the refurbishment of Nuffield House. A feasibility report has been prepared by Watkins Gray International, and Dauncey Lynde Mellstrom and Bass indicating how this could be done. The cost would be dependent on the level of refurbishment which could be met in full from the sale proceeds of Deptford Laundry. The Regional Health Authority have indicated that they would be prepared to release the full sale proceeds from Deptford provided that the funds are used solely for this purpose.

A forecast profit and loss account has been prepared showing the income that would accrue to Guy's Hospital. This indicates that it is possible to achieve a profit of £2m per annum at 70% - 75% occupancy which would be sufficient to (a) offset income shortfall, (b) repay the debts accumulated since 1986 and (c) provide additional funds for the NHS.

For this project to succeed the hospital needs to be run day-to-day on a professional basis. It is proposed that Guy's Hospital recruit a Hospital Director for Nuffield House either directly or via a contractor who would be required to run the hospital in accordance with annual profit and service quality targets with Guy's assuming the role of the holding company.

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7. DISABLEMENT SERVICES CENTRE

The McColl Report on artificial limbs recommends devolution of this function to more local level. Early indications are that the Special Health Authority for artificial limbs will consider a bid to form such a local unit at Guy's with a patient workload of approximately 1200 cases per annum from Lewisham and North Southwark and the immediately surrounding Authorities. A bid is currently being presented to the Special Health Authority for conversion of part of an existing hospital building (Shepherd's House) to provide an immediate and interim solution. Discussions are also in hand with the London Docklands Development Corporation to include a GAIT Laboratory for disabled children in the Guy's area.

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8. RESOURCE MANAGEMENT

Guy's Hospital has been recognised as one of the five pilot sites participating in the NHS Management Board's National Resource Management Project. The programme for 1988/89 reflects our aim to consolidate and further develop our management structure and provide better information about clinical practice and performance. In 1988/89 it is planned to:

(a) Introduce guidelines for Clinical Directors, and agree objectives for Business Managers, and Senior Nurses, as well as in the Central Services, as the first stage in introducing a systematic review of the performance of all hospital staff.

(b) Identify what further training or development is needed and set out programmes for Clinical Directors, Business Managers and Senior Nurses.

(c) Achieve the above objectives as part of the Management Development project now being implemented in collaboration with the King's Fund College.

(d) Further refine and improve the financial information provided to Clinical Directorates to include additional reporting of variable costs, for example, Pharmacy, Radiology and Pathology.

(f) Develop Clinical Information Systems which classify patient episodes into clinical meaningfull groups, stimulate development of clinical peer review, and collect details of the resources consumed by clinical activities.

(g) To commission the FIP Theatre System and use this to improve the utilisation of theatre time.

(h) To commission the Ward based FIP system which links units of nursing time to patient dependancy and enables better planning and management of nursing resources.

A Resource Management Project Steering Group has been set up under the Chairmanship of Professor C. Chantler to review the progress of the project as a whole.

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9. CAPITAL PROGRAMME

(a) Progress Report on the 1987/8 Programme

During 1987/8 a total of 22 schemes were progressing (excluding New Cross schemes) within a total allocation of £1.637m. This allocation was provided from a variety of sources including the minor block allocation, The Special Trustees, land sale proceeds, The Friends of Guy's, Kidney Patients Association and Regional AIDS monies.

Although final figures are not yet to hand it is estimated that there will be an end of year overspend of approximately £58,000 with a carry over commitment of £83,000.

(b) Use of Capital Resources 1988/9

Major Schemes

(i) Replacement Switchboard

Following a detailed analysis of the Guy's Switchboard it has now been agreed that it should be replaced as a matter of urgency. This proposal has been supported by the Regional Health Authority and tender documents are currently being prepared for immediate implementation of the scheme.

In view of the urgency of the scheme, agreement has been reached with the Special Trustees for a loan of £1.2m which the Unit will repay from its Minor Block Capital allocation at a rate of £200,000 per annum for the next six years.

(ii) Radiotherapy Department

The Special Trustees have granted a sum of £1.267m for the Radiotherapy Department which will enable:

- the formation of a bunker for the new LINAC being purchased by the Region.
- works, such as road diversion, to be carried out before the formation of the new bunker.
- minor upgrading of the remainder of the Radiotherapy Department including a new air conditioning system.

Estimated expenditure in 1988/9 is £726,000 with an expectation that the new LINAC will be installed by November 1989.

(iii) Minor Block Capital

As stated in previous pogrammes the Guy's Unit is committed to using its minor block capital allocation to rectify its present and growing problems of backlog maintenance.

The formation of the Guy's Phase III Development will, with the consequent demolition of a number of its condition E buildings, have a significant effect on this declared aim. The Unit's first priorities for the 1988/9 financial year are therefore the enabling works which will free up the Phase III site.

The District Works Officer has identified the main areas where maintenance is urgently required. These fall into the following categories:

- airconditioning/replacement of lifts - continuation of a phased programme.
- structural repairs and building maintenance - continuation of a phased programme.
- maintenance of engineering infrastructure - continuation of phased programme.
- energy conservation schemes - continuation of a phased programme.
- health and safety - continuation of programme of remedial measures consequent upon removal of crown immunity.
- replacement of Tower refrigeration absorption plant.
- phased replacement of electrical distribution system.
- phased major redecoration/building programme.

The Unit has been notified that its Minor Block Allocation for 1988/9 will be £510,000 to which can be added the anticipated proceeds from the sale of the Dunoran Orchard, Deptford Laundry and the part of Nuffield House owned by the Hospital. (This sum will be used for upgrading work and Dunoran itself).

(c) Analysis of Objectives

Objective 3.12 - "To manage the District's Capital Programme as efficiently as possible"

The main procedures for managing the District's Minor Block Capital Programme were agreed in 1987/8 and are now in operation. The Head of District Planning co-ordinates these procedures and will be submitting her own paper on this objective as part of the District Headquarter's Business Programme.

However, there are certain points which the Guy's Unit would like to make on this objective:

(i) The management of individual schemes is the responsibility of the Units but monitoring and reporting procedures are confused because payments against job numbers/cost centres are made at a District level.

(ii) Delays in issuing cost centres/job numbers for schemes result in programming problems within the Unit Works Department. This has a "knock-on" effect on ensuring schemes are completed in the year of funding.

(iii) The Unit Works Department has set up a commitment accounting system for the management of the Guy's schemes. However, as progress is monitored on the basis of payments made, reconciliation is difficult. This is particularly important towards the end of the financial year when the projected out-turn and carry forward commitments need to be assessed.

To try and alleviate these problems it is proposed that:

1. the Guy's Unit should not only run and control each scheme but that the financial reporting should be undertaken by the Unit Finance Director, This would make the system more efficient and would allow closer control and monitoring of schemes.

2. when 1. is implemented a small Capital Monitoring Group would be established with representatives from Works, Finance and Projects Directorates. This small group would meet every month to analyse the progress and expenditure on each scheme. Reports to both the District Capital Planning Group and the Members Sub-Group would subsequently be more accurate.

3. computer links between the Works, Projects and Finance Departments should be investgated if 1. is accepted.

Objective 3.13 - "To deal with maintenance needs in a planned and coherent way"

The Unit recognises the need for investment in backlog maintenance but the very scale of the problem (£17m to bring the District's building stock back to condition B) and competing priorties such as Crown Immunity, Lift Replacements and the Replacement Switchboard make anything but the minimum level of investment impractical. The scale of the problem is well known and attempts have been made in recent years, and will continue in 1988/9, to support small maintenance schemes from revenue allocations.

The continued implementation of the Works Information Management Systems (WIMS) and the Labour Management System will, in 1988/9, assist in the structured planning of maintenance.

The maintenace schemes that will be funded from the Minor Block Capital allocation in 1988/9 are included in Appendix 4.

It is also proposed that £300,000 revenue will be spent on minor schemes. However, this will have to cover all the following areas:

- backlog maintenance
- crown immunity
- health and safety
- fire precautions

Objective 3.14 - "To achieve the improvements required by the Environmental Health Officer in all areas, particularly kitchens, following the removal of crown immunity"

The Guy's Unit has had very good relationships with the EHO at Southwark for the last ten years and the problems resulting from the removal of crown immunity are not as acute as those at Lewisham. However, a great deal of work has been undertaken to satisfy the hygiene requirements and in 1988/9 the Unit will be:

- completing the work specified by the EHO in respect of the Tower kitchens and the Coffee Bar
- undertaking a major refurbishment of the main kitchens with money from both minor block capital and revenue sources
- commencing a rolling programme of ward kitchens upgrades with appropriate equipment replacement
- undertaking an extensive programme of food handler training to include not only catering staff but domestics and nurses as well (the regulations stipulate a minimum of 8 hours training per annum for each food handler)
- pursuing an in-house solution to pest control

Any further developments will be greatly affected by the central policy decision on the introduction of cook-chill across the District.

Progress throughout the year will be monitored by the EHO and his reports will provide the key quality indicator. The appointment of a District Quality Control Officer in the Catering Department in 1987/88 will provide a focal point for liaison with the EHO.

Expenditure proposals - £69,000 for Crown Immunity and fire precautions etc.

Objective 3.16 - "To invest in medical and scientific equipment"

The pressure on the Minor Block Capital allocation for the Guy's Unit because of:

- the need to top-slice the allocation to support the site strategy developments
- the extent of the demand for work on backlog maintenance and crown immunity
- the implementation of large schemes such as the switchboard replacement

means that no Minor Block Capital will be specifically allocated for medical and scientific equipment in 1988/9.

However, bids have been made to the RHA through the Short Term Programme mechanism for:

	No.	Total Cost (£000's)
Items over £20,000	55	1,527.7
Items under £20,000	62	60.3
	117	1,588.0

It is unlikely that the RHA's decision will be before June 1988.

An inventory of all medical and scientific equipment will be completed very shortly by the newly created EBME Department. This will allow rational decisions to be made as to what level of investment will be required in the future.

Objective 3.17 - "To invest in energy conservation/management"

No specific allocation has been made from Minor Block Capital for investment in energy conservation/management. In 1987/8 the Unit received £67,000 from the RHA towards the installation of a Heat Exchanger which had a total cost of £101,000 (£34,000 from Minor Block). It is expected that for 1988/9 the RHA will be again asking for bids for energy conservation projects. When notification is received from the RHA the Unit will be putting together bids to take advantage of the Regional funds. For 1988/9 the Unit will in addition be:

- aiming to make the maximum utilisation of energy, and
- taking a hardline in negotiations with public utilities on prices.

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10. FIVE YEAR OBJECTIVES FOR GUY'S HOSPITAL

Introduction

After nearly three years of the new management structure, Guy's is in a better state organisationally and financially than for many years. Yet many desirable changes have still to be achieved and this paper begins the process of defining the aims for the next five years. Once these overall aims have been agreed, each directorate and other unit should develop corresponding and more specific plans of their own. For this reason, this statement of aims will need to be debated and then refined. Ideally, the aims should be specific enough to give direction to our activities, without being so specific as to preclude genuine local interpretation at directorate and departmental level. At the end of this process, it should be possible to say "this is how we want our hospital to look in five years' time".

Pursuing Efficiency

Guy's exists to provide the best possible service to patients from its own district and from outside. Like any NHS hospital, it has to work within the constraints of governmental, DHSS, regional and district policies. Nevertheless, within these constraints, there are many opportunities and it is up to management at every level to make the most of them in striving for efficiency. Underlying all these efforts there will be an inevitable tension between the desire to treat as many patients as possible and awareness that when the system is overloaded, the quality of care falls. Another way to express this might be by the equation:

$$\text{Efficiency} = \frac{\text{Quality} \times \text{Workload}}{\text{Resources}}$$

The Aims

1. **Patient Care**

   Within the overall aim of providing a service to all district patients and as many non-district patients as resources allow, we must achieve the highest possible quality of care. Quality here does not only mean good clinical diagnosis and treatment. It also means minimising delays or discomfort and giving each patient a sense of individual consideration by every member of the hospital staff whom he or she meets. This aim should inform every aspect of the hospital's work and will generate specific targets in different areas - for example, to reduce waiting time in outpatient clinics or eliminate cancelled admissions.

   Like all those which follow, if these broad aims are to be achieved, it will be necessary to translate them into specific targets and to identify who will be responsible for achieving those targets.

2. **Personnel**

The hospital must set higher standards for all personnel and this may mean amended job descriptions and more extensive reviews of performance. On the other hand, it is a prime aim that all personnel shall feel:

(i) Proud to work for Guy's

(ii) Aware of their value to the hospital and their place in its working, i.e. to know what is expected of them and what constitutes good performance.

(iii) Confident that good work will be recognised and rewarded.

(iv) Confident that their voice will be heard by those senior to them.

(v) Clear as to their opportunities for improved training and for promotion.

(vi) Interested in and responsive to ideas as to how to do their job better.

3. **The Fabric of the Hospital**

The first aim must be that in five years, Phase III of the hospital's redevelopment will be well on the way to completion. In addition we must give a larger proportion of the hospital's finances to the maintenance and cleaning of the hospital buildings and grounds. Aims are:

(i) To improve maintenance of all buildings

(ii) To achieve efficient utilisation and conservation of energy.

(iii) To improve the standard of decoration and cleanliness of the environment. (One means to achieving this aim has been the allocation of responsibilities for specific areas of the hospital to the appropriate directorate or department.)

(iv) To speed the system of repairs and replacements.

4. **Equipment**

Well-designed, modern, user-friendly equipment helps to increase productivity and efficiency. We hope therefore, to allocate a regular slice of income for new equipment and its maintenance. The aims are:

(i) A full equipment inventory.

(ii) Replacement of sub-standard equipment by modern, reliable equipment.

(iii) Improved in-house maintenance with an agreed proportion of this work being carried out by outside firms.

5. **Communications and information**

These are vital both to the clinical and organisational running of the hospital. Specific aims are:

(i) Everyone in directorates and in other departments should be fully aware of the aims of and developments in the hospital.

(ii) Up-to-date, relevant and accurate information on financial and operational matters should be available so that all end of month data are available by the middle of the succeeding month.

(iii) Telephone and computer links within the hospital will be fully implemented and efficient. This will include a regularly updated telephone directory.

(iv) The critical importance of two way communication (e.g. between the executive and directorates) requires that all communications, of whatever kind, need to be expressed concisely and with clarity (a jargon-free hospital).

6. **Organisation**

Decentralisation has still some way to go. Aims here are:

(i) That directorates and other divisions assume full responsibility for their operations and budgets.

(ii) That a mechanism is found, in the larger directorates, for creating sub-directorate sections in which particular specialty groups can organise their work with as great as measure of independence as possible.

(iii) That business managers are all clear as to their roles and responsibilities and are fully supported by their clinical colleagues.

(iv) That the non-directorate sections and divisions of the hospital are similarly clear as to their roles and responsibilities and feel fully involved in the hospital's working.

(v) The central hospital organisation and all directorates and other divisions should have produced handbooks defining their policies and practices.

(vi) That means be devised (eg incentives) to encourage individual directorates to adopt an 'entrepreneural' style of management both in relation to new clinical developments and in securing additional resources for the hospital. (Here the central organisation has to keep a balance between Directorates, ensuring that the activities of one do not harm the interests of another).

7. Teaching and Research

Guy's will not remain a first rank teaching hospital if it ceases to regard undergraduate ad postgraduate teaching and research as important. It is, however, essential that all aspects of quality of care and of management should come to be regarded as subjects for teaching and research, alongside the more familiar clinical topics. Suggested aims here would be:

(i) That staff and students of all kinds should learn from the example of those senior to them how to treat patients with courtesy and consideration, as well as efficiently and to demonstrate this to those junior to them.

(ii) That staff and students should be aware of the importance of good practices in the efficient running of their work whether in a clinical firm, a department or other section of the hospital, and that they should be interested to learn about management.

(iii) That relevant, effective programmes in these topics are available.

8. Training and Development

The provision of effective training and development is an integral part of our overall objectives. The aims are:

(i) That all staff should have access to training and development opportunities to enable them to make an effective contribution in the areas for which they have responsibility.

(ii) That individual's needs for training and development should be renewed regularly and systematically by the individual concerned and their manager or supervisor.

(iii) That staff with management potential should be identified early on and provided with a structured learning and development programme.

(iv) That all managers should receive the necessary training and development to enable them to manage the organisation effectively.

9. **Support Departments**

These, from catering, stores and works, to theatres, pathology and imaging departments, provide services on which the throughput of patients depends. Their efficiency would be greatly increased if most of their work was scheduled and predictable. Aims here:

(i) Waste due to incorrect requisitioning of stores or catering supplies to be reduced below an agreed target.

(ii) Response time of the Supplies Department to be improved in accordance with an agreed target.

(iii) An agreed proportion of theatre cases to be booked in advance. Utilisation of theatre time during the working day to be increased to an agreed level.

(iv) A minimum of patients to be admitted purely for investigation: those who are so admitted have all investigations booked in advance.

(v) Investigative departments to have all reports or results on computer within an agreed time period of the tests being performed.

10. **Relations with the Community**

This includes patients, the community services and family doctors. The aims include:

(i) That residents of and G.P.'s in our district shall feel that Guy's is "their" hospital.

(ii) That communication and understanding between community and hospital services should lead to improved quality of care before, during and after visits to or stays in the hospital. To be specific, that admissions and discharges are planned in relation to home conditions and support services.

(iii) That family doctors receive an agreed proportion (95%?) of discharge summaries within a week.

(iv) To devise ways in which the work of social workers can be integrated with and where appropriate managed by, the hospital.

11. **Relations with the District**

(i) All clinical services should be co-ordinated within directorates across the district.

(ii) Information and record services should follow unified policies with a district patient number.

12. **Relations within the NHS**

(i) That Guy's must meet the statutory requirements for information from DHSS and Region, as funding allocations to Guy's are based on this data. Standards for accuracy and timeliness should be set and monitored for key reports (e.g. discharge summaries).

(ii) That Guy's must be able to respond to the initiatives of DHSS, Region and District and match these to the priorities set within the hospital or be in a position to argue the case against. Again, accurate records of clinical activity and expenditure will be vital to pursue these objectives.

APPENDIX 1

GUY'S HOSPITAL

1988/89 BUSINESS PROGRAMME - ALLOCATION

	Recurring	Non Recurring	Total
	£'000	£'000	£'000
Start Allocation	49,860	19	49,879
1) Opthalmology to WLHA	(60)		(60)
2) 3 Sessions Dr Clarke	(8)		(8)
3) Radiotherapy to WLHA	(245)		(245)
4) New Cross FYE Reversal	21		21
5) Clinical Asst FYE	(6)		(6)
6) Learner Shortfall	700	150	850
7) Planned Addition		150	150
8) Resource Management		123	123
9) Caseload Preservation	150		150
10) Supplies Savings	10		10
11) Renal 1988/89 Activity		380	380
Total expected allocation	50,422	822	51,244
Other Funds :-			
Evelina Appeal Support			222
Total Available Funds			51,466

APPENDIX 2

GUY'S HOSPITAL

1988/89 BUSINESS PROGRAMME - REVENUE BUDGET

	1987/88FYE ALLOCATIONS AT MARCH 1988	RECURRING ADJUSTMENTS	NON RECURRING ADJUSTMENTS	INITIAL 1988/89 BUDGETS
Clinical Directorates :-	£'000	£'000	£'000	£'000
Surgery	2,287	3	0	2,290
A&E/Orthopaedics	1,843	1	20	1,864
Medicine	3,258	(54)	0	3,203
Neurosciences	429	4	18	451
Paediatrics	2,858	103	0	2,961
Obs & Gynaecology	1,976	11	2	1,989
Renal	2,299	(29)	256	2,527
Cardiac Services	3,145	12	0	3,157
Oncology	701	18	9	728
Dental	3,126	(91)	0	3,035
Anaesthetics	1,055	68	0	1,123
Radiological Services	2,134	0	0	2,134
Pathology	2,298	(2)	0	2,296
	27,410	43	305	27,758
Poisons Unit	793	(18)	0	775
Regional Genetics	613	13	0	626
C.T. Scanner Exps	43	0	0	43
Total Directorates	28,859	38	305	29,202

Residual Functions :-	1987/88FYE ALLOCATIONS AT MARCH 1988 £'000	RECURRING ADJUSTMENTS £'000	NON RECURRING ADJUSTMENTS £'000	INITIAL 19[illegible]/89 BUDGETS £'000
Medical Staff Services	1,172	(51)	0	1,121
Nursing - Residual	995	(41)	0	954
MSSE - Central & Other	104	0	0	104
Theatre Function	1,381	0	0	1,381
Pharmacy & Drugs	3,230	165	0	3,395
C.S.S.D.	1,400	0	0	1,400
Clinical Physics	377	0	0	377
Administration	1,386	5	0	1,391
School of Radiography	245	(4)	0	241
School of Physiotherapy	367	(40)	0	327
Catering	1,692	(71)	14	1,635
Domestics & Portering	2,914	(85)	0	2,829
Linen Services	378	0	0	378
Estate Management	2,816	0	0	2,816
Energy and Utility	1,511	0	0	1,511
Rent & Rates	1,327	(52)	0	1,275
Medical School Charges	76	0	0	76
Losses & Compensations	75	25	0	100
Mortuary	21	0	0	21
Non Capital Programme	300	15	0	315
Telecommunications	620	20	0	640
Security	137	1	0	138
Accommodation Income	(379)	(60)	0	(439)
Personnel	236	(5)	0	231
Superintendants Office	137	0	0	137
Deptford Support Service	46	0	0	46
Finance Directorate	167	0	0	167
New Cross Hospital	618	(618)	0	0
Total Res Functions	23,350	(795)	14	22,569
Rerserves etc. :-				
Pay Award Reserve	188	0	0	188
Caseload Preservation	0	(0)	0	0
Renal Activity	106	(106)	0	0
Vacancy Contributions	(385)	0	0	(385)
87/8 Prices Reserve	225	(225)	0	0
Saturday Theatre	0	0	0	0
	134	(332)	0	(197)
Annual Revenue Budget	52,344	(1,089)	319	51,574

GUY'S HOSPITAL

1988/89 BUSINESS PROGRAMME - MANPOWER BUDGET

Clinical Directorates :-	87/88 W T E	Changes W T E	88/89 W T E
Surgery	149.75	1.50	151.25
A&E/Orthopaedics	120.45	0.30	120.75
Medicine	254.20	(3.00)	251.20
Neurosciences	25.88	0.35	26.23
Paediatrics	216.79	6.00	222.79
Obs & Gynaecology	152.93	0.56	153.49
Renal	96.09	2.50	98.59
Cardiac Services	157.54	3.50	161.04
Oncology	52.63	2.00	54.63
Dental	250.91	(16.14)	234.77
Anaesthetics	33.01	1.00	34.01
Radiological Services	113.51		113.51
Pathology	130.12	(0.73)	129.39
	1,753.81	(2.16)	1,751.65
Poisons Unit	47.34		47.34
Regional Genetics	37.52	1.00	38.52
C.T. Scanner Exps			
Total Directorates	1,838.67	(1.16)	1,837.51

Residual Functions :-	87/88 W T E	Changes W T E	88/89 W T E
Medical Staff Services	3.09	(2.00)	1.09
Nursing - Residual	84.50	(2.00)	82.50
MSSE - Central & Other			
Theatre Function	101.50		101.50
Pharmacy & Drugs	57.30		57.30
C.S.S.D.	41.80		41.80
Clinical Physics	22.00		22.00
Administration	81.09	(2.69)	78.40
School of Radiography	6.96	(0.25)	6.71
School of Physiotherapy	10.25		10.25
Catering	117.80		117.80
Domestics & Portering	336.89		336.89
Linen Services	12.75		12.75
Estate Management	141.83		141.83
Energy and Utility			
Rent & Rates			
Medical School Charges	3.00		3.00
Losses & Compensations			
Mortuary	2.00		2.00
Non Capital Programme			
Telecommunications	16.00	1.00	17.00
Security	5.56		5.56
Accommodation Income			
Personnel	14.00	(0.50)	13.50
Superintendants Office	10.00		10.00
Deptford Support Services			
Finance Directorate	9.00		9.00
New Cross Hospital			
Total Res Functions	1,077.32	(6.44)	1,070.88
Rerserves etc. :-			
Pay Award Reserve			
Caseload Preservation			
Renal Activity			
Vacancy Contributions			
87/8 Prices Reserve			
Saturday Theatre			
	0.00	0.00	0.00
Total W.T.E. (Contracted Hours)	2,915.99	(7.60)	2,908.39

BUSINESS PROGRAMME [illegible] CAPITAL AND MAINTENANCE PROGRAMME — APPENDIX [illegible]

UNIT:...GUY'S.............

1. SOURCE OF FUNDS	£	£	£	£	COMMENTS
MINOR BLOCK ALLOCATION..	510,000				
CARRY FORWARD 1987/88 (+/-).......	(58,000)				
SUB-TOTAL....................	452,000			452,000	
ANTICIPATED LAND SALES:					
a) Dunoran Orchard *		60,000			
b) Deptford Laundry **		1,200,000			
c) Nuffield House (Hospital owned – Part)		150,000			
d)......................................					
SUB-TOTAL................................		1,410,000		1,862,000	
AVAILABLE FROM OTHER SOURCES (PLEASE SPECIFY):					
a) Special Trustees			726,000		
b) Regional Aids Funding			30,000		
c)......................................					
d)......................................					
e)......................................					
f)......................................					
SUB-TOTAL................................			756,000	2,618,000	
GRAND TOTAL..............................				2,618,000	

* If the sale proceeds from the Dunoran Orchard accrue in 1988/9, the estimated £60,000 return will be spent on upgrading work at Dunoran itself.

** The sale proceeds from the Deptford Laundry have been 'ear-marked' for the necessary conversion work on Nuffield House which will be undertaken by the Special Trustees - the figure of £1.2m. is at present a rough estimate of these proceeds.

2. PLANNED EXPENDITURE

BRIEF SCHEME DESCRIPTION IN PRIORITY ORDER	PLANNED START DATE	PLANNED FINISH DATE	CATEGORY (Please tick) BACKLOG MAINT	CROWN IMMUNITY	H & S FIRE PR	MED/SC EQUIP	SAFETY/ STANDARDS	OTHER	ANTICIPATED COST £
A. Minor Block									
1987/8 Carry forward	April '88	March '89							83,000
Switchboard-Repayment to Trustees	April '88	March '89							200,000
Lifts-Phased Replacement Programme	April '88	March '89							200,000
Phase III Enabling Works	April '88	March '89							50,000
Crown Immunity/Health and Safety/	April '88	March '89							69,000
Fire Precautions									
B. Special Trustees Funding									
Radiotherapy Bunker	Jan '88	1991							726,000
C. Other Initiatives									
William Gull Conversion (RHA AIDs funding)	March '88	May '88							30,000
* Dunoran Home Upgrading work	April '88	March'88							60,000
** Nuffield House Conversion - Repayment to	April '88								1,200.000
Trustees									
SUB-TOTAL									2,618,000

2. PLANNED EXPENDITURE (CONTD)

BRIEF SCHEME DESCRIPTION IN PRIORITY ORDER	PLANNED		CATEGORY (Please tick)					ANTICIPATED COST £
	START DATE	FINISH DATE	BACKLOG MAINT	CROWN IMMUNITY	H & S FIRE PR	MED/SC EQUIP	OTHER	
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SUB-TOTAL THIS PAGE								00
SUB-TOTAL PREVIOUS PAGE								2,618,000
GRAND TOTAL								2,618,000

3. ANTICIPATED REVENUE EXPENDITURE ON MAINTENANCE: (UNITS TO IDENTIFY CATEGORIES OF MAINTENANCE EXPENDITURE)	1987/88	1988/89	COMMENTARY
Small Schemes in the areas of:- - Backlog Maintenance - Crown Immunity - Health and Safety	300,000	300,000	