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SECRET SERVICE

WHY WHISTLEBLOWING SHOULD BE ENCOURAGED, NOT PUNISHED 15

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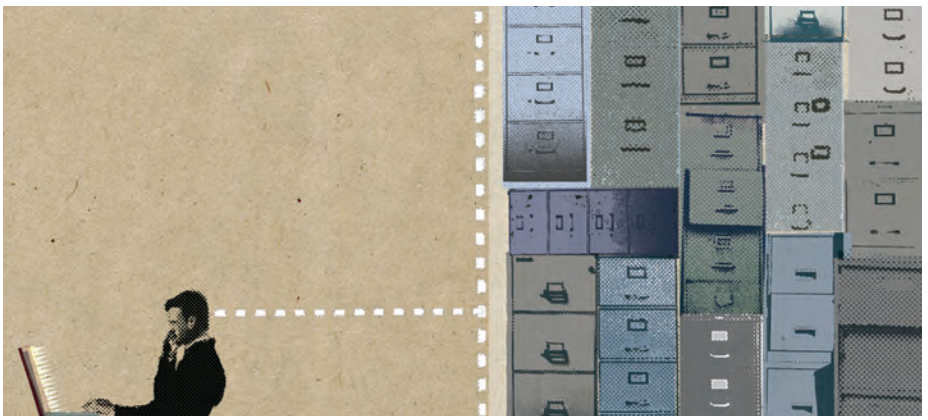

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Contracts may be signed in good faith, but a change in circumstances can mean a provider is no longer able to fulfil the terms of its contract. Knowing how to prepare for, and deal with, such events is invaluable. Page 23

FROM ACT TO ACTION

Now the Health and Social Care Act has come to fruition, it's time to focus on how to make it work in practice, Mike Farrar tells Alison Moore

JAMES ROYALL

Pragmatism is the order of the day for the NHS now the Health and Social Care Act has been passed. The divisions of the last two years have had to be put to one side as managers and clinicians face the task of putting the changes into practice.

Mike Farrar, chief executive of the NHS Confederation, is a man made for pragmatism. A constructive critic of the bill, he has managed to remain on good terms with all sides despite the bitter debates, and is acutely aware that NHS organisations will have to implement and make sense of the coming changes. If he thinks it's a pig's ear of an act, he is too diplomatic to say so.

"It's now down to us," he says. "Whatever people think about the rights and wrongs of the legislation...we have to make the architecture work for the benefit of the patients."

He sees opportunities in the overall vision of the bill, one of which is the ability to connect with people about their own health and lifestyle factors. This includes areas like exercise, which he is passionate about.

A 'good' result

Another is around engaging and explaining with the public about what is a "good" outcome for a health service. That is likely to be keeping people out of hospital rather than obsessing about the size of hospitals, and looking at the outcomes of treatment rather than where that treatment is provided.

"We need to be much more proactive," he says. "When we talk about these things reactively we almost put the public and politicians on the back foot...it looks like these changes are being forced on them."

Talking about variation and seeking the best outcomes is part of this.

"Can we be more transparent so people can see variations in outcomes and push us so we have to deliver the best everywhere?"

Despite the heavily politicised nature of the debate around the bill, he believes all parties accept change has to come. But is it the way the debate is framed in the UK that causes some of the problems? The Dutch talk not of reconfiguration but of ebb and flow, seeing changes as a two way process, he says. Some services move further away, but others are provided closer to home.

He gives an example from the North West, where he ran the strategic health authority for many years. The people of Rochdale are concerned about the loss of services at their local hospital but there has been far less focus on the way in which some services are moving closer to them – for example, the Christie Hospital will be operating two linear particle accelerator machines at a

A matter of life and death

Established in 2008 to ensure all adults nearing the end of life have access to high quality care, the National End of Life Care Programme (NEoLCP) has made significant progress over the past four years, developing on previous work which supported Building on the Best (DH, 2003). Claire Henry assesses the challenges facing the programme and its achievements so far.

Established in 2008 to ensure all adults nearing the end of life have access to high quality care, the National End of Life Care Programme (NEoLCP) has made significant progress over the past four years, developing on previous work which supported Building on the Best (DH, 2003). Claire Henry assesses the challenges facing the programme and its achievements so far.

It's a stark reality that many people do not die in the place of their choice - usually their home or a hospice - or have a 'good death' free from pain and distress. For example in 2005, 58.3% of deaths were in hospital, which may not have been the choice of the dying person or the best use of hospital resources.

The End of Life Care Strategy for England (DH, 2008) was the catalyst for bringing about a fundamental change in policy. Developed in partnership with 300 stakeholder groups and organisations, the strategy gave the NEoLCP responsibility for translating this new approach into practice, supporting and enabling staff and employers across health, social care and third sector organisations.

End of life care pathway. Adapted from End of Life Care Strategy (DH, 2008)

The NEoLCP is not simply a co-ordinating body or networking group. It is rooted in the QIPP agenda as a core workstream, and has to meet performance indicators and deliver value for money.

So how have we fared in delivering quality, innovation, productivity and prevention?

Quality

To get consistent quality of care delivered in every setting – home, hospital, community – a number of strands have been woven together to support transformational change. These require multiple key interventions working together across a whole system and include promoting best practice in areas such as:

- Communications skills
- Advance care planning (ACP)
- Recording and sharing information effectively between various agencies via Electronic Palliative Care Co-ordination Systems (EPaCCS)
- e-Learning courses via e-ELCA
- 'Route to Success' guides for specific settings and professions (acute hospitals, care homes, nursing, ambulance services)
- Care after death and developing bereavement services.

The quality outcome can be measured by the proportion of people who die in their preferred place of care. By 2010, the number of deaths in hospital had fallen to 53.3%. The percentage of deaths in the usual place of residence is rising, from just under 38% to 41.5% in the first three years of the programme. A dedicated '1%' campaign working with GPs and other partners aims to maintain this improvement.

Innovation

Innovation too has played a key role. For example, in 2010 we launched the National End of Life Care Intelligence Network (NEoLCIN). By consolidating, analysing and sharing data about age, place and cause of death, NEoLCIN has helped commissioners, providers and policymakers to make major decisions about end of life services.

New approaches to joint working have proved invaluable. Truly co-ordinated care for people at the end of life involves social care as well as NHS professionals and the voluntary sector. NEoLCP brought together an expert working party in 2010 to develop a social care framework. It maps out how social care commissioners and providers, together with those involved in training and education, can boost the contribution of social care to overall end of life care.

Productivity

Providing the best care for the dying person and their family also leads to productivity and efficiency gains. Unnecessary emergency hospital admissions in the final year of life, delays in discharging people home to die in accordance with their wishes and inappropriate or unwanted interventions have a financial as well as a human cost.

In England, a 10% reduction in the number of hospital admissions ending in death could result in a saving of £52m (CMG42 Guide for commissioners on end of life care for adults, NICE 2011). Similarly, a 10% reduction in bed days for a person who is in hospital for more than eight days before death could save around £57m – assuming a cost per bed day of £200 (QIPP Reviewing end of life care costing information, NEoLCP 2012).

Prevention

Working with around 40 individuals from seven PCT areas which were performing well in terms of preventing people from dying in hospital if this was not their wish, we were able to identify nine critical success factors.

These ranged from strong commissioning and clinical leadership, use of national payment incentives plus flexible joint budgets and care packages to use of nationally recognised tools, clearly defined access to 24 hour cover, development of care homes, co-ordination of care across professional/organisational boundaries and training.

To give just one illustration of some of these factors in practice, in County Durham two Macmillan discharge facilitators received 181 referrals in five months. Some 80% of the people referred died in their preferred setting.

Death may still be a taboo subject in society, but those responsible for providing care at the end of life need to speak out loud and clear. With significant changes to the way the NHS commissions services currently being implemented, improvements in care quality which in turn generate cost savings are a priority.

End of life care could be a blue print for how a structured, co-ordinated approach can deliver both better quality and more cost-effective care. It really is a matter of life and death.

Claire Henry is Programme Director of the National End of Life Care Programme (www.endoflifecareforadults.nhs.uk) and also Joint National Lead for the Department of Health's end of life care QIPP workstream.

satellite site in Oldham, saving many patients from that area having to make repeated trips to its main site.

"We somehow only get the debate about services moving further away. We know a lot of diagnostic tests and equipment are not only moving closer but are coming to the high street," he says. "We can deliver things in your own home which, 20 years ago, you would have had to go to hospital for."

And he sees clinical involvement as a useful means to help the public understand some of these messages. "It's not just the message, it's the messenger," he says. "We know how well trusted our colleagues are. That is one of the great opportunities of having them engaged in management."

While simply saving money may not be the natural territory of clinicians, improving services and reducing variations is. But Mr Farrar says the NHS does need leaders who are more upfront about managing their organisation as a healthcare business.

He has an unfashionably Keynesian approach, suggesting the NHS could have a role in regeneration, and investment in its infrastructure could be helpful in the current financial situation. "We should be campaigning quite hard to get the government to invest in infrastructure because it is so cheap at the moment... The NHS could kickstart through government investment in infrastructure."

But the taxpayer should not be asked to keep on paying for inefficiency, he says.

Looking to the future

The next few years will be incredibly difficult and will require more efficiency savings. He says a lot of work has been done within organisations to make savings – but the focus must now move towards collaboration as the ability within single organisations to find yet more savings may "run out of road".

"It is in the boundaries of healthcare that we will find savings – for example, community to primary care, hospital to hospital and health and social care," he says. "All of these areas where there is a boundary are probably where you get systemic savings on a scale necessary to solve the problem."

Getting more productivity out of the workforce – albeit in a way that is fair – is another part of the solution, he says. "There is a trade off – amount of labour versus cost of labour." How to motivate people to work in what Farrar calls "the greatest organisation in the world" is another part of this, and here he is concerned about how managers are treated. Manager bashing is "short sighted" he says.

"This is about understanding that to get great quality outcomes you need to organise care well and spend money properly. Belittling the money you spent on organising care, and then saying you only value those who deliver care, will get you poorer outcomes."

There's widespread scepticism, even among clinicians, that the reforms will cause the government to withdraw from its central role in healthcare in favour of local solutions. He says it will still have a big role and needs to make sure all the elements are aligned. Commissioning is just one of the levers.

'Whatever people think about the rights and wrongs of the legislation we have to make the architecture work for the benefit of the patients'

He highlights as important the drive towards integration and the need for Monitor to work in the public interest. And he admits he is optimistic about the future. Finances may still be difficult in five years' time he says, but there could be understanding of the need for change and the value of clinicians in management could have been unlocked. "I think we will be moving forward," he says.

But where will the NHS Confederation fit into this? Over the last few years its future has seemed uncertain – the divergence of the Foundation Trust Network nearly led to a complete split and the coming of clinical commissioning groups, with the tendency of GPs to look towards other representative organisations, may diminish its role on the commissioning side.

Mr Farrar says providing a place where the industry can come together is very important. It can also provide thought leadership and vision. "We have to move forward from some of the issues that we had in the last five years," he says.

The Confederation is now working with the NHS Alliance and the National Association of Primary Care in a new umbrella organisation – NHS Clinical Commissioners. Support from the Confederation has been "received warmly" he says, and he is at pains to point out that as a former head of primary care at the Department of Health he does know the field well.

But he thinks the areas in which the Confederation can really score is in bringing together people from all sides of healthcare in a way that adds value and weight. There is less of the 'they would say that, wouldn't they?' reaction because of this diverse membership, individuals of which may have different perspectives on key issues.

"We have not just got the providers in the room. We have NHS and non-NHS providers, mental health trusts...all working through these things together. The Confederation is a 'community of interests'," he says.

But it has to deliver value for its members. "I'm pleased with progress but not complacent," he adds.

So what for Mr Farrar now? The man who started as a hospital gardener (and had a promising career in professional sports ruled out by injury) has now done some of the biggest jobs in the NHS. For the moment, he seems content to lead the Confederation.

Commentator Roy Lilley has rather mischievously suggested he could lead the Care Quality Commission but Mr Farrar dismisses the idea. "I don't think my strengths are as a regulator but I can think of some very good people who could do it."

Above all, Farrar seems to have pride and gain an enormous amount of enjoyment from working for or with the NHS. He would have no hesitation in recommending a career in it to his children.

"I can honestly say – and I do say – I have never had a Monday morning where I have thought I don't want to work in this organisation any more. I've always believed it was one of the world's best creations...people should feel privileged to have an opportunity to work at senior level," he says. ●

JAMES ROYALL

MATT OAKLEY ON IMAGE STORAGE

As the national contracts for picture archiving and communications systems (PACS) come to an end, NHS trusts are reviewing their medical imaging services and considering their options. In doing so they are facing an unprecedented set of challenges, from an explosion of data to the lack of resources available to manage and report it effectively.

With no centralised procurement body to manage this on their behalf, many trusts are coming to market alone or as mini consortia. Other than for those with scale, this is putting significant pressure on providers to respond.

What we are seeing emerge from all of this is a shift to localisation in terms of decision making and solution choices. This is counter the trends we see around the world where, in line with other industries, health organisations are looking to leverage investments made to date, scalable operations and modern technology solutions such as cloud.

This is an important consideration and, while a shift to local decisions and contracts may be vital to the delivery of high quality local care, it should not necessarily default to local solutions. The end of national contracts does not mean trusts should forgo the many advantages that come through a fully managed service from a proven and trusted supplier, and the investments the NHS has itself made in standing these services up in the first instance.

'We're seeing a shift to localisation, which goes against world trends'

Scale is the key to this. A fully managed service offers highly competitive pricing and the lowest total cost of ownership (TCO) through the scale and efficiency of operations. It also means peace of mind – trusts can leave the end to end management of their service to teams experienced in delivering against benchmark service levels over several years – and technology can be reduced or removed from the care setting leaving trusts to concentrate on delivering the best care to patients.

Accenture is committed to providing lowest TCO and outstanding end to end service. Our one year contract extension for PACS means we can offer continuity to trusts in this time of change. Building on this we intend to be a market leader in medical imaging for the long term.

We're investing in innovation by extending our operations in the Central Data Store to include a cloud based Vendor Neutral Archive and developing a revolutionary PACS in the cloud. We're also working with leading PACS suppliers to offer trusts the solution that's right for them. Choice, together with end to end service excellence, innovation and lowest total cost of ownership, are what trusts need in this brave new world of medical imaging.

Matt Oakley is medical imaging lead at Accenture. www.accenture.com

MEDICAL IMAGING

THE BIGGER PICTURE

As current PACS contracts come to an end, trusts need to work out exactly what they want and need their new storage solutions to deliver, explains Alison Moore

Every year millions of patients in hospital will have images taken that are critical to their diagnosis and treatment. Storing and sharing these images is made possible by picture archiving and communications systems (PACS), which have become an integral part of how trusts operate over the last decade. However, with the current PACS contracts coming to an end in 2013 and 2014, trusts will have to make decisions about what their needs are going to be in the future and how these can be best met.

It is almost unprecedented for all NHS trusts to be thinking of reprocurement of such a major service at the same time; in addition, this comes at a time when the technology available has moved on dramatically. Although the existing PACS systems were usually provided through the National Programme for IT, with a number of local service providers being selected through a tender process, this time, trusts will be on their own and have greater choice over what they can procure.

The contracts with local service providers end for most strategic health authority regions on 30 June 2013 and for London a year later, with a two year transition period after this. Trusts in the regions served by Accenture will be able to take advantage of an extension to their contracts, enabling them to stay with the same provider until 2016. But, sooner or later, all trusts will have to start thinking about a new contract – and that means looking at how their future needs may change.

Imaging in the NHS is still developing. Both the number of images being taken and the complexity of these is increasing year on year. And while imaging was once seen only as the fiefdom of the radiology department, it is now used across hospitals in other departments such as dental and cardiology.

"The vast majority of trusts went from wet film to a PACS service through the national programme," says Matt Oakley, Accenture's medical imaging lead. "They did not have to think about the contract situation at all because it was dealt with by the National Programme for IT.

"Now we are seeing a seven to eight per cent increase in the number of images taken each year for each of our current customers, plus an 18 per cent increase in the size of studies."

So what should trusts be thinking about? The first decision is probably whether to roll over their existing contract if this option is available. This will give them security of provision – often at a reduced price – plus extra time to decide on a longer term solution. Accenture says around three-quarters of its existing clients across three SHA areas (East of England, East Midlands and the North East) have already agreed to do this and others are considering it. The rollover that has been agreed will see Accenture continuing to run its central data store until June 2016.

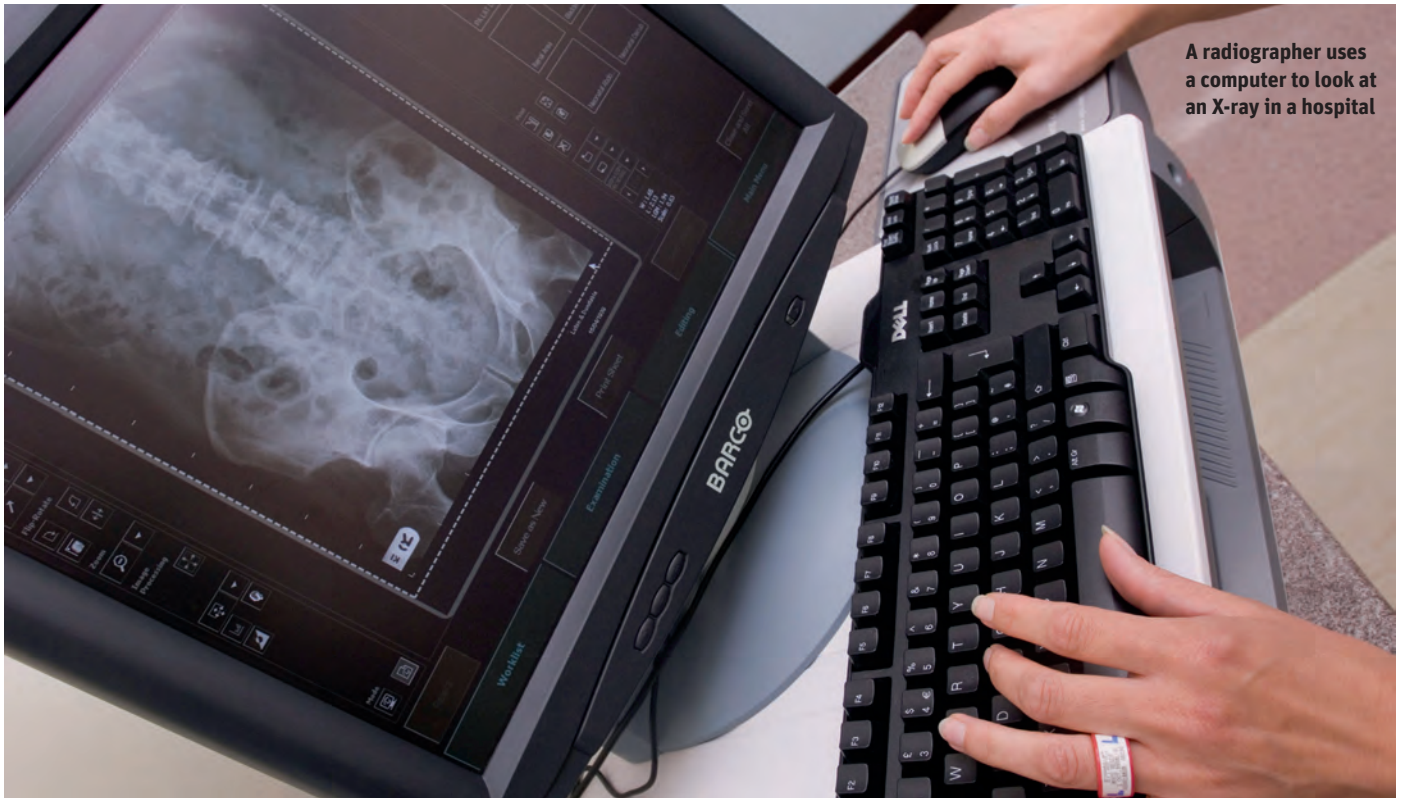
But for trusts that do want to retender there are lots of issues to consider. One is the involvement and support of clinicians – the end users of any system who often have strong views about how the existing provision is doing and the specification for any new system.

"Medical imaging is so important to a trust that clinical directors should be involved," says Mr Oakley. "It is all about making sure you have the service that will best enable you to give the best care to patients."

But he stresses the evolving role of medical imaging across trusts and the need to get perspectives from different specialties that may be using it.

And the technology available has moved on dramatically in the last few years. Whereas trusts used to think in terms of infrastructure and staff for any PACS system being sited in their IT department, around the world many healthcare organisations are storing both digital images and the PACS software in the cloud.

CASE STUDIES OVERLEAF ▶



A radiographer uses a computer to look at an X-ray in a hospital

ALAMY

This means trusts no longer need banks of servers to run the system – and therefore no longer need to employ specialists to maintain them.

"A bank does not spend its own time working out how to run data storage," says Mr Oakley. "Someone else does it. The same should be true of a hospital – it's not its core business.

"This is where the rest of the world is heading, there is no reason why the NHS should not take advantage of it as well."

Healthcare organisations are already reaping the benefits of a cloud based PACS system, he says. These include reduced infrastructure costs, a smaller onsite hardware and software footprint, resilience against systems failure, enhanced operation efficiency and faster implementation.

From a clinician's point of view, cloud based systems can make sharing images and viewing them remotely easier. They can be accessed where and when they are needed – which can support remote working. This can be useful for trusts trying to provide services on a limited rota or out of hours. Scans of people with suspected strokes, for example, can be accessed by consultants from home (provided they have a standard broadband connection) and staff in hospital told what action to take. This can both speed up decision making – to the benefit of patients – and reduce costs.

Trusts may be concerned about the risk to data protection with cloud based systems, although this has not proved to be an issue in the rest of the world. Systems with centralised data have governance systems and data protection to protect their clients.

'While imaging was once seen only as the fiefdom of the radiology department, it is now used across hospitals in other departments'

Mr Oakley urges finance directors, who are likely to have a key role in procurement decisions, to look at costs and benefits over the whole life system of a service or piece of equipment. This can include savings from quicker readings and reduced out of hours payments.

Trusts may also want to look at buying in collaboration with other organisations. One clear advantage of this is it can reduce the burden of procurement, which can be time-consuming – many PACS procurements will need to go through the *Official Journal of the European Union* process. Another is that aggregated buying can often reduce costs.

But timing may also be important. With the unusual position of so many trusts going to market within a short time, suppliers will be under pressure and may have capacity issues. Responding to tenders can be time-consuming for them as well – one recent procurement involved more than 1000 questions that bidders had to respond to and procurement staff had to evaluate. Collaborative tendering could help providers respond to more tenders and could lead to cheaper solutions for trusts.

With such a crucial service involved, Mr Oakley urges boards to stay abreast of the trust's plans for future procurement. "It is going to be a relatively significant risk that they are managing. It's not just a financial risk, it's a clinical risk," he adds. ●

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MEDICAL IMAGING: CASE STUDIES

FOCUS ON THE RIGHT THING

Choosing an image storage solution that suits the needs of clinicians and finance personnel means knowing what is important to both parties, says Alison Moore

THE FINANCE DIRECTOR'S PERSPECTIVE

Aaron Cummins is finance director at the Liverpool Heart and Chest Hospital Foundation Trust, chair of the Foundation Trust Network's finance director forum and chair of the Government Procurement Services NHS Customer Board. Centrally led procurements may not be flavour of the month, but Mr Cummins says the situation over the procurement of picture archiving and communications systems (PACS) has shown it does have some advantages.

The centrally led procurement process worked well last time, he says, and those responsible for procurement are now asking how they maintain value and leverage in trying to get their own solutions.

"We are all having to say what does this mean for us. Some organisations are going to go on their own but many areas are coming together to go to the market as a group. In some cases, that might be three organisations but there are as many as 11," he says. With so many procurements being contemplated at the same time "it is certainly not the greatest position to be in."

Mr Cummins is clear this needs to be a clinically led procurement, as it is integral to patient care. "The radiology function supports the whole hospital. You need IT savvy clinical leaders involved – and there may not be enough of them.

"The radiology lead will have a view of the specification but so will the cardiology lead, for example."

In terms of the procurement, he thinks organisations within the local health economy could come together to commission data storage together. But he senses some nervousness about cloud based storage.

"The cloud still makes people nervous. As a concept it is absolutely right. You only pay for what you use. But finance directors and IT directors still like putting their hands on a piece of tin and knowing if it goes wrong someone will be there within the hour."

Data protection can still be seen as more of an issue with remote storage, he says, and trusts are anxious about this – especially as the Information Commissioner's Office can impose massive fines. One solution is a hybrid where there is a private cluster of data but this can be more expensive.

The solutions that trusts adopt will depend on their circumstances, he says, suggesting trusts with plenty of capital but concerns about future revenue may be happier to pay more of the costs up front. Trusts that are short of capital, however, may look at different solutions and be happier to pay costs out of an ongoing revenue stream.

"It could come down to a financial model that is more attractive, but I would be surprised if finance trumped governance," he says.

THE RADIOLOGIST'S PERSPECTIVE

Dr John Somers is a consultant at Nottingham University Hospitals Trust, specialising in paediatric radiology. It is common to find doctors who are critical of national procurements; while Dr Somers has few criticisms of the original PACS procurement, he is concerned the current reprocurement could lead to fragmentation.

The current PACS system he uses has been "pretty good" he says, although he has had more concerns about the radiology information system (RIS), which was procured separately, and voice recognition. "As a radiologist I would like to see these three elements tightly integrated in a single envelope with someone responsible for keeping them all working," he says. "I don't see that there is any appetite to go through a reprocurement of PACS in the near future." Changing systems can be disruptive and requires many staff to learn a new system.

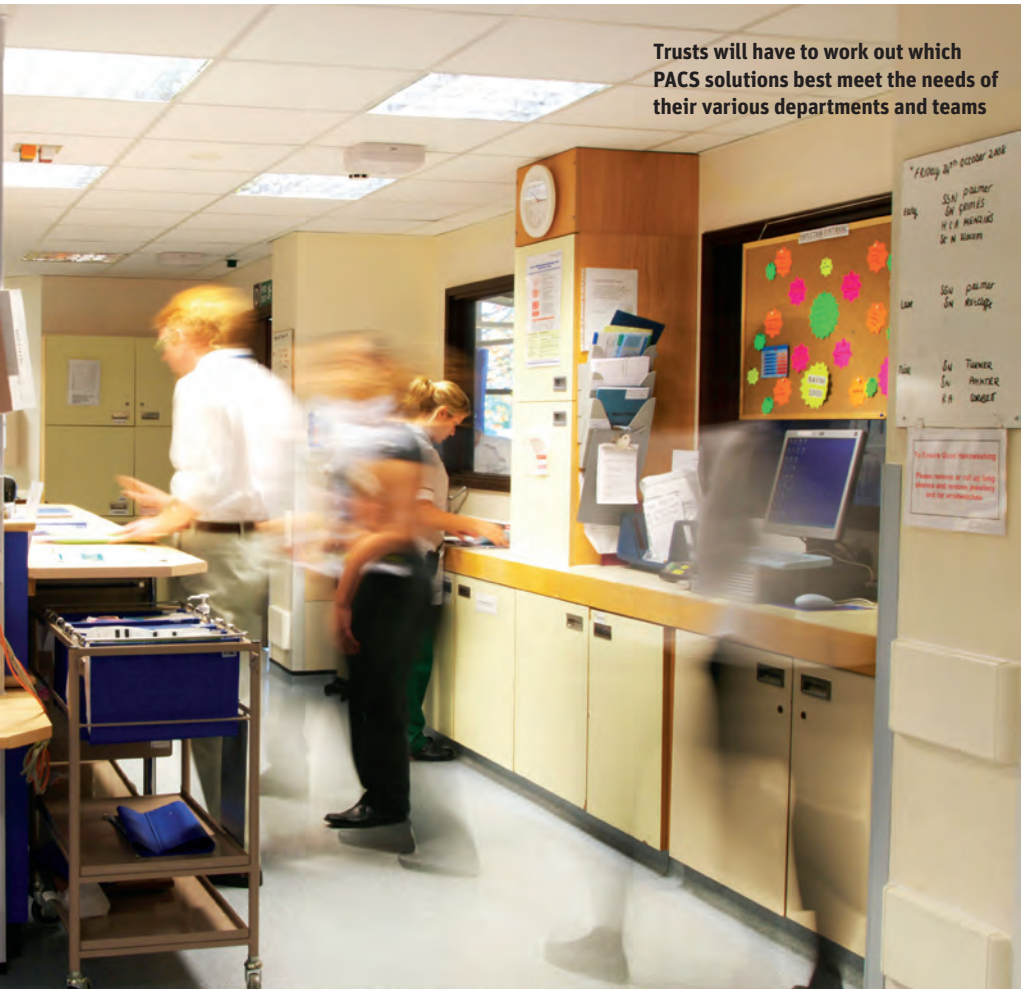
What he does want to see, though, is progress on improving systems and emphasis on the seamless electronic transfer of information between hospitals.

"If we go to piecemeal trust based procurement of different PACS systems, who is going to look after image sharing? We are developing trauma and cancer networks but we are going to locally procured solutions."

Fragmentation of the system could affect the viability of some providers and also lead to difficulties in sharing images, he says. "I would not like to buy a PACS system and then an RIS system and then an image sharing system."

As one of a few specialists in paediatric radiology in the country, he is often asked to assist with interpreting results taken in other hospitals. These can be of seriously ill children, where a second opinion is needed, or cases of suspected non-accidental injury. With some of these, time is of the essence and his reading of the scan can have serious consequences such as affecting whether a child is allowed to go home with parents or is taken into care.

Dr Somers currently reads images sent from Peterborough City Hospital electronically and can often respond within an hour. He gets a text message to alert him



Trusts will have to work out which PACS solutions best meet the needs of their various departments and teams

a scan is being sent; if more hospitals were able to send scans as easily as Peterborough, he believes Nottingham could start to provide a 24/7 service across a wide area and give specialist input like this to other hospitals receiving sick children.

And systems that allow smoother wider sharing of images could also improve care. For example, trusts could collaborate to reduce times when a department is under pressure and reading is delayed. Several trusts could work together to smooth out the work and get images reviewed quicker – something that could benefit patients. "This is something that could be developed but only if you had a regional supplier," he adds.

THE CENTRAL PERSPECTIVE

Professor Erika Denton is the national clinical director for imaging at the Department of Health and the senior responsible officer for the national PACS programme. Mary Barber is programme director for PACS at Connecting for Health.

Trusts need to be making decisions now about what happens when their central PACS contracts expire and ensure they know what they want to buy if they are not extending their contracts. That's the message from Professor Erika Denton and Mary Barber. They have worked with individual trusts to ensure they know when their current contract will expire and the options that are available to them.

'If we go to piecemeal trust based procurement of different PACS systems, who is going to look after image sharing?'

These options include "going it alone" to commission a new system – "perfectly reasonable" says Professor Denton – procuring with neighbouring trusts, and extending their current contract which allows them some breathing space and could also prevent the market becoming swamped. But where trusts in the same area all want to procure, it would be crazy for them not to work together, she says.

She highlights that NHS Supply Chain has a national framework around PACS, which ensures that suppliers already meet governance standards.

Ms Barber points out there might normally be five to eight *Official Journal of the European Union* procurements for PACS systems each year. The ending of the national contracts means there were potentially 128 trusts procuring in a short timespan. However, around half of those had started reprocurement by March and another 23 had taken out an extension to their existing contract.

She encouraged trusts to be aware of how PACS has moved on in the last few years and the lower cost of storage now. "But they are still fundamentally a big filing system," she says. In addition, she urges trusts to remember there could be more benefits to come from PACS. "We say to trusts we know this is tough. But think about the vision. Do we want radiology in primary care but reporting in secondary care, for example?"

"We are not going to be proscriptive about how local institutions procure PACS," says Professor Denton. "How they store images will be up to local trusts. But we do dictate the standards for that storage."

Trusts are expected to procure in line with those standards but the choice of whether they have solid state storage or cloud based is up to them she says.

Ms Barber points out that data is already stored outside the boundaries of the organisation, through the existing central data storage system. "The technology is already out there and in proven use," she says. "Some of the newer technology takes us a little bit further."

But the issue is less about where data is stored and more about the controls around information governance, which ought to be in place – including multiple copes of data and arrangements for disaster recovery.

So are there are worries about the procurement? Although they are supportive of local ownership, Professor Denton and Ms Barber say the danger is that silos develop. They have already written to chief executives currently using centrally procured systems to warn them of the need to get involved. "We have told them that the risk is their risk. We are doing all this but the decisions are for them to make," says Professor Denton. The letter says trusts should be reporting the potential loss of PACS and the associated systems in their risk logs.

Professor Denton says the NHS system has become dependent on PACS since the current system was brought in between five and seven years ago. Any interruption in PACS would have massive consequences – as a result, the current system will have to run in parallel with any new systems that trusts adopt while data is transferred. Ultimately the old system can be turned off, but trusts will be anxious to avoid any interruption in what has become an essential clinical tool. ●

ALAMY

COLLABORATE AND CONQUER

Partnerships are vital to providing effective nursing home care for older people and reducing unnecessary hospital admissions, but working together means more than just being at the same meeting, as this *HSJ* roundtable proves. Daloni Carlisle reports

ROUNDTABLE PANEL

Stuart Bain, chief executive, East Kent Hospitals Foundation Trust
Robert Flack, chief executive, Locala Community Partnerships Community Interest Company
Richard Hardman, director of service development, Barchester Healthcare
Jeremy Hughes, chief executive, Alzheimer's Society; chair, National Voices
Professor Finbarr Martin, president, British Geriatrics Society
Steph Palmerone, director of strategic initiatives, Barchester Healthcare
Mike Sobanja, outgoing chief officer, NHS Alliance (roundtable chair)
David Walden, director of adult services, Social Care Institute for Excellence
David Worskett, director, NHS Partners Network

There is an assumption that nursing homes provide only long term care. But is this true? And if not, how can the NHS work with the care home sector to develop and commission innovative services using shorter stays to support older people and keep them out of hospital?

Barchester Healthcare has worked with the NHS for many years and in many places to offer alternatives to acute care, developing approaches to prevent admission to hospital and support earlier discharge. These include re-ablement beds, short term intensive nursing care for people with Alzheimer's disease or bringing primary care services into care homes.

Barchester, and others, have demonstrated clear savings through reduced length of stay and avoidance of unnecessary admissions as well as improved quality of care. In each case, success hinged on partnership between the NHS, social care and the care home provider. Rather than explore the specific examples of these, chairman Mike Sobanja first focused on exploring their characteristics. What did they look like? How could they best be made to work?

Stuart Bain, chief executive of East Kent Hospitals Foundation Trust, was upfront about what partnership meant to him in this context.

"To have a healthy partnership you need to be clear about the outcomes each partner wants separately, what they want to achieve together and how you measure outcomes. If you don't have a clear scope at the beginning, there is the potential for it to creep," he said.

"For ourselves, we are very, very clear about what added value there will be from managing the care differently for a particular group of patients. We are very clear about the criteria for selection, the expectations we have about how quickly someone will be moved on and how long they will be in that care setting. We carry out retrospective reviews every three months." The upshot of that clarity was a growing level of trust and knowledge between the partners, he added.

Know your partner

Robert Flack, chief executive of Locala Community Partnerships Community Interest Company, which provides community care services for people in and around Kirklees, said this intimate knowledge of different services' working processes was an important factor.

"It is something that is often missed," he said. "A ward based nurse says 'this is the care home's responsibility' but they may have very little understanding of the care home's role. Sometimes the simple measure of getting people together in a room will help develop that understanding."

Agreed – but was this the nub of partnership working?

"There is a real difference between partnership working and collaboration," said Steph Palmerone, director of strategic initiatives for Barchester. "A lot of people's experience of partnership is coming to a partnership board meeting where everybody sits around a table but it is not part of their core business. We are quite good at making it work for individuals but not so good at explaining why this is good for the organisation and for the public purse."

This raised the issue of how formal partnerships should be. David Worskett, director of the NHS Confederation's NHS Partners Network, said: "Partnership is a much over-used word. It is not just subcontracting or a contractual relationship. There is something in it about genuinely respecting and valuing each other."

He suggested the NHS and care home sector might explore some of the newer vehicles now being tested in the NHS, such as joint ventures. These had a good track record in industry from which the NHS could learn.

Mr Flack agreed: "It feels to me, in a community interest company, we are now able to be more innovative. We can think about this in a different way. New ideas about joint ventures are much more alive to us as we can do it quickly and begin to reap the benefits quickly too. But it is still early days."

Such formal arrangements could lead to legal challenges, however. Mr Bain described some work done by his trust in partnership with a local community organisation on neurological rehabilitation. "We are now getting legal challenges from other community providers. Where is the balance between a very formalised approach through joint ventures and the less formal?" he asked.

Professor Finbarr Martin, president of the British Geriatrics Society and a geriatrician at Guy's and St Thomas' Foundation Trust, said there was a dilemma between informal working that

Round table participants included (clockwise from left): Stuart Bain, Robert Flack, Richard Hardman, Professor Finbarr Martin, Steph Palmerone and Jeremy Hughes

'Partnership is not just subcontracting – there is something in it about genuinely respecting and valuing each other'

allowed relationships, trust and knowledge to develop slowly over time and more formal arrangements that specified groups of patients, outcome criteria and review as suggested by Mr Bain.

Setting boundaries

"Informal working is a way of reaching an operational understanding but also a recipe for creating a morass of misunderstanding," Professor Martin concluded. NHS and care home staff needed to agree on the objective, he said. For the NHS, the "job" was to find alternatives to acute admission. But this was not a responsibility the care home sector felt it shared – although it may benefit commercially.

On the flip side, he described how some joint work in his own patch to train care home staff had been stymied by rigid funding mechanisms.

"Commissioners need jointly to say it is their problem, but they do not perceive it as their problem. I think partnership requires both parties to share the problem," said Professor Martin.

Mr Bain agreed. "Both parties need to accept it is their problem and their opportunity and that it needs to be their business," he said. "Certainly the relationship we have with Barchester is about what they can do better than us, and testing and evaluating that. That is about understanding which cohorts are better cared for in what way and evaluating against criteria. People see themselves as part of a team."

But who are the partners? Jeremy Hughes, chief executive of Alzheimer's Society and chair of National Voices said all partnerships must be at least three way and include service users and carers. "Otherwise you risk paternalism," he said.

David Walden, director of adult services at the Social Care Institute for Excellence, added social care to the list. Meanwhile Richard Hardman, director of service development at Barchester, put in a bid for commissioners. He described work with NHS Central Lancashire's commissioning team to develop innovative use of nursing homes to manage acute demand.

"From a commissioning point of view they have a very clear idea about the kind of services they want," he said. "They have a dementia forum with users and carers as members who help to share ideas about what is best for the community. While there is no formal structure to it, there is a clear idea about what is required and we have adapted our services around that and it works well."

But the partnership with commissioners was of a different quality to that with providers, said Ms Palmerone. "It is almost as if commissioners perceive themselves as the people in the position to enable providers to work together or not," she said.

This was becoming more apparent as personal social care and health budgets come more into play. "It almost feels like

WILDE FRY

Clockwise from left (this page): Robert Flack, Steph Palmerone and Richard Hardman. Clockwise from top left (opposite): Mike Sobanja, David Walden, Professor Finbarr Martin, Richard Hardman, David Worskett and Stuart Bain

personal budgets are being asked to glue the pieces together," said Ms Palmerone.

The changing shape of the NHS, including the move both to social enterprise with its freedom to innovate and to the new clinical commissioning groups, presented a challenge, said Mr Bain. "These new organisations are relatively immature and for partnership to work, people need to be confident in their roles," he said. "So we have an opportunity to unfreeze the system but also a challenge here."

Mr Walden pointed out that commissioners do not always represent the entire population when it comes to nursing home care. In the south of England, some 80 per cent of nursing home residents are self-funded so the local authority and local NHS commissioners did not feel relevant to them, he said. "What does partnership mean in that context?" he asked. "Does it become more like a planning function?"

Mr Hughes suggested this is where the forthcoming social care white paper may come into play – although any mention of it was singularly absent from the recent Queen's speech.

"If you take an optimistic viewpoint, the social care white paper with its intention to focus on information provision for all rather than for recipients of funding may support this," he said. It is also expected to have an emphasis on integration that could, in theory, support shared risk taking.

'For partnership to work, people need to be confident in their roles'

Mr Bain argued that the commissioner's role in partnership was fundamentally different to the provider's. Commissioners should be deciding the what, and providers in charge of the how.

"[The] commissioner's role is about making sure people stay well," he said. "They help them engage with their own illnesses, ensure that the right services exist for them if they need an intervention. It is not necessarily about telling all the providers how they should do that."

He argued that it was up to providers to build care pathways. "It is of no benefit to my organisation to have people in hospital who should not be there or to be there for too long. This is about how we add positive value and that is best understood by providers of care."

That was not to suggest providers should not work with commissioners, he added. "But I find commissioners are quite frightened of that. They want to tell you how to provide services and I do not think they are best placed to do that." Rather, they should be defining excellence and outcomes.

There was general agreement about this – although it should be pointed out there was no commissioner to argue the case. However, Mr Hardman said an organic approach was needed. It was no good developing a service if commissioners then won't buy it, he pointed out.

"It is about getting partners together with innovative ideas along with the commissioners. Commissioners will say they will commission the service if it has the features they know are needed. They set the parameters."

The consensus view around the table, though, was that most NHS commissioners are not interested in the care home sector. *Quest for Quality*, a recent report from the British Geriatrics Society, highlighted how geriatrics expertise and primary care services had been withdrawn from older people as their long term care has shifted from the NHS to the care home sector.

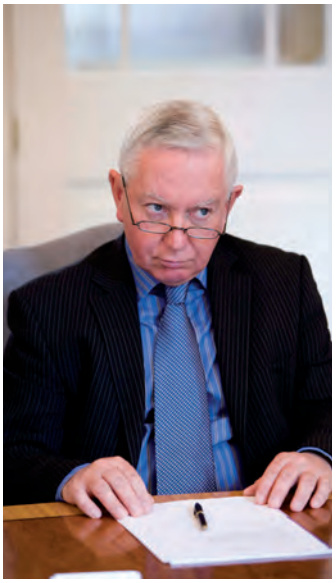
Professor Martin said: "I do not see any strong evidence around that primary care trusts have regarded the quality of care experienced by individuals as their problem. I do not have any confidence that that is going to change quickly because I do not think commissioning groups will have the experience to do it."

He felt there was a role for concerned geriatricians in the acute sector to make the case for better healthcare provision in the care home sector and prove to commissioners there was a win-win to be had.

A question of trust

There were also issues of trust between providers and commissioners. Too often, said Ms Palmerone, commissioners wanted to repeat assessments already carried out by providers and this led to a very bureaucratic approach that benefitted no one and stifled innovation. The regulatory regime was similarly poorly equipped to support innovation, the participants agreed.

Mr Hardman said: "As a society we are so frightened that something will go wrong so no one takes a risk and we are all



looking for the person who left the stable door open."

This left frail older patients in the wrong place to meet their needs, said Mr Bain. "Certainly from a provider perspective there is a default position where everything ends up in the most expensive, least flexible part of the service. Meanwhile, care homes are becoming like mini institutions. There has to be something more flexible that works around the needs of patients."

Mr Sobanja posed the killer question: "How do we break through the set architecture and landscape? What is the stimulus for innovation and personalisation in a market where providers are not shifting the system?"

Several themes emerged from this including information and idea sharing, supporting patient choice, improving customer service, financial flexibility, using technology and demonstrating efficiencies. All these would drive innovation in one way or another.

For example, Ms Palmerone called for a "dating agency". "Traditionally the NHS and not for profit and for profit providers of care have not got together. That has tended to happen via local authorities and PCTs. We need a 'dating agency' where people can explore together how they can work together," she said. This would perhaps be a role for the new national and regional commissioning bodies, she added.

Mr Sobanja suggested this was perhaps an area where the new health and wellbeing boards could bring their influence to bear.

Mr Hughes highlighted the work of the Dementia Action Alliance, made up of over 100 organisations committed to transforming the lives of people living with dementia and the people caring for them. Each has signed a call to action, describing seven outcomes that patients and carers say would improve their lives, and each has an action plan with specific outcomes they wish to achieve by 2014. They include organisations as diverse as the Royal College of Nursing, the National Institute for Health and Clinical Excellence and Alzheimer's Society.

Commissioners need to tap into this alliance, he said. "They need to be permissive rather than controlling."

Mr Bain addressed efficiency. "Efficiency is driven by looking at how we add value to the patient experience and outcomes while saving money. When you are faced with the reality – 5-7 per cent savings every year – there is a very powerful incentive to make sure you are doing the right thing for patients. That is the big driver from the acute side and I cannot imagine it is very different in the care home sector."

This was all well and good in theory but the changes involved as services shift are complex. The NHS had experience of closing mental health institutions but, in many places, this was a slow process with additional resources that allowed community alternatives to build up. This time, there is no money.

"The money issue is absolutely vital," said Mr Hughes. Mr Walden agreed. "There is an opportunity to reshape rather than just contract. But the danger is that we end up with the same stuff but less of it."

Desired change

At the end of this wide ranging debate, Mr Sobanja set a challenge to the participants: name the one thing they would change today.

For Mr Bain this was clearly financial – the need to align health and social care budgets. "A more aligned system of funding would remove some of the discussion we have had to have." Mr Hughes' ambition was similar: "To give health and wellbeing boards real power over NHS and social care expenditure."

Mr Flack and Ms Palmerone both wanted to introduce a care coordinator for every person over 65. This would improve their customer care – something the NHS gets badly wrong at times – drive innovation and help them access the services they need, when they need them.

Professor Martin said he would like people to "stop thinking that primary care will come up with the solution because I don't think it will."

Mr Walden made a plea for "really good information and advice provision for individuals, so, if they do have some choice, then it is a real choice and an informed choice."

While Mr Worskett said he wants "to jump three years into the future in terms of educating and informing commissioners about what is possible," Mr Hardman was also ambitious: "I want to get away from the idea that a person centred approach is an innovation and see a system where people feel empowered when they are receiving care." ●

WILDE FRY

Leading Transformation whilst in Turnaround

In September 2011 Monitor placed Burton Hospitals NHS Foundation Trust into financial turnaround. Whilst immediately instigating a turnaround programme, the Executive Team, led by **Helen Ashley, Chief Executive Officer,** wanted more.

"Delivering turnaround was critical to our short term survival. However, we also knew that we had to lead the organisation towards a future vision and a better operating model. To achieve this we had to engage our clinical leaders and the broader Health System on a transformation journey".

The Trust appointed Capgemini Consulting to work alongside it to define and deliver a change programme.

Burton's vision is to be the local healthcare provider of choice, acting as the patient's 'conductor' through community, secondary and tertiary health systems. (See figure 1) This will be achieved through a clinically led model and effective community networks and partnerships. In order to do this, Burton needs to ensure it is delivering its own services effectively and efficiently, and has developed a suite of KPIs for each of the clinical specialities (See Figure 2).

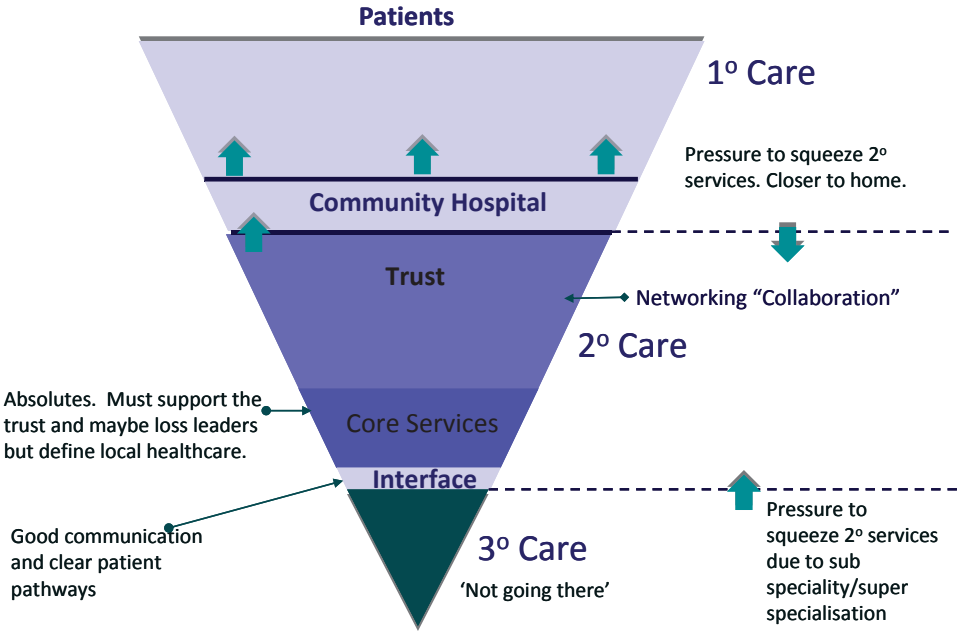


Figure 1: Shows how the Trust will need to evolve in order to be the local provider of choice

	Level 1 – Need to Transform	Level 2 – Need to Improve	Level 3 – Good	Level 4 – Excellent
Patient Satisfaction would you recommend this service to a relative?	<80%	80 - 90%	90 - 95%	95 - 100%
Staff empowerment and confidence in own service	<60%	60 - 70%	70 - 80%	>80%
Quality and Safety[1]	Readmissions >7.5%	Readmissions 6.5 - 7.5%	Readmissions 3 - 6.5%	Readmissions 0 - 3%
Access A&E Outpatients Diagnostics Inpatients	<92% <4hours <88% <6 weeks <88% <2 weeks <90% <10 weeks	92 - 95% <4hours 88 - 90% <6 weeks 88 - 90% <2 weeks 90 - 95% <10 weeks	95 - 98% <4hours 90 - 95% <6 weeks 90 - 95% <2 weeks <95% <10 weeks	<98% <4hours <95% <6 weeks <95% <2 weeks <95% <8 weeks
LOS (Based on CHKS)	>10% worse than peer group mean	0 - 10% worse than the peer group mean	0 - 20% better than the peer group mean	>20% better than the peer group mean
Finance (SLR)	EBITDA <4%	EBITDA 4 - 6%	EBITDA 6/7%	EBITDA +7%

1. Will use existing quality and safety metrics by exception to monitor that there is no reduction in performance

Figure 2: Heat Map

Engaging the broader leadership team is critical, and the Trust invited 70 clinical, operational and commissioning leaders from the Burton Health system to a 2 day Accelerated Solutions Environment (ASE) event.

Martin Charters, Vice President at Capgemini said:

"Our ASE is widely used in multi-national companies, and across the NHS, to answer challenging questions that involve a large number of stakeholders to build broad based solutions, create energy and drive towards an effective transformation.".

During the ASE the Associate Clinical Directors were able to share their strategies and work with colleagues to evolve them.

Two further themes arose from the event:

1. A deal was struck between Corporate and Clinical leaders setting out the expectations that each required of the other to achieve the levels of performance required.
2. There was a need to work across the Health system to provide the best care at best value, which included commissioners and clinicians working more closely together.

Jackie Jones, Transformation Director commented:

"When you are in turnaround there is a real danger that the existing operating model is simply driven harder and responsibility for delivery rests with just a few leaders. With the scale of change that is going to be required this model will simply not be good enough. Through our transformation programme we are beginning to work differently. We are being clear about what we expect from our clinical leaders and they are being clear about the support that they require to make the required changes. We are all now committed to this approach".

The Trust has agreed 7 corporate projects to deliver new capabilities into the organisation whilst the clinical teams have agreed a further 12 to drive through their strategies to achieve their KPIs.

These provide an effective framework, within a programme structure, for the clinical leaders and executive team to hold each other to account for delivery.

In addition to the Hospital wide change programme, the Trust and its Commissioners are now sharing strategies and plans and are exploring a joint programme to deliver those changes that require system wide change to be successful.

CULTURE SHOCK

To blow the whistle without fearing the consequences requires more than a change in the law, says Alison Moore

Health secretary Andrew Lansley came into office promising protection and new rights for NHS whistleblowers. But two years on have things changed – and do NHS staff feel any happier about speaking out?

The NHS Constitution has been amended to include:

- an expectation that staff should raise concerns at the earliest opportunity;
- a pledge that NHS organisations should support staff when raising concerns by ensuring the concerns are fully investigated and there is someone independent, outside of their team, to whom they can speak;
- clarity around the existing legal right for staff to raise concerns about safety, malpractice or other wrongdoing without suffering any detriment.

New guidance has been issued to NHS organisations saying whistleblowing rights should be included in employment contracts. In addition, an NHS whistleblowers' hotline is now being run by Mencap and also covers social care workers.

But is that enough? Jon Restell, chief executive of Managers in Partnership, welcomes the changes but points out the importance of also having cultural change within organisations. Staff feeling a need to use formal whistleblowing procedures can be a sign that something has gone wrong in an organisation, he says. It can indicate that they are unable to discuss concerns with colleagues and managers and see them resolved, and so resort to formal processes. "Policies and procedures can support a culture but they can't create it," he says.

Dean Royles, director of NHS Employers, agrees about the importance of culture. But as well as being able to raise concerns, he believes it is key to feed back to someone who has done so. Managers need to be active in changing culture, he says.

"It is a journey but I have not come across anyone who thinks we should not be encouraging people to safely and confidentially highlight issues of concern," he adds.

Desire versus duty

Public Concern at Work believes things have improved in the NHS but there is still a long way to go. Francesca West, policy director, points to the increasing role of the Care Quality Commission in hearing from staff with concerns as one example of improvement practice. And organisations are now more likely to have a whistleblowing policy with pockets of excellent practice. Brighton and Sussex University Hospitals has a patient safety ombudsman whom staff can approach.

But while many NHS organisations now have whistleblowing policies, there may still be a culture that prevents people speaking out, says Ms West. The role of managers – likely to be whistleblowers' first port of call – is important here, she says. How they deal with a whistleblower will affect whether other people want to raise issues.

'Staff feeling a need to use formal whistleblowing procedures can be a sign that something has gone wrong in an organisation'

She is also sceptical about the growing emphasis by professional regulators on a duty to speak out. This may ignore the clinician's working environment, she says, and could lead to people being disciplined for not raising concerns despite the circumstances. "It feels like we are putting people between a rock and a hard place."

Kim Holt, a paediatrician who whistleblew over what she saw as unsafe practices, says trusts are often defensive and find it difficult to be open about mistakes. She is involved with Patients First, which is regularly contacted by health professionals with concerns about their organisations. "There are some very high profile hospitals where things are not good," she says. Many people just want their organisations to learn from their mistakes. This is also an issue for managers she points out, saying: "There are various chief executives who won't work in the NHS again."

So what does the future hold? The Department of Health is considering whether there is a need for more action. "Together with the national regulators, we are looking at how whistleblowing concerns are currently handled and, where appropriate, implementing improvements to systems for ensuring concerns are not overlooked," it says.

But Mr Restell says financial pressures in the NHS may create additional tensions as tough decisions are made, which will impact on services. Having the right culture around decision making and raising concerns about the impact of those decisions will be important; engagement and communication will be key to avoid defensiveness and adversarial relationships in which clinicians could claim their concerns are being overlooked. Kim Holt believes boards could do more to question their executive teams.

NHS Employers is planning to work with other organisations to look at whistleblowing and the associated issues. But many people are holding their breath to see what comes of the final Mid Staffordshire Inquiry report – unlikely to appear before autumn. This could lead to much tighter regulation of managers and increased emphasis on supporting whistleblowers. ●

ALAMY

We're on the same team

The NHS and local government must share common goals to meet their community's health and care needs. Collective leadership and strong relationships are required to make this happen says John Wilderspin

Over the course of the last year, one of the issues which has constantly been at the forefront of our minds has been 'integration'. People have different perspectives on what it might mean, but everyone agrees that it is important. However, as is often the case with worthy aspirations, delivering the goal is much harder than simply agreeing that it is important.

To be fair, many bright and committed people have spent time thinking through how we best define integration, how we might measure whether it is happening, and how we create the pre-conditions to allow it to flourish. On this latter point, there is an emerging consensus that it can only really happen if organisations work together across their local system. In practice, this means that organisations need to share a set of common goals, and empower their staff to work together around the interests of the individual patient or user.

As with any change process, this also requires strong leadership, but collective leadership, not just leadership of individual organisations within the system. This is much harder and requires different leadership skills and behaviours. It also requires a broader perspective than we have traditionally taken within the NHS. Most of us appreciate that integrated care is going to require us to work with colleagues in social care, whether for adults or for children and young people. However, as our success starts to be measured in terms of outcomes, we are increasingly realising that the system we must work in is much bigger than just the NHS and social care.

But this 'whole system' thinking is by no means universal, and the NHS transition process has had an impact even in those places where a 'whole system' approach was embedded. This is largely because good system leadership relies on a shared sense of purpose and strong relationships, and transition has often resulted in a change of leaders, particularly on the NHS commissioning side.

Fortunately, the advent of health and wellbeing boards means that CCGs, the new leaders of NHS commissioning, are already starting to form productive relationships within their local system. Shadow boards have been up and running for several months, and CCGs are getting used to working with elected politicians and senior officers from local government, as well as with their directors of public health. Crucially, they are also working with representatives of service users and the local public, recognising that true system leadership has to have public engagement at its core. Local Healthwatch – running from April 2013 – will be the champion for people using local services and will help ensure that these views and perspectives are fed in at every stage of the commissioning process.

Health and wellbeing boards are also thinking through what it means to be the 'system leader' in this much broader system. Local government is used to influencing a wide range of partners to get things done for local people; 'leadership of place' is their core role. But delivering integrated care and improving health outcomes in a truly integrated way will require co-leadership between local government and the NHS, which creates some substantial challenges.

By definition, local government is locally focused; the NHS has to balance national and local priorities to a much larger extent. The NHS is also made up of a number of powerful stakeholders and their active commitment is required if real integration is to become the norm. Actively engaging providers, and other key NHS stakeholders, whilst ensuring that the NHS is not completely dominant, will be a key test of the maturity of a local system.

"It is really important that these integrated health and wellbeing boards deliver for the people who really matter – the populations we serve. By working in an integrated way we can make a real difference to the lives of ordinary people across the country. Everyone has a part to play – whether leaders, clinicians or politicians. It is up to all of us involved to make them a success."
Professor Mike Cooke CBE, Chief Executive of Nottinghamshire Healthcare NHS Trust on Nottinghamshire County Health and Wellbeing Board

John Wilderspin is the Department of Health's National Director for Health and Wellbeing Board Implementation.

Visit us on stand C15 to find out more about the work underway to support shadow boards to succeed in their statutory role from April 2013.

Join the online community for the National Learning Network for health and wellbeing boards at http://knowledgehub.local.gov.uk/

JIM BEAGLE ON STORAGE SYSTEMS

Healthcare organisations and the NHS are facing a data tsunami. Picture archiving and communications systems (PACS) images, electronic health records (EHRs), electronic clinical correspondence and all the different 'ologies' and diagnostic reports, are all being created in digital form. With a lack of clear regulation, the default is to store everything forever, but how can we afford to carry on keeping all this data? With the proliferation of data, what are the implications of enabling easy retrieval and accessibility at the patient level?

A key issue is the disparate nature in which data has been collated. Different departments act independently, creating silos of data, keeping their information in their own preferred format, and indexing it differently. All this information needs to flow into an EHR that is accessible to all those who need it, irrespective of format or the location in which it is stored.

It makes sense to have a single integrated approach to the management of this data. However, this comes with its own challenges. For example, traditionally the ownership of PACS radiology data has been with the clinicians. With Digital Imaging and Communications in Medicine (DICOM) data taking a different form to other types of information, clinicians are reluctant to allow the IT department to manage it for them. Conversely, IT professionals see DICOM images

'The most expensive storage is only used for the most important data'

purely as data – after all, to them, this is just another file format. This leaves radiologists feeling vulnerable that their accessibility requirements are not understood, and concerned that their data may be compromised.

At BridgeHead, we understand the issues and requirements of each department and have developed solutions to meet the needs of all parties. Our solutions allow for DICOM data to be effectively stored, alongside other file types, making all the data available to the EHR.

By using tiered storage, data is stored on different mediums corresponding to its level of importance. In this way, the most expensive storage is only used for the most important data, making for a far more cost effective solution. Our healthcare data management platform also allows for effective and timely data backups to be made, focusing efforts on data that has been recently created or amended, and enables faster operational recovery. This ensures business continuity for the clinician.

BridgeHead's unique approach enables clients to generate operational efficiencies, save costs, deliver return on investment and have a robust, future proof strategy for this data tsunami.

Jim Beagle, president and chief executive, BridgeHead Software.
www.bridgeheadsoftware.com

DATA MANAGEMENT

LOCK UP YOUR DATA

How you store and safeguard digital information could make or break your organisation, learns Claire Read

Some 30 per cent of the world's data is now healthcare related, and many organisations are facing a storage emergency. The reasons are simple but multiple – more digital imaging systems taking ever more detailed pictures, the introduction of the electronic patient record, the increasing use of email. Finding an efficient and cost effective way of storing and safeguarding all this data is essential but difficult.

Imaging data is a good example. Accenture, which provides picture archiving and communications systems (PACS) solutions to 31 trusts in England, currently has 1.5 billion images in its central data store – around 300 terabytes of data. Matt Oakley, who leads the company's medical images practice in the UK and Ireland, says such figures are just the tip of the iceberg.

"Last year we saw a seven per cent growth in the number of studies [a patient episode such as a computer tomography scan] and an 18 per cent growth in study size," he explains. "The size increase is due to people moving to using CT scans rather than X-rays and increasing the number of slices taken. And increasingly we're getting significant demand through cardiology, dental, mammography."

The result of this data explosion is, says Edward Kenny, director of healthcare and local government at information management company EMC, "complete chaos for IT and storage at an average trust."

Reducing that chaos is now becoming urgent. PACS and radiology information system services – and the storage associated with them – are currently provided to 75 per cent of NHS acute trusts by local service providers under contract to the Department of Health (including the 31 contracts held by Accenture). Come June next year, many of those contracts will have expired. Connecting for Health is providing guidance as this transition happens but some fear the situation is now a precarious one.

"Healthcare always fixes what's most on fire today and at the moment the biggest fire is radiology and the end of the national programme," says Jamie Clifton, director of product management at healthcare data storage specialists BridgeHead Software. "But from our perspective, the clock has already finished on that – if you haven't started migrating your data now, you will be hard pushed to do it within the timescales given."

Some organisations are opting to continue with the storage offered by their current PACS provider, and the DH recently extended Accenture's contract by a year. Trusts can now opt to continue to use Accenture PACS including an additional two years' data storage taking them to 2016. Others are taking the opportunity to review and consolidate their data storage – Mr Clifton reports that his company has seen a "phenomenal" increase in enquiries since the start of last year. It is an approach that can offer significant benefits.

"The average trust currently has anywhere between 200 and 500 applications, 300-400 physical servers and may have multiple storage area network storage," explains EMC's Edward Kenny. "All of those carry support costs – both staff support and maintenance. And they all use up heat and power, something which is often overlooked, and take up space. Once you start to boil all that down into smaller, more efficient units, the benefits are enormous. There are genuinely millions' worth of savings to be made."

Whatever path trusts take, the stakes are high. Data storage may sound like a dry issue far removed from frontline practice but, as Mr Oakley points out, "medical images are an increasingly critical part of delivering patient care."

"It's easy to forget that if the data isn't available, nothing works," Mr Clifton points out. "From the radiology perspective, for instance, what's the alternative if you lose your data? Do you go back to film? Well, Kodak have just gone bust, so is that a realistic option? When you get involved in these conversations, it becomes about

Efficient digital data storage solutions are crucial to an organisation's operability

clinical workflow; it becomes about all of these things that a trained medical professional would be interested in."

Mr Clifton and his colleagues at BridgeHead Software have had many such conversations in recent years. The firm was founded in 1994 and for the past decade has exclusively specialised in healthcare data storage, advocating the concept of "store, protect, share".

Its products centre on an archiving policy separating "dynamic" data – frequently accessed and/or changed – and "static" data that will not change and is unlikely to be accessed after 90 days. So the email about last year's Christmas party gets archived while current accident and emergency admissions get backed up. There is little to no change for staff – they don't know they access their data from a different location – but the impact on the wider organisation is significant.

"There will be some clinical improvements which are obviously fundamentally important, but the benefits are really to the trust, to the full hospital, to the IT department," explains Mr Clifton. "They will be able to go home at night knowing their data is protected and their costs minimised."

'For radiology, what's the alternative if you lose data? Go back to film? Kodak have just gone bust so is that realistic?'

Developing such a solution has not been without difficulties, not least because of the sheer number of systems from which information must be stored. "The demand is for some form of flexible repository that will accept different types of clinical input," explains Murray Bywater, managing director of health IT research firm Silicon Bridge Research. That demand has led BridgeHead to develop a "vendor-neutral approach", and now Accenture is going the same way. The idea is to store data in such a way that it can be subsequently used in any other similar system – for instance, to ensure that an image captured by an Agfa PACS can subsequently be read by a GE PACS.

Both Mr Clifton and Mr Oakley say standardisation is a real issue and, even apparently uniform guidelines like Digital Imaging and Communications in Medicine (also known as DICOM), are loose. "The government hasn't set the standard or said 'this will be the standard we should follow'," explains Mr Clifton. But for now, the main focus is on dealing with the government's decision to end the national programme for IT and the consequences for PACS storage. Mr Clifton warns that it's a challenge on which healthcare must focus.

"PACS is a castle built on sand," he says. "It looks lovely when the sun's out but as soon as there's any type of disruption to it, it will collapse." Although radiology may be the prime motivating factor today, it creates a relatively modest size of data compared with some other services such digital pathology. The tide hasn't come in yet, warns Mr Clifton, but it will soon. ●

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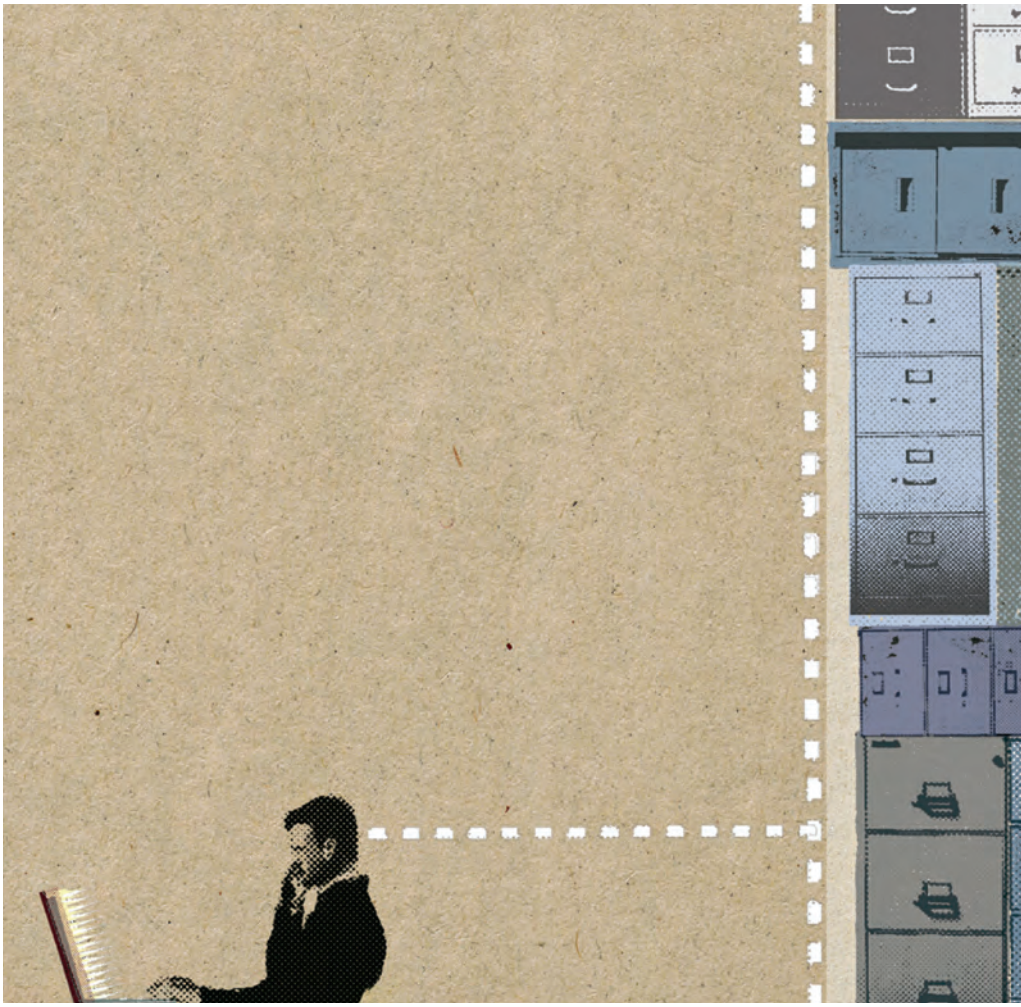
DATA MANAGEMENT: CASE STUDIES

SOLVING THE STOR

As the quantity of data increases so too must the capacity to store it. Two organisations explain how BridgeHead Software solved their storage problems



THE ROTHERHAM FOUNDATION TRUST

It was the move to an electronic patient record and the desire for a paper free hospital that initially led The Rotherham Foundation Trust to look at the issue of data storage.

"We wanted to have an integrated disaster recovery and backup solution for what was going to be our primary clinical system in the hospital," explains David Brown, head of ICT at the organisation.

"As it's the system running the whole hospital, we can't afford any sort of outage of any description and need to be able to recover data almost instantaneously. Clearly for us and for other trusts, data protection, security, management and storage are absolutely critical to underpin our wider IT initiatives."

One of the main challenges in finding such a solution was the nature of the electronic patient record the hospital opted to introduce. The system, provided by Meditech, has what Mr Brown describes as "a very specific proprietary database."

"The opportunity or problem Meditech presents is that it's not based around SQL or any other common database language," he explains. "And therefore there are a limited number of backup solution companies and disaster recovery companies that can provide a solution for the product."

One of the companies that could provide such a system was BridgeHead Software. In October 2009, after a tendering process, the company was awarded the contract to support the management and storage of the increased levels of data generated by the electronic patient records.

In opting for Meditech and BridgeHead at the time it did, Rotherham as an organisation definitively and consciously opted out of the national programme for IT. According to Mr Brown, one reason for that decision was that BridgeHead could offer helpful support beyond backup.

So the second phase of the project involved the introduction of FileStore EHR, a program that indexes files to make searching easier, removes any unnecessary duplicates, and encrypts data in line with data protection and privacy regulations. The idea was to make the transition from paper to digital pain free for clinical staff and to ensure they could access the data they needed, when they needed it. Soon after, attention was turned to improving storage for non-clinical information as well.

'The system runs the whole hospital so we can't afford any outage and need to be able to recover data instantly'

"The benefit of using our own product set – although it did cost the trust money – is that we can use it for all of the corporate environment. So if you're down at the data centre with your national solution, I guess backup and disaster recovery is covered for you, but that would not be extendable into the remainder of your services."

Services such as email, for example, have for the past two years been archived via BridgeHead's MailStore product. Rather than old messages being stored on the trust's Exchange server, they are now stored in an archive on a BridgeHead server.

"We were migrating from Exchange 2003 to 2010 and we were running out of disc

AGE PROBLEM

space because of the size of people's inboxes," recalls Mr Brown. "So this solution allowed us to continue with that migration because we archived about half a million emails."

The result is that storage space was freed up – "we're saving a massive amount of space within our email system," says Mr Brown – storage costs lessened, and now the computer systems run much faster for the many hundreds of staff who use email on a daily basis. All are allowed 12 months' worth of emails within their own mail store with archived messages retained for seven years.

Mr Brown says he is delighted with the progress that has been made and that it has, to a large extent, been made possible by the strength of the relationship with the organisation's private sector partner.

"Because BridgeHead specialises in healthcare, they are well placed to understand our data, our hospital environment and our industry. And I think because they are a smaller company they are very proactive in terms of support, even just in the procurement process. We were very impressed with how they dealt with performing the install and, more importantly, the after support has been good. You can get straight to support because of the size of the organisation."

'If patients understood that doctors have access to their data quickly and it is secured safely, they would feel reassured'

THE LONDON CLINIC

It is four years since Mike Roberts, IT director at The London Clinic, decided the Harley Street hospital could better manage its vast quantities of data. It was a decision influenced in large part by his background.

"I'm from consulting and have worked for IBM and PwC," he explains, "so coming into this sector was an interesting change. Looking at banking and mobile phones and utilities and all these other big commercial organisations, I believe there's a lot healthcare can learn about data architecture and management. I wanted to try to move our architecture towards that common commercial way of working."

One of his main aims was to address increasing problems with backing up data.

"Our previous backup architecture was based around the sort of standard Microsoft way of backing up," he explains. "But we have a large number of physiological devices all with data on them that all need backing up. So we had this myriad of backup jobs and backup servers all taking copies of the data, and trying to manage and organise those was becoming really difficult. We had some backups taking 23 hours and that's clearly not where you want to be."

Such problems were addressed by the 2008 introduction of a solution from BridgeHead Software. The product has created a single data store for all clinical and administrative data and, significantly, limited the amount of data that is backed up by identifying what can, in fact, be archived.

"Data ages very easily and there's a lot of data duplication," explains Mr Roberts. "We needed to find a way of getting rid of that duplication and getting rid of the data that has aged, but still have it available to users because there's always somebody who's going to say: 'Oooh, I wanted to look at Mrs So and So's records from five years ago.'"

The new system allows for just that and, although the data may be archived into a different place, Mr Roberts says the differences for users are minimal. "From the end user's point of view, they don't really notice. Data might take a couple of seconds longer to turn up but they're unaware of that, it's transparent at their level."

For the IT team, however, the benefits are clear – lower overheads, not being tied in to specific vendors, and cost savings from being able to reduce the amount of disc storage space that is needed. "Anything that reduces the storage requirements, particularly for expensive storage area network [disc space within a network], is going to make my life a lot easier," explains Mr Roberts. But that is not to say the project has been completely free of challenges. By his own admission, Mr Roberts has stopped and started it "a number of times" to confront issues that have been thrown up by the process.

"The sort of thing that has been problematic from my point of view is trying to get the data into a fit state to actually be archived," he says. "As you take this journey, you unearth other issues that you perhaps might have known were there but you were just living with, or you hadn't a clue were there. There's lots and lots of bits of the wider service delivery jigsaw puzzle that start to come at you."

Mr Roberts is confident that confronting these challenges has led to better care, even if the benefits aren't – and he says they should not be – immediately visible to patients.

"We have long term relationships with some of our patients, because they know and love us, or they're local, or unfortunately some people have conditions that require hospital visits over a lengthy period.

"So the knowledge that we are able to ensure our doctors have access to that data quickly and that it is secured safely in multiple places – I think if they understood that, they would feel happy and reassured. But I'd be rather uncomfortable if there was a wow factor: it should facilitate the patient experience rather than being in their face, because it's the clinicians using the data." ●

TO PROTECT AND SERVE

A trust should be able to offer a variety of services to its patients so what can you do to prevent using a provider that may face going into administration or deal with one that is failing to fulfil the terms of its contract? Alison Moore finds out

The proposed new failure regime for foundation trusts and the need for existing trusts to get foundation trust status quickly may be concentrating NHS managers' minds. But the proliferation of other providers – increasingly in frontline services – raises the question of how the NHS should prepare for a private provider going bust or withdrawing from providing a service.

No one is suggesting big providers such as Circle or Virgin Healthcare are likely to get into financial trouble or decide not to continue with a contract, but the NHS also has contracts with a large number of smaller companies and social enterprises. Research by accountancy firm Wilkins Kennedy found that, last year, 251 firms that focused on health and social care went bust, compared with 214 the year before. Care home insolvencies have been increasing rapidly – the collapse of Southern Cross last year showed that even big providers are not exempt from financial difficulties.

Earlier this year St Luke's Healthcare, a private company that provides 134 mental health beds from Essex to Wales, went into administration. East Coast Ambulance Services Ltd, which provided services for several ambulance service trusts, has been wound up, owing money to many employees. And in some cases companies have either withdrawn from providing services or lost contracts halfway through. Three homes run by Castlebeck closed last year after adverse reports from the Care Quality Commission as well as reports of staff abusing patients.

All this provides a conundrum for commissioners – while ensuring a fair procurement process, how can they protect themselves against the risk of disruption to patient services and deal with it, should it happen? Part of the answer lies in doing the groundwork beforehand. Procurement processes such as credit agency checks, asking for references and several years' experience could throw up concerns about the financial stability of some companies. And ongoing monitoring of companies that are providing services can sometimes pre-empt problems – Great Western Ambulance Service, for example, had stopped using East Coast some time before it went into administration. Great Western uses a credit rating service that can flag concerns about a company's finances.

No provider is immune to difficulties – ambulance services have closed because of financial failure

Trust versus trouble

Other procurement processes can include specifying a minimum size for a bidder for a substantial contract or previous experience of running similar services. But commissioners will be aware that these methods are likely to undermine smaller providers, including social enterprises and, if one of the aims of procurement is to open the market to new entrants, then setting too many hurdles may be counterproductive.

Nor are methods of checking in advance always foolproof. Shane Mills, who is leading for the Welsh local health boards on St Luke's, says a company that appears financially stable at the outset – when NHS organisations will be undertaking due diligence – can change rapidly. With high-cost placements in the mental health field, changes in vacancy rates can make or break providers. Mr Mills says the NHS had concerns about this with St Luke's but was not aware it was on the brink of going into administration.

Chris Calkin, chair of the Healthcare Financial Management Association Policy Committee and national media officer for HFMA, says asking companies to put up surety bonds and including "step in" rights in contracts can also be used to mitigate the effects of financial failure. A bond was used in

The Southern Cross collapse showed big providers can still get into trouble

'A mutual end to a contract that is not working out can be negotiated, which can help the smooth transition of patients to another provider'

the Surrey community services procurement last year and is thought to have posed difficulties for a social enterprise that bid for the contract and lost out to Virgin Healthcare.

Mr Calkin adds: "A lot of it is about building relationships in terms of how organisations work together. It's building trust and encouraging transparency and openness." But he warns of "optimism bias" – a company's management team may be reluctant to admit it is in deep trouble.

David Worskett, director of NHS Partners Network, points out that under the new failure regime, services can be designated as essential, regardless of who provides them. This designation will be key to getting additional money to keep services in place.

Monitor suggested providers of such services be "credit rated" and meet certain standards in advance but this may be hard to achieve and potentially expensive – not to mention the fact that there has been criticism of the idea that such providers could face limits on the amount of debt they hold (debt was an issue for collapsed care home operator Southern Cross).

But for other services, the position will be different. Mr Worskett suggests there will be times when alternative providers are available, which will lessen the impact for patients. But although this "survival of those who are fit to provide services," as he terms it, could lead to some dislocation in the short term, he suggests, overall, the ability of providers to fail can be a positive asset and can lead to new providers emerging and offering better care.

Of course not every failure is likely to cause significant problems – a small private provider, working under any qualified provider, could probably disappear without much fuss and with only a few patients needing to be found alternatives. The problem may be in the middle ground with services that are not deemed essential but still treat significant numbers of people or are specialist.

Stepping down

If an unprotected service does run into financial trouble, commissioners are likely to have to move quickly. If an administrator is appointed, it may continue to run the company as a going concern while a buyer is sought, but this won't be indefinite.

At St Luke's, administrators are hopeful a buyer will be found for the units in England. However, the procurement framework in Wales meant the contract could not be taken on by a purchaser, but would instead have to be retendered. So the units in Ebbw Vale will be closed, patients moved and staff made redundant. The Welsh health boards – which recently examined the availability of similar low secure units in Wales – are hopeful patients can be found other places.

Many people would say it is better to intervene early if a private provider seems to be running into trouble. This can be tough however – cancelling a contract may result in penalty fees and can further undermine confidence in a company (and impact on its share price). NHS organisations may only be able to watch and wait, and perhaps discreetly scope alternatives and whether or not they have capacity for more patients.

There are times when a private provider chooses to withdraw voluntarily. Private companies may be less tolerant of contracts that make a loss or are only marginally more profitable than NHS organisations – and may have better data on how costs are changing. One clinical commissioning group had to renegotiate its contract with a private provider of ultrasound services to prevent it withdrawing. The rising costs of employing sonographers threatened the profitability of the service for the provider.

In East Kent, a private provider suddenly withdrew from cataract services, leaving a gap that could not be filled by the local hospital trust. A new service, provided by three ophthalmologists working in their spare time, was eventually set up. This not only filled a substantial gap but the consultants are now treating around 20 patients on a Saturday morning.

Sometimes a mutual end to a contract that is not working out can be negotiated, which can help the smooth transition of patients to another provider or the takeover of a service. Last year, Tower Hamlets Primary Care Trust and Atos Healthcare went their separate ways over a GP surgery contract that still had seven years to run; they allowed four months for a handover. An agreed process of withdrawal from provision could be written into contracts – but be aware that this might not work if the firm goes bust.

Poor performance is another concern. In theory, it might seem to be a case where the NHS can end a contract; in practice, it can be hard to do so while keeping within the terms of the contract. The Department of Health had to pay £8m to Clinicenta when a five year contract for North London services was cancelled two years in – despite services being suspended twice due to safety concerns and a critical report that highlighted significant failings. Good procurement, including minimum quality standards, might help to avoid such cases. However, commissioners will also want to be certain of their grounds if they are cancelling a contract; CQC involvement could be helpful.

In addition, poor performance often creates immediate problems for commissioners. Clinicenta is now running an independent treatment centre in Hertfordshire, which has had a critical CQC report. NHS Hertfordshire has had to make arrangements for some patients to be treated elsewhere to limit waiting times.

As more independent companies start to provide services that are funded by the NHS, commissioners could face increased problems – expect the writing of watertight contracts and contingency planning to take centre stage. ●

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