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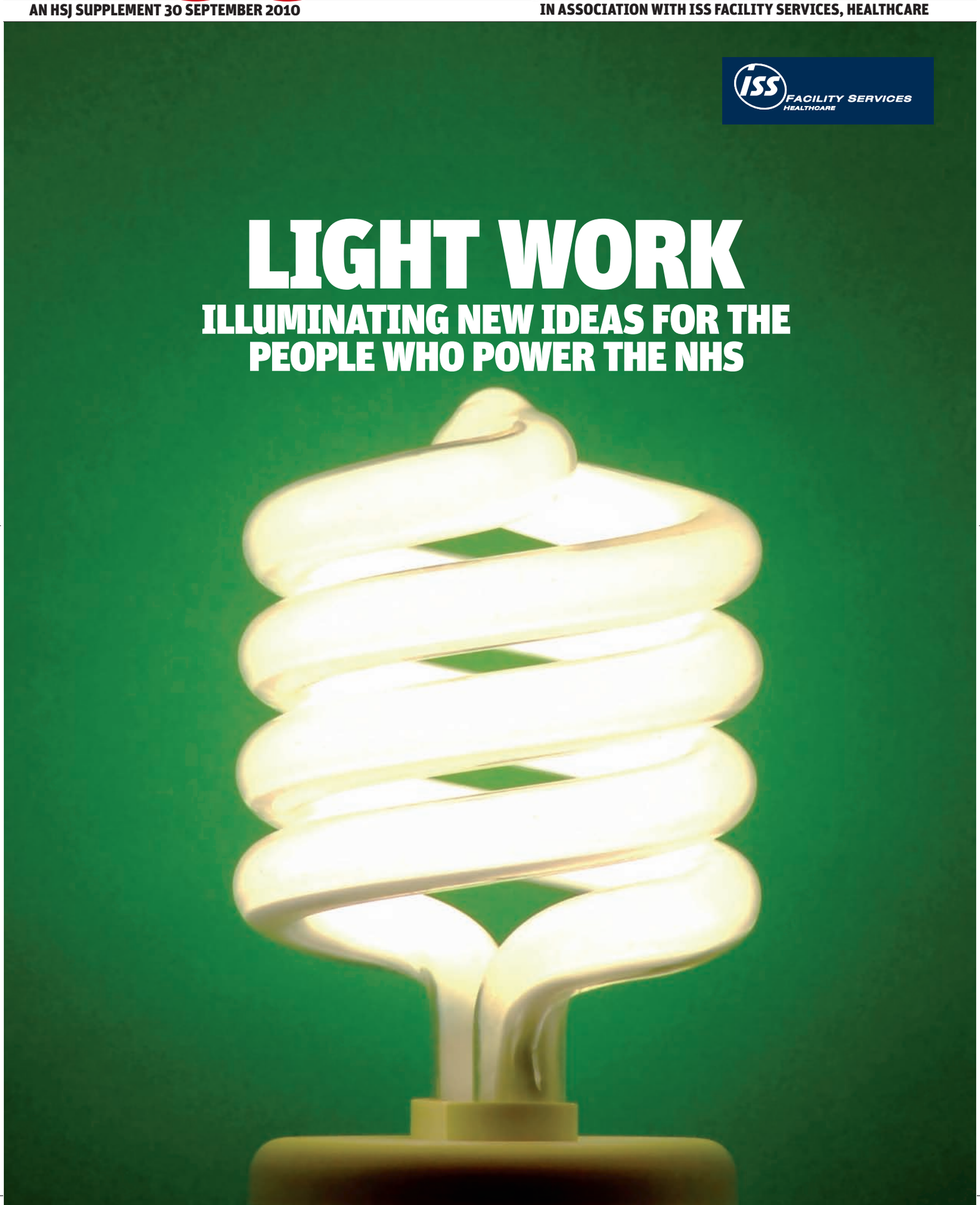
LIGHT WORK

ILLUMINATING NEW IDEAS FOR THE PEOPLE WHO POWER THE NHS



CONTENTS

INSIDE

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FOREWORD

Lifeblood of the NHS

I am delighted to have been asked to write the foreword to this supplement on facilities management because it has been recognised by the leading health policy and management publication that the work provided by ISS and other FM companies, along with the in-house teams, is at the heart of delivering services to the patient.

The NHS depends on serviceable buildings in which it can function. This requires a wide range of skills within the estates department, which provides the hard FM, ensuring the utilities and the fabric of the property are fit for purpose. If you look inside that building you will see a hive of activity which involves so much more than just the clinical staff. Without the porter taking the patient to theatre the surgeon cannot carry out his important work. Before the nurses have prepared the theatre for surgery they need to be assured that the area is not just clean but clinically clean; something that depends on the healthcare cleaner, part of the soft FM team, and so the process continues.

Simply put, without these critically important teams, and the supporting industries, the NHS would grind to a halt within hours. That being said, we must also recognise that we are living in difficult times, particularly in the public sector, where every pound spent is coming under increased scrutiny. It is the responsibility of all of us working in, or alongside, the NHS, to provide the highest standard of FM support services that can be afforded within challenging budgets.

We have moved a long way forward over the past 10 years in terms of recognising the importance of investing in people, estate and standards and the problems in the economy should not be used as an excuse to move backwards, particularly in the area of reducing healthcare acquired infections and offering choice at the point of delivery.

The NHS always needs to adopt and embrace new ideas and up to date thinking and the FM market is constantly coming up with innovative solutions. Ozone cleaning and single portion catering are just two examples of soft FM ideas that are making a positive impact on the patient stay experience, while the lessons learned from the private finance initiative are now being adopted into conventional contracts.

This supplement showcases up to date thinking and should be a valuable resource to every reader. ●

Simon Cox is managing director of ISS Facility Services, Healthcare.

ISS FACILITY SERVICES HEALTHCARE

'Without these teams and supporting industries, the NHS would grind to a halt within hours'

LET THEM TAKE THE STRAIN

If trusts can negotiate a really watertight contract from the start, outsourcing can be a flexible and cost-efficient way to offload a wide range of services

Given that a number of services in facilities management lend themselves to outsourcing (see box), efficiencies can be made by putting one company in charge of several areas.

Healthcare Initial sales director Alan Starling says there has been a trend over the last few years for trusts to wrap up services into a multi-service pack. A hotel services bid, for example, would include cleaning and housekeeping, catering and portering services. Other soft services packages would add in reception and help desk services.

Standard contracts are for five years, normally with the option for two one-year extensions. Staff transfer under the Transfer of Undertakings (Protection of Employment) Regulations and services are provided for a fixed price each month, uplifted by Agenda for Change and the retail prices index.

"Trusts can concentrate on the clinical side and we can take the day to day management of the non-core services away from them," he says.

When there is a need to modernise or change a system – for instance introducing a new microfibre cleaning system – companies like Healthcare Initial have the expertise and partners to implement the new process and train staff.

The big growth area of outsourcing for trusts is collaborative procurement, says University College London Hospitals Foundation Trust director of estates and facilities management Trevor Payne. UCLH is doing just that as part of University College London Partners, the academic health science centre which includes Great Ormond Street Hospital for Children Trust, Moorfields Eye Hospital Foundation Trust and the Royal Free Hampstead Trust.

UCLP is considering collaborative outsourcing for catering, cleaning, laundering, portering and estates maintenance.

Mr Payne adds: "I think there are opportunities in the future to look at all back office functions... from payroll, finance, looking at shared services options."

Collaboration brings greater buying power in the market, with leverage to dictate the terms and to focus on cost and quality. In general, outsourced contracts also have the benefit of flexibility and services can be scaled up or down depending on activity.

The key to securing best value is procuring a partnership that will be sustainable in the longer term, and making a decision based on cost and quality. In the past there has been a tendency for trusts to rush to the market and to a decision.

"If the trust feels that the lowest possible price is the only meaningful outcome, it is unlikely to achieve efficiencies," says ARAMARK Healthcare director of healthcare UK and Ireland Kevin Holder.

FOTOLIA

Value for money

A good contract recognises that while the trust is looking to obtain value for money, the contracted partner organisation needs to make an acceptable profit. Mr Holder warns that trusts should be wary of companies "who appear willing to accept contracts at margins that indicate a likely inability to meet the required service standards and also provide for a realistic profit margin".

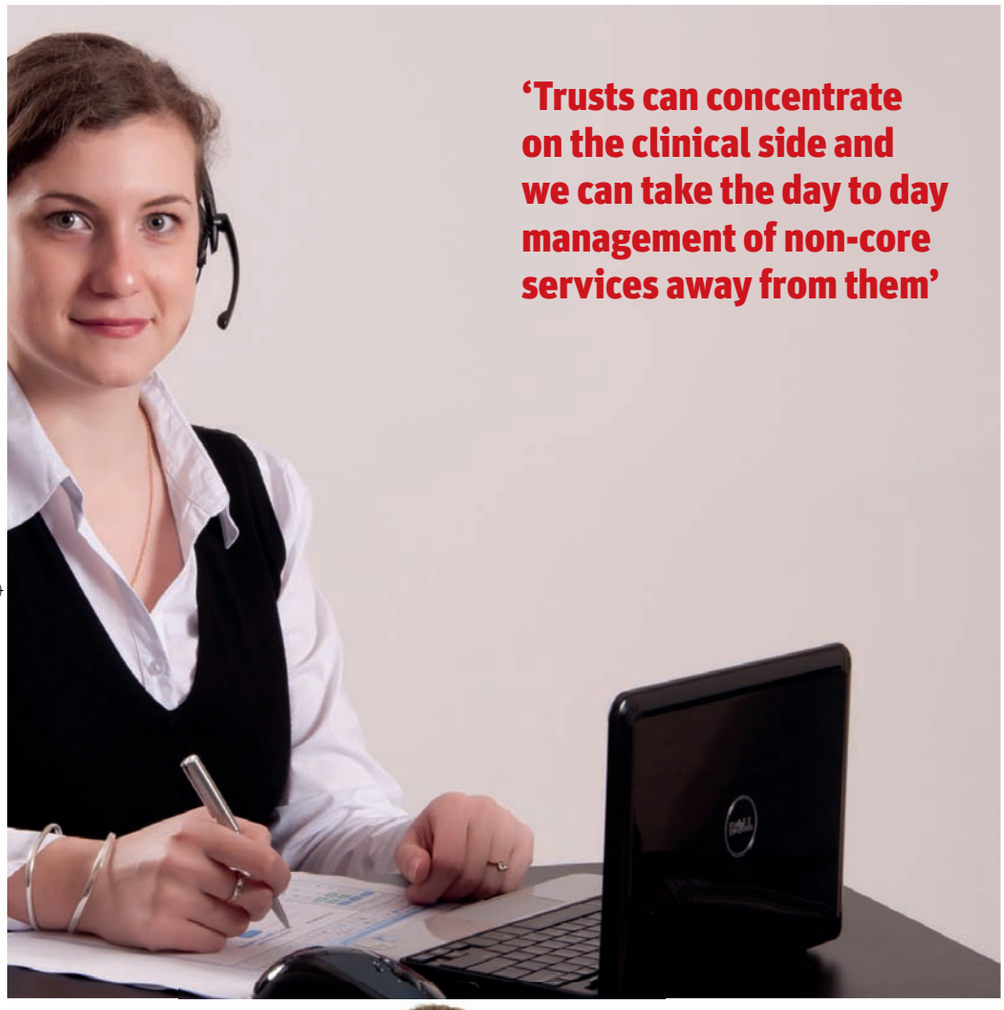
He adds: "This is an unsustainable position and likely to result in pain to both parties during the contract term."

There are numerous legal issues to consider when thinking of outsourcing. As public sector bodies, NHS organisations must comply with the requirements of the procurement regulations. Depending on the value of the deal, they may need to advertise. This is likely, given the scale of most contracts.

It is then essential to ensure that what they are tendering for matches what they need because changes further down the tendering process can cause problems, says Hill Dickinson partner Shelley Thomas.

The next step is deciding how to structure the deal.

In the classic scenario, the trust procures a company to provide the services. Joint ventures are another option, in which trusts set up a special purpose vehicle with the provider, which becomes the company that provides the services. The issue of liability and guarantee from the parent company needs to be considered.



‘Trusts can concentrate on the clinical side and we can take the day to day management of non-core services away from them’

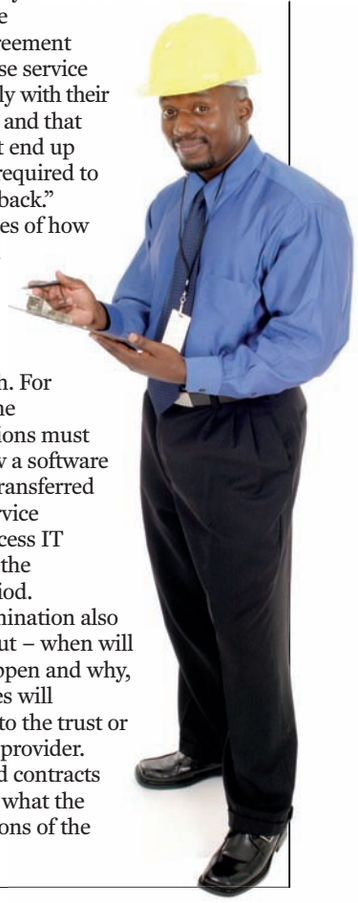
AREAS OF OUTSOURCING IN FACILITIES MANAGEMENT

- Catering
- Cleaning
- Laundry
- Decontamination of surgical equipment
- Portering
- Estates maintenance
- Back office functions, including payroll

Ms Thomas explains: “The financial model they put together for what you are going to pay them may well be affected by how many staff they are obliged to take.”

Second, there are legal obligations under TUPE to consult with staff and notify them about what is happening. As far as the end of the contract is concerned, it is difficult to predict at the outset how many staff will be left, and who they will be. But a contract should set out from the start what the parties’ responsibilities are going to be, such as who will pay for the costs of transferring staff to another service provider.

Ms Thomas says: “The trust wants to make sure in the outsourcing agreement that both of those service providers comply with their legal obligations and that the trust doesn’t end up liable by being required to take these staff back.”



Practical issues of how the services will transfer to the service provider also need to be thought through. For example, in some contracts, decisions must be made on how a software licence will be transferred and how the service provider will access IT systems during the transitional period.

Issues of termination also need to be set out – when will termination happen and why, and how services will transition back to the trust or another service provider.

In short, good contracts set out in detail what the various obligations of the parties are.

From laundry to estates management, outsourcing can be a very flexible option for trusts

Property is another area to be ironed out. Decisions are required on how service providers will access the property they need to provide the services. Will they be given a lease or a licence to access the premises, or will those premises be transferred to them?

Similar issues must be considered for intellectual property rights, software, equipment and other movable items – will they be transferred to the incoming service provider or will a licence be granted for their use?

TUPE is a big aspect of outsourcing contracts, and is important at the start and finish of a contract. At the start, trusts need to have in mind which staff are likely to transfer, first because it will probably have an effect on the service provider’s financial model.

"If you can do that then you are 90 per cent of the way to making sure that the contract is successful," says Ms Thomas. "Most issues that arise out of contracts like this are because there has been a misunderstanding between the service provider and the customer – in this case the trust – about what is actually going to be provided."

Because circumstances do change, contracts should set out a change management procedure. For example, the trust may want the service provider to provide more of a service than it had originally envisaged.

Drawing up and negotiating a good contract will take at least eight to 12 weeks.

Removing risk

Trusts can insert benchmarking provisions into the contract to ensure that they get best value. At certain points during the contract – annually, for instance – the trust will go out to the market and seek quotes for the service. It will then compare those against what it is paying the service provider.

The contract will outline what happens if the market price is lower. The service provider could be required to reduce its rate to the average market price, or the trust could be allowed to terminate the contract and go out to tender again.

"The idea of a good contract is that you are trying to predict all of these various scenarios and then say what is going to happen in this particular scenario," Ms Thomas says.

When looked at purely on a cost basis, outsourcing services may not always be cheaper than providing services in-house but the aim is to transfer the risk of providing those services to the service provider and get a better deal commercially overall.

"It should work out that the trust is in a better position commercially and ultimately in a better position financially because it is removing that risk," says Ms Thomas.

And while Mr Payne says that outsourcing is not always the answer, he adds: "If it's specified correctly and funded correctly, there's just as much opportunity for an outsourced contract to survive, flourish and deliver as there is with an in-house team." ●

LOOKING TO CLEAN UP: HOW SYNERGY HEALTH DOES IT

Synergy Health's expertise lies in the field of decontamination and sterilisation. It is the third largest company in the world for outsourced sterilisation in the healthcare market.

That includes sterilising medical devices such as orthopaedic implants and drug-eluting stents before they can be sold for the big medical device companies in plants around the world.

It has also developed an outsource service for the NHS to provide the same service but for reusable surgical instruments.

Synergy Health is a UK-based company that was set up in 1991 by its chief executive Richard Steeves. In 1996 it created the first outsource service for decontamination in the NHS at what was then the Derby Royal Infirmary, now called Royal Derby Hospital.

It remains a market leader and today provides around 15 to 16 per cent of the market in the UK and a slightly higher proportion in England alone.

Three-quarters of NHS hospitals do sterilisation in-house, and one quarter outsource the service. Over the last six months or so Synergy Health has been targeting hospitals in England that it thinks could benefit from its outsourcing service.

Synergy Health's commercial team put together a database of publicly available information on hospitals, including Care Quality Commission documents, and minutes of meetings at board or operational level. From that they have developed a picture of hospitals' financial performance, postoperative infection rates and compliance with the decontamination requirements for the UK and Europe.

The company has been introducing itself to the acute hospitals in the NHS that it thinks could benefit from its services the most. Today, around eight or nine hospitals are working their way towards outsourcing.

"They have to go through the formal tendering process but we've been involved at a very early stage and feel reasonably confident," says Mr Steeves.

He has not set a specific target number of hospitals in England "but if we're going at 20 per cent a year we'd be very happy with that", he says. The figure is in line with efforts to grow this service area at around 20 per cent a year internationally.

Hospitals can benefit from outsourcing this service in several ways. First, hospitals that outsource the service to Synergy Health have a postoperative infection rate that is half that of hospitals that do it in-house.

Second, Synergy Health can run the service more cost-effectively because it invests heavily in IT systems, has specialist knowledge and operates on a larger scale than in-house services.

Third, hospitals in the UK can recover VAT on an outsourced service. About two-thirds of the costs of decontamination are labour, but hospitals that switch to outsourcing could recover VAT on the remaining one-third.

'The NHS is accountable for taxpayers' money but the process gets drawn out'

Mr Steeves says: "When VAT goes up from 17.5 to 20 per cent that will add to the attraction of outsourcing."

A fourth element that supports an outsourcing market is the ban on capital expenditure. Maintaining decontamination facilities or building new ones that comply with the regulations requires investment.

Mr Steeves says the UK has been a world leader in public/private partnerships and outsourcing generally, with companies like Serco and Capita showing the way.

What has been slightly more difficult in the UK is the fact that the NHS is a large public body which "sometimes finds it difficult to make decisions". In other countries with a national insurance scheme and independently run hospitals it can be easier to operate because people are able to make quicker decisions in a commercial environment.

But he adds: "That's not a criticism at all because at the end of the day they're accountable for taxpayers' money and so they have to do things properly. But inevitably what that means is that the process gets drawn out a bit."

Mr Steeves says he is "not seeing any hesitation" from hospitals about the idea of outsourcing.

"We're not expecting to see any change in the level of demand for surgery either," he adds.

He believes there is too much capacity for healthcare services in the UK and that the future could see the best hospitals (private or public sector) becoming more efficient, while hospitals that are struggling either economically or with quality may be absorbed or shut down.

But even with these potential changes, the market for outsourcing decontamination of surgical equipment will remain.

He says: "At the end of the day, I don't think that has any impact on the numbers of surgical procedures that take place."

CARBON CHAMELEONS

Retrofitting, good maintenance and board buy-in are the next steps in sustainability for trusts

Estates and facilities departments have been working on sustainability for many years and much has been achieved.

"Now that it's becoming a broader topic across all departments and directorates in the trust we still need them to be actively engaged and to keep building on what they've been doing," says NHS Sustainable Development Unit operational director Sonia Roschnik.

The mandatory targets in the Climate Change Act are ambitious: a 34 per cent reduction in carbon emissions by 2020 and 80 per cent by 2050.

The best way to reduce carbon is for trusts' premises to match the model of care they want to deliver, says Ms Roschnik.

"If we have too big an estate or an estate that we're not using in a flexible enough manner, we're going to be contributing a lot of carbon unnecessarily," she says.

Space needs to be used to its maximum, which includes using buildings across a community, says Milton Keynes Hospital Foundation Trust director of facilities Robert Heavisides. Buildings should be designed and used flexibly so that minimal adaptations are needed.

Retrofit revolution

Mr Heavisides adds that choices on investment and disinvestment need to be linked to future sustainability. Trusts can save money and carbon at negligible cost by running an awareness campaign or reducing the ambient temperature. Initial investment is required for things like a combined heat and power plant but the rate of return is coming down as the price of energy climbs. Good maintenance and upkeep can ensure that savings continue, and staff training is essential.

Mr Heavisides says: "If people don't operate and use the building effectively and efficiently, you're not going to get the best out of it."

Disrupting staff and services while making changes that reduce carbon is a concern for trusts. But Energys Group managing director Aidan Salter says that retrofitting can avoid any hassles. The approach is primarily used for lighting but other areas can be tackled – for example, they also do an add-on to a boiler control.

"You're not disturbing the fabric of the building, you can normally do it during the working day and you don't need to redecorate," says Mr Salter.

Retrofitting new, modern fluorescent lighting does not disrupt the normal electricity supply and avoids fitters suddenly coming across electrical problems with the wiring, since they do not have to touch the existing wiring. Payback for retrofitting the lights in a hospital corridor is less than one year and for an office is typically three years. That takes account of a reduction in energy and maintenance costs, compared to the cost of installation.

The NHS carbon footprint shows that 24 per cent of energy comes from the estate, 17 per cent from travel and 59 per cent from procurement. Efficiencies can be made and carbon saved by procuring only what is needed.

Most NHS staff want to be engaged in reducing carbon and they can be a very powerful source of change, says Ms Roschnik. Boards should approve a sustainable development management plan so that everyone has buy-in from the top to take this agenda forward.

She says: "It should make it easier to bring business cases forward." ●

NEW LIFE FROM AN OLD ESTATE

The challenge of reducing energy use in an old trust is one that David Houghton, project manager for the Children's Health Park Project at Alder Hey Children's Foundation Trust, took on in his former role as estates manager.

Over 60 per cent of the children's hospital, founded in 1914, is more than 75 years old. Obvious things were done such as double glazing and insulating. Heating load was reduced by replacing gas boilers with more efficient ones and using heating controls to turn heating down or off in empty areas. But the big savings were made with electricity.

"The carbon output of electricity is much higher than gas," says Mr Houghton.

Inverters were put on large motors (for boilers and air conditioning), reducing electricity use with no drop in performance. New energy efficient lighting requires less maintenance and a combined heat and power plant has reduced the trust's electricity bill and carbon output.

Getting buy-in from the board and staff was essential. A Save It campaign led by nurse Gina Shaw increased awareness and encouraged staff to participate.

Funding came from the trust (£200,000) and NHS North West (£800,000).

Annual revenue savings amount to £134,000, including £125,000 from electricity, and 763 tonnes of CO_2 have been saved per year.

FOTOLIA

CHANGING ROOMS

Taking a long, hard look at their – sometimes ageing – built stock can enable trusts to shrewdly reconfigure rooms and pave the way for more efficient use of assets

In the NHS estate, 60 to 65 per cent of the built stock is thought to be more than 30 years old and about 23 per cent of all built stock predates the NHS. To compound the problem, many new buildings were out of date when they opened, says John Cooper Architecture director John Cooper.

"The significant investment in new buildings which was made in the last decade was in some cases ill directed," he says.

Generic design principles, which allow flexible use of rooms, were seldom applied, for example. And the generation of hospitals that were developed from 1998 to 2010 should have been part of the migration of services into the community.

"We put the cart before the horse," he says.

While certain hospitals are amenable to conversion and refurbishment to meet today's standards, Mr Cooper says that many that were developed in the 1960s or 1970s are "difficult to convert and in many cases could prove as expensive as their replacement by new buildings".

NHS Tower Hamlets director of capital development and ICT David Butcher argues that NHS organisations should be able to use the capital receipt from property sales to regenerate their assets. At the moment the money goes back into the central pot so there is little incentive to maximise the use of assets.

Mr Butcher has been charged with reviewing the Commissioners Investment and Asset Management Strategy returns for the three primary care trusts in inner north-east London, to make sure the community estate is fit for purpose.

He says: "We need to ensure that we develop a market and promote some sort of contestability around how we provide the estate in the coming years."

'The significant investment in new buildings in the last decade was in some cases ill directed'

More rooms should have a generic design so they can be shared and used flexibly, generic reception desks could be shared, health and social care services could be more integrated, and certain outpatient services could be moved to primary care settings.

The transition to care closer to home will reveal areas where there is more space than required. Some GP practices may have consulting rooms that are not fully used.

Mr Butcher says: "As you're helping to reduce the size of the estate you would look at the cost of each practice, how old it is and then do whatever you can to help increase its effectiveness and productivity."

Significant saving

Local improvement finance trust (LIFT) companies are helping PCTs identify what services are needed in the area, what buildings thye have and how they can best be used. This could mean refurbishing, disposing of or moving services.

Community Solutions for Primary Care partnerships director Peter Cox says for every square metre saved, the NHS could save £290 (average rent for a new building).

"That's a fully wrapped LIFT price," he says. "If you say you want 3,600 and we work out that you only need 1,500 square metres, that's quite a significant saving." ●

CASE STUDY: NHS BURY

NHS Bury rationalised its estate and by the end of the year will have reduced the number of administration buildings from 10 to five.

The process started by visiting every building and mapping out who worked where.

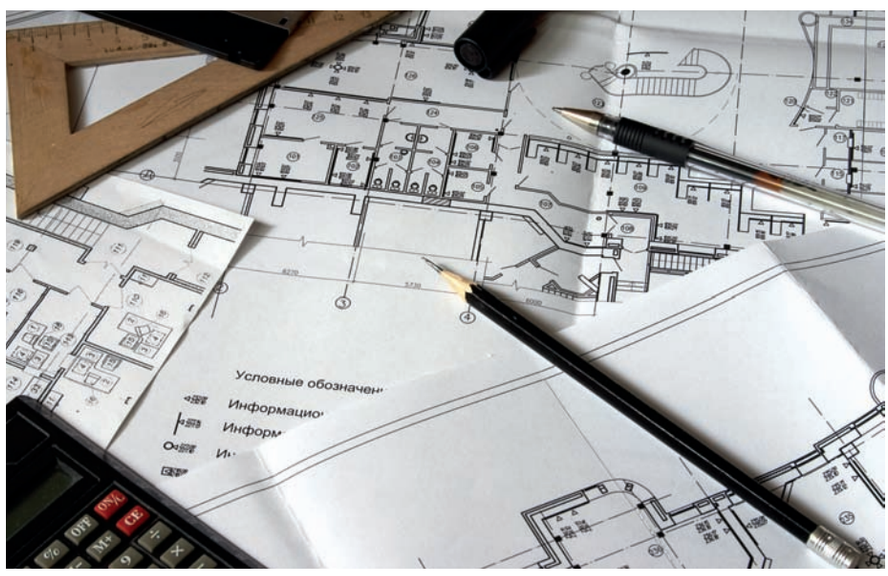
"We previously didn't have a real understanding of who was delivering what and how that impacted across the estate," says Chrisella Morgan, a senior contracting manager for estates and procurement at the PCT. "What that flagged up was we weren't using our estate effectively and we had a lot of capacity that we weren't utilising."

Some administration functions could be accommodated in two health centres owned by the PCT by introducing hotdesking for the district nurses.

"It has allowed us to take a break clause on quite an expensive lease for us," says Ms Morgan.

Specialist services for audiology, dentistry and podiatry were moved into a new LIFT building. Training and development has been relocated to a LIFT building in the town centre, allowing the PCT to sell an older building on the outskirts.

A room booking system now keeps track of how every room across the PCT is being used.



FOTOLIA

TAKE THE DRAMA OUT OF A CRISIS

Risk management errors can cost trusts dearly – and new legal developments have raised the stakes even higher

The number of prosecutions under the Regulatory Reform (Fire Safety) Order 2005 have been increasing. In a case that went before the Court of Appeal in June 2010, New Look's fine of £400,000 for breaches of fire safety obligations was upheld. It included £250,000 for a failure to have suitable and sufficient risk assessment in place and £150,000 for inadequate fire safety training.

Infrastructure changes, such as mergers or transfers of property, could occur as a result of the health white paper and facilities managers will need to ensure that they are still compliant, says Beachcroft LLP solicitor Tracey Longfield.

The sentencing guidelines for corporate manslaughter and health and safety offences causing death were published in February 2010 and imposed greater sanctions. For corporate manslaughter offences the fine may be measured in millions of pounds. The fine for health and safety offences leading to death will seldom be less than £100,000 and may be measured in hundreds of thousands of pounds or more.

In addition to the significant fines, organisations found guilty of corporate manslaughter may be subject to publicity orders, requiring them to put information on their website about a conviction or fine.

The Care Quality Commission was established last year and as of April 2010, NHS providers must register with it. Registration hinges on compliance with essential standards, including safety and suitability of premises. The CQC monitors compliance and can take enforcement action which could include a penalty, suspension of registration or prosecution. Facilities managers could have a direct impact on a trust's registration status if an area of their responsibility was judged non-compliant.

STEPS TO RISK ASSESSMENT

- Identify your risk
- Rank it in priority
- Put in steps to mitigate the risk
- Inform staff
- Keep policies up to date
- Establish proper lines of communication for risk assessment
- Appoint a board champion for risk

'Anything which is very newsworthy will be the biggest thing that you want to avoid'

Worst nightmare

The Health and Safety (Offences) Act 2008 came into force in January 2009 and raised the maximum fine that can be imposed in a magistrates' court for most offences under section 33 of the Health and Safety at Work Act from £5,000 to £20,000, and prison is a possible penalty. Failure to maintain risk assessments is one offence that could be punished in this way.

Trusts' biggest concerns are over "anything which is very newsworthy or very expensive", says Bevan Brittan medical law and personal injury partner Joanna Lloyd. But she adds: "Out of those two, anything which is very newsworthy will be the biggest thing that you want to avoid."

The public inquiry into deaths at Mid Staffordshire foundation Trust makes the kind of headlines "that are every chief executive's worst nightmare", she says, and trusts need robust risk processes to make sure such an incident does not occur.

But what should trusts do if something does go wrong?

"It is a question of first impressions," says Capsticks partner David Firth. When the Health and Safety Executive and/or the police visit the site, trusts need a board representative who can respond efficiently to inquiries. That person must understand how risk is identified and managed in the trust, and have sufficient clout to call members of staff for interview.

Records should be kept of who has been interviewed and what documents have been handed over. At the same time, the trust will be running its own internal investigation.

If trusts are convicted or have pleaded guilty, they need to acknowledge that they are at fault and that new procedures have been put in place.

In a corporate manslaughter trial, the jury will not want to hear that the trust is in denial.

They are also more likely to find a trust guilty of a corporate manslaughter or health and safety offence if risk management policies are not up to date and people do not attend training. ●

ALAMY