

**NATIONAL CLINICAL ASSESSMENT
AUTHORITY**

BUSINESS PLAN 2001/02

To The Secretary of State for Health

We are pleased to present the first Business Plan for the National Clinical Assessment Authority. Reflecting the importance which the Board and the Executive attach to the work that has gone into its production, and to the large body of work for the Authority in its first year of existence, this letter of introduction comes jointly from the Chairman and Chief Officer.

This first year of our work is inevitably one of rapid change and development, and which presents huge challenges, both in tackling the managerial and policy agenda facing us. We started three months ago in April with a small team of senior staff, almost all of whom were seconded in from other organisations. We would therefore like to pay particular tribute to the hard work and support this team has given the Authority. And we are indebted to the Department of Health Sponsor Branch and our Senior Departmental Sponsor for all their help and guidance.

We hope this first business plan meets your requirements and look forward to receiving your comments.

Mrs Jane Wesson
Chairman

Dr Alastair Scotland
Chief Officer

30 July 2001

BUSINESS PLAN 2001/02

CONTENTS

1. Executive Summary
2. Introduction
3. Environmental Impact
4. Aim and Corporate Objectives for 2001/02
5. Key Targets for Performance Monitoring
6. Work Programme
7. Resource Management
8. Organisational Development

Annex	A	NCAA Budget 2001/2
Annex	B	Assessments Timetable 2001/2
Annex	C	Organisational Chart

BUSINESS PLAN 2001/02

1 Executive Summary

The National Clinical Assessment Authority (NCAA) was established as a Special Health Authority in April 2001, as part of the modernisation of the NHS to improve the standards and quality of our health services. The aim of the Authority is to provide a support service to health authorities and primary care trusts, hospital and community trusts who are faced with concerns over the performance of an individual doctor. It is there to provide support to doctors in difficulty and to boost patient confidence in the NHS.

In order to help doctors in difficulty, the NCAA will provide advice, take referrals and carry out targeted assessments where it is deemed necessary. The NCAA's assessment will involve trained medical and lay assessors. Once an objective assessment has been carried out, the NCAA will advise trusts or health authorities on the appropriate course of action. The NCAA is established as an advisory body, and the NHS employer organisation remains responsible for resolving the problem once the NCAA has produced its assessment.

The NCAA also sees it as centrally important that key stakeholders at all levels are thoroughly consulted throughout all stages of the work of the organisation. Consultation with key stakeholders will lead to a more productive relationship and will ensure that procedures developed by the NCAA are fair, effective and transparent.

The Business Plan in this paper should be read alongside the Framework Document agreed with the Department of Health at the start of the year. The plan sets out an interim aim for the Authority to promote excellence in medical practice and patient care. A formal vision or mission statement will be developed towards the end of 2001/2.

The plan's Corporate Objectives for the year cover the development of methods for assessment, handling requests for our help, and developing guidance for the service. They also focus on the need to work with our stakeholders, particularly the General Medical Council and the Commission for Health Improvement, and the development of the headquarters function.

Key performance targets are provided, including a target to deliver twenty prototypes across primary care and hospital and community care. 80% of these prototypes are scheduled to be completed in 10 weeks from appointing assessors. The plan details the work programme to be undertaken, focusing on the development and evaluation of prototype systems for dealing with referrals concerning individual medical practice, arising from ill-health, conduct or competence. Other tasks cover the development of stakeholder groups and the recruitment of assessors, whilst recognising the dependencies and risks for achieving the targets.

The resources to be made available during the year are outlined covering accommodation at Market Towers, an initial staff of 25 and a revenue budget of £2.8m in 2001/2. There is considerable enthusiasm and commitment within the NCAA to deliver the challenges contained within the plan.

2 Introduction

This is the first Business Plan for the National Clinical Assessment Authority (NCAA), and covers the year to 31 March 2002, our first year of operation.

This year is inevitably one of rapid change and development, and presents huge challenges in tackling the managerial and policy agenda facing us. The Authority started work in April 2001 with a small team of senior staff, almost all of whom were seconded in from other organisations, and who have worked hard on a wide front. They have set the organisation up from scratch while at the same time working hard to devise our methods of working, so that we can meet the policy framework set for us through the modernisation agenda.

In reading the plan, the Authority would draw attention to two central elements. First, as this is the initial year of working, all our work must be seen as in a 'prototype phase'. We have taken this approach primarily in recognising the importance of being able to respond as quickly as possible to real concerns about individual practice. As a result our caseload for this year will be lower than would be expected from a more routinely running system, and our cost per case is projected to be significantly higher. This reflects the individual attention each referral will receive from us, from the early stages of discussing potential referrals with Health Authorities and Trusts, through to discussing local action plans to respond to our recommendations. It also reflects the need to evaluate every case in order to gain valuable experience. This is therefore a complex agenda - developing our working methods and collaborating with a wide range of stakeholders in the NHS, the public and the profession to gain their confidence in our work.

Second, a large part of our work is spent establishing a firm and robust management base for our organisation. Internally, this focuses on building a staffing and resource structure that is fit and flexible enough for a rapidly developing organisation. Externally, this has involved working closely with a wide range of key partner organisations whose work closely relates to ours. The early part of the year has involved intensive working with the General Medical Council (GMC) and the Commission for Health Improvement (CHI) in order to achieve an interim memorandum of understanding. This is only part of the wider network of organisations we are working with to ensure clarity in a complex field. Others include the medical royal colleges, deans of postgraduate medical and general practice education, and the Department of Health regional offices. Our external agenda develops directly from this, and is focused on a tight structure for consulting with key stakeholder organisations in gaining their acceptance and confidence in our work.

3 Environmental Impact

3.1 Policy Context

The NCAA is one of the central planks of the NHS' agenda for quality improvement. Our immediate policy context is set out in the consultation document *Supporting Doctors, Protecting Patients*, and the response to the results of the consultation, is set out in the document *Assuring the Quality of Medical Practice*. More widely, however, the Authority's creation and the need for our work is part of a much broader set of initiatives put in place as part of the modernisation agenda within the NHS.

In taking forward our work, the most immediate policy initiatives that the NCAA are concerned with are the employment of medical staff within the NHS and the Prison Medical Service, the contractual arrangements for doctors in general practice, and the regulation of medical practice as a whole, especially the revalidation and fitness to practise procedures of the GMC. This is a field of rapid and radical change, and provides a 'moving target' for the NCAA in devising its policies, protocols and methods of working. The changes which stand to have the most profound effect on our work and our working methods include

- The reform of the disciplinary policies for medical and dental staff working in the NHS
- The introduction of appraisal systems for medical staff in the NHS
- Changes to the NHS Tribunal procedures in relation to the contractual arrangements between health authorities and doctors in primary care
- The further development of the assessment processes used by CHI
- The further development of the GMC's fitness to practise procedures, especially the performance procedures
- The structural reorganisation of the NHS

Note that the terms '**primary care**' and '**hospital and community care**' are used throughout this document to cover medical practice in these settings. We recognise that the terms cover practice across all clinical professions. However, the terms are used for ease of referral and consistency.

3.2 Service Priorities

The priorities for the NCAA are:

- Set the Authority on a sound organisational footing with a formal framework for direction and control including, for example, Standing Orders and IM & T Security Policy
- Develop the mission and the strategic principles which will guide our work
- Develop interim policies and protocols that will form a prototype framework for the period to 31 March 2002
- Develop alliances with our key stakeholder organisations which ensure understanding of our prototype framework
- Work with the Prison Medical Service to devise a service level agreement governing how we can meet their needs
- Work with the Welsh and Northern Ireland Assemblies to reach agreement on collaborative working arrangements.

3.3 Partnerships and Alliances

The NCAA is one of a group of bodies helping to achieve the NHS objectives set out in the NHS Plan. Our key partners include the Commission for Health Improvement and the General Medical Council. In addition, close collaboration in our field of work is needed across the three key sectors of NHS management, patient and public interests and the medical profession itself. Our partners will, among others, include the Medical Royal Colleges and Faculties, the British Medical Association (BMA) and the Medical Defence Organisations (MDOs), the National Patient Safety Agency (NPSA), National Institute for Clinical Excellence (NICE), Postgraduate Deans and the NHS Litigation Authority (NHSLA).

4 Aim and Corporate Objectives for 2001/2

4.1 Aim

To promote excellence in medical practice and patient care by:

- providing a support service to NHS organisations and the Prison Service faced with a concern at the performance of individual doctors
- working with NHS organisations and the Prison Service to improve their capability in dealing with doctors in difficulty
- working in a way which provides a supportive environment for the organisations and medical staff involved, which underpins high quality patient care, and which promotes public confidence in the medical profession and the NHS.

4.2 Corporate Objectives

4.2.1 We will develop methods of assessment that

- address the full breadth of individual medical practice in a local setting
- take full account of concerns raised about individual cases, whether these arise from issues of health, personal behaviours or clinical performance in the individual practitioner
- are able to address and analyse problems which may be attributable to the individual practitioner or the organisation within which they work
- exhibit fairness, transparency and an appropriate level of confidentiality, to both the doctor who is the subject of the referral and the referring organisation
- are focused on identifying areas for improvement and making recommendations based on this
- deliver reports to referring organisations which:
 - are comprehensible and useful
 - enable those organisations to develop action plans which address the original concerns and deliver practical solutions
 - enable those organisations to understand the resource impact and make appropriate decisions on this basis
 - complement processes used by other organisations, especially the GMC and CHI

4.2.2 We will develop methods for responding to requests for our help which

- provide useful advice to referring organisations¹
- are supportive of referring organisations' attempts to analyse the problems
- enable as many as possible of the cases discussed with us to be resolved without requiring formal assessment
- enable an effective and efficient assessment process where this is required
- help those whose referral is not appropriate to our work understand where they may take their concern

¹Throughout this document 'referring organisations' refers at present predominately to hospital and community trusts and Health Authorities. This will change in future as the impact of NHS reorganisation takes place.

4.2.3 We will develop a first tranche of guidance for our referring organisations which

- helps them understand how to access our help quickly
- helps them analyse the concerns facing them and present them to us in a way which makes our assessment methods fit for purpose
- helps build capacity in the field to deal with concerns at clinical practice without reference to the Authority

4.2.4 We will work with the General Medical Council and the Commission for Health Improvement to develop memoranda of understanding covering the 'rules of engagement' between our organisations

4.2.5 We will develop our relationships with our stakeholders to ensure that

- they have confidence in the methods of assessment that we put in place
- they have confidence in the methods for handling requests for our help
- they understand the guidance we publish for potential referring organisations
- we develop and maintain a continuing constructive dialogue with those who are key to our work

4.2.6 We will build our headquarters function to enable us to deliver the work programme required to meet the above objectives, and to do this we will

- develop our mission and guiding principles
- support the recruitment and induction of the whole Health Authority
- complete substantive recruitment and induction to the executive team managing the Authority
- recruit and induct the staff required to support the executive team and help deliver the work programme set out in this business plan
- initiate modelling work on the disposition, structure and function of future local 'NCAA organisations' across the country
- work with the Prison Medical Service to agree arrangements for providing a service to them
- work with the National Assembly for Wales and the Northern Ireland Assembly to establish collaborative working arrangements

4.2.7 We will undertake the work needed to plan for our likely workload, and to do this we will

- commission work to estimate likely volume and pattern of referrals
- plan the infrastructure required to meet this projected volume of work which we will ensure is flexible enough to handle potential variation in workload
- achieve the right balance between the headquarters function and the need to develop local expertise

4.2.8 We will assess our performance in meeting these objectives through

- evaluation and review of

- all prototype assessments undertaken in 2001 / 2002
 - all prototype referrals, to assess the proportion which are resolved at each stage of the process we put in place
 - the volume, pattern and source of requests for advice and help
- feedback reports from
 - referring organisations and from the individual doctors concerned and their advisers, as appropriate
 - sample health authorities and trusts
 - our stakeholder groups
 - regular review with
 - the Authority, internally
 - Senior Departmental Sponsor and DoH sponsoring branch

4.2.9 **We will track areas of concern of which we become aware in the course of our work**, in order to identify any patterns emerging. This information can then be shared with the Department of Health and the wider NHS, ensuring appropriate confidentiality, to increase system-wide learning as appropriate.

4.3 Milestones

The principal milestones for delivery of these objectives are set out below:

April-September

- Finalise and publish Business Plan for 2001-2002
- Agree interim service contracts for finance, internal audit, IT and legal services
- Agree internal/external audit plans
- Prepare draft briefing and guidance to the Service on NCAA work
- Identify components of assessment framework and options for recommendation
- Complete initial recruitment
- Appoint all headquarters staff

October-December

- Send out guidance to service
- Prototype assessments instruments identified
- Recruit and train assessment teams
- Commence prototype assessments
- Evaluation of prototypes commissioned and initiated
- System in place to monitor all NCAA referrals
- Train (and provide on-going supervision for) for caseworkers
- Develop induction/training arrangements for headquarters staff

January-March

- Produce draft Business Plan for 2002-2003

- Produce draft Corporate Plan for 2002-2005
- Undertake 20 prototype assessments by 31 March 2002

5 Key Targets for Performance Monitoring

These targets will be mainly related to the advice function of the NCAA and to assessment prototypes to be conducted in the second half of the year.

5.1 Referral Process

A set of principles and protocols for taking referrals from health authorities and trusts will be devised and put in place by October 2001. This will include a sifting process aimed at selecting cases appropriate to the NCAA's assessment process, and a high quality advice service to potential referring bodies aimed at helping them resolve the concern they face without requiring the direct involvement of the NCAA

5.2 Design of Prototype Assessments

A prototype framework for use in primary care and hospital and community care will be devised by October 2001.

5.3 Volume of prototype assessments: October 2001- March 2002

Prototype assessments will commence in primary care and hospital and community care, based on referrals taken from October 2001 onwards. Twenty assessments will be undertaken by March 2002.

5.4 Turnaround Time for Prototype Assessment

During the period to March 2002, 80% of prototype assessments will be completed in 10 weeks from appointing assessors to delivering a draft report to the referring service.

5.5 Guidance to the Service

Guidance will be sent to the Service in October 2001

5.6 Recruitment

By the end of March 2002, up to 25 staff will be recruited by the Authority, including all four directors.

Directors	4
Other Staff	21
Assessors	To be determined

5.7 Financial Balance

Expenditure will be in balance with the resource limit at 31 March 2002, as required under Resource Accounting and Budgeting requirements.

6 Work Programme

6.1 Core Tasks within the Authority's Framework Document

The following sections 6.2 to 6.10 describe the core tasks of the NCAA's work programme for the year, the broad concept for which can be seen in the diagram below. The evaluation and review process will help identify information on which to base subsequent projections of volume and patterns of referrals and sources of request for advice.



The core tasks are also contained in the Framework Document for the Authority. The primary focus of our first year of operation lies at the heart of why we were set up: the development and evaluation of prototype systems for dealing with referrals concerning individual medical practice, whether these arise from issues of ill-health, conduct or competence. When these have been developed with sufficient robustness to move to a more routinely managed system, we will be able to broaden the agenda of work to encompass the full range of our tasks. This section of the Business Plan makes reference to those tasks which, by their nature are more appropriately tackled at the point where the individual referral, assessment and action planning processes are more clearly framed.

6.2 Dependencies and Risks

6.2.1 Dependencies

The NCAA is a central part of a complex jigsaw of changes to the quality framework of professional practice in the NHS. Many of these changes are not yet complete and depend on each other for their success in achieving the quality improvements. Among these are some which are centrally important to the success of the work of the NCAA, such as changes to the disciplinary procedures for medical and dental staff in the Hospital and Community Health Service, and the proposed changes to the NHS Tribunal arrangements in primary care.

The success of the assessment processes which we develop will depend on cooperation by all involved, including the doctor about whom the referral is made. The proposed changes to the NHS Tribunal arrangements in general practice are particularly important in putting both the referring health authority and the doctor about whom a referral is made in a position to cooperate with our work.

Based on our understanding of the GMC's experience with its performance procedures, up to 50% of our referrals are likely to come from primary care. In this setting, the changes to the Tribunal can be seen as a key dependency for our work programme timetable.

6.2.2 Risks

The greatest risk this year is likely to arise from unrealistic expectations in the field, which the NCAA is not resourced to fulfil. These include

- expectations that the NCAA will resolve all patient and professional concerns about doctors in difficulty. We need to be clear that we are a service that can and will assist, but the responsibility still lies with the health authority or trust, or with the GMC
- expectations that the NCAA will be able to deal with a large volume of cases immediately
- expectations that the NCAA will take on all existing outstanding cases, declared or otherwise, and resolve them
- expectations that the NCAA will provide on-going support for doctors in difficulty – that is not our role.

The other major risk is that we shall be expected to adopt a punitive approach. This would be unwise for two reasons. First, the NCAA has no powers or sanctions to punish. Secondly the NCAA will only be effective if its recommendations are used by both the doctor concerned and the health authority or trust to improve practice. This is most likely to be achieved by an authoritative yet supportive and constructive approach.

6.3 Prototype Assessment Framework

The elements of developing an assessment framework for the NCAA will be as follows:

- Design of primary care and hospital and community care prototypes

- Testing of this design with partners and obtaining feedback from them
- Starting referrals with primary care and hospital and community care
- Evaluation using Working Groups (see below)

The timetable for these will overlap, and this is shown in **Annex B**.

- 6.3.1 A primary care Working Group, to provide expert input on the process and methodology for primary care assessments, has been convened at the end of May. The Group will be drawn from our key Stakeholder Reference Group. The NCAA will now be able to undertake and evaluate ten prototype assessments in primary care, from November 2001 to March 2002. The aim will be to design a prototype assessment for primary care by October 2001. Furthermore, the process for handling NCAA reports and recommendations will be completed by October 2001.
- 6.3.2 A further Working Group, also drawn from our key Stakeholder Reference Group, will be developed in parallel to design and assess the fitness for purpose of a prototype referral and assessment framework for hospital and community care. Both these working groups will then be tested with our partners.
- 6.3.3 The aim will be to start 20 prototype referrals by 31 March 2002, with approximately 50% each in primary care and hospital and community care. The referrals will be selected to achieve an appropriate balance between types of cases so as to ensure a firm base for evaluation
- 6.3.4 Finally, it will be necessary to identify aspects of NCAA work that will require evaluation (e.g. provision of advice, handling of casework, assessments, use of recommendations, outcomes, NCAA internal process) and commission appropriate evaluation. We will complete the work of devising prototype evaluation from November 2001.

6.4 Reference Group and Stakeholders

It is centrally important that key stakeholders at all levels have an understanding of the development of NCAA systems, and can have confidence in them. A detailed consultation process will therefore be undertaken at three principal levels. First, wide formal written consultation will take place with all key stakeholders. Secondly within that group, a reference group will be established which will take part in a direct process of discussion meetings at which our work will be shared in more detail. Thirdly, the work discussed with them will be informed by a network of working groups aimed at covering key areas of work, for example the groups established to devise and test the prototype assessment frameworks for primary care and hospital and community care. The stakeholder group will include at its heart, representatives of the medical profession, NHS managers and patients' groups, but will also include wider groups with an interest or other contribution to make to our work.

Once the assessments have begun, we will ensure that we consult with our key stakeholders on a continuing basis to help our evaluation work.

6.5 Development of a Reassessment Framework

The Authority is charged with developing a reassessment framework, which will encompass mechanisms for return to practice following implementation of recommendations and action plans arising from assessments carried out by the Authority. Our work on this will inevitably follow that of devising the primary referral and assessment process, and will therefore have its focus in 2002/03.

6.6 Guidance to the NHS and the Prison Health Service

Since 1 April 2001 the NCAA has produced two information sheets for the health service. The first was sent out on request; the second, a more detailed version, was disseminated to the Service through the Department of Health electronic bulletins. An adapted version will be sent to the prison health service. The information sheet has also been distributed to our key stakeholders and is included on our web site.

We shall continue to keep the Service informed of our work as it develops through regular NCAA bulletins. These will include updates on the consultation process we are conducting to develop our guidance.

The guidance to the service on our assessments will need to be disseminated widely to the Service. It will need to be professionally designed and printed and appropriate quantities produced. An electronic version should also be available. We will need to use the Department of Health's postal systems for ensuring that the publications are targeted at the right groups. Publications will also need to be distributed to NHS employees by NCAA spokespeople at conferences and workshops. We will need to publicise the guidance widely in the national media and specialist press.

6.7 Recruitment of Assessors

The programme for the design of assessments will identify the skills and experience required for assessors and scope out options for recruitment, training and contracting.

The selection of assessors will be as open as possible, consistent with appointing suitably qualified people. By agreement, we will also make use of individuals already trained and experienced in assessment techniques who are carrying out related work for Royal Colleges, GMC and CHI. Training of NCAA assessors will, however, be specific to the needs of the Authority, which are different from those of other bodies.

It is envisaged that we will design a 'tailor made' training programme, which will be run at regular intervals. The training will be supported by appropriate materials (for example the Principles of Assessment referred to earlier) and will be evaluated.

The assessors will be supported in their work by a Headquarters team headed by a Senior Casework Manager who will be a senior and experienced person. It is likely that the casework team will also relate to the Regional presence for the NCAA which will be developed during 2001/2.

6.8 Legal Services

In common with all NHS bodies, the Authority must have access to high quality, responsive and timely legal advice and support. In addition, its work is likely to engender a significant level of legal activity of a complex and specialist nature, arising from our core work of investigating the performance and capability of clinical staff. In this first year, we will put in place interim arrangements to meet a 'needs-must' requirement:

- to provide a legal service to support our work
 - in devising our operating policies, protocols and procedures, ensuring that they are legally robust.
 - in managing and learning from the prototype phase of our assessment work in the latter six months of the year to 31 March 2002, ensuring we are able quickly to access skilled legal help and advice when we are challenged on any aspect of our individual handling of referrals.
- to enable us to conduct a competitive tendering exercise for a longer term agreement, both by giving us the 'space' to conduct the process robustly, and also to help us define clearly the basis and content of a longer term agreement.
- to put in place arrangements to enable us to handle internally, as much as possible, aspects of our work, and only to access solicitors when outside help is essential.

6.9 Development of Local Services

A core task in the Framework Document is to coordinate the creation and development of local services under the auspices of the Authority. As with reassessment frameworks, we see this as something more appropriately developed as a result of experience of the prototype phase of assessments. Nevertheless, as the work on developing systems for dealing with referrals is proceeding, each of the working groups drawn from our stakeholder reference group will discuss how local services may help the work of the Authority. For example, this will include how we would establish a network across the country providing an accessible source of expertise to advise health authorities and trusts faced with concerns at individual practice.

6.10 Communication

Communication is a key function for the National Clinical Assessment Authority. By communicating what we are doing, our key audiences will be clear about our role and have a realistic expectation of what we can achieve. The NCAA has many audiences it must communicate with. Key groups include the NHS, the Government, the public, the medical profession, the NCAA's staff and Board members.

The following work is underway to communicate our messages to key stakeholders:

- A communications strategy will be produced to guide the NCAA's communications work. The strategy will be agreed with the Department of Health's Director of Communications.

- The NCAA is managing requests for speakers at *conferences and workshops* to ensure that we are addressing a cross-section of our key audiences. A standard NCAA *presentation* is available for Authority spokespeople to adapt for different audiences.
- The NCAA will disseminate its guidance to the health service in Autumn 2001.
- Regional roadshows will be held from December 2001 to March 2002 to explain to the NHS our role and how the performance assessments will work. A NCAA conference and a Parliamentary Reception should be considered for Autumn 2002 as a way of spreading the message about the Authority's role.
- The NCAA's *web site* will be re-designed and developed to reflect our growing information. This will be a major communication tool for the NCAA. As our work develops, we will put up-to-date information on the web site on a regular basis. The design of the site will be reviewed each year.
- An *intranet* for internal communications will be developed.
- We will produce regular *NCAA updates* about our work for our key audiences. These will be issued to Chief Executives, Medical Directors, Primary Care Directors and HR Directors through the Department of Health electronic bulletins, and also through our web site. They will also be issued to the Prison Health Service. The first information sheet about our work was issued in May.
- A *Frequently Asked Questions briefing* is being prepared for the web site and information pack. This will be ready in Summer 2001.

7 Resource Management

7.1 Controls Assurance

7.1.1 The Authority will be required to comply with the controls assurance standards that apply to the NHS. A Treasury guidance on risk management for smaller government bodies will assist in this respect.

7.1.2 A small internal group under the coordination of the Corporate Business Manager will evaluate the categories of risk, and produce a draft baseline risk assessment of the most relevant risk areas for the Authority's business.

7.2 Staff Recruitment and Establishment

By the end of September we will have recruited the headquarters staff required to support delivery of the organisation's objectives during its first two years. We estimate that the majority will be in post by the end of November.

The staffing structure (see enclosure) is necessarily interim, as the Authority's work is at a development stage, and its role and processes will alter over time. However, we are confident that the headquarters staffing structure is sufficiently robust and flexible to accommodate the initial work that will be required, in particular support to the assessment teams, the Executive Team and the Board

By the end of March 2002 up to 25 staff will be recruited by the Authority, including all four directors. **(See Annex C):**

Directors	4
Other Staff	21
Assessors	To be determined

We will set in place induction and training arrangements for the staff recruited, ensuring that

- Staff are inducted and trained to the level required for effective performance
- Our training plan and procedures enable us to make progress towards achieving Investors in People status within three years

An important part of the Authority's work will be the recruitment and training of assessors. We will set out our *Principles of Assessment* in a document which will be discussed in draft with key stakeholder and will inform the process of recruitment, induction and training of assessors. We will ensure that assessors are recruited in accordance with equity and good practice, and that as far as possible the composition of assessment teams reflects the diversity of the population

The number of staff required to support the Authority's objectives cannot be finally fixed until we have a clearer idea of the volume of work, particularly performance assessments, that we shall be handling. Headquarters staff will be kept to the minimum consistent with the achieving the organisation's objectives and subsequent business plans will address these issues more specifically.

7.3 Human Resource Policies

The Authority will devise and implement HR policies and procedures, which follow best practice and legal requirements, including but not limited to the following areas

- Recruitment and Selection
- Equality and Diversity
- Sickness and Absence
- Grievance
- Discipline
- Health and Safety
- Public Interest Disclosure
- Performance Appraisal and Personal Development

The terms and conditions of staff will be those of Senior Managers and Administrative and Clerical Staff in Health Authorities in the NHS. All HR policies and procedures will be agreed and in place by the end of December 2001.

7.4 Information and Information Technology

- 7.4.1 The Authority has put in place the basic information technology (IT) infrastructure of the Market Towers site, through a Local Area Network (LAN), servers and desk-top computers. A basic digital connection was made to the NHSnet, and this will be shortly replaced by a faster link.
- 7.4.2 A first draft at developing an IM &T Security Policy has been made, and this will provide a systematic framework for determining priorities. The next step will be to obtain expert advice on the key security arrangements before strategic investments are made. The two particular areas of need are a firewall between our LAN and the NHSnet, and safe remote access from externally based users such as Board members or assessors. The NCAA is also required to carry out a BS 7799 (ISO 17799-1) security baseline self-assessment, and we will aim to complete this as a draft by March 2002. An IM&T Security Officer and Caldicott Guardian have been appointed. A Caldicott Committee will be set up by the end of 2001/02.
- 7.4.3 IT maintenance and user support will be outsourced through an external contract. This has been awarded on an interim basis for nine months, following quotes from NHS and private sector organisations. Near the end of this initial period there will be an evaluation of the Authority's future needs.

7.5 Accommodation

The Authority entered into an initial three-year agreement for 312.7 sq metres at Market Towers, as its headquarters function. This term should be able to be extended in line with the main lease with the Department of Health, which runs to 2011. The lease enables us to benefit from the central management of the building in a number of ways such as mail, reprographics, portering, cleaning, and security, and these are all included in the agreement costs.

However, some of the assumptions about the availability of common space within the building, including boardroom, meetings, conference and training facilities, have not borne out the initial indications when the facilities were first visited. This has meant that the Authority's headquarters offices are already inadequate for our needs, not only in the facilities summarised above, but also in providing space for authority members when on NCAA business. This is needed as many of the members are based in distant parts of the country. This shortage of space takes no account of potential increase in staffing in the future, and early indications are that this is likely. Work is therefore under way with the MCA to identify additional space within Market Towers.

7.6 Financial Framework and Budgeted Expenditure

- 7.6.1 The recurring funds provided as the NCAA's Resource Limit was £14,309k. In addition, £1,001k has been provided as start-up capital for the Authority.
- 7.6.2 The Authority has completed a 'working' assessment of its budgeted expenditure, and this is shown in detail as **Annex A**. As there is yet no history

of expenditure, the pay costs are based on the recruitment plan and the non-pay costs are broad estimates at this stage.

The recurrent expenditure in 2001/02 is limited by the number of referral prototypes, and will be about £2.8m, well short of the Resource Limit. However, if referral activity were to increase from the planned twenty prototypes, to say a level of two hundred and fifty referrals in 2002/3, then the projected indicative expenditure would rise to over £10m.

- 7.6.3 The key budget areas for the 2001/2 budget are shown below, and these are contrasted with the 'crude' figures projected for 2002/3.

	<u>2001/2 Budget</u>	<u>2002/3 Projection</u>
	£	£
Board	146,050	180,000
Medical	475,640	690,000
Corporate Services	744,710	1,236,600
Human Resources	470,575	525,000
Corporate Communications	310,500	356,000
Assessments	504,000	6,680,000
Regional Presence	<u>120,000</u>	<u>480,000</u>
Total Expenditure	2,771,475	10,147,600

- 7.6.4 Clearly, the £14m 2001/2 Resource Limit will not be fully utilised and, later in the year, a year-end out-turn position will be agreed with the DoH and the balance is likely to be returned to the centre. However the NCAA has been informed that the Resource Limit for 2002/3 will remain at £14m, which should be adequate to fund the Authority's likely level of expenditure next year.

- 7.6.5 Start-up expenditure for 2001/2 is estimated at £587k (**Annex A**), on the assumption that a further wing of Market Towers will need to be refurbished and furnished. This amount is also less than the start-up costs allocated, and will need to be carried forward for the final start-up stage of the organisation in 2002/3, including the purchase of systems to handle the data of the organisation. The amount carried forward will need to be agreed with the Department of Health in the second half of this financial year.

- 7.6.6 A more accurate projection of 2002/3 expenditure will be made once the prototypes have been evaluated. This will then be reflected in the 2002/5 Corporate Plan and 2002/3 Business Plan to be produced nearer the end of the financial year.

7.7 Audit Arrangements

The Audit Commission is currently appointing an external auditor, likely to be District Audit. An internal audit arrangement has been agreed with the London City Audit Consortium, and a contract and audit plan will be finalised by the end of July. The terms of reference of the Audit Committee have been approved by the Board, a chair has been appointed and the first meeting was held in July 2001.

8 Organisational Development

8.1 Principles

As already stated, the Authority is a new and developing organisation and development activity will be needed to ensure that

- The organisation is stable and grows its workload at a reasonable pace, consistent with meeting its business plan objectives and providing necessary training and support for its staff
- Relationships with key stakeholders are carefully developed and the Authority achieves a name for responsiveness, efficiency and good practice
- Board members are appropriately involved and supported, and the role of the Board in setting the corporate objectives of the Authority is effectively developed
- The Authority maintains good relationships with the CMO and sponsor department at the Department of Health

8.2 Approach to work

8.2.1 In order to achieve these objectives we will aim for transparency, fairness, equity and integrity in all our dealings and ensure that staff are aware of the need to strive for the highest professional standards. We will be responsive in our dealings with the public, the NHS and the profession, and resolve rapidly any complaints from users. We will rapidly develop the highest possible standards consistent with our need to grow the organisation at a reasonable pace and develop our own structures, skills and base of experience skills (staff, assessors, Board)

8.2.2 In developing our staff and assessment teams, we will ensure that appropriate training and induction is carried out, and achieve continuous improvements in the quality of training. We will place particular emphasis on evaluation and feedback and will actively seek the views of users and incorporate these into our training and assessment procedures. We will put in place HR policies and procedures, which enable us to recruit and retain high quality staff.

8.2.3 We will place particular emphasis on supporting Board members in developing the corporate objectives for the Authority.

8.2.4 We will effectively support the recruitment and development of assessment teams.

8.2.5 We will produce detailed evaluation and analysis of our activity and progress in our Annual Report.

8.2.6 In our internal workings, there will be emphasis on open communications and learning from experience. The Authority will aim to be a learning organisation,

able to respond to constructive criticism, learn from experience and continuously improve our service.

ANNEX A

NCAA Revenue Working Budget 2001/02

Cost Area (Budget Holder)	Pay	Non-Pay	Total	2002/03
Board (Corporate Business Manager)				
Chair/Non-Executive Directors	£ 107,050		£ 107,050	£ 110,000
Board Committees		£ 5,000	£ 5,000	£ 20,000
Board Meetings/Workshops		£ 10,000	£ 10,000	£ 10,000
Travel/Hotel Exp:Chair/Non-Execs		£ 24,000	£ 24,000	£ 40,000
Medical (Medical Director)				
Staff	£ 264,240		£ 264,240	£ 350,000
Legal Advice (External)		£ 71,400	£ 71,400	£ 200,000
Pump-prime Projects		£ 140,000	£ 140,000	£ 140,000
Corporate Services (Finance Director)				
Staff	£ 185,135		£ 185,135	£ 280,000
Agency PAs		£ 24,000	£ 24,000	£ 15,000
M Towers:Rent/Rates/Service Chg		£ 190,575	£ 190,575	£ 254,100
Stationery		£ 25,000	£ 25,000	£ 40,000
Photocopier Rental		£ 5,000	£ 5,000	£ 20,000
Telephones (Non-M'Towers)		£ 5,000	£ 5,000	£ 10,000
Hospitality		£ 5,000	£ 5,000	£ 7,500
Financial Services Contract		£ 50,000	£ 50,000	£ 60,000
IT Support Contract		£ 17,000	£ 17,000	£ 40,000
IT Infrastructure,ISDN Lines		£ 30,000	£ 30,000	£ 50,000
Travel/Hotel Expenses: Staff		£ 60,000	£ 60,000	£ 200,000
Internal/External Audit		£ 48,000	£ 48,000	£ 60,000
Contingency		£ 100,000	£ 100,000	£ 200,000
Human Resources (HR Director)				
Staff	£ 218,575		£ 218,575	£ 300,000
Recruitment Services (Staff/Assrs)		£ 147,000	£ 147,000	£ 90,000
Training: Assessors		£ 75,000	£ 75,000	£ 75,000
Training: Staff/Board		£ 30,000	£ 30,000	£ 60,000
Corporate Communications(Coms Dir)				
Staff	£ 100,500		£ 100,500	£ 150,000
Service Guidelines		£ 40,000	£ 40,000	£ 60,000
Web Site Development		£ 20,000	£ 20,000	£ 30,000
Reference/Stakeholder Groups		£ 20,000	£ 20,000	£ 20,000
Publications/Annual Report		£ 15,000	£ 15,000	£ 25,000
Roadshows (6 Eng/Wales)		£ 90,000	£ 90,000	£ 40,000
Specialist Support		£ 20,000	£ 20,000	£ 25,000
Journals/Subscriptions		£ 5,000	£ 5,000	£ 6,000
Assessments (HR Director)				
Design & Evaluation of Prototypes		£ 116,000	£ 116,000	£ 30,000
Prototypes: Locums		£ 28,000	£ 28,000	£ 700,000
Prototypes: Assessor Fees		£ 224,000	£ 224,000	£ 3,500,000
Prototypes: Assessor Travel/Hotel		£ 76,000	£ 76,000	£ 1,700,000
Local Facilities/Simulators/Dir Costs		£ 60,000	£ 60,000	£ 750,000
Regional Presence (Prim Care Dir)				
Primary Care		£ 60,000	£ 60,000	£ 240,000

Hospital/Community Care	£	60,000	£	60,000	£	240,000
Prison Service (Self-financed)	£	-	£	-	£	-
Total Expenditure	£	875,500	£	1,895,975	£	2,771,475
					£	10,147,600

NCAA Capital/Start-up Budget 2001/02

	2000/01*	2001/02**	Total
Property Refurbishment	£ 59,580	£ 326,600	£ 386,180
Office Furniture		£ 111,700	£ 111,700
IT Equipment/LAN/Systems		£ 148,900	£ 148,900
Total Expenditure	£ 59,580	£ 587,200	£ 646,780

*Paid from 2000/01 DoH Budget

**Based on 2 wings at Market Towers

ASSESSMENTS: PROJECT TIMETABLE 2001/02

TASK	LEAD	CONTRIBUTOR	2001					2002					
			JUNE	JULY	AUG	SEPT/OCT	NOV	DEC	JAN	FEB	MAR		
Primary Care Working Group	1° Dir	Med Dir	←	→	←	→	←	→	←	→	EVALUATION	←	→
Hospital and community care Working Group	HR Dir	Med Dir	←	→	←	→	←	→	←	→	EVALUATION	←	→
Testing with Partners (1:1)	Med Dir		←	→	←	→	←	→	←	→	FEEDBACK	←	→
Reference Group	Chairman	Med Dir	←	→	←	→	←	→	←	→		←	→
Stakeholder Group	Coms Dir	1° Dir/Med Dir				←	→	←	→	←	→	←	→
Recruit Assessors for Prototypes	1° Dir/HR Dir	Med Dir				←	→	←	→	←	→	←	→
Primary Care Prototype Referrals	1° Dir	HR Dir						←	→	←	→	←	→
Hospital and Community Care Prototype Referrals	Med Dir	HR Dir						←	→	←	→	←	→
Road shows	Coms Dir	All Directors						←	→	←	→	←	→

CODES: Med Dir = Medical Director
 1° Dir = Primary Care Director
 HR Dir = HR Director
 Coms Dir = Communication Director

National Clinical Assessment Authority

Proposed Organisation Structure

