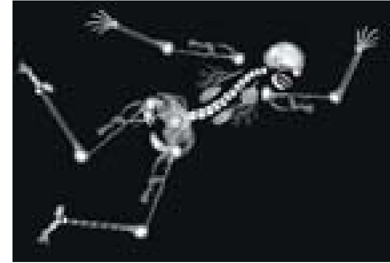
THE
Pulse
Issue Number 29
February 2007

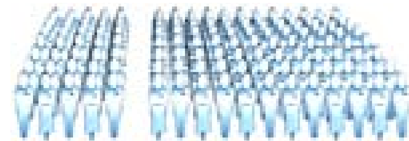
Norfolk and Norwich University Hospital

NHS Trust

Nuclear power
Behind the scenes in Nuclear Medicine



Flight of fancy
The staff who are taking a fresh look at radiology



A new Foundation?
Why we want to become a Foundation Trust

The gastro revolution
How gastroenterology is changing with the times

Target 18 weeks
The race to reduce long waits

INFO

Norfolk and Norwich University Hospital

Colney Lane, Norwich, Norfolk NR4 7UY
Tel: 01603 286286 www.nnuh.nhs.uk
Restaurant
West Atrium Level 1, open daily 7am-2.30am
Serco cafe bars
Outpatients West and Outpatients East, open Mon-Fri, 9am-5pm
WRVS coffee shop Plaza (East) open Mon-Fri 7am-7pm, weekends 11-5pm
WRVS shops East Atrium, open 8am-8pm Mon-Fri and 10am-6pm weekends
Plaza (West) open 7am-8pm Mon-Fri 8am-6pm weekends
The Stock Shop (ladies' fashions) open 9am-5.30pm Mon-Fri and 12-5pm Saturdays
Serco helpdesk (for housekeeping, porters, catering and maintenance). Call ext. 3333
IT helpdesk (for tel./computer faults): Refer to the online call-logging facility on the intranet home page
Security Call ext. 5156 or 5656
Reception
East Atrium Level 1: ext. 5457 or 5458
West Atrium Level 1: ext. 5462 or 5463
Outpatients East Level 2: ext. 5474 or 5475
Outpatients West Level 2: ext. 5472
East Atrium Level 2: ext. 5461
Travel Office Ext. 3666
For car parking permits, ID badges, keys to the cycle sheds, use of pool cars and the Trust bicycle. Also information about buses and other transport services
Bank
Cash dispensers in East Atrium Level 2 and in WRVS shop (west)
Chapel
Open to all. For details of services or to contact the Chaplains, call ext. 3470
Sir Thomas Browne Library
Mon, Wed, Thurs: 9am - 5.30pm,
Tues: 9am - 8pm, Fri: 9am - 5pm
Holiday Playscheme
At Blackdale Middle School during school holidays for the children of Trust staff.
Contact Christine McKenzie on ext. 2213

Cromer Hospital

Mill Road, Cromer NR27 OBQ
Tel: 01263 513571
Restaurant 7.45am-6.45pm

Other departments are based at:

- **Cotman Centre**, Colney Lane, Norwich Cellular Pathology, (Histopathology and Cytology), Radiology Academy

- **Norwich Community Hospital,** Bowthorpe Road, Norwich NR2 3TU, Tel: 01603 776776: Breast Screening, Health Records Library, Pain Management

- **Aldwych House,** Bethel Street, Norwich, NR2 1NR: Occupational Health (ext.3035): Outpatient Appointments, Training, Nursing Practice, Choice team, Norfolk Research Ethics Committee, some IT services

- **The Norwich Central Family Planning Clinic**, Grove Road, Norwich NR1 3RH. Tel: 01603 287345.

NEWS ROUND

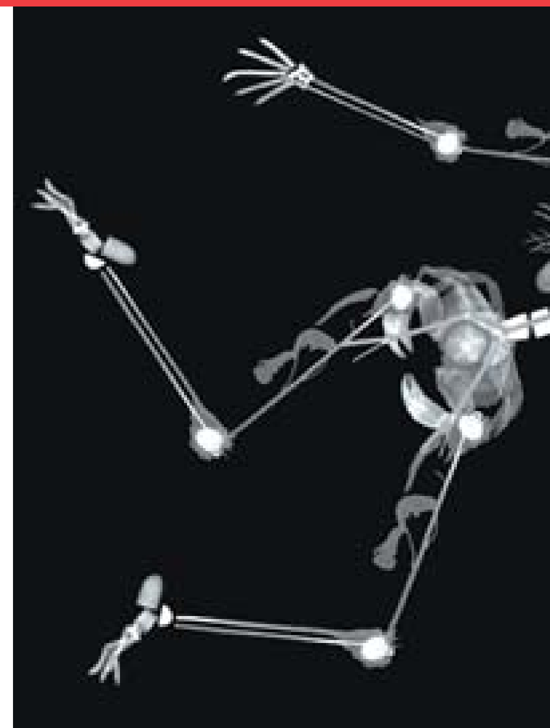
Sterile team sets high standards

STERILE SERVICES, the department responsible for sterilising up to 26,000 surgical instruments a day at NNUH, has been awarded top European certification for its high-quality standards.

The 80-strong team provides a 24-hour service for 28 operating theatres at NNUH and Cromer, as well as the local Primary Care Trusts and many GP practices and health centres.

The department is well equipped with all the latest technology to ensure that surgical instruments are thoroughly decontaminated, including software to track and monitor the instruments all the way through the sterilisation process and back to the operating theatres.

Sterile Services manager David Scotton commented: "This accreditation was difficult to achieve and our staff have worked extremely hard. European certification means we can place the CE mark on sets of sterilised instruments if we wish to market them."



WELCOME

...to **Dr Kristian Bowles**, consultant in haematology, who joined the Trust in December 2006.

FAREWELL

...to the following long-serving staff who have recently left the Trust: **Carol Tooke**, operational practitioner, after 35 years; **Hazel Sturman**, nursing assistant on Dunston Ward, after 33 years; **Robert Hutchings**, service manager in Oncology, after 32 years; **Jeanette Hardy**, nursing assistant in A&E, after 31 years; **Janet Townly**, switchboard manager, and **Valerie Alexander**, physiotherapy assistant, both with 25 years' service.

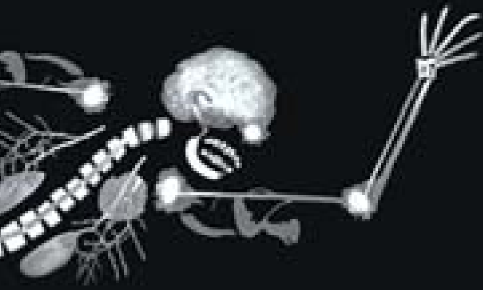
A&E patients quizzed about alcohol

NATIONAL RESEARCH shows that alcohol is a factor in 40 per cent of A&E attendances, rising to 70 per cent on Friday and Saturday nights. Now patients in A&E are being asked about their drinking habits and may be offered help and education about the dangers of drinking to excess.

Julia France and Sarah Dunbar

A questionnaire developed at St Mary's Hospital, Paddington, is being used to screen patients and check whether their drinking habits could be doing them harm. Those deemed to be at risk are given an information leaflet and offered a follow-up appointment with one of two substance abuse nurses based at NNUH, Julia France and Sarah Dunbar.

"This is not about making judgements or being critical but about helping someone to realise there could be a problem and offering help and support to deal with it," says Julia.



Taking a fresh look at radiology: a collaborative effort from David Pechey and Steve Bell

FLIGHT OF FANCY

IS IT A bird? Is it a plane? No, it's a selection of fruit and vegetables conjured into the shape of a flying skeleton by two of our more creative members of staff. The image now has pride of place in the new Radiology Academy, thanks to the help of the Hospital Arts Project.

"The idea came from discussions with the department about finding suitable artwork to display in the Academy," explained our hospital arts co-ordinator Emma Jarvis.

The 'artists' were radiologist David Pechey and IT systems support engineer Steve Bell, who worked together to create this intriguing photo from a series of x-ray images.

So can you spot the foods they used? Look closer and you will find a cauliflower (brain), asparagus (fingers and toes), banana (jaw), sunflowers (elbows and knees), cucumber (backbone), prawn (ear) and crab (pelvis).

Whoever said art and science don't mix?

MBE FOR CHAPLAIN

Congratulations to Pat Atkinson who received an MBE in the New Year's Honours in recognition of her work with street children in India. Pat would like to thank all those who have supported and raised funds for the Vidiyal Trust (formerly part of the Cooper Atkinson Trust) over the years. "Without this support, none of our efforts to make life better for these impoverished children would have been possible," she said.

Whatever happened to IWL?

WOULD YOU like to get involved in Improving Working Lives for all our staff in 2007? If so, our IWL team would like to hear from you.

The team meets on a quarterly basis, chaired by non-executive director Sue Whitaker, to ensure that the views of staff throughout the Trust are heard.

Since achieving Practice Plus in 2005, our IWL groups in Norwich and Cromer have contributed to the debate on a number of key issues, including the no-smoking policy, equality and diversity, and the re-allocation of office and clinical space in the hospital.

They have raised concerns about the footpath to the new School of Nursing and Midwifery at NNUH, and in Cromer they have succeeded in gaining a new resource area for IT training. They have also supported a new post of childcare co-ordinator to provide help and advice for carers throughout the Trust.

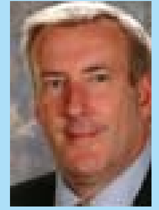
Other issues for discussion in 2007 include healthy eating, a staff recognition scheme and a new policy for study leave.

"The next meeting is on 29 March and we would love to welcome new members with new ideas," said deputy head of HR Lynne Middlemiss. "We are also starting a new group at Aldwych House.

• *If you would like to get involved in IWL, contact Lynne Middlemiss or Tina Chapman by email.*

WELCOME

A change for the better



A VISIT TO our critical care complex the other day reminded me just how far we have come in the field of technical innovation. I was there to see how a new IT system was helping staff to record the patients' progress hour by hour, a task previously done by writing on giant paper charts mounted on boards beside the bed. (see *page 5*).

I was struck by the amazing progress we have made in recent years, and how lucky we are to work in a hospital where such technical wizardry is almost taken for granted. If there are any cynics out there who question the value of investing in IT, this inspiring project should dispel their doubts.

Of course, there is rarely gain without pain and new ways of working can be uncomfortable in the short term. Equally, it is very frustrating to have our pace of change limited by the resources available to us.

Next year we will need to make significant progress in reducing waiting times, not just to meet NHS targets but to ensure that we are the patients' choice for acute care. As Anne Osborn explains on page 14 ('Target 18 weeks') we will not achieve this simply by working harder. We will need to generate greater productivity, and this will involve working differently. If you have any ideas or suggestions for improvements, please let us know.

I am grateful for your hard work to reduce costs and I am pleased to say that we are currently on target to keep within our expenditure budget for the current year, despite having to find significant savings – a considerable achievement.

As you will see from our four-page supplement on page 7, we believe that achieving Foundation Trust status will allow us much greater freedom to look ahead and set our own agenda for change. The troubles of the NHS will not be solved overnight. However, by working together and seeing the bigger picture, I believe we can make a real difference for our patients.

Paul Forden
Chief Executive, Norfolk and Norwich University Hospital NHS Trust

LETTERS

WRITE TO SUE JONES, EDITOR, COMMUNICATIONS TEAM, NNUH

No more ties!

I FULLY AGREE with the views expressed by Nick Levell ('Who needs a tie?', *The Pulse*, December 2006).

A tie is a pointless accessory at the best of times. For doctors, all it does is serve as both an obstruction to examining patients and a fantastic culture medium!

As long as doctors look well dressed, a tie does not make any difference. Indeed, there are many junior doctors who wear ties with black jeans.

Wearing scrubs around the hospital is probably the answer to the clothing issue. Doctors can change when they get to work and not have to worry about clothing issues.

It is interesting that the tie raises so much debate, yet the attire of our female colleagues, which at times is dubious in itself, is never questioned!

I think the tie should be banished to the same place in heaven that we sent the white coat.

Darren Klass,
Specialist registrar in Radiology

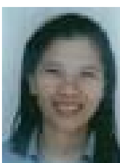
PROGRESS BY DEGREES

Congratulations to our students who successfully completed a Foundation Degree in Health Studies while working as healthcare assistants at NNUH. Pictured at their graduation are, from left: Julia Watling, Practice Development Nurse, who was awarded a BSc (Hons) in Social Studies at the same time, Sandy Lines (Jack Pryor Unit), Linda Speller (Delivery Suite), Helen Tullett (Cromer outpatients), Sandra Bishop (Dermatology) and Carol Edwards Deputy Director of Nursing and Education.

OBITUARIES

DR PHILIPPA WHITE, consultant microbiologist and a former director of the Public Health Laboratory based at Norwich Community Hospital, died in December after a long illness. Philippa had worked in the laboratory (now part of the NNUH Trust) since 1988 and specialised in Virology. She was Chair of the Trust Drugs and Therapeutics Committee in the early 1990s and contributed to many national working parties on public health.

RACEL CERVANTES, a staff nurse on EAU (surgical), has died from cancer at the age of 34. Racel was one of the first Filipino nurses to be recruited in the Philippines, having joined the Trust in 2001. She will be greatly missed by her colleagues.



PRIZES TOTALLING £18,000 could be won by NHS staff for ideas or services that improve the patient experience. Health Enterprise East is appealing for NHS staff to come forward with their healthcare innovations by 30 March 2007. Entry forms are available online at www.hee.org.uk or contact steph.presland@papworth.nhs.uk

Promoting equality for all disabled people

AFTER SEEKING the views of staff, patients and visitors, the Trust has prepared an action plan to improve services for disabled people.

The Disability Discrimination Act (2005) requires all public bodies to promote equality for all disabled people and to eliminate discrimination, even if this requires more favourable treatment.

Improvements planned at NNUH as a result of the survey include better signposting, more disabled parking spaces and further training for staff to increase awareness of disability issues.

"I am pleased to say that the comments we received were very positive, in particular about staff attitudes and understanding," said the Trust's Director of Nursing Chris Baxter. "However, we are committed to making health services more accessible for everyone, so we welcome these practical suggestions for improvement."

• *You can find out more about our Disability Equality Scheme at www.nnuh.nhs.uk/TrustDoc.asp?ID=226*

The Pulse takes silver in Pride awards

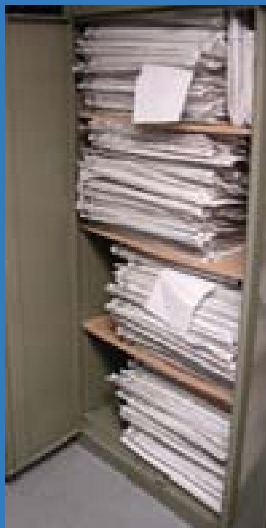
THE PULSE magazine picked up a top communications award in the Chartered Institute of Public Relations Pride Awards 2006 for East Anglia. It was runner-up in the category 'Best Newspaper or Magazine' beating off competition from a number of professional PR agencies and in-house teams. The judges said the magazine was good value for money, professional and appealed to a wide-ranging audience.

Produced in-house by our communications team, *The Pulse* is funded from donations and not from NHS funds. The editor, Sue Jones, commented: "*The Pulse* celebrates the work of all our hospital staff so it's great to get this recognition. But what do you think? If you have any ideas or suggestions, or would like to see your department featured in the magazine, please contact me on ext. 5944"

Cutting the paper trail in Critical Care

STAFF CARING for our most critically-ill patients now have a computer system to help record their progress hour-by-hour.

Until recently, all the information gathered from our hi-tech intensive care equipment had to be written down on a large paper chart for each patient. This would include information such as heart rate, blood pressure, arterial blood gas analysis, fluid inputs and outputs, clinical observations, temperature, neurological observations, drugs administered and nursing interventions.



Now the new Clinical Information Management System (CIMS), supplied by iMDsoft, records all this information in one system and also links in with other hospital systems to help provide a more complete picture of the patient's condition.

The new computer system cost £332,000 and was delivered under budget and on schedule. Consultant anaesthetist Dr Mark Dixon (pictured, right, with IT project manager Heiko Kausch and physiotherapist Alison Lucas) commented: "The new system is working well and making a big difference to the clinical team. Handwritten records could potentially create problems with legibility and accuracy, and the e-prescribing part of the system also helps to prevent medication errors."

Last year the Critical Care team cared for more than 2,000 patients – 563 more than in 1999.

YOU COULD *be forgiven for thinking we had taken a step back in time when a group of pupils from Hethersett Old Hall School greeted visitors at NNUH in December. The students dressed up in Victorian costume to sing carols in a series of performances organised by the Hospital Arts Project. "The response was heart-warming," said hospital arts co-ordinator Emma Jarvis. "People stopped in their tracks to listen to the voices ringing out from the top floor of the West Atrium. It sounded lovely as the acoustics are*

Sponsored swim gives ENT a boost

A SPONSORED swim by Fakenham Swimming Club raised £600 for the ENT (Ear Nose and Throat) department in memory of a former patient, Margaret Mason. The cheque was presented by Mrs Mason's husband, Eric, as a thank-you for the care she received from the ENT team.

The swimmers were aged from five to 16 years and swam distances ranging from 10 metres to three and a half miles, raising a total of £1800 to be shared with the Big C charity and Fakenham Medical Centre.

Pictured with ENT consultant surgeon Mr Junaid Hanif are (from left) Sister Laura Woodhouse, Mr Mason, volunteer Derek Minns, senior receptionist Val Humphries, Macmillan Nurse Tim Bradnam and Speech and Language Therapist Barbara Blagnys.

STAND BY FOR OUR SECOND OPEN DAY

NNUH is once again inviting the general public to go behind the scenes for our second open day on 6 July. A series of tours is being planned, together with a careers fair, well-teddy clinic, sculpture trail and a chance to learn how our medical students practise their clinical skills (*see left*). If you would like to take part in the open day and showcase your department, please contact Hayley Gerrard in Communications on ext.

A gastro revolution

From humble beginnings, our gastro-enterology department is now one of the busiest and most progressive in the country. Having reached the final of the Hospital Doctor *'Team of the Year' awards, the staff are also riding high on the success of a new screening service for bowel cancer, which could potentially save many lives*

PICTURE: MALCOLM WATSON, HOSPITAL DOCTOR MAGAZINE

Dr Hugh Kennedy with some of the gastroenterology team at NNUH

WHEN HUGH Hugh Kennedy joined the staff of the old N&N 20 years ago, he was the first consultant to specialise in gastroenterology. Today he is part of a team of seven consultants, four nurse endoscopists and seven specialist nurses in a department that in 2005/6 carried out nearly 12,000 clinical procedures, – a figure that has nearly doubled in the last five years.

So why this dramatic increase? Is it down to lifestyle changes or have rapid advances in 'scope' technology opened up new possibilities for diagnosis and treatment?

"Certainly the investigation of gastric and bowel disorders was revolutionised in the 1970s with the invention of endoscopy, which meant we could pass a telescope and see directly into the stomach and colon," said Dr Kennedy.

"Today we use digital technology and the whole theatre team can follow the proceedings on a TV screen. The picture is much clearer and we carry out clinical procedures, such as biopsies and removing polyps.

"We are also able to investigate the tubes draining the liver and pancreas. We can remove gallstones from the tubes draining the liver and pass 'stents' through pancreatic and bile duct tumours to relieve jaundice."

Besides launching a national screening programme for bowel cancer in older people (see box, below) the team is involved in a number of research projects with the UEA and the Institute of Food Research to study different aspects of liver and bowel disease, including the effects of diet and other contributory factors.

"Sadly much of the disease we now see is self-induced – by a combination of bad diet, lack of exercise and alcohol abuse. It's especially sad to see young people in their 20s and 30s suffering the advanced stages of liver disease after years of heavy drinking.

"Increasing numbers of patients are found to be suffering from NASH (Non alcoholic steatohepatitis), a form of hepatitis caused by fat in the liver. This can lead to cirrhosis which is bad scarring in the liver. It is associated with diabetes, high blood pressure and high blood cholesterol levels.

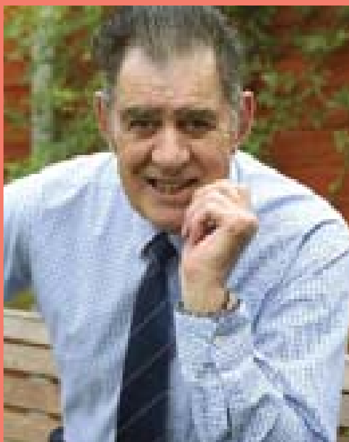
"The most common problem we are asked to investigate is irritable bowel syndrome, which is still something of a mystery, although we know it can be stress-related and is sometimes triggered by a bout of gastro-enteritis.

"There are billions of bacteria in the gut – more than cells in the body – and we still have a lot to learn about how these work to maintain a healthy balance.

"Our success as a department can be attributed to the hard work of many people, both within the hospital and in the community. The move to Colney gave us an opportunity to expand and we now have first-class facilities both here and in Cromer.

"Over the years we have also been extremely fortunate to have financial support from the Big C charity as cancer investigation is an important part of our work.

"We continue to improve with the help of feedback from our patients, including support groups for those with liver disease, inflammatory bowel disease and coeliac disease."



PICTURE: ARCHANT

RAYMOND MIDDLETON, *from Poringland, has good reason to be grateful for the bowel cancer screening service launched at NNUH last September. He took a test at home, which proved positive, and later had a successful operation to remove a cancerous tumour.*

NNUH is one of only two centres in country to launch a national screening programme whereby local residents aged between 60 and 69 are sent a simple home-testing kit for bowel cancer. The programme will be rolled out nationally over the next two years.

In addition, anyone over 70 can request a kit by calling 0800 707 6060.

Norfolk and Norwich University Hospital NHS

NHS Trust

Building a firm Foundation

We are united in this Trust by our desire to do the very best for our patients. We are consistently rated highly for the quality of treatment and care we provide, being placed in the top 10 per cent of hospitals nationally.

In tandem with our very strong financial track record, we have world-class facilities and we are successful in recruiting and retaining excellent staff, helped by our close partnership with the UEA.

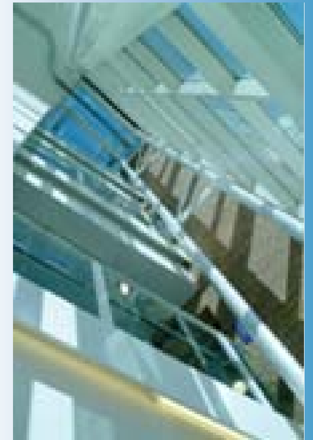
But what of the future? The NHS is undergoing a period of rapid change and our aim is to provide services that will meet the needs of our local community for many years to come.

We firmly believe that the achievement of Foundation Trust status will enable us to realise our vision in a way that is right for us, our employees, and the community we serve.

As you will see from the following pages, Foundation Trust status is designed to establish local 'ownership', engagement and accountability, while maintaining the core NHS principles of free healthcare based on need and not the ability to pay. In essence, this means that every single one of our local residents could have a stake in our future and influence decisions affecting their care.

As a Foundation Trust we will be able to harness the enthusiasm and commitment of our staff and stakeholders, using new flexibilities to invest in the future and develop our services for the benefit of our patients.

Paul Forden
Chief Executive, Norfolk and Norwich University Hospital NHS Trust



TOWARDS FOUNDATION STATUS

Why I believe this is the right way forward

By **David Wright,** acting chairman, NNUH Trust

Many people ask me why we are applying to be a Foundation Trust. There is no simple answer, as there are so many advantages.

If we can achieve this significant step, then you and I will be in a position to make a real difference to our own healthcare. Together we will be able to plan our services to respond to the changing needs of our local community.

Where investment is required, we can organise our own finance without reference to the Strategic Health Authority. We can plan to create a surplus, knowing it will not be clawed back, and use it to achieve local priorities.

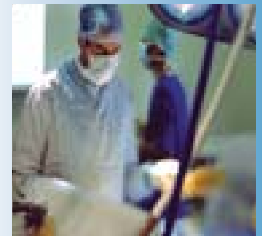
Perhaps the most significant change is that we will no longer need to look to the SHA and Whitehall before making our own decisions. We will be free to work with our local partners to plan for the future.

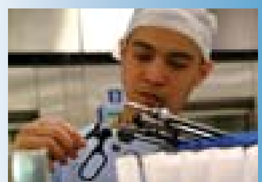
There will be a new governance structure of 'members' (ie staff and local residents) and a 'council of governors', some of whom will be elected while others are appointed from partner agencies. It is through these groups that our strategies will be developed, tested and then agreed by the Trust Board.

The Governors will appoint the Chairman and Non-Executive members of the Trust Board – currently appointed by the Appointments Commission – and this will put decision-making back with the local community.

There will still be a requirement to meet maximum waiting times and other centrally driven standards and targets. But how we achieve our objectives will be down to us.

As we put more detailed plans out for consultation in April, I am sure you will see that this is a great chance to control together our own destiny and therefore the services we provide now and in the years to come.





YOUR QU

What is an NHS Foundation Trust?
NHS Foundation Trusts are established in law as legally independent organisations (called Public Benefit Corporations) with a duty to provide NHS services to NHS patients.

What does this mean for patients and staff?
As members of a Foundation Trust, the public and hospital staff get a direct say in how our hospitals are run. Decisions are taken locally, which means that hospitals are more responsive to the needs of their patients.

Are Foundation Trusts still part of the NHS?
Yes. Foundation Trusts remain part of the NHS family. They continue to deliver healthcare for their population, paid for by local NHS Primary Care Trusts.

They are still ultimately accountable to Parliament and the freedoms given to NHS Foundation Trusts are underpinned by a framework of national standards which safeguard quality and protect the public interest.

So what are the benefits?
Benefits of of being an NHS Foundation Trust include:

- Accountability to our local population and not the Department of Health
- More freedom to manage our services according to local needs
- Greater financial freedom

NHS Foundation Trusts encourage establishment of stronger links between local hospitals and their local communities. Local people still experience healthcare according to the core NHS principle – free healthcare, based on need and not ability to pay.

How are NHS Foundation Trusts run?
An NHS Foundation Trust is governed by local people through a membership made up of local residents, patients, carers and hospital staff. There is no maximum limit on the number of members but they must all be locally-based.

Members elect the Governors who in turn help to determine the direction of the Trust and monitor the Board of Directors.

Any member is able to stand for election as a governor, and members help vote for the governors of the Trust. Governors are responsible for representing the interests of the members and partner organisations in the running of the NHS Foundation Trust.

This sort of public ownership is designed to ensure hospital services better reflect the needs and expectations of local people when delivering high quality healthcare.

Who are the members?
Over the coming months, staff and the public will be consulted on becoming a Foundation Trust. Should we decide to go ahead, patients and local residents will be invited to apply for membership by post or on our website.

Staff employed in our hospitals will automatically become members unless they opt out. This includes volunteers and anyone who is employed by the Trust or by private contractors such as Serco and Norfolk County Services .

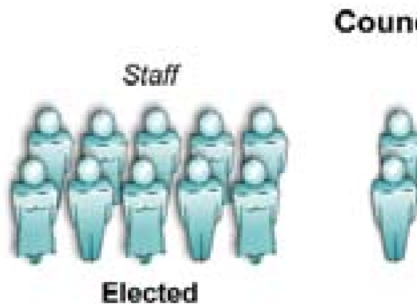
Becoming a member gives people an opportunity to influence the way a hospital is run and ensures that their ideas are considered in the development of services. All members are entitled to:

- Receive regular updates about activities
- Be consulted on how the provision of services could be improved.
- Be invited to member events
- Be able to stand for election to the board of governors
- Vote in the election of representatives to the board of governors
- Be able to apply to become a non-executive director

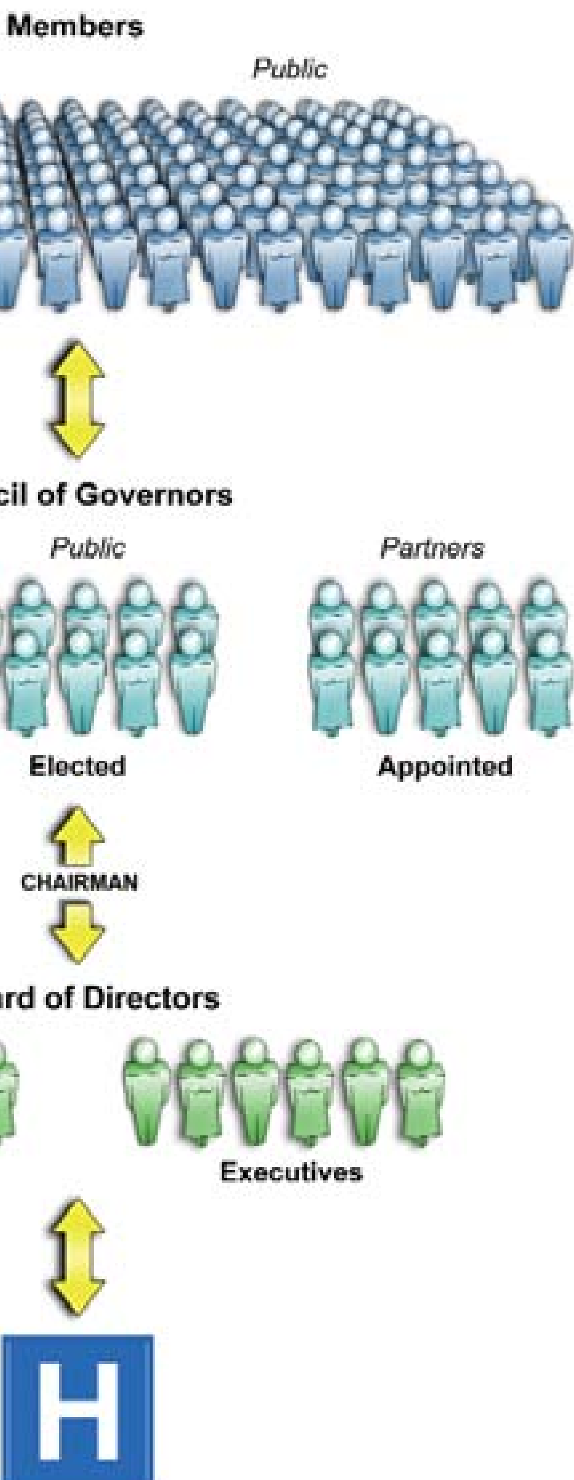
The Board of Governors is made up of governors elected by the members as well as people appointed from other local partner organisations.

The main role of the board of governors is to advise the board of directors with regard to the future plans of the NHS Foundation Trust, to ensure the NHS Foundation Trust acts in a way which is consistent with its objectives and that it operates under the terms of its authorisation (licence).

The Governors provide the public, staff



ESTIONS ANSWERED



and stakeholder input to the strategic direction of the NHS Foundation Trust.

The exact number of governors is up to each NHS Foundation Trust and is for local people to decide. However, the board of governors has to be made up of:

- A majority of governors (at least 51%) elected by members of the general public
- At least three governors representing staff
- At least one governor representing local NHS Primary Care Trusts
- At least one governor representing local councils in the area
- At least one governor appointed from the university

The board of governors monitors and advises on the strategic plans of an NHS Foundation Trust. They also ensure the membership is representative of the local population.

The board of governors has a key role in holding the board of directors to account for meeting its strategic objectives. It is also responsible for the appointment and setting the pay of non-executive directors and for approving the appointment of any chief executive.

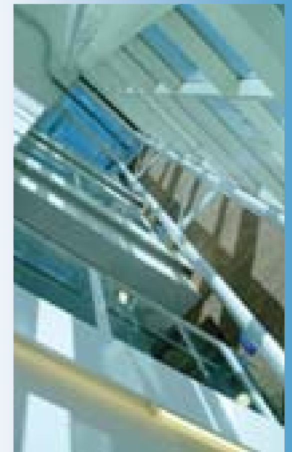
The Board of Directors is responsible for the day-to-day operational management of NHS Foundation Trusts. The board of directors is similar to an NHS Trust board, made up of executive and non-executive directors.

Will my terms of employment change?
Becoming an NHS Foundation Trust does not affect the continuity of service of staff. Staff will have full access to the NHS pension scheme and other NHS benefits.

What about job prospects?
NHS Foundation Trusts are able to develop a range of local initiatives. They are encouraged to create new types of jobs, new ways of working and more flexible shift patterns to meet local needs.

Can NHS Foundation Trusts 'opt out' of the NHS?
Becoming an NHS Foundation Trust does not mean opting out of the NHS. Foundation Trusts are fully part of the NHS

(Continued on page 10)



YOUR QUESTIONS ANSWERED

TOWARDS FOUNDATION STATUS

(Continued from page 9)

family, subject to NHS systems of inspection. They treat NHS patients according to NHS principles and NHS standards, but are controlled and run locally, not nationally.

Foundation hospitals are similar to mutual organisations such as the Co-op, John Lewis Partnership and housing associations. They are legally prevented from having shareholders and their members can make no profit from them.

NHS Foundation Trusts are prevented from selling off or mortgaging NHS property and resources needed to provide key NHS services.

How does Foundation status affect finances?
NHS Foundation Trusts are able to keep their financial surpluses, borrow capital and use it to improve and develop services.
They can plan their finances over the course of three years instead of just one, and any contracts with their commissioners (Primary Care Trusts/GPs) are legally binding, which is not currently the case.

How are Foundation Trusts regulated?
Like all other NHS bodies, NHS Foundation Trusts are inspected against the national standards set by the Healthcare Commission. An NHS Foundation Trust is not accountable to the Secretary of State for Health but to an independent regulator called Monitor.

Who or what is Monitor?
Monitor is an organisation set up to ensure that NHS Foundation Trusts do not breach the terms of their authorisation (licence). The role of Monitor is designed to give NHS Foundation Trusts the freedom to deliver services to meet local needs while safeguarding the interests of NHS patients.

When does Monitor step in?
In normal circumstances Monitor will have no reason to intervene in the running of an NHS Foundation Trust. However, if an NHS Foundation Trust seriously breaches the terms of its authorisation, or finds itself in difficulty, Monitor has the power to step in to resolve things. Monitor has a range of intervention powers. It can:

- Issue warning notices
- Require the board of governors or board of directors to take certain actions
- Suspend or remove the board of governors or members of the board of directors

What if there is a serious problem?
In the most serious cases, where intervention by Monitor could not resolve a serious problem, an NHS Foundation Trust could be dissolved.
If this were ever to happen, the Health and Social Care Act provides mechanisms to ensure NHS patients continue to receive high quality treatment.

What does the authorisation (licence) issued by Monitor set out for NHS Foundation Trusts?
The authorisation (licence) sets out:

- A list of goods and services a Trust is required to provide to the NHS
- A requirement to operate to high standards, based on the national healthcare standards.
- Any major changes to services (for example, in response to a changing local population) need to be discussed locally and agreed by Monitor.
- A list of assets such as buildings, land or equipment are designated as 'protected' because they are needed for NHS services.
- Limits on the amount of private work an NHS Foundation Trust can carry out. Foundation Trusts will be subject to strict limits on private patient work based on the amount of private work they currently do. If an NHS Foundation Trust wishes to treat more private patients, it will need to treat more NHS patients first. This will ensure that NHS Foundation Trusts continue to focus on NHS work.
- The amount of money an NHS Foundation Trust is allowed to borrow.
- The financial and statistical information an NHS Foundation Trust is required to provide.

Who decides whether we can become an NHS Foundation Trust?
All Trusts will be assessed to see if they are fit to apply for NHS Foundation Trust status by 2008. If a Trust is judged ready then the Secretary of State for Health will consider each proposal against set criteria, alongside evidence of relevant and inclusive consultation.

If the Secretary of State gives her support, applicants will be asked to submit an application for an authorisation to Monitor. The final decision on whether an organisation can be established as an NHS Foundation Trust rests with Monitor.

HELP US TO HELP YOU

*As treatments improve and patients are living longer, our clinical workload is increasing and patient case notes are expanding too. **Gil Rattner**, head of Health Records for the NNUH Trust, explains how you can help to keep the system running smoothly*

HERE IN the Health Records Library we look after the case notes for all our hospital patients - more than 13 km of paper files, stacked on shelves up to 2.6m high.

We supply and retrieve at least 900,000 sets of notes each year, which equates to around 4,000 a day - an impressive workload by any standards. Eventually, of course, we can look forward to a time when all this information is available on screen at the touch of a button, with no need to transport piles of paper from one place to another. But for now we must do our best to safely store our existing files and ensure they arrive at the right time and in the right place.

This mammoth task has been steadily growing over the years as treatments improve and patients live longer. The notes are bar-coded to help us keep track of them, but there is still a great deal of manual work involved. Our staff can frequently be found at the top of a ladder or rummaging through multiple cabinets as they search for a particular folder.

Each year around 9,000 notes are transferred to the deceased file following notification of death. However, an estimated 32,000 more are added as new patients are registered, so the paper piles are not getting any smaller!

The question of storage has been raised many times in our history as we struggle to find room for these burgeoning files. On moving to Colney, the decision was taken to continue to use the old laundry at the former West Norwich Hospital (now the Norwich Community Hospital) and for a time it seemed we had caught the tiger by its tail.

But now, five years later, we have run out of space in the laundry building and are on the move again - this time to

"We handle at least 900,000 sets of case notes each year – that's around 400 a day"

Francis Way on the Bowthorpe Industrial Estate, where there is the potential to improve our working conditions and introduce more efficient working practices to provide a better service to specialties.

We are hoping to make the move in April and May. In the meantime, here are some of the ways that you can help us to provide a more efficient service. Please remember:

- Case notes should not be returned to the library if they are needed within the next 10 working days – it is the responsibility of the holder to send them on.
- Only case notes needed within 24 hours should be requested using the emergency phones. Other requests should be made on PAS.
- Loose filing should be forwarded to the area where the case notes are tracked.
- Do not delay receipting or dispatching case notes on PAS, or sending them on to their next destination.
- Ensure the cabinet of notes is completely emptied on delivery.
- If you are replacing the bar code label on a patient's notes, make sure you remove the old one.
- When dispatching notes to BUPA Hospital Norwich, ensure you select the correct private secretary location codes.
- When a patient dies in hospital, the death must be recorded on PAS and RIP and the date of death should be written boldly on the front of the case notes.
- If case notes need to be sent back to the Health Records Library, this can be achieved by clicking the Ad hoc Dispatch button, then inserting the relevant site (WN) and location code (0291).
- Before receipting, ensure you are logged into the correct location code (using the 4 digit numerical code) and not the hospital site, such as NNU, CR, BUPA etc.

Nuclear PO

You can learn a lot from the images generated in Nuclear Medicine. Clinical scientist **John Skrypniuk** *talks to Sue Jones about the latest advances in this fascinating area of medical science*

HAVE YOU ever wondered what goes on behind the doors of Nuclear Medicine? The name itself can be rather daunting, especially for patients entering those lead-lined doors for the first time.

Precautions are necessary because the staff are routinely working with radioactive materials, although these generally have a short half-life and are specially designed for medical use, which means they pose relatively little danger to the patients or their carers. Levels of radioactivity are closely monitored and the preparation of nuclear pharmaceutical products and waste is strictly regulated.

Perhaps the more surprising aspect of nuclear medicine is that this relatively low cost and well-tried method of detecting medical abnormalities could be much more widely used by clinicians as a diagnostic tool.

"I think the main problem is that it is so little understood, even by doctors," commented clinical scientist John Skrypniuk, who trained as an industrial chemist before specialising in nuclear medicine

"The key is in the chemistry. We use radioactive pharmaceutical products which are either injected, swallowed or inhaled and these are designed to interact with the body's natural biochemistry to yield information about abnormal organ function or blood flow. Most of the procedures involve the production of digital images which 'map' the distribution of radioactive materials within the body using a type of scanner known as a gamma camera.

"We are looking at metabolic activity – or the lack of it – so we can show areas where there is too much growth (as in cancer or infection) or too little (as in blocked arteries or poorly functioning tissue).

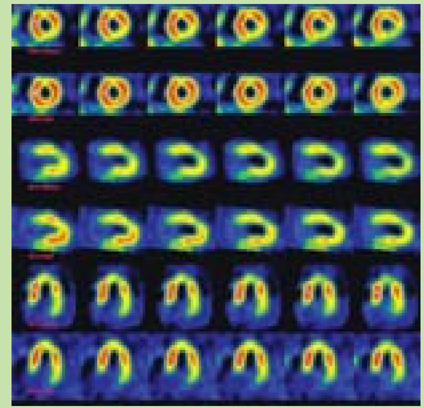
"Although a CT scan will produce a much clearer, more detailed image of a tumour than a gamma camera, it will not show whether the tumour is still active. A gamma scan can be useful to decide treatment options or to see whether previous treatment has been effective."

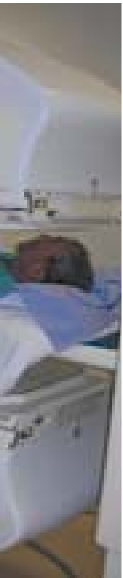
Technology in this field has taken another leap forward with the invention of the PET (Positron Emission Tomography) / CT scanner, which effectively combines gamma camera technology with CT scanning. The images can be fused together to show the exact anatomical location of an active tumour or infection.

By next summer, our patients will have access to a PET/CT scanner in a vehicle parked in the hospital grounds, as a contract is about to be awarded to provide a PET/CT service throughout the UK. .

Analysis of kidney function using gamma technology is particularly common in children as the radiation dose received from the nuclear medicine scan is less than that from a conventional Xray.

OWER





ABOVE *Images produced in nuclear medicine can help to detect whether blood flow around the heart is impeded by a blocked artery. A recent enhancement to the computer system, funded by the Norfolk Heart Trust, enables the radiographer to animate the image and see whether the heart walls are moving.*

NEAR LEFT *In 90 per cent of Nuclear Medicine procedures the raw material used is technetium-99 which is produced from Molybdenum-99, a product of the nuclear power industry. Each test-tube sized generator (shown here with John Skrypniuk) will provide enough isotope for a whole week's work at NNUH, until the molybdenum decays and has to be replaced. The generator is encased in a thick lead shield and must be kept sterile.*

CENTRE LEFT *Radioactive pharmaceutical products are either injected, swallowed or inhaled and are generally harmless as they emit only gamma rays. Beta rays are used in some cancer treatments but the more potent alpha rays (which featured in the poisoning of the former Russian agent Alexander Litvinenko) are used only in a few specialist research centres.*

FAR LEFT *Pharmacists prepare the nuclear products in a sterile environment under strictly regulated conditions. Special licenses are required by medical staff to prescribe these products.*

Combining gamma technology with traditional surgical methods has also proved useful for breast cancer patients, helping surgeons to detect whether the cancer has spread to lymph nodes in the surrounding tissue.

The patient is injected with a radioactive colloid which travels quickly to the first lymph node within the breast (the sentinel node). If the cancer is absent in the sentinel node, there is no need to remove any other lymph nodes and the patients are spared the possibility of developing lymphodema, (swelling of the arm), which is a common side effect after breast surgery. Recovery is also quicker and patients return home more quickly as the surgery is less invasive.

Sometimes treatment is possible using radioactive materials to 'zap' a tumour. In the case of thyroid tumours, the treatment may involve high levels of iodine which remains radioactive in the body for several days. Patients need to be isolated in a shielded room on Mulbarton Ward for up to three days, with visits from staff and patients limited to about an hour each day.

Training in nuclear medicine is highly specialised and combines a variety of skills, from radiology to a specialised knowledge of pharmacy. A special licence is required to prescribe radioactive product and medical staff need to demonstrate support from suitable experienced scientists and pharmacists.

AS PART OF his role as the lead clinical scientist in Nuclear Medicine, John Skrypniuk is responsible for checking levels of radioactivity throughout the Trust. "The rules and regulations make this a real challenge," he commented. "We need to keep careful checks on radiation levels and calculate the expected pollution levels in our waste products, too. One of the more glamorous aspects of my job is to check that our sewage outlets are safe whenever maintenance work is required!"

The countdown has begun... By the end of 2008, all NHS hospital patients can expect to receive their first treatment within 18 weeks of referral, including any consultations and tests that may be required to diagnose their condition. For staff in the front line, this will be a considerable challenge. So how do we hope to achieve it? **Anne Osborn** *explains how the 18-week target will revolutionise patient care throughout the NHS*

TARGET 18 WEE

AROUND 40 PER CENT of our patients can already expect to be diagnosed and treated within 18 weeks of being referred by their GP. By the end of 2008, this will be a requirement for *all* NHS patients – and some can look forward to even shorter waiting times.

For example, all 'urgent' cancer patients will receive treatment within two months of referral by December 2005, and there will be a maximum one-month wait from diagnosis to first treatment for all cancers.

These new targets will have a dramatic effect on how the NHS works. For the first time, patient journey times will be measured as a whole, including diagnostic and outpatient appointments that until now have been largely unmeasured.

"We have cut our waiting times considerably in the last two years but these new targets cannot be achieved simply by working harder," says Anne Osborn, director of strategy, planning and performance for the NNUH Trust. "The challenge will be to find new ways to shorten the patient journey. For instance, is it possible to refer a patient for tests at the same time as their first appointment? Or perhaps we could make more use of 'see and treat' clinics so patients do not have to return to hospital at a later date?

"Some departments have made already tremendous progress and have introduced changes that are making a real difference for our patients. (*See Audiology leads the way, right*). However, we need to be working together right across the Trust and with Primary Care to ensure that we meet these targets for all patients by December 2008.

"We do face limited financial resources but many of the best ideas are free and even fairly small changes can make an enormous difference to our patients.

"If you have any ideas and suggestions on how we could cut waiting times and smooth the patient journey, please contact me ext. 3064."

Countdown to the 18 week target

WE HAVE been working steadily to reduce our waiting times ever since the Government first published its NHS Plan in July 2000.

The Plan set out its vision for a health service built around the needs of the patient, rather than the organisation, and encouraged hospitals and Primary Care Trusts to increase efficiency and work together to achieve a better service for all patients in their community.

A series of targets were set to reduce waiting times over the following eight years. At that time, it was not unusual for patients to wait up to two years for routine hospital treatment.

Since then, thanks to a great deal of hard work and commitment on the part of our staff, we have managed to hit all our key targets while keeping within our financial constraints.

Waiting lists at NNUH are down from a peak of 14,000 in 2002 to 10,000 today.

By December 2008,we aim to have no patients waiting more than four weeks for their first outpatient appointment, while patients needing hospital treatment should have to wait no longer than 18 weeks from referral by their GP.

"We can't achieve these new targets by simply working harder... The challenge will be to find new ways to shorten the patient journey"

'Some patients may require up to six separate procedures before their condition is diagnosed'

ONE OF THE main obstacles to the 18-week target is likely to be whether all the necessary diagnostic tests can be completed in time to meet the maximum wait for each patient.

With this in mind, NNUH is taking part in a National Physiological Measurement Project aimed at reducing waiting times for all diagnostic tests.

"Some patients may require up to six separate procedures before their condition can be accurately diagnosed," explained project manager Fiona Durban.

"There is a general belief that tests involve only radiology (X-rays, CT and MRI scans) and pathology but there is a whole host of physiological measurements that require highly specialised staff and equipment. It's been estimated that up to 100 different tests are possible, ranging from the simple to the complex.

"If we are to achieve the Government's target of having no patient waiting more than 18 weeks for treatment by the end of next year, we need to co-ordinate our efforts and ensure that patients have much quicker access to the tests they need.

"We can't afford to be complacent about this. We have a real challenge ahead to make sure we meet these targets for each and every one of our patients by December 2008."

KS

DR JOHN FITZGERALD *(left) combines his clinical role with a progressive management style: "Change is a continuous process and it's essential to listen to your staff, who often have good ideas to improve things."*

BELOW *Katie Tipple is one of two secretaries in Audiology who have been specially trained to call patients at home and check on their progress. Most of the patients are very happy with this service and welcome the fact that they don't need to return to hospital for a follow-up appointment.*

Audiology leads the way

DESPITE DEALING with major changes in recent years, including the introduction of digital hearing aids and routinely screening the hearing of all newborn babies, staff in Audiology are leading the field nationally in finding new ways to cut their waiting lists.

Head of Audiology Dr John FitzGerald admits the department was inundated with requests for new hearing aids when the devices became available in 2004. They struggled to cope with the demand and some patients were forced to wait up to 30 weeks to see an audiologist.

"There was a national shortage of audiologists, making it difficult for us to recruit qualified staff," he explained. "It was clear that if we didn't act fast, we would face serious pressure in this department.

"Many of our patients are quite elderly so it's not fair to ask them to wait many weeks for an appointment."

John set about introducing a number of measures to cut the lists, including extending the working day by an hour and three quarters (full-time staff now work four longer days instead of five) and setting up a telephone service to save many patients from having to return uneccesarily to hospital for a follow-up visit. A new post of audiology assistant was created, with a training scheme devised and run in-house.

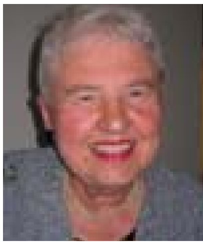
Such innovations have cut waiting times to a maximum of 13 weeks, compared to a national average of 64 weeks.

"My research background has been useful because I'm always prepared to try different solutions to see if they work," said John. "For instance, we were one of the first to try out a new type of disposable earmould that is quicker to fit and very popular with our patients, although it is not suitable for everyone and its cost-effectiveness in the longer term still needs to be assessed.

"Change is a continuous process and it's essential to listen to your staff, who often have good ideas to improve things. I'm especially lucky to have an enthusiastic team who are always willing to implement change for the benefit of the patients.

"I don't believe I could do my job effectively if I was seeing patients five days a week. It's important to maintain my clinical role but the key to successful change is good planning, staff development, monitoring the change and measuring its impact – and that takes time and good team work."

Friends in deed



The new hospital planned for Cromer is not the first to be funded by the generosity of local residents. **Mary Northway**, *chair of the Friends of Cromer and District Hospital, explains why the hospital has such strong support*

AFTER SAGLE Bernstein generously left £11.4 million to Cromer Hospital in her will, you might expect the Friends to relax their fundraising efforts and rest a little on their laurels. But this is far from the case.

Under the chairmanship of the lively Mary Northway, the Friends of Cromer and District Hospital have raised more than £46,000 in the last five years and talk of the new hospital has given them renewed enthusiasm to carry on the good work.

"People respond well when they can see progress being made," said Mary. "They were quick to contribute to our campaign to buy televisions and an ECG machine (with help from the Norwich Lions) for the new dialysis unit. I am sure they will come forward again when the new hospital gets underway".

Mary points out that all three of Cromer's hospitals have been funded from donations, and the proposed new hospital is no exception. The plan is to use the Bernstein legacy to create a centre for daycase and outpatient services, along with a minor injuries unit on site. The new dialysis unit and centre for diagnostics (x-ray and MRI) units will remain where they are.

"In the last year I've had several day procedures at Cromer myself, including two cataract operations, and I share the affection that many people feel for their local hospital," said Mary.

"Of course, there has been a lot of debate about the future of the hospital and the delays are very frustrating. I really believe we have to move forward to keep our hospital– if we stand still we will lose it."

An infant teacher for most of her working life Mary, 66, has been chair of the Friends for the past six years, fitting this in with her work as a town councillor and with other local organisations.

Aside from the Friends' committee, one of her greatest supporters is her husband David, a retired hotelier who helps out by transporting kidney patients to the new dialysis unit at Cromer on a regular basis. Remarkably, the couple met and married within six weeks of their first meeting, with Mary taking on David's three small children from a previous marriage when she was 35.

Along with pictures of the grandchildren, the Northways now share their home with a large number of cuddly toys and the odd water gun – all waiting to be used as tombola prizes at Friends' events.

WHEN A NEW HOSPITAL COST JUST £166 A YEAR

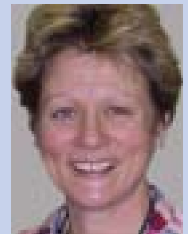
CROMER'S *first cottage hospital in Louden Road (right), now a family home, opened with six beds in 1866. Records show that a grand total of £166 and 15 shillings was spent on patient care during the first year.*

The matron, Mrs Stokes, received three months' training and a salary of £20 a year. Her duties included all the washing, and her daughter acted as an unpaid help.

In 1888 a larger hospital was built in Louden Road – now the local Conservative offices and a pub – to be replaced in 1932 by the existing Mill Road building after a three-year fund-raising campaign.

In 1978 a former patient, Mr B. A. Steward, recalled his operation 65 years earlier for appendicitis ("an affliction made fashionable by King Edward VII.") The surgeon, who also acted as anaesthetist, prescribed a milk and water diet for the first week and the patient eventually returned home "a walking skeleton" after a six-week hospital stay.

Progress at last on our new hospital



WE ARE finally making some progress on plans to build a new Cromer hospital, with a scheme to redevelop our existing hospital site in Mill Road. The new proposals would involve increasing the amount of day surgery and removing our inpatient beds.

The communications team is currently analysing the response to more than 64,000 questionnaires sent out to local residents. The consultation process is due to end on 28 February, by which time we should at last have a clear view about how services will be developed here in the future.

Meanwhile, the Norfolk Primary Care Trust is reviewing the provision of intermediate care services across Norfolk – it seems that hardly a week goes by without Cromer Hospital and North Norfolk making headline news.

It is quite a challenge to keep staff informed of all these developments. So far, their response to our plans for the new hospital are very encouraging.

The new Dialysis Unit was officially opened on 20 December, when the ribbon was cut by our Trust chief executive, Paul Forden. The unit is already a hugely successful and busy part of our hospital. We can't remember what life was like without it!

Helen Lloyd
Service Manager, Cromer Hospital

THE PULSE

Head of Communications, NNUH
Andrew Stronach (ext.3200)
Editor Sue Jones (ext.5944)
Pictures Medical Illustration and Sue Jones
Communications Officer
Hayley Gerrard (ext. 5821)
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