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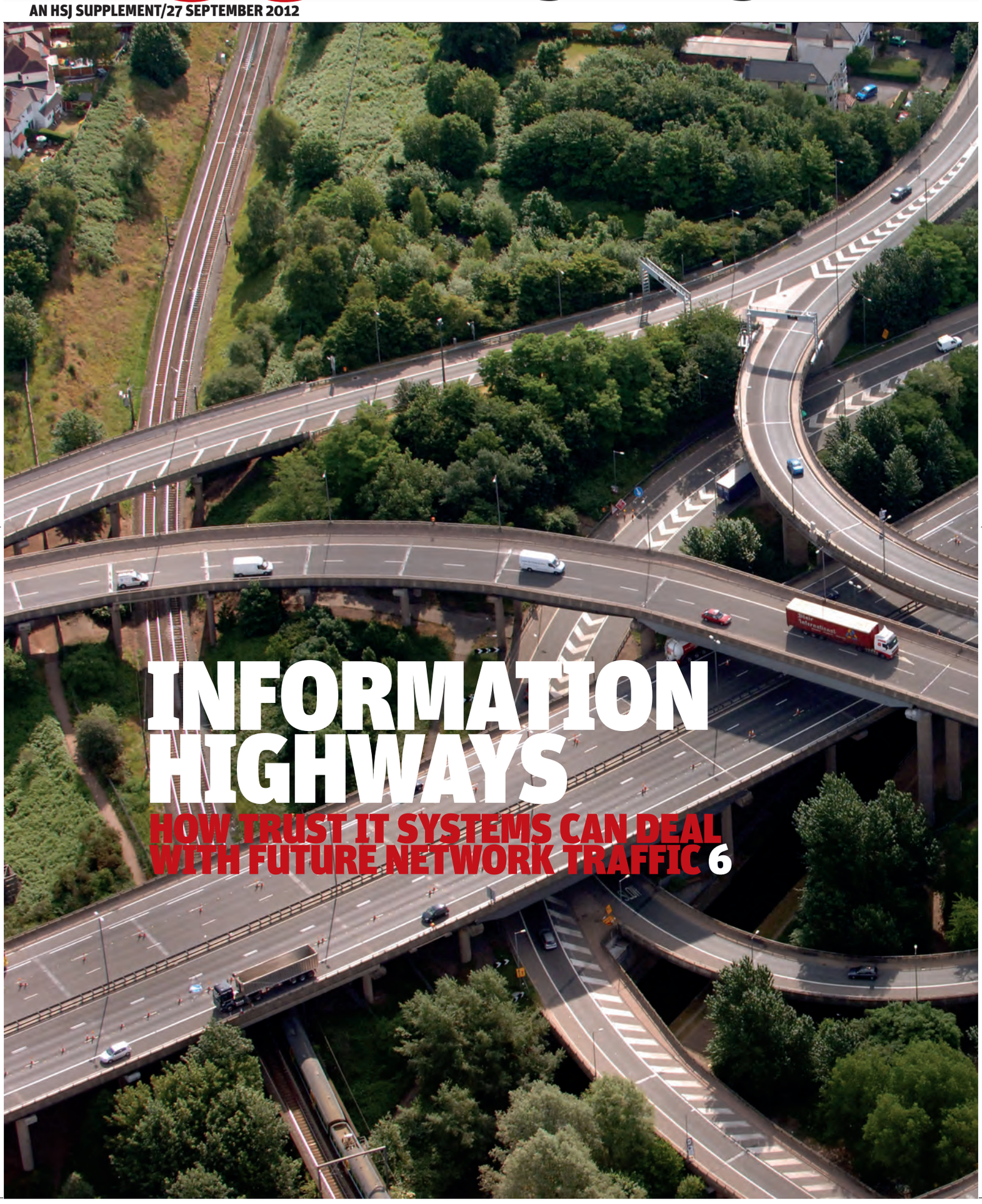
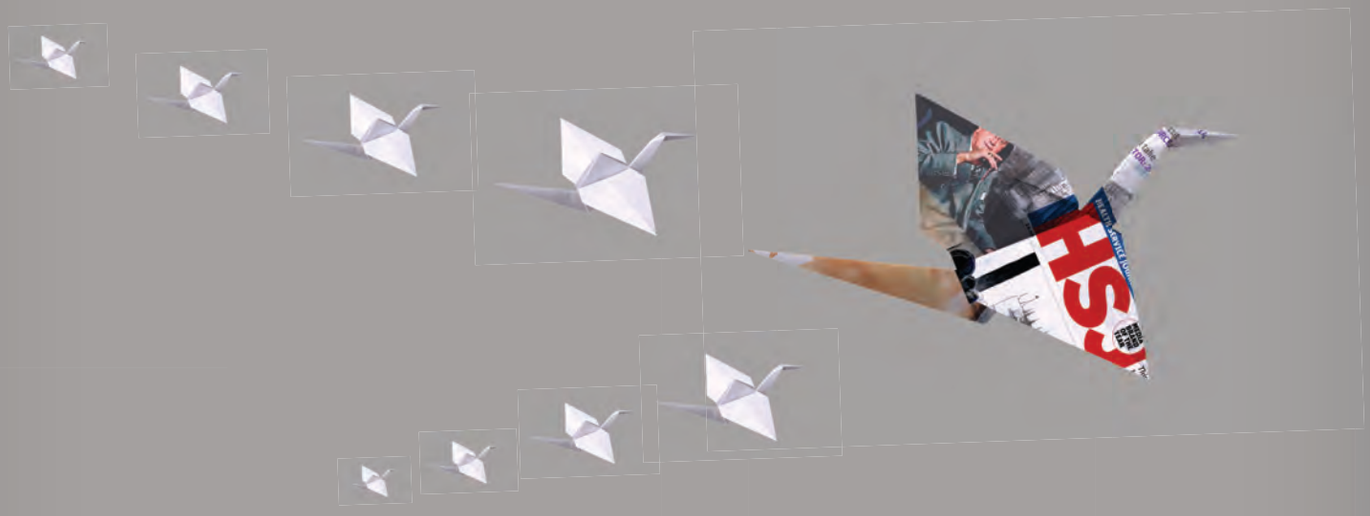


INFORMATION HIGHWAYS

HOW TRUST IT SYSTEMS CAN DEAL WITH FUTURE NETWORK TRAFFIC 6



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Supplement editor
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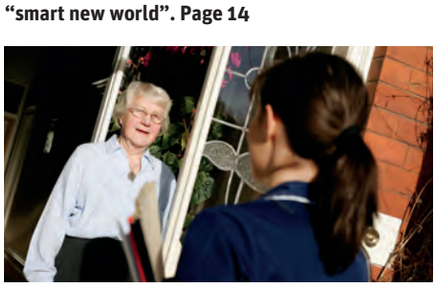

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NICK GERRARD ON BETTER DEALS

May 2012 saw the publication of *NHS Procurement: raising our game* by the Department of Health together with the NHS standards of procurement. Led by Sir Ian Carruthers, the report identifies the need for a new approach to procuring products and services to address the financial challenge facing the NHS over the coming years.

As a business working to deliver £1bn back to the NHS, NHS Supply Chain is in a unique position to help trusts rise to this challenge. Our response to *Raising the game* focuses on a key areas we believe are critical in supporting trusts to deliver an NHS fit for the future.

Trusts can achieve significantly better deals on procurement by working with NHS Supply Chain to aggregate demand, consolidate supply and eliminate duplication from the supply chain. This is most valuable in areas of high value trust spend, such as capital medical equipment. The new DH-sponsored capital fund discussed in this chapter has already driven additional savings of 12 per cent on a £90m volume commitment for the NHS, offering huge potential for further efficiency savings.

Service resilience and the delivery of consolidated supply chain solutions is another imperative. By using technology already available in trust systems and developing new ways of thinking, trusts can work with providers such as NHS Supply Chain to drive efficiencies.

'Aggregate demand, consolidate supply and eliminate duplication'

We are working with our suppliers to understand how to remove costs from the supply chain. Removing barriers to market entry and accelerating diffusion of innovation in the NHS is key to driving sustainable value.

We welcome the focus in the procurement strategy on leadership at a trust board level to ensure value for money. NHS Supply Chain's customer board was developed with this in mind. It is independently chaired by Chris Sharratt, former chief executive of Sheffield Children's Foundation Trust, with representation from key NHS decision makers.

Finally, the procurement strategy recognises the importance of effective control and management of demand in optimising supply. This includes the adoption of GS1 (global standards) coding to remove complexity and cost and achieve a common data set across the NHS, and improved inventory management to reduce waste and manage trust spend.

The challenge for the NHS and its partners is huge. By working with partners such as NHS Supply Chain and using their expertise, trusts can develop a supply chain model that is truly world class.

Nick Gerrard is chief executive officer of NHS Supply Chain
www.supplychain.nhs.uk

NHS Supply Chain

PROCUREMENT

THE £1.2BN QUESTION

Does one trust really need 177 different types of glove? Claire Read on huge potential procurement savings

The Nicholson challenge has made £20bn the sum of money most commonly quoted in relation to the NHS. But earlier this year, the government tried to increase the profile of a figure which forms part of that sum – £1.2bn. As stated in *NHS procurement: raising our game*, that is the amount the Department of Health believes could be saved if the NHS were to procure supplies more efficiently.

It initially seems like a generous estimate but consider the catalogue of issues which the guidance goes on to describe and it almost starts to look conservative.

Raising our game describes a fragmented procurement system in which trusts are comprehensively failing to coordinate or standardise demand. It reinforces the findings of a 2011 National Audit Office report which discovered that 61 trusts were purchasing a staggering 21 different types of A4 paper, 1,751 different cannulas and 260 different administration sets. One trust alone bought 177 different types of glove, highlighting the failure to capitalise on the collective purchasing power of multiple NHS trusts. Even individual trusts are not standardising products or grouping demand to drive bulk buy savings.

"A few years back we mapped demand for capital equipment to look at our ability to make better savings through aggregation," says Andy Brown, managing director for business solutions at NHS Supply Chain. "We found several instances where hospitals bought the same ultrasound machine separately, when they could have reduced costs by aggregating demand through us."

Given the current economic climate, there is a growing sense that such behaviour must now change. "I think that for many years, as consistently highlighted by accounts committees and health select committees, we have not been as strong as we should be in ensuring we're getting the maximum value from our expenditure with suppliers," admits Mike Farrar, chief executive of the NHS Confederation. "But looking at the financial challenges we now face, we can't afford not to get every penny of value out of them."

Some trusts are turning to NHS Supply Chain to help them do that. The organisation, operated by private firm DHL as an agent for the NHS Business Services Authority, offers a single point of access to over 600,000 products. Instead of individual trusts going out and negotiating prices with individual suppliers, the idea is that NHS Supply Chain can help aggregate the demand and so drive better deals.

Kevin Oxley, commercial director at North Tees and Hartlepool Foundation Trust, is an enthusiastic supporter. "By driving more volume through NHS Supply Chain we've been able to reduce the administration of invoices in our accounts payable team," he says. "This has the added benefit of allowing NHS Supply Chain to go out and negotiate better deals with their own suppliers."

He urges trusts to look beyond the headline price in the catalogue. "I do think that trusts have perhaps been carried away by the thought that they can buy cheaper than through NHS Supply Chain's catalogue and save money. When you take into account the buyer's time and the additional invoicing this incurs, it is often a false economy. Invoice processing can cost between £25 and £45 and we deal with hundreds a month," he says.

"So if we have hundreds of different suppliers of goods and services we may occasionally save a penny or a pound on the unit cost offered by NHS Supply Chain. But then the administration of looking at all the accounts, paying the invoices and so on very, very quickly overtakes NHS Supply Chain's slightly higher unit cost."

Mr Oxley says NHS Supply Chain has almost become "part of the fabric" at his trust and he now sits on the organisation's customer board. "I think they realised they needed to engage more with their clients, and especially with senior managers in the NHS," he says.

CASE STUDIES OVERLEAF ▶

It is the sort of close relationship the staff at NHS Supply Chain would like to have with more trusts. "When it comes to capital planning, we're engaging in a lot more conversations but not as many as I would like and not at the level I think is needed," reveals Mr Brown.

He is optimistic that a £300m capital fund, announced at the same time as *Raising our game,* may make a difference. Created by the DH and NHS Supply Chain, the idea was to enable bulk buying of large equipment such as CT and MRI scanners.

NHS Supply Chain already has 20 deals in place as a result of the fund. That will mean trusts buying capital equipment through them will see significant savings. When it comes to organisations replacing older equipment, Mr Brown argues that the benefits go even further.

"One of the biggest benefits is the healthcare benefit," he says. "Take radiotherapy as an example. Old linear accelerators are not as accurate and they give a higher dose of radiation; they're like hitting a tumour with a blunderbuss. New technology delivers radiotherapy with much greater accuracy. You're going to do a lot less damage, the patient's going to suffer a lot less, and they're going to recover a lot quicker."

'Several hospitals bought the same ultrasound machine separately, when they could have reduced costs by aggregating demand through us'

Staff at North Tees and Hartlepool Foundation Trust have already seen the safety benefits of better procurement. "Through standardising products, we really are creating a much safer environment," says Kevin Oxley.

"For example, we've standardised on ultrasound machines and that means we only have to train staff on how to use a single device – they get used to using a single product."

According to Mr Farrar, understanding that link between procurement and quality – and having NHS staff who act accordingly – will be crucial to the success of the government's initiatives on procurement.

"I think that *Raising our game* has been very, very good at raising the problem," he says. "Whether it will find or identify the solutions depends on how NHS organisations behave. What I don't think anyone will doubt though is that we must and should do better on procurement." ●

PROCUREMENT: CASE STUDIES

BEST OF THREE

Glimpses of the future of procurement, including a project that shows standardisation need not mean restricting trusts' choice to just one product

DRESSINGS

Four years ago, the use of wound care products in the East Midlands was inconsistent and often complex. Different hospitals used different products, dressings in the community were supplied on prescription, and compliance with organisations' wound formularies was often weak. With no standard approach, trusts were often paying over the odds.

There was clear potential for improvement and so healthcare providers in the area joined with NHS Supply Chain to form a working group. "The idea was to have a standardised approach and one centralised supply route for both acute and community trusts," explains NHS Supply Chain senior account manager Oliver Booth.

Establishing that standardised approach involved each organisation evaluating products in a specific wound care category. Price, quality and other relevant factors were considered and the results shared – with the understanding that each trust in the group would accept colleagues' evaluations.

The result was a comprehensive list of approved wound care products for the East Midlands region. Suppliers on the list were approached by NHS Supply Chain and offered the opportunity to return improved pricing based upon the likelihood of increased and consistent orders. Some returned discounts of up to 40 per cent.

"This helped the tissue viability nurses pick the most cost effective items," says Mr Booth. "They knew there were going to be no quality issues because all the products had been assessed and approved by their colleagues. Reducing the number of items being used and going to market to secure the best price on these products has helped achieve savings across the region."

Simultaneously, community dressings were taken off prescription. Not only did this increase the efficiency of wound care for patients at home, it significantly reduced wastage.

"Previously the district nurse would visit the patient and prescribe them a large amount of dressings. Once a dressing is prescribed it's the property of the patient and so if it wasn't used it would just go to waste. Now the nurse just provides enough dressings to meet a specific need."

Mr Booth emphasises that the project has not removed choice for local organisations. There is a recommended product in each category of the region's new wound care formulary, but two other approved products are listed too.

"A lot of collaboratives fall apart by saying that we need to move down to just one supplier," he argues. "If there's a big group of trusts it's very difficult to do that – you're always going to get differences of opinion. That's why we've got three options – to allow for different preferences. And of course all the choices have been approved by the whole group.

"The clinical engagement on this project was key really," he continues. "It wouldn't have gone anywhere if NHS Supply Chain went to all these trusts and said: 'These are the savings you can make by moving from product a to product b'. All the products were evaluated by trusts and that puts weight behind it."

ETHICAL PROCUREMENT

Its founding member freely admits that the creation of the British Medical Association's Medical Fair and Ethical Trade Group was something of an accident. Dr Mahmood Bhutta says the impetus came from a trip he took during his honeymoon, when he was travelling through Sialkot in northern Pakistan.

"My family are originally from Sialkot and one of my cousins, knowing I was a surgeon, asked if I wanted to see how surgical instruments are made," he explains.

"So we went and I saw manual labourers working in very cramped, dirty conditions with poor lighting. There were children there as well, making the instruments we were buying. And I just thought, well, this is wrong. It shouldn't be happening."

It is a viewpoint that has long been shared by NHS Supply Chain, according to the organisation's ethical and sustainability manager. "Ethical procurement has been on our agenda since we became operational, back in 2006," says Stephanie Proctor. "As a public sector organisation providing a service to healthcare we wanted to find a better way of working."

Initially that meant a clear code of conduct for suppliers but in the past year the organisation has taken an increasingly practical approach to the issue. Its recently-issued surgical instruments tender has contract conditions around labour assurance developed in conjunction with the DH. Suppliers must demonstrate what they are doing to manage labour standards in their supply chain thereby reducing the risk of non-compliances and abuses. There are similar plans for a forthcoming textiles tender.

Ms Proctor admits that it isn't always an easy sell, however: "When you talk about ethical procurement everybody initially thinks: 'Oh, this is going to cost us money.' But the advantages far outweigh cost savings, and cannot simply be measured in pound notes."

According to David Pierpoint, clinical trading director at NHS Supply Chain, those advantages are spread across the supply chain. "There are benefits for industry, benefits for the NHS and of course most importantly benefits for the people who are actually at the point of manufacture," he argues.

"Suppliers who have gone through our Labour Standards Assurance System (LSAS) can demonstrate that they are committed, responsible and transparent. And for the NHS, organisations can purchase products with a level of assurance as to how they have been manufactured."

While both Mr Pierpoint and Ms Proctor say trusts are becoming more interested in ethical procurement, they also argue there is a need for more widespread awareness. The Medical Fair and Ethical Trade Group is working hard to create just that.

Last year it issued an ethical procurement for health workbook, offering practical advice to healthcare staff grappling with the issue, and in July it released a video entitled *The human cost of healthcare*, which included a supporting contribution from NHS Supply Chain.

Dr Bhutta argues that ultimately it comes down to a moral issue. "It's about the ethos of healthcare," he argues. "It just doesn't sit comfortably that we are harming the health of people elsewhere in the world for the benefit and health of people in our populations. It seems completely wrong."

CAPITAL EQUIPMENT

When staff at Barnsley Hospital Foundation Trust decided a new CT scanner was the only way to meet growing demand, they did what they now always do when purchasing major medical equipment – approached the team at NHS Supply Chain.

"As a small trust, if we try and take out our own *OJEU* [*Official Journal of the European Union*] procurement, there's a very long and protracted procedure," explains Dave Houghton, imaging services manager at the trust. "The technical specifications are very complex and take a long time to write. It is then a long and time consuming process to evaluate and shortlist the companies against these specifications.

"With NHS Supply Chain, we know all that work has already been done for us. This allows us to concentrate our efforts on ensuring we get the right scanner to meet our clinical needs, rather than looking at all the other aspects of procurement. It allows people to get on with their jobs instead of trying to do yet another job on top of their day job."

"It simplifies the whole procurement process," agrees supplies manager Neil McConville. "We are able to draw from contracts and agreements which are informed by a wide number of NHS stakeholders so we've confidence that the resulting contracts are robust."

In the case of the CT scanner, the trust was the first to benefit from the recently announced £300m capital fund from the DH. The scanner preferred by the clinical team did not initially fall within the price guidelines set by the trust. However, the capital fund enabled NHS Supply Chain to put a number of commercial bulk deals in place, leveraging the national demand for capital equipment and driving significant savings back to the NHS. This made the trust's clinical preference affordable and available.

Mr McConville is confident that this sort of aggregated approach is the most effective way to procure in the NHS. The problem, he suggests, is a health service environment that is not conducive to it. "Getting the best procurement deal requires some degree of centralisation but we're operating in a highly devolved environment," argues Mr McConville. "What we need to do is strike the right balance so the trust does have the latitude to get the equipment they want, but we've also got to take advantage of the potential leverage of NHS spend.

"We simply cannot get the best prices if we've got a highly devolved environment in which individual trusts are doing their own thing and are not sharing information." ●

ALAMY

TERRY ESPINER ON BUSINESS-LED ICT

There has been, and will continue to be, much debate over the efficiency challenge facing the NHS, and whether such savings can be made at the same time as transforming the service. Can you really deliver quality, innovation, productivity and prevention improvements all at the same time?

One of the key tools that can help to deliver a positive answer has been in the kitbag of all NHS organisations for around two decades but has yet to realise its true potential. That tool is information and communications technology.

In the NHS, it is typical to find ICT departments delivering very good services to the organisation they are supporting. Their services are often critical to the business and any outage is certainly noticed more today than ever before. However, increasingly we are seeing ICT emerging as a true enabler, intrinsically linked to the needs of the business.

So what do we mean by business-led? Surely ICT is always business-led? To some extent, this is true. Historically, ICT departments have worked to a budget to deliver the best service possible. This has been coupled with capital programmes for high value projects where ICT has been recognised as a prerequisite. However, a shift in thinking is seeing business leaders taking a more strategic view of ICT, where business plans or discrete projects are the starting point for technology enablement.

'Plan ICT based on need. Then build the solution from the bottom up'

For example, take a business operation such as Hospital at Night (H@N). Taking the time to understand the workflow requirements of this critical function allows us to consider a solution from the perspectives of people, process and technology. H@N requires real-time communication, task allocation and prioritisation, information management, collaboration and an audit trail. Once we understand these, we can plan a solution and then understand how that should be supported by infrastructure. The Nottingham hospitals case study featured in this supplement is an excellent example of business-led ICT and undoubtedly meets all aspects of QIPP.

In simplistic terms, Cisco advocates a "plan down, build up" approach to NHS ICT. Plan your ICT solutions based on business need. Then build the solution from the bottom up, ensuring you have all the features required to deliver the solution effectively. In this way ICT can return much more value back to the business.

By doing the homework together, we can determine the technical solutions that address business problems, and deliver against as many of the QIPP pillars as possible.

Terry Espiner is health sector manager UK at Cisco
www.cisco.com

TECHNOLOGY

OPEN ROADS

The traffic on NHS computing systems is surging – and needs infrastructure that can cope. By Claire Read

Ask Mike Badham to explain his job – solutions architect for the UK healthcare team of computer networking giant Cisco – and he offers an interesting analogy. If you are building a road network, he explains, you really only want to build it once and design in all the intelligence you need, such as bus lanes or traffic lights. Fundamentally, you want the system used to transport things from A to B to be fit for purpose for the present and foreseeable future.

It is an approach that, he says, is equally important when it comes to healthcare IT. "Information technology is an obvious area where invest-to-save can work," emphasises Mr Badham. "But it has to be planned appropriately."

In other words, before investing in solutions such as e-prescribing and barcode tracking, it is necessary to ensure the infrastructure is in place to run those systems effectively. Where cars run on roads, software runs on a network.

Great Ormond Street Hospital is only too aware of the problems of introducing an IT solution on a network ill equipped to run it. A few years back, e-prescribing was launched at the hospital, relying on mobile computers and a wireless signal.

"The problem was that the signal was too weak, and there were black spots where there was no signal at all," recalls Martin Elliott, professor in cardiothoracic surgery and the trust's medical director. "And you cannot do clinical care with black spots. It doesn't work. It's just too unreliable."

Experiences like this prompted the trust to turn to Cisco's "architectural" approach to healthcare IT. In simple terms, the idea is to make sure the nuts and bolts of IT infrastructure are up to scratch before investing in more complex solutions – similar to ensuring a PC has the specifications to run all required software before purchasing the software.

"The ethos is to consider the business requirements of an organisation, from a trust strategy point of view right down to individual business projects," explains Mr Badham. "You then invest in the infrastructure once to ensure you've got all the capabilities you need. But after that you can exploit the investment over and over again."

It is an approach that, for Great Ormond Street, has led to a huge range of improvements (see case study, overleaf). A fundamental overhaul of IT infrastructure means that e-prescribing now works effectively and the trust's 10-year-old picture archiving and communications system (PACS) has been replaced. Other advances included the introduction of high quality video conferencing throughout the hospital, a radio frequency identification (RFID) system which makes it possible to track assets such as wheelchairs to an average accuracy of two metres, electronic note taking at the bedside, and a massive email system upgrade. The result has not only been efficiency savings but also improvements in patient care.

Video links

"The video system, for instance, has actually changed the way we work with our patients," explains Mark Large, the trust's director of ICT. "Why would we ask patients and families or indeed our staff to travel across the country when an appointment or meeting could be held via a video link?"

"I can envisage a time where it's cheaper to give a patient an iPad loaded up with video conferencing and a secure copy of their medical record than it is to see them in outpatients," argues Professor Elliott. "And certainly that matters if you live in Aberdeen and you've got to bring a family of four down for a half hour visit to see me. Using video conferencing, I can offer a proper opinion, very quickly, and with good face-to-face engagement."

High quality wireless networks are not just enabling improved communication with patients. At Nottingham University Hospitals Trust, a major upgrade to IT

CASE STUDIES OVERLEAF ▶

ALAMY

infrastructure made it possible to introduce Nervecentre, which provides a workflow management system which has greatly improved staff communication. Services that have benefited include the Hospital at Night scheme (see case study, overleaf).

Previously, all contact between members of the H@N team had been via pagers and landline telephones, with negative consequences for staff satisfaction and patient care. Now, however, the trust has a solution based on wireless phones and both desktop and tablet computers. The H@N coordinator is aware of the location and workloads of all team members at all times and can easily reach them on the phone.

"My favourite element of these projects is the idea you actually increase human interaction," says Paul Cook, the Cisco account manager for Nottingham.

"The trust has recently extended the wireless phones to porters and the theatre staff have admitted a few times that they used not to see porters as individuals and perhaps did not respect them as such.

"But now the porters are carrying phones and you can search for an individual porter by name, and you'd have to be quite an arrogant person to interact with someone directly and not get to know them. They're co-workers and suddenly individuals have all kinds of professional relationships that didn't previously exist."

'A radio frequency identification (RFID) system makes it possible to track assets such as wheelchairs to an accuracy of two metres'

The changes at Nottingham have also resulted in significant financial benefits, outlined in two reports by The Association of Chartered Certified Accountants. ACCA estimates that the Hospital at Night project alone will lead to real cash release savings of around £105,000 a year and the reinvestment of approximately £323,000 into patient care.

"I don't think it's over ambitious, if we were able to address absolutely everything, to save several percentage points out of the trust's annual £750m budget," says Mr Cook.

"For me it is now impossible to be a credible doubter about this," he continues. "Everybody has to understand that, provided they are managed professionally, IT systems and solutions do work." ●

TECHNOLOGY: CASE STUDIES

THE ONLY WAY IS UP

How the network going down at Great Ormond Street proved to be a blessing in disguise – and rethinking Hospital at Night in Nottingham

GREAT ORMOND STREET HOSPITAL FOR CHILDREN FOUNDATION TRUST

A major network outage does not sound like the best welcome for a new head of ICT. But Mark Large says that in many ways he was "the luckiest IT director around" when he joined Great Ormond Street Hospital for Children Foundation Trust back in 2008.

Why? "Because there was a clear challenge. I had to fix things that very clearly needed repairing and upgrading," he explains. "There was an understanding that we couldn't carry on the way we were and that we were in a situation where the infrastructure definitely needed upgrading."

In the run-up to his joining the trust, the issues being caused by its ageing IT systems had become increasingly clear and increasingly troublesome. Basic IT infrastructure problems had made it impossible, for instance, to replace the hospital's outdated picture archiving and communications system (PACS) and an e-prescribing system had faltered due to problems with the wireless network.

The board decided something had to change, and part of that change was Mr Large's appointment – the trust had never previously had a director of ICT. Mr Large had spent most of his career outside the NHS, much of it working in technology companies specialising in performance, architecture and strategy – a background that was to prove invaluable.

"My role at GOSH has been a lot about strategy; a lot about architecture and a platform approach," he explains. "We had to stabilise all the various layers of the infrastructure – the network, the server room, the storage, the wireless system.

"By investing heavily in that we've given ourselves a platform – Cisco Network Architecture Blueprint for the NHS – from which we can do most things without having to change our architecture or reinvest in technology. Previously the IT department was operating in firefighting mode. Now we've moved to an open-for-business type attitude where we try to make the answer 'yes' wherever we can."

The ability to introduce new IT systems is arguably of particular importance at a tertiary paediatric hospital. "We're caring for the digital generation," argues trust medical director Professor Martin Elliott.

"Recently I was in my clinic talking about a particular operation to a parent and an eight-year-old child. The child was very quiet, playing on an iPad. And I turned to him and said: 'Did you understand everything that's been said? Have you got any questions?' and he said: 'Oh, no, I've been looking up the operation. I can see how it's done. It's really good and the results look good'."

"Some of the kids that come to us are probably streets ahead of us on use of consumer technology," adds Mr Large. "We need to try and think more like they do, providing services that can more easily use. We will not overtake them but we will at least try to keep up with the way they interact with technology."

Collaboration is critical to doing that, says Mr Large. Cisco helped develop and deploy the network improvements that made it possible to replace the PACS system, get the e-prescribing system working properly, and introduce a range of new systems including improved video conferencing in theatres and seminar rooms that enable clinicians around the world to observe surgical interventions and other treatments.

Cisco's TelePresence Content Server and Media Experience Engine allow invited users on any device, anywhere in the world, to join a video conference safely and securely and to share documents and images.

But for everyone at the trust, this is all about the patients. "My title is director of ICT but I take my contribution to the patient's wellbeing and experience in the hospital very seriously," says Mr Large. "At the end of the day if our systems aren't working properly that will impact patients very quickly."

'Some of the kids are streets ahead of us on use of technology. We need to try and think more like they do'

Professor Elliott agrees. "There's no point in being in healthcare if you don't care about patients. Great Ormond Street's motto is: 'The child first and always', and we would expect anybody working here to have that tattooed on their forehead almost!

"So if you put yourself in that empathetic position then you cannot be a clinician or a nurse and not be interested in the IT and nor can an IT department make changes without engaging you."

Network rebuilt: Great Ormond Street has invested heavily in IT infrastructure

NOTTINGHAM UNIVERSITY HOSPITALS TRUST

The role of a Hospital at Night coordinator is a demanding one. Responsible for ensuring that patients receive the care they need during the long nighttime period, coordinators must manage medical review requests from ward staff and then assign those requests to the small team of junior doctors on duty.

It can be a tricky job at the best of times but at Nottingham University Hospitals outdated technology was making it even more challenging. Communication between members of the team was entirely by landline phones and what Andrew Fearn, the trust's director of ICT services, characterises as "an ancient bleep system".

"It meant that 97 per cent of the time, the Hospital at Night coordinator was in an office looking at a computer screen, or on the telephone sending bleeps out and receiving calls back," says Mr Fearn. "We were finding it incredibly difficult to recruit coordinators because these are senior nurses and, as you will appreciate, they want to do nursing, they don't want to do administration."

The situation was not much better for the junior doctors receiving the bleeps. Their pagers were unable to offer any indication of how urgent the job was and so they simply had to stop what they were doing and find a phone as quickly as possible. That meant knock-on consequences for patient care.

"There was one occasion where an elderly patient was brought into the hospital at about 11.20pm. She was seen by the junior doctor within five minutes to do the initial assessment but during that assessment the doctor's pager went off four times," remembers Mr Fearn. "So this poor old lady's assessment didn't finish until well after midnight. Each time the junior doctor came back he had to wake her up."

Night shift: Nottingham's IT has been transformed

Following a major upgrade of the trust's basic IT infrastructure "things like that simply don't happen any more," says Mr Fearn.

Doctors on the H@N team now have BlackBerrys that work on the trust's upgraded network. The coordinator sends alerts to these phones with clear indications of what the job is, where it is, and how urgent it is. Should the doctor be in the middle of another task, he or she can decline the job and it can be assigned to another member of the team.

"What that means is that we don't get patient care interrupted," says Mr Fearn. "It also means the noise level's reduced significantly in the wards at night – the bleeps aren't always going off."

Since the Hospital at Night coordinator can now assign tasks from a tablet computer, the new system also means that he or she is no longer spending a major part of the shift sitting behind a desk. A report by the Association of Chartered Certified Accountants shows that in the week of 14 March 2010, the Hospital at Night coordinator was not able to leave the office once. A year later, following the introduction of the new system, the coordinators spent an average of 60 per cent of their shifts delivering direct clinical care on the wards.

The benefits of the new system have been far reaching. Mr Fearn highlights the reduction of information governance risks thanks to junior doctors no longer recording their tasks "on the piece of paper in their pocket" – not just unsafe for patient care but also less than ideal as evidence for their training record.

"We're now able to give them that information in a printed off report direct," says Mr Fearn. "And if they need to increase their numbers in a certain procedure they can ask the Hospital at Night coordinator and they can direct them to do it. So it means their training is more effective."

Mr Fearn stresses that none of the improvements would have been possible without the IT infrastructure upgrade.

"The idea was if you can build a reliable platform that you can use again and again then that's where the investment is going to pay off," he explains. "We then looked at technology we could use in a variety of places, such as wireless telephony and the workflow management system. If you've got that basic building block of a high quality network in place then you can exploit it to its full potential." ●

ALAMY

DMITRY DORSKY ON FINANCIAL MANAGEMENT

IN ASSOCIATION WITH ALBATROSS FINANCIAL SOLUTIONS

The mind-boggling scale of cost reduction in the NHS has placed an unprecedented demand on efficiency and necessitates a completely new way of thinking. It must be clear to every NHS manager by now that meeting these objectives requires bold changes to the existing financial management mechanism.

A new finance mechanism must be sharp and clear in highlighting any cost variations, it needs to provide clinicians and managers with evidence-based best practice guidelines and identify any potential budget "pitfalls" with transparency and timeliness, allowing budget holders to take decisive action when it matters.

Making such changes is an enormous challenge and I am pleased that a number of leading NHS trusts have teamed up with us to take up this challenge. In recent years we have been privileged to work in a close partnership with two such organisations: Guy's and St. Thomas', and King's College hospitals.

Combining Albatross's technical expertise with the forward thinking approach adopted by these two trusts has facilitated the creation of a number of unique financial management solutions, as documented in this chapter.

A significant number of NHS organisations have adopted the Patient Cost Benchmarking solution (PCB) developed in partnership with King's, and the Integrated Service Line

'PCB and iSLR are making an impact on clinical engagement'

reporting system (iSLR), developed in collaboration with Guy's. Both solutions have already proved their worth at an individual trust and national level, generating significant and tangible savings while delivering transparency and efficiency.

They have highlighted new opportunities too and work is underway on a new Integrated Patient Acuity Recording system (iPARS) in partnership with Guy's, designed to allow patient acuity information to be captured in real time by nursing staff on wards using advanced web-based technology.

The data is used to aid nurse management by identifying "hotspots" and redirecting the necessary resources thus reducing the need for bank/agency staff. It will also play a major role in improving the accuracy of the costing process by adjusting the existing cost allocation approach based on the length of stay with the introduction of a "complexity" weighting factor.

PCB and iSLR, on which we report here, are making a real impact not only on trusts' bottom lines but also on clinical engagement in finance. The story of their development and use shows collaboration is the key to success.

Dmitry Dorsky is managing director of Albatross Financial Solutions
www.albatross-fs.com

FINANCE

HOW DO WE MEASURE UP?

Dozens of trusts have joined a 'benchmarking club' that allows them to compare patient costs. By Helen Mooney

Many NHS trusts around the country have now either implemented patient level information and costing systems (PLICS) or are in the process of doing so. The next logical step must be benchmarking.

And this is where one group of trusts with fully established PLICS is ahead of the game. The group, which includes many specialist organisations, district general and teaching hospitals, has established its own patient cost benchmarking club.

It was originally established at London's King's College Hospital Foundation trust in 2010 in a bid to answer the question of how a rich amount of patient cost data generated by the trusts within King's Health Partners (King's College Hospital, Guy's and St Thomas's and South London and Maudsley) could be used to drive efficiencies and identify anomalies in the national tariff across the organisations.

Now consisting of 40 trusts and with the expectation that a further ten will join this autumn, the club is going from strength to strength.

The members use the Patient Cost Benchmarking (PCB) system developed by King's and Albatross Financial Solutions. In essence, PCB enables trusts to compare their cost and activity information at various levels (specialty, healthcare resource group, procedure, diagnosis, consultant, etc) and drill down to the patient episode. According to those involved it has the added benefit of improving clinical engagement in PLICS.

Mike Hamilton, business development director at Albatross, says that it is the first financial benchmarking tool to go down to episode and patient level on a national scale.

"These trusts were putting a lot of effort into patient level costing so they asked what was the next step. They were asking 'what can we do with this information?' and benchmarking is the logical next step," he explains.

Simon Taylor, chief financial officer at King's College Hospital Foundation Trust was instrumental in devising the benchmarking system. He says that the system is invaluable in helping trusts compare their patient cost data.

"The way the benchmarking system is set up means it is possible to compare against the whole group or against particular peer groups and trusts can also look at each specialty," he says.

He hopes that as the benchmarking group gathers ever richer data it will also be able to broaden the scope of the information "horizontally and even out anomalies in data sets".

He also believes that the group will be able to start to extend its reach and begin benchmarking non-financial areas such as theatre times and to examine HRG coding differences.

"With more data mining and analysis of the whole data set we can start to look for example at the top 10 HRG errors," he adds.

David Paris, deputy director of finance at North Middlesex University Hospital Trust says that using the benchmarking data has allowed his organisation to see that in some specialties patient length of stay did not compare well with other trusts.

"We have been able to look at exactly which HRGs we are not performing well at and try to understand why," he says. "In obstetrics our length of stay has been very poor. We found that we were recording patients as without complications when in fact they had complications.

"After identifying this through the benchmarking data we were able to look into it and found that it was a clinical coding issue that meant complications were not being picked up so we have been able to improve coding and get an increase in our tariff payment as a result."

Crucially, the benchmarking tool means trusts can review "everybody else's data", says Mr Paris, and along with a peer group review it quickly becomes obvious where an organisation is costing or coding something incorrectly.

The benchmarking tool has not gone

unnoticed at a national level. A recent report commissioned from management consultancy PricewaterhouseCoopers by Monitor used the benchmarking tool to help understand how actual costs vary across patients within an HRG, what the drivers are for those costs, and what risks the variations pose to trusts.

PwC proposed that Monitor drop the use of average reference cost data currently collected from all NHS acute hospitals and used to set the PbR tariff and instead use individual patient costs.

The PwC proposals, which Monitor is understood to be seriously considering, would see price setting based on information collected from a representative sample of providers that accurately tracks the costs of treating individual patients.

The benchmarking group is excited by this prospect and the hope is that many of the trusts involved could become part of such a sample.

Janice Fawell, programme manager for Project Diamond – a network of large teaching and specialist hospitals across London all of which are involved in the benchmarking group – says that the benchmarking data shows "that there are substantial amounts of work done by specialist trusts that are more than five times tariff."

'Provider organisations have now got a much greater willingness to share. You can't improve in isolation'

She says that, using the benchmarking tool, trusts have been trying to get a better understanding of the tariff for specialist work under PbR and whether it adequately funds specialist complex work.

"What we have found is that the tariff at the moment is over costing the easy stuff and under costing the difficult stuff. As a result some of the "simpler" activities are overfunded while the specialist and complex work is underfunded."

Suzanne Robinson, head of income, costing and contracting at specialist cancer centre The Christie Foundation Trust says that, for her trust, the networking and communication offered by the benchmarking group is also a "real opportunity".

"You can only go so far when you are looking internally ... the network is important, provider organisations have now got a much greater willingness to share and there is much greater transparency. You can't improve in isolation."

One thing that many trusts also find attractive about the patient cost benchmarking tool is that helps get clinicians interested in patient costing.

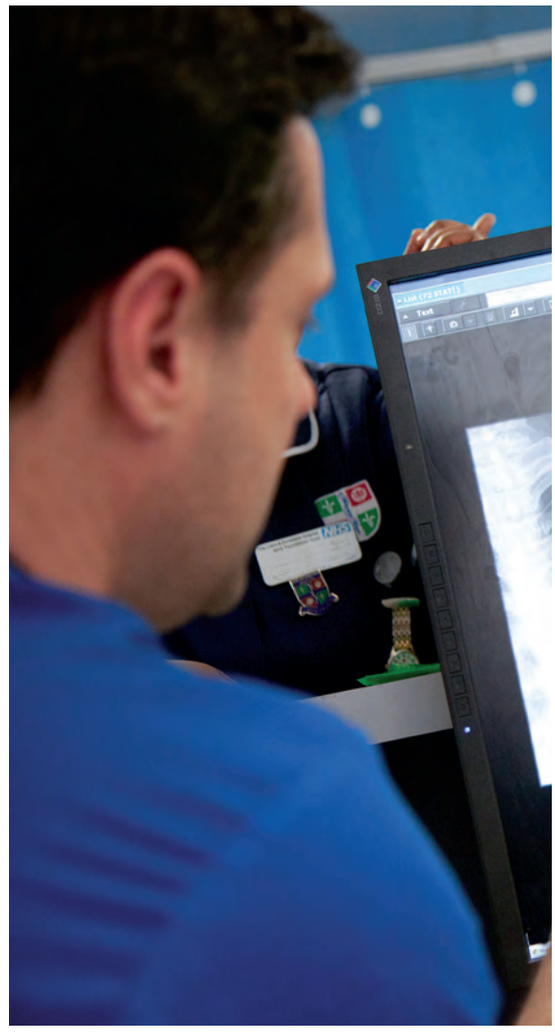
Ms Fawell says that benchmarking provides "transparency of costing and activity within the system" that means trusts can look at all available data. 'The data is so wide it is conducive to clinical engagement because it is about individual patient costs and that is key."

This is crucial to service improvement. As Ms Robinson puts it: "Benchmarking data takes things to another level where we can ask questions as to how we run services. We can change the way we do things if clinicians recognise that financial stability is a platform for growth." ●

ALAMY

FINANCE

CREDIT IS DUE



How iSLR lets departments in a hospital charge each other accurately for every activity – helping managers and clinical staff get a grip on costs. By Helen Mooney

Over the last few years four London NHS trusts have been quietly implementing a new financial management system that could radically overhaul how trusts and the specialities and departments within them calculate their income and expenditure. Ultimately, it aims to drive efficiencies.

Also known as second generation SLR, the system can measure an organisation's full profitability by each of its service lines, as well as a top aggregated level.

Originally developed and implemented by London's Guy's and St Thomas's Foundation Trust in collaboration with Albatross Financial Solutions, it is now also being used by Barts Health Trust, Royal Free Hampstead Foundation Trust, and King's College Hospital Foundation Trust.

Imperial College Healthcare Trust is about to implement the system as is South London Healthcare Trust and Leeds Teaching Hospitals Trust.

The new system, known as "integrated Service Line Reporting" or iSLR, is an integrated internal trading solution designed to recharge all the internal activities carried out by provider departments within a trust such as radiology, pathology, wards or theatres to purchasers such as general surgery and general medicine.

The system operates based on a set of standard tariffs in creating the recharges between provider departments and services and therefore makes transparent the costs associated with a department's or service's activity, clearly identifying the difference between volume and price related variances allowing managers to keep a tight control on their budget.

Each patient activity (bed day, diagnostic test, theatre minute, etc) is converted in to a recharge that debits the "customer" and credits the "provider" in order to create an internal trading system and allow publication of a full service line reporting system report. The iSLR system is fully automated and takes data feeds directly from various frontline service applications, applies the appropriate calculations regarding tariffs, internal cross-charging, and determines a distinct profit and loss position for each given service line.

On a particular ward for example, each bed day will generate a "debit" for the relevant speciality or service using the bed as the "customer" and a credit for the ward providing the bed.

iSLR's advanced reporting module provides a full drill-down from the budget line all the way to an underlying patient activity that triggered the charge providing managers with a clear and transparent view of the service's performance.

The main difference between iSLR and traditional service line reporting is that the new system integrates with existing business reporting processes and so provides the end user with a single performance report via the trust's main general ledger.

This integration is possible because iSLR converts all the internal charges into a set of financial journals.

As a result, it allows departments to operate as business units within a trust. All the SLR recharges are processed monthly within 24 hours of month end, much quicker than traditional SLR data and with a fraction of the resources required to deliver an SLR based on PLICS (patient level information and costing systems).

Jonathan Rowell, head of financial management at King's College Hospital Foundation Trust (part of the Kings Health Partnership), explains: "It is a management accounting system that works in the same way as monthly budget reports so there is still a budget as before but it is split down to specialty level and we have added in more cost allocations, so for example bed days on a ward is key thing so when general medicine use a bed on that ward they get charged for it."

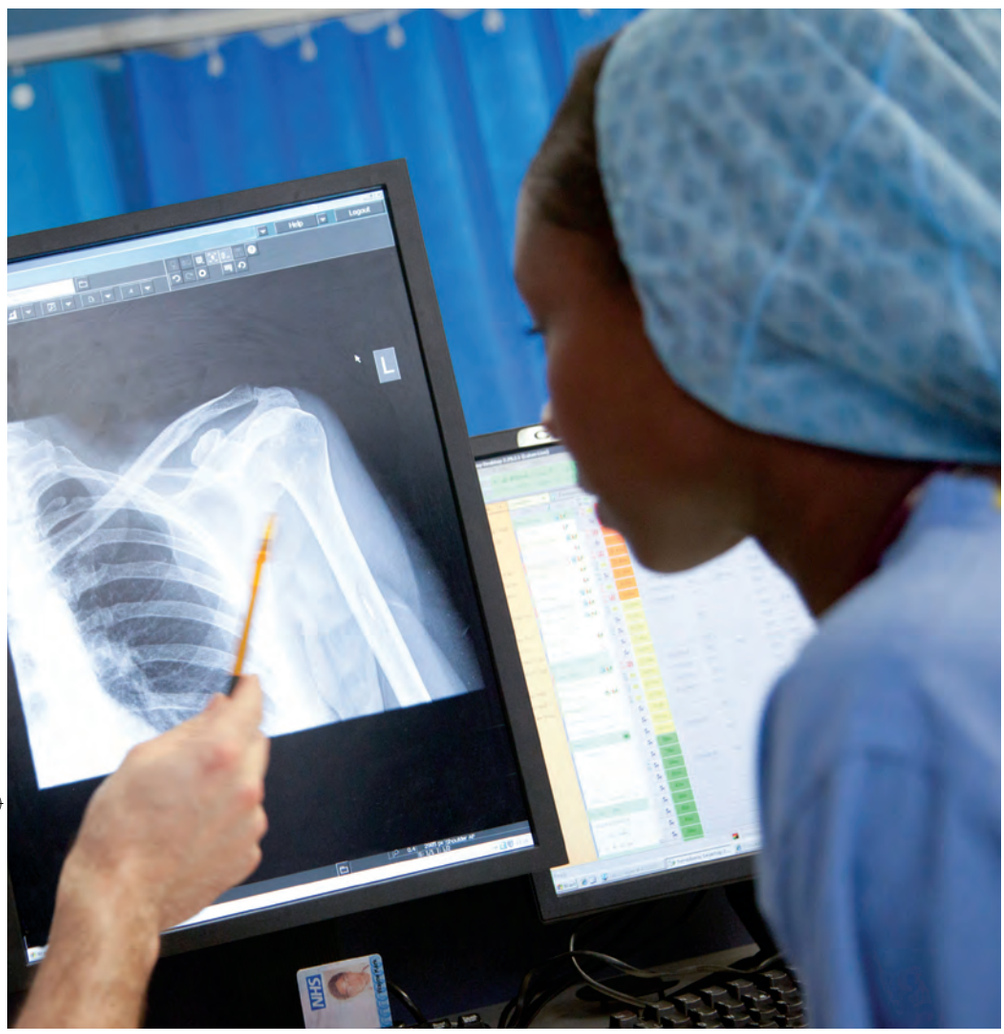
Mr Rowell is convinced the new system will bring efficiencies and savings. "The traditional finance ledger is too clunky ... my hope is that this is the third way that allows clinical teams to have a conversation about what they are using in their specialities."

"It is simple to understand but robust enough – bed days is a key example of how general medicine will be able to see their patients by ward and reduce medical outliers which means increased profitability."

The ability to manage resources efficiently is dependent on a trust's awareness of accurate and transparent costs. The iSLR system enables operational teams within trusts to understand their real operational service costs and therefore also begin to improve service efficiency.

The ever increasing demand for up-to-date, integrated, accurate and transparent information means that a system such as iSLR, which provides real time financial performance monitoring, can be invaluable.

The solution provides budgetary and actual information, integrates easily with a



Transparent cost: the exact cost of X-rays and other activities is clear under an iSLR system

trust's existing ledger system and delivers "one version of the truth" information to all the budget holders.

At King's Health Partners the vision is that, as clinical academic groups are developed, they will also become business units and the new system will allow the organisation to have an accurate, up-to-date picture of the financial position of each unit.

Albatross business development director Mike Hamilton explains that the system allows departments in a trust to be accurately reimbursed for the services they deliver and incentivises them to be more efficient and cost effective.

"At the beginning of the planning period any department can agree their income, cost and activity plan and if they go over, it is their responsibility to steer it back into line," he says. "However, should their profitability performance improve they will be able to benefit from exceeding their financial targets by, for example, gaining funding for new equipment. The system significantly increases the way each department understands their business."

Jeremy Brinley Codd, associate director of finance at Guy's and St Thomas', explains that, under a traditional service line reporting model, activity is divided by costs compared to income to establish profitability but that, under such a system, it is not possible to understand why a particular service has become more or less profitable. "Under this system there is absolute clarity," he says.

'In pathology, for example, we can see which consultant ordered which test and how many per month'

In its first year of operation, the range of volume based charges included in the iSLR system included radiology, theatres, therapies, wards and nuclear medicine. For service departments where electronic activity information was not readily available Guy's and St Thomas' processed what it calls a standing charge or availability fee. Now the organisation continues to expand the range of services charged on a volume driven basis and has more recently transferred pharmacy charges from being an availability fee to being activity based.

In a number of services iSLR has already informed decisions. For example, in one service a doctor wanted to increase the amount of therapy a particular patient group received from one to two visits a day, explains Mr Brinley Codd. "Thanks to the new system the doctor knew that they could afford to do this and pay therapies for it and that ultimately it would reduce length of stay on the ward for patients, reduce the charges they would receive for being on the ward and save money for the service to re-invest in patient care."

"iSLR is putting the ability to change in the hands of those people who need to make those changes quickly," he says. "This is a key tool to help managers and clinical leaders on the frontline bring into effect more rapidly than they otherwise could have things that can be changed quickly."

Caroline Clarke, director of finance at Royal Free Hampstead Foundation Trust, explains the system is of real value for the services the trust provides where it is difficult to work out the cost because there is no HRG attached directly to their work such as in pathology, radiology and pharmaceuticals.

"iSLR shows you where the income is and where the direct cost of the service is," she says. "In pathology, for example, we can see which consultant ordered which test and how many per month. We can drill down into the budget statement and see how much was spent on bandages last month and where."

And as Martin Shaw, director of finance at Guy's and St Thomas's, simply explains: "With this system what we are trying to do is devolve budgetary ownership to frontline staff so ultimately we get them to save money for the trust." ●

ALAMY

JIM CHASE ON MOBILE TECHNOLOGIES

The NHS is facing its biggest challenge in history – supporting an ageing population with a severely diminished budget. The figures don't stack up – £20bn efficiency savings by 2015 and a population where 23 per cent will be over 65 by 2035.

If the NHS is to meet the needs of a growing and ageing UK population, it needs to find innovative ways of delivering efficiency savings without compromising quality of care.

Exploiting smart mobile technologies is one such innovation that will prove key. By using mobile patient management and point of care solutions, cost-effective out-of-hospital care can be more efficiently delivered by clinicians and care workers, laying the foundations for an NHS that can keep its head above water by 2035 without compromising on personalised care.

Mobile patient management systems enable community clinicians and nursing teams to record and communicate patient care information, including consultation outcomes, using secure handheld devices. Eliminating paper records and frequent trips back to head office to collect and disseminate information drives up efficiency and productivity. In fact, team visits can be increased by up to 25 per cent through reduced paperwork and unnecessary travel time, increasing capacity and allowing more time with patients.

Intuitive point-of-care solutions designed for providers of home care, extra care and supported living are also vital for enabling workforce mobilisation and delivering cost and efficiency savings while supporting compliance and lone worker safety. These solutions can deliver live rosters and service user information to care workers via mobile phones and, by using near-field communication technology combined with smart tags placed in service users' homes, record proof of attendance instantly.

'Eliminating frequent trips to head office drives up efficiency'

Care workers' mobile devices can receive care plans while they are on the road. They can tick off each task and send the completed task list straight to head office. Mobile solutions for care providers frequently result in significant efficiency savings, providing the NHS and local authorities with a vital platform for supporting an ageing population within their own homes.

Mobile technologies are the future. They are already commonplace in our personal lives with more mobile phones in the UK now than people and 52 per cent of users now having a smartphone. If the NHS is to survive against a backdrop of severe budget cuts and a growing population, mobile devices need to be embraced, and quickly.

Jim Chase is managing director of Advanced Health & Care

www.advancedcomputersoftware.com

TECHNOLOGY

MAKE A BIG MOVE

The NHS is at a tipping point in using mobile technology, particularly in the community, reports Jennifer Trueland

Saving £3,000 per clinician per year looks seductive in an era of tightening resources, coupled with demands for financial efficiencies. Add to that evidence of improved productivity, quality gains in terms of more time spent with patients, and lower hospital admissions, and it looks even better.

These are the benefits of adopting mobile technology in delivering healthcare, particularly in the community; the numbers come from a Department of Health report published last year. The National Mobile Health Worker Project aimed to provide quantifiable evidence to back up what many people felt instinctively – that a workforce armed with mobile technology made sense.

The report recognises, however, that many mobile working programmes fail to realise benefits fully, or even get past the pilot stage, often because of a lack of appropriate strategy, business leadership, or clinical engagement.

In a world where most of us rely on an increasing array of devices from smartphones to tablets to the relatively old-tech laptop in our working and personal lives, the only surprise is that the NHS has been so slow to catch up.

All this could be changing, however. The Mobile Working Knowledge Centre, hosted by the NHS Information Centre website, is now live, offering case studies and information to inform business cases and support implementation of mobile working.

In addition, the DH Mobile Health Worker Project's progress report offers quantifiable evidence of the benefits of mobile devices, based on 11 pilot sites.

And the companies providing the technologies are themselves beginning to notice a sea change. For example, Advanced Health & Care, providers of iNurse, a mobile solution for nursing and community care teams, has seen a 200 per cent growth in the number of mobile users in the last year – and expects this rise to continue.

So why has it taken the NHS so long to reach the mobile working tipping point?

According to a report from the Queen's Nursing Institute published in January 2012, there are a number of barriers hindering the move to a "smart new world".

These include the upfront costs of technology in a tight financial climate – which increase the risks of waste and blame if the technology is not used; the fact that savings often occur in the medium term rather than the short term, and they may not be realisable savings, just theoretical reduced costs which are immediately taken up elsewhere in the system; and different approaches to implementation, from "big bang" to incremental.

There is also a perception of professional resistance. The QNI reports nurses' concerns, ranging from confidentiality to fears of professional expertise being replaced by technology.

Many feel this is changing – and rapidly. Rosemary Cook, who was director of the QNI when the report *Smart New World: using technology to help patients in the home* was published in January, says that nurses recognise that technology is transforming care in the community – and that, in many cases, nurses have been at the forefront of that transformation.

She says: "I think there's a bit of momentum around mobile working at the moment, and the challenge will be to make sure it continues. Society is changing, and a new generation of nurses and patients will have grown up with technology at the centre of their lives."

The DH report lists as potential barriers connectivity issues, the need to find the right technology, and the importance of making sure staff are on board and properly trained.

Carrie Goodbourn, business development director at Advanced Health & Care, believes that national policy around healthcare generally, and information systems in particular, have not encouraged the speedy spread of mobile working – partly because

CASE STUDIES OVERLEAF ▶

Quality time: mobile technology should free up community nurses to see more patients

managers have had other things on their minds.

"We've had a lot of structural change and people have been concentrating on that," she says. "But we're coming out of the change period now and I think that managers are beginning to see that mobile solutions can help them meet challenges in terms of making savings and improving quality."

The benefits listed in the DH report are tempting. Clinicians across the 11 pilot sites estimated that the devices allowed them to save 507 referrals – 9 per cent – and to avoid 49 referrals, a saving of around 21 per cent over the pilot period.

"Using iNurse saves each nurse one to two hours a day," adds Ms Goodbourn. "If you think about it, even saving one hour a day means that for every eight nurses, you gain the equivalent of an extra member of staff.

"Think about what you could do with that time – even if you're just seeing one extra patient per day, it soon stacks up. And if you're freeing up the equivalent of one fulltime employee for eight, right across a healthcare organisation, then you can really see that you're increasing capacity. It's about improving the quality of care and enabling nurses to spend more time with patients."

'Society is changing, and a new generation of nurses and patients will have grown up with technology at the centre of their lives'

She believes the future of mobile working will involve solutions that do not have to be online. "With iNurse you can work with or without a signal," she says. "You can input information offline and it will transfer as soon as you hit an area with a signal."

Given the benefits in terms of time saved, capacity built and quality improved, what can be done nationally to drive the adoption of mobile technology?

Fiona Stephens, director of clinical quality at Medway Community Healthcare believes that simplifying the procurement process for NHS bodies would be a big step forward. Ms Stephens, who is also chief clinical information officer, says the community interest company's structure outside the NHS allows it to act more quickly (see case study, overleaf).

Alex Yeates, a GP for 25 years, was one of the founders of the pioneering Medway GP co-operative (MEDDOC), which influenced development of out-of-hours services in many parts of the UK. Now as medical director with Advanced Health & Care he is at the forefront of the mobile technology roll-out. As a Caldicott guardian it goes without saying that he believes data security is of paramount importance.

Like Ms Goodbourn, however, he also believes it is essential that devices can operate offline, so that users aren't limited by the vagaries of the signal network. Good battery life and stability are also near the top of his list, as interoperability with different computer systems.

Given that suitable technology has been around for a while, what has hindered its take-up? "Fear," he says. "Fear of change, and fear of the device itself. But from my experience even the techno-wary grow to like it very quickly. It is the future." ●

ALAMY

TECHNOLOGY: CASE STUDIES

BACK ON THE ROAD

As live patient information pings to NHS staff around the country, trusts are reaping the benefits of reduced travel time and streamlined processes

LIVERPOOL COMMUNITY HEALTH

More than half of Liverpool Community Health NHS Trust's 3,300 staff are on the road. The mobile workforce includes community nurses, physiotherapists and others treating people in their homes, and close to home, many of them around the clock.

Head of planning information and technology Caroline Rand has a vision that, when realised, will see all the mobile staff – some 1,700 of them – using mobile technology. This, she admits, is quite a challenge.

"We've done some small pilots using different technologies including iNurse, laptop with 3G and tablet technology and we are building up the business case for how we roll it out," she says. "We're looking at radical change with staged benefits. It certainly won't all happen overnight, but we believe it's the way forward for us."

One of the pilots involved trialling iNurse, the mobile application from Advanced Health & Care, in the South Sefton area (the services were run by NHS Sefton at the time), as part of a transformation of urgent care.

The aim was to cut hospital admissions by designing a streamlined urgent response community nursing team to triage and manage patients at home where possible.

Developing care pathways covering the most common reasons for urgent referrals, including heart failure, chronic obstructive pulmonary disease, urinary tract infection and falls, was a key part of the strategy.

According to Colette O'Loughlin, Out of Hospital lead with Liverpool Community Health Services, the aim was to meet the challenges of looking after a frail, elderly population. "People don't want to go into hospital if it can be avoided. We wanted to find ways of improving the quality of care, avoiding hospital admission, and treating people close to home," she says.

The team had a number of demands for the technology and managers worked with Advanced Health & Care to adapt the iNurse solution so that it met their needs.

They wanted information to be transferred from a single point of contact to the nurse on the road.

"The system allows live information to be sent to the nurse and this is a great benefit that enables the nurses to prioritise calls. The information pings straight to the device," says Ms O'Loughlin.

The solution eliminates the need for intrusive phone calls to nurses while they are in patients' homes and arms the nurse with up-to-date essential information. The nurse updates the record while she is with the patient, ensuring real-time, accurate notes and avoiding duplication.

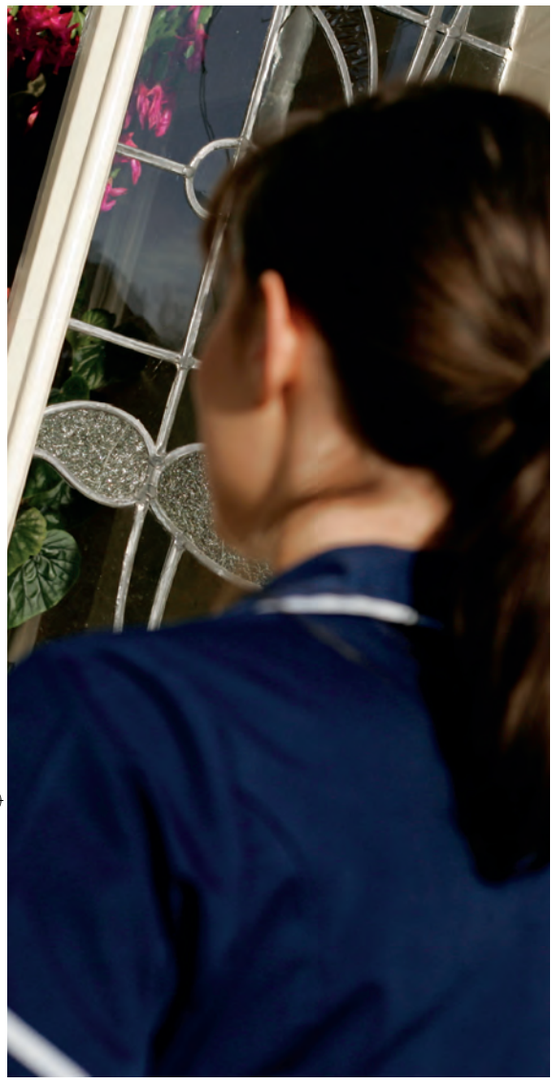
Getting nurses on board well before actual implementation was important, she says, and nursing staff were included every step of the way.

The majority of the team were excited to be using technology, though some did need convincing. As soon as they saw the benefits to patients, however, many became enthusiasts.

The main efficiency is reduced travel. Ms O'Loughlin says: "Nurses don't have to come back to base to pick up notes." This time can be used in various ways, allowing nurses to fit in extra visits, or to spend more time with patients.

The system also provides real-time productivity information – a great bonus for capacity management, says Ms O'Loughlin. "Our nurses embraced the fact that we could measure the work they did – when they saw the response times, they were pleased and proud at how quickly they could attend a patient and go straight to the next patient; one of the benefits was that they could really show how productive they were."

Ms Rand believes that mobile working is



Welcome visit: a district nurse visits a pensioner. Mobile technology is helping to cut admissions of the elderly in Liverpool

the way forward for community services in the NHS. "National policy is pushing us in that direction," she says. "We've had great support from our board, managers and from most of our staff. They have been asking for this – they're banging at our door for technology which does what they want it to do, but we've got to get the right technology, and we have to involve our staff every step of the way."

In addition to saving time and avoiding duplication, she cites other less quantifiable benefits to mobile working: community physiotherapists use laptops to show patients pictures – or even videos – of equipment or exercises.

Once everyone has a mobile device, fewer desks will be needed; bookable desk hubs would save space and money.

"We all know that the way we deliver healthcare has to change," says Ms O'Loughlin. "Mobile technology brings benefits which are fantastic for clinicians and fantastic for patients. The use of mobile technology in the community can be complex – it's not easy – but our trust's vision is to make it happen."

MEDWAY COMMUNITY HEALTHCARE CIC

At Medway Community Healthcare community interest company, mobile technology is already helping nursing teams to work smarter, saving on travelling time and duplication. According to Susan Craighill, lead nurse for unscheduled care, it's definitely the way ahead.

Medway Community Healthcare is a community interest company social enterprise that provides community services to 270,000 patients across Medway in Kent. Its 1,250 staff provide a range of services including community nursing, urgent out of hours care and physiotherapy. It was one of the early adopters of Advanced Health & Care's iNurse mobile application – and there's a lot of enthusiasm for the technology on the ground.

At the moment, iNurse is deployed by the out-of-hours nursing team, and the in-hours Advanced Clinical Assessment Team (ACAT) but there are plans to expand mobile working across all community services.

"We piloted it with the night nurse team, and it was very successful," says Mrs Craighill.

"It's a very small team – just two nurses – covering Medway from 10.30pm to 8am. The nurses aren't usually making planned visits, although they do have some regulars, but will be called out to palliative care patients, for example, who might need medication, or to someone with a blocked catheter."

A big advantage of iNurse is that, if a call comes in while the nurse is with another patient, then she is alerted by a discreet bleep, rather than an intrusive phone call. The details of the next visit are transmitted to the device, so the nurse is armed with appropriate patient information.

"The workload fluctuates overnight – it's impossible to predict how many visits will be needed – but we wanted to deploy what is a small team as effectively as possible," she says.

Ensuring nurses had accurate and timely information while out and about helped to save time, particularly with unnecessary trips back to base, as well as providing a more streamlined service for patients.

After successful deployment at night, iNurse was then introduced to Medway's innovative Advanced Clinical Assessment Team (ACAT). This group of highly experienced band 7 nurses work from 8am and 8pm Monday to Friday and 10am to 6pm at weekends and bank holidays with the aim of helping to avoid unnecessary hospital admissions. The system really saves on travel time – both in terms of reducing the numbers of journeys back to base, and in helping the nurses to organise their visits to patients efficiently, says Mrs Craighill.

'Initially there were concerns that "Big Brother" was watching them, but it really hasn't been an issue'

"We need to be able to demonstrate the amount of work that our staff do – with iNurse, everything our staff does is timed; there are no estimates," she adds.

But what about the staff – do they feel that iNurse interferes with their autonomy? Not a bit, says Mrs Craighill.

"Initially there were some concerns that 'Big Brother' was watching them, but it really hasn't been an issue. I can see that it might be a concern for some teams in other organisations – where traditionally, for example, things had been more elastic – but that wasn't an issue for our staff. I think they also appreciate that it's useful for lone worker safety."

Mrs Craighill has tips for other organisations thinking of implementing mobile working. These include:

- make sure managers see the system in action before it is implemented to encourage enthusiasm;
- get staff buy-in before you get the devices;
- training has to be good, as does support for staff who will have varying degrees of receptiveness to, and experience of, technology. "The mystique has to be taken out," she says;
- choosing the right device is important – it's tempting to choose the cheapest to keep prices down, but cheaper doesn't necessarily mean more cost-effective;
- if possible give clinicians their own device – they will "own" it, take care of it, and make sure it is charged;
- make sure you have support from the IT department; and
- to make the most of management reporting functions, think about what you want it to do before you get it, so that your needs can be built in.

Fiona Stephens, clinical quality director with Medway Community Healthcare, is also an enthusiast. "Working with Advanced Health & Care has allowed us to build a local solution which meets our needs," she says.

"We estimate that we are able to free up one to two hours per day – that's two, three or even four extra patient visits. And it's reducing paperwork as well." ●

ALAMY

JANET WILLIAMSON ON A GOOD WALK

IN ASSOCIATION WITH NHS IMPROVEMENT

NHS Improvement

Improving efficiency is the challenge facing every provider and commissioner of care in this country. How can we do more for less? Where is the waste in the system? How will we know what to do and how and have we got the time?

With over 12 years of improvement experience in redesigning clinical pathways across a range of specialties, NHS Improvement knows a thing or two about what pathways of care really look like as well as how to unravel and redesign them to see lasting quality improvements and efficiencies.

How many times have we seen leaders in healthcare juggling the efficiency challenge but without the first idea about what the whole pathway of care looks like for a patient and without any experience of the journey?

In our view, this is fundamental. If you want to change something and guarantee improved quality and efficiency you have to understand the pathway, not just from a department or a provider perspective but also from a whole system and patient perspective.

For example, this might be from the moment the GP suggests the patient needs a blood sample to the moment the patient is advised of the result. Or from a patient requiring an operation to recovering from the procedure.

Walking the pathway, going an extra mile to see what it looks like from the patient

'Walking the pathway is the starting point for all leaders'

perspective is the starting point for all leaders. You will be surprised at the opportunity for efficiencies, better ways of delivery and steps in a process that make absolutely no sense at all – yet the service keeps on doing them because they have always done them. As leaders this must be our basic core competency – getting away from the desk and becoming obsessively connected to the pathway of care.

This year NHS Improvement is in transition towards the new national NHS improvement body – of which we will be part. We will take our skills and knowledge into this new organisation as it shapes its mission to spread improvement at pace and scale. The challenge of QIPP will remain a priority for us all.

There are plenty of ideas on transformational change that have improved efficiency. Book your pathway walk today and tomorrow take a colleague. Are you obsessively connected to the pathway of care? We urge you to find out more about how we can support you to gain efficiencies and improve outcomes for your patients, carers and staff by reading this supplement and looking at our latest reports and interactive pathways on our website.

Dr Janet Williamson is national director of NHS Improvement

www.improvement.nhs.uk

SERVICE IMPROVEMENT

DO THE SMALL THINGS WELL

The DH is hoping to see major strides this year in improving recovery from surgery, reports Helen Mooney

In April this year the professional royal colleges and associations came together to sign what they and the Department of Health believe is a major step forward in the implementation of best practice care for patients undergoing surgery in the NHS.

They agreed to endorse the "enhanced recovery" model of care as "standard practice for most patients undergoing major surgery across a range of procedures and specialties".

The royal colleges of surgeons, anaesthetists and physicians and British associations representing orthopaedic, urological, cancer and coloprotology surgeons signed the consensus statement supporting the adoption of enhanced recovery as a model of care for surgical patients. Both chief nursing officer of England Jane Cummings and the Royal College of Nursing have signalled their support for enhanced recovery.

So what is enhanced recovery? According to its DH champion Professor Sir Mike Richards, national clinical director for cancer and chair of the Enhanced Recovery Partnership steering group, it is doing everything that is "sensible and logical" to help patients to return to normal as soon as possible after surgery.

"It's about doing 20 different things differently," he says. "It is a new approach particularly to surgery that necessitates doing things differently pre-operatively, during surgery and post-operatively. So, for example, it's about carbohydrate loading before surgery, fluid management during an operation, and early post operation mobilisation and encouraging people to eat and drink as soon after surgery."

In simple terms it does two things. First it improves quality of care by helping patients to get better sooner after major surgery. Second, it reduces length of stay with obvious benefits to the NHS. In doing so it fulfils the quality and productivity criteria of the quality, innovation, productivity and prevention challenge.

According to the DH guidance, "patients participate as partners in their care and have an active role in decision making and take responsibility for their own recovery, while a multidisciplinary team ensures that the patient is in the best possible condition throughout their treatment and stay in hospital".

Originally pioneered in Denmark, the approach has been championed by the UK government through the Enhanced Recovery Partnership since 2010 and indeed many trusts have implemented some of the ideas – even if it is not always known as enhanced recovery. This year, however, the DH hopes to see major strides in its implementation across a wider range of specialties.

Enhanced recovery of patients undergoing surgery is still a relatively new concept in the UK. It is an evidence-based approach involving a number of interventions which, when implemented as a group, have a greater impact on outcomes than when implemented individually.

Essentially the underlying principle is to enable patients to recover from surgery and leave hospital sooner by minimising the stress responses on the body during surgery.

The model of care means that the patient is in best possible condition for surgery by, for example, identifying co-morbidities, improving anaemia, addressing hypertension, stabilising diabetes and stratifying risk. Ideally, this is undertaken by the GP prior to referral, or, at the latest, at pre-operative assessment.

Better rehabilitation

The patient has the best possible management during and after their operation to reduce pain, gut dysfunction and immobilisation by using the appropriate anaesthetic, fluids and pain relief and minimally invasive techniques.

And finally the patient experiences the best pre- and post-operative rehabilitation in which rehabilitation services are available

CASE STUDIES OVERLEAF ▶

Cut above: tactics such as carbohydrate loading before surgery can be part of the enhanced recovery package

RECOVERY PRINCIPLES

Enhanced recovery: four working principles

- All patients should be on a pathway to enhance their recovery. This enables patients to recover from surgery, treatment, illness and leave hospital sooner by minimising the physical and psychological stress responses.
- Patient preparation ensures the patient is in the best possible condition, identifies the risk and commences rehabilitation prior to admission or as soon as possible.
- Pro-active patient management components of enhanced recovery are embedded across the entire pathway – before, during and after operation/treatment.
- Patients have an active role and take responsibility for enhancing their recovery.

seven days a week for 365 days a year, enabling early preparation, recovery and discharge from hospital, as well as a return to their normal activities sooner. The approach should also include planned nutrition and early mobilisation after surgery.

NHS Improvement cancer director Dr Ann Driver is leading the Enhanced Recovery Partnership programme. She says that the partnership is currently conducting a survey with strategic health authority leads to investigate enhanced recovery practice in trusts across the country.

"Enhanced recovery includes a whole range of components and trusts are at various stages so some have fully implemented the model and some only partially but they are going in the right direction," she says.

She explains that the model is based on four working principles (see box) and that the direction of travel means that the principles have begun to extend from elective surgery in the four original areas of colorectal, orthopaedics, urology and gynaecology, to emergency surgery and to new specialties including liver, lung, breast, and upper GI and there is growing interest in application to acute medicine.

"Enhanced recovery should be considered a complete pathway of care and standard practice. It is about changes in clinical practices to include making sure the patients are well prepared at all stages, have carbohydrate drinks, the right anaesthetics and that they are mobilised as soon as possible following surgery."

It requires team working, she adds, and NHS managers and clinicians working together are key to promoting it as an important innovation. To become embedded as standard practice its needs to be everyone's daily business.

Monty Mythen, professor of anaesthesia and critical care University College Hospital, London and national clinical lead for the programme, describes Enhanced Recovery as a "bundle of care that is about doing the little things well". "It is about paying attention to every detail – in this respect it is not dissimilar to improvement thinking. Doing the right things at the right time, with the right skills and overall the benefits can very great," he says.

He also believes that NHS managers will be crucial to its successful role out and that each trust should invest in a dedicated programme manager to manage the care pathway effectively.

"I believe that trusts need to invest in an implementation manager such as a nurse, physiotherapist or service improvement lead for at least a year to ensure enhanced recovery is actually delivered and embedded in practice. Ultimately it saves trusts money in the long term in reduced complication rates, reducing the need for unnecessary scans, in length of stay and in the reduction in the need for antibiotics." ●

IMPROVEMENT: ENDOSCOPY

'NONE OF THIS IS ROCKET SCIENCE'

Plans for bowel screening will mean a huge rise in demand for endoscopy services. Helen Mooney looks at how two trusts have ramped up their productivity

Demand for lower gastrointestinal endoscopy has never been greater and is set to double over the next five years.

The twin driving forces are both the government's age extension to the existing bowel screening programme with the forthcoming flexible sigmoidoscopy bowel screening programme for those over 55 and the expectation set out in the NHS Operating Framework for 2012-13 that fewer than 1 per cent of patients should wait longer than six weeks for diagnostic tests. It is vital for all NHS trusts' endoscopy units to make best use of existing capacity and manage capacity in line with demand.

Increasing capacity

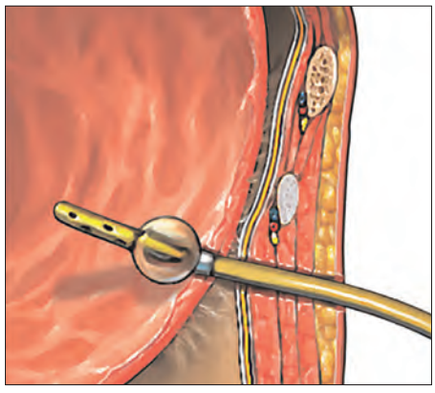
Lisa Smith, NHS Improvement's national improvement lead for endoscopy, explains that the implementation and extension of the national bowel screening programme has laid bare some capacity and process management issues and provided a prompt to offer some central support.

"We believe that at most sites a 25 per cent increase in capacity can be found," she says.

NHS Improvement recently offered support to endoscopy sites to increase their capacity through process redesign and by applying recognised service improvement methods such as 'lean' to improve productivity.

The organisation is working with 23 trusts over the next nine months in a bid to help reduce their waiting times for endoscopy tests and support increases in capacity and productivity.

"In some areas we've already got waiting times down to below four weeks," says Ms Smith. She believes that, although there is no single "one size fits all" answer, there is "very considerable scope to improve service delivery". Some suggestions are outlined in NHS Improvement's *Rapid review of endoscopy services* (February 2012)



Demand for endoscopy is set to double

ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS TRUST

Dr Sanchoy Sarkar, consultant, gastroenterologist and endoscopist at Royal Liverpool and Broadgreen University Hospitals Trust, explains how the endoscopy unit has introduced a three-session working day and is aiming to move to a seven-day working week in the autumn. The unit has already managed to cut waiting times from more than 13 weeks to less than four weeks.

"We have always had a reputation for endoscopy and are an endoscopy training centre and although our output is good we just did not have the capacity going forward to fulfil the increase in demand for our services," he explains.

"We looked at our estate and our capacity and decided that we would move from two to three sessions a day with the extra session in the evening. We also moved some work to the outpatient setting and scheduled diagnostics in the evening."

As a result waiting times have gone down drastically. The three consultant endoscopists working in the unit were all contracted to work flexibly including in the evening from the start.

However, Dr Sarkar admitted, challenges included increasing the nursing workforce, changing nursing hours and practice and asking nurse endoscopists to work flexibly, including evening working.

"It was a challenge for the nursing staff because the numbers required were not calculated properly when the lists were initially set up. We are getting round this now and we have gone from 12,000 to 15,000 tests per year."

From September the unit will also begin to work on inpatient lists at the weekend.

BARTS HEALTH TRUST – WHIPPS CROSS HOSPITAL

"The massive increase in demand for endoscopy tests that is required means that we need to make do with the same resources but act more efficiently and that is where the experience of NHS Improvement has come in," explains Dr Ed Seward, clinical lead in endoscopy at Whipps Cross Hospital, now part of Barts Health Trust.

The NHS Improvement team visited the trust's endoscopy unit and examined the buildings physical layout, patient flow and capacity and demand.

Dr Seward says they have already picked up on four areas for greater efficiency – list start times; filling the list efficiently; did not attend and patient cancellation rates; and improving the flexibility of the workforce.

He says that as a result of implementing different ways of working throughput has already increased from 150 to 200 units a week. "If there was one big answer [to improving efficiency] people would have done it years ago. The nice thing about this is that it can be done in bite-sized chunks which makes it more manageable.

"None of this is rocket science, we are obliged to keep to a [maximum] six week patient waiting time but since we started to implement NHS Improvement's proposals this has gone down to three weeks. Whether this is cause and effect is uncertain, but it is

IMPROVEMENT: SEVEN-DAY SERVICES

EVERY DAY IS LIKE MONDAY

Seven day services can deliver a jump in quality and outcomes in respiratory care. Helen Mooney on how a pioneering trust abandoned the five-day week

Patients are not ill five days a week, nine to five. They need seven-day services and evidence is now mounting in respiratory medicine that this model can deliver significant efficiencies. That's why NHS Improvement is keen to promote it.

Not only are seven-day services are popular with patients, who like having access to services at the weekend, but also they can reduce length of stay on acute medical and surgery wards by an average of two days.

In addition NHS Improvement figures show that seven-day working can help hospitals reduce temporary staffing usage saving on average £52,000 a year, staff sickness rates which can total around £45,000 per annum, and out-of-hours payments for on-call staff, again saving on average £45,000 a year.

In respiratory medicine, NHS Improvement has helped a number of trusts explore and establish seven day working. They have variously employed extra consultants, nurses and physiotherapists, or rearranged shifts and the make-up of respiratory medical teams to offer services to patients on both Saturdays and Sundays as well as during the traditional working week.

SANDWELL AND WEST BIRMINGHAM HOSPITALS TRUST

Sandwell has the third highest asthma admission rate for respiratory illness in the UK and a high prevalence of asthma in its local population. Yet until recently relatively few patients were being referred either by their GPs or from secondary care to Sandwell and West Birmingham Hospitals Trust's Community Respiratory Service.

So the community respiratory team began a project to increase asthma referrals into the service by 50 per cent by improving links with acute sites in order to receive more referrals after patients had attended

Breathe easy: many asthmatics need urgent care

A&E or been admitted to hospital, and with GP practices that had high admission rates.

The team also wanted to ensure that 80 per cent of its patients on its asthma register were managed in accordance with the British Thoracic Society/Scottish Intercollegiate Guidelines Network guidelines on managing asthma in adults, which includes diagnosis using spirometry, a self-care plan, patient education and inhaler technique check.

Kelly Redden-Rowley, a respiratory physiotherapists and the team's clinical lead, explains that the team introduced a seven-day service and now tries to action all urgent referrals within 24 hours.

"Previously we were not convinced we were giving the best care," she says. "This project has been about tightening up how we deliver asthma care for patients."

Support came from NHS Improvement in using lean methodology to improve the service, including process mapping and examining demand and capacity.

There has since been an increase of 75 per cent of referrals into the service with A&E attendances down 29 per cent and hospital admissions down 21 per cent.

Of the seven-day service Ms Redden-Rowley simply says: "Where else are patients going to go for help to manage their condition before they get ill [at the weekend] except to A&E?"

SOUTH TEES HOSPITALS FOUNDATION TRUST

South Tees Hospitals Foundation Trust has introduced a seven-day respiratory surgical physiotherapy service and a new role of physiotherapy assistant practitioner.

Both the service and practitioner role are targeted at elective surgical patients on an enhanced recovery programme in order to improve quality, patient experience, clinical outcomes, cost efficiency and length of stay.

Baseline data showed physiotherapists were more likely to encourage and motivate patients to over achieve their post-operative recovery goals compared with ward staff.

In addition, the figures also showed that length of stay increased by 2.3 days if patients received surgery on a Friday, compared with receiving surgery Monday to Thursday. The requirement for weekend physiotherapy was clear.

A further audit highlighted that one third of patients could have been assessed, treated and discharged by staff with different skills and competencies than the band 5 physiotherapists. This informed the decision to appoint a band 4 physiotherapy assistant practitioner to improve the service and speed up discharge.

Senior physiotherapist Heidi Williams says that when the service proposed introducing seven-day working the idea was initially met with caution by staff.

"However, staff soon realised that being able to give continuity of care also gives everyone a lot of job satisfaction," she says. "We were also given additional funding by the trust to do this [as part of the enhanced recovery programme] as we could not have stretched the original staff across seven days." ●

ALAMY

SIMON TURPIN ON WARM WELCOMES

IN ASSOCIATION WITH GENTIAN MANAGEMENT SERVICES AND ARAMARK

Gentian

The main entrance to an NHS hospital needs to fulfil many roles for many different user groups, from early in the morning until late at night 365 days a year. It provides a focus for activity and is the starting point for a huge number of journeys around the hospital.

A good main entrance delivers a warm and safe welcome. It helps to create a good first impression and to generate positive perceptions about the hospital, its values and the quality of the services it provides. The appearance and functionality of the main entrance can play a significant role in delivering good visitor and patient experiences.

But too often the overall utility and commercial potential of the main entrance is overlooked and the prime commercial space it offers is put to other less valuable uses. Why have a coffee machine that breaks down, needs change and dispenses a drink of questionable quality when you could have a familiar high street chain selling good coffee – and bringing you an income stream?

Our experience in over 20 NHS trusts in England and Wales shows that main entrances have the potential to provide vibrant shops, coffee bars and restaurants that are well received by visitors, patients and staff and that also generate good income for the trust.

Since opening our first retail concourse at

'The commercial potential of the entrance is often overlooked'

Addenbrooke's Hospital in Cambridge in 1997, Gentian have become the market leaders in the development of new main entrances. We have played a pivotal part in the evolution of this specialist and growing market.

Gentian have designed and financed bespoke retail, visitor and staff catering facilities at over 20 NHS hospitals in England and Wales. We work with large food service organisations, such as ARAMARK, and high street brands such as M&S Simply Food, WH Smith, Costa Coffee, Starbucks and Boots, as well as charities and League of Friends.

Our financial model does not require NHS trusts to sell us land and, at the end of our lease, everything is returned to the trust. Alternatively we can provide consultancy advice to trusts wishing to refurbish or redevelop from their own capital reserves. We understand the importance of the trust being involved throughout design and construction. We never lose sight of the fact that we are working with and in the hospital and appreciate the need to ensure products detrimental to health are never sold from any of the outlets.

Simon Turpin is a director at Gentian Management Services

gentianpartnerships.com
www.aramark.co.uk

FACILITIES MANAGEMENT

YOUR SHOP WINDOW

How can you make the most of the hospital entrance? Daloni Carlisle reports on the leasing option

Take a moment to wander around the main entrance to your hospital. Is it a light and airy space that says welcome? Is it a wind tunnel, cold in winter and hot in summer? Or is it dark and dingy, exuding an air of "abandon hope all ye who enter here"?

Simon Turpin, director of Gentian Management Services has a professional eye for these things and says there is a huge range on offer in the NHS – and that many miss a trick: this is a space that could be vastly improved at no cost to the trust and with an income attached.

"I do see a huge range of entrances," says Mr Turpin. "Some are very professional but some are simply dreadful. Sometimes there is a volunteer shop that, however well meaning, is only open for a few hours a day and sells an antiquated range."

He argues that NHS trusts should think of the main entrance as the window to the trust. "If I have not been to the hospital in a long time and the entrance is exactly as I remember it from my last visit, what does that say about how the trust has moved on? Often the entrance does not accurately reflect the ambitions of the trust or its overall ethos."

But with finances tight, can a trust really justify spending money refurbishing the entrance? Mr Turpin says there is an alternative: lease the main entrance to a company prepared to spend the capital to bring it up to standard and create an income by bringing in high street shops to rent the space.

Trusts get the space back at the end of a 30-year lease, they don't have to manage the retail units, they get regular index-linked payments while giving patients, staff and visitors access to high street brands that they know and love in a pleasant environment.

Trusts can go a step further and build in a food hall – seating areas surrounded by a range of food outlets – and do away with the staff restaurant and releasing that space for better use.

'Should trusts run staff restaurants at a subsidy? I would say no. Should they exploit the value of their estate? Yes'

"This is an area that should not be part of a trust's core business," he argues. "Is refurbishing a main entrance a good use of public money? Should trusts be running staff restaurants, often at a subsidy? I would say no. Should they be exploiting the latent value of their estate? Yes."

Gentian Management Services has done just this in 20 NHS trusts in England. They lease space, create retail units, let them to high street brands and then manage the overall service offering.

The exact payment to the trust depends on an equation involving, for example, the number of beds and staff, whether there are other shops nearby and the physical condition of the existing building. Trusts can opt for an upfront lump sum payment (and this may amount to a seven-figure sum) and a smaller annual payment or a larger annual payment, all linked to the Retail Price Index. Gentian carries the risk – if they cannot let the retail units, they still pay the trust.

Mr Turpin is clear that trusts retain a good deal of control. They can specify opening hours to fit staff and visitor needs and always have the final say on which shops go into the retail units and what they can sell. No shop in a hospital would ever be allowed to sell cigarettes or top shelf magazines, for example.

But he has some useful advice about what works – and what doesn't. His list includes high street brands such as WH Smith, Costa Coffee, Starbucks, Boots and M&S Simply Food. "Essentially, if you can't eat it, drink it or read it, then it will do well to justify its

ARAMARK

‘Do not expect the earth, there are no magic wands conjuring £5 notes from the sky’

existence within a modern main entrance,” he says.

“Trusts can proscribe certain items – for example we had one trust that wanted to stop the sale of backless slippers as they were thought to contribute to falls. But the more restrictions you put in place, the more you restrict the opportunity for shops to make a profit.”

Gentian Management Services works closely with ARAMARK, an international integrated services company that has relationships with some of the biggest high

Revenue generator: leasing hospital entrances to high street chains can raise capital for trusts

street food outlets, including Starbucks and Subway, meaning they can be brought in without protracted negotiations.

Kevin Wood, a director at ARAMARK in the UK, says: “We take responsibility for the whole service for a particular space – for the cleaning, recruiting and managing the staff, procuring the goods and selling them in a professional way.”

Some trusts can be sceptical about the “fit” between the NHS and some fast food outlets. “We provide a wide range of food services and it is this choice which contributes positively to the perception people have of a particular hospital,” says Mr Wood. “Ultimately, it is down to the customer whether or not to use them.”

Paul Aitchison, who has worked with the Department of Health PFI unit and as an NHS trust commercial director but now runs his own management consultancy, says these kinds of leasing arrangements can be very advantageous to trusts. But he warns them to limit their expectations. “Do not expect the earth, there are no magic wands conjuring £5 notes from the sky.”

More practically, he says trusts need to consider carefully the opening times. “In one trust the shops wanted to open 8am to 6pm but we needed them to stay open to 7pm so we put that in the contract.”

He also advises including the local league of friends and WRVS shops within the retail units, even if they are subsidised. “They are important fund raisers for any hospital and they need the visibility.” They can also be offered an exclusive deal to take newspapers and refreshment trolleys to the wards.

Finally, he warns trusts to take the long view. “You can end up with discussions in the board about what would happen if the service provider was making a huge profit and the payments to the trust were only rising by the RPI. Yes, you can put in a break clause to reconsider the deal after five years, but to my mind this is a risk and reward calculation. What if they are not making a profit after five years?” ●

ALAMY

FACILITIES MANAGEMENT: CASE STUDY

FOOD FOR THOUGHT

The facilities director at Broomfield Hospital in Essex has some useful tips for others looking to transform their main entrance areas

BROOMFIELD HOSPITAL, ESSEX

When Broomfield Hospital in Essex planned a new PFI wing it created an opportunity. There would be a space between the old hospital and the new £148m building that would be ideal as an entrance to the hospital and a waiting area for outpatients. But how to fund building it?

The answer was by including a retail concourse. Mid Essex Hospital Services Trust teamed up with Gentian Management Services to create a light and airy atrium equipped with high-tech screens for directing patients to the right place at their allotted time. While waiting, they can buy a coffee or shop for food or a newspaper at high street stores sited within the atrium. It opened in 2010.

Staff can pop into the M&S Simply Food or buy their lunch from a panini store on site. The trust also gets an income.

"It works really well as a space," says Carin Charlton, director of estates and facilities management at the trust. "It is where patients come into first contact with the hospital and the whole ambience is one of calm. There are recognised brand names which helps create a welcome rather than the entrance being daunting."

Ms Charlton is not willing to talk numbers but says Gentian provided the capital to create the atrium in return for a long-term lease of the space. The company is responsible for making sure the shops are let and managed well and in return had made an initial payment to the trust followed by annual index linked payments.

"The principle is that the private sector puts some funding into the whole enterprise so it is not publicly funded," she says. "The funds set aside for patient care are not diverted."

The trust also benefits from Gentian's expertise in retail. "They are the experts in the field of retail," says Ms Charlton. "They can find the right concessions to maximise the income from the space."

Calm beginning: Broomfield patients will find a new retail concourse at the main entrance

Having worked now in two hospitals with this kind of leasing arrangement – she moved to Broomfield this spring from Addenbrooke's Hospital in Cambridge – she has some thoughts to share with others now exploring the idea.

"I think it is important that organisations have a careful look at the financial modelling and ensure that they scan the horizon," she says. "These arrangements are normally 15, 20 or 30 year concessions and they are significant capital investments and it is important to think ahead."

Take, for example, healthy eating policies that have developed quickly in the last five years. At one time it might have been acceptable to have a Burger King in a hospital but it is certainly not now.

"It is important not to give the management company carte blanche," she says. "But it is important to remember that if a trust insists on having only healthy eating outlets, the appetite from customers may not be there and the partnership may not meet its financial targets."

She also urges trusts to think carefully about where the volunteer organisations fit into such arrangements. "It is very easy for organisations to start thinking only about the commercial and forget the third sector. But it is important not to underestimate the value that the third sector organisations bring to the trust in terms of fundraising and the volunteer time they bring," she says.

At Broomfield, the WRVS shop remains – although not in the atrium – and the League of Friends has exclusive rights to take tea and newspaper trolleys to the wards. ●

FACILITIES MANAGEMENT: Q&A

TALKING SHOP

Daloni Carlisle asks Gentian director Simon Turpin (pictured below) some key questions about leasing

Does the trust need to sell land?
No permanent transfer of trust-owned land is involved. Gentian operate fully funded service concessions on trust premises and typically take a lease for a term of 30 years for which we pay an initial premium and/or annual revenue.

What influence does the trust have over what is built?
When Gentian is appointed preferred partner, following an appropriate competitive tender process, the trust would form a working group with senior managers and key personnel from the company to finalise the design and a schedule of works for final costing purposes. Both our expectations need to be met and this can only be achieved through partnership.

Do Gentian only work with certain operators?
As the largest provider in this sector Gentian have good working relationships with a wide variety of operators including WRVS, WH Smith, Costa Coffee, M&S Simply Food, Spar and a range of food services companies. For example, we recently teamed up with ARAMARK, an international integrated services company that has relationships with some of the biggest high street food outlets, including Starbucks and Subway. We have a vested interest in ensuring a properly functioning market for the space we create and have always resisted forming strategic alliances with specific operators. This provides the freedom to work with the right operator on each individual project.

How can the trust be sure operators will charge competitive prices?
It essential that our tenants trade profitability and charge prices that members of the public are willing to pay. Our underleases contain provisions whereby the prices they charge are in line with those charged by commercial operators at other hospitals in the local area.

How will you go about selecting a building contractor?
It is our experience – based on numerous projects – that building in a working hospital demands a sensitive, pragmatic and highly professional approach. We only invite tenders from suitably experienced contractors who have worked on similarly complex projects. It is a competitive tender, ensuring value for money. However we think that the lowest bid should not necessarily be the winner and Gentian reserve the right to appoint the contractor who is best placed to undertake the work.

Will you look to sell the investment interest on completion?
Gentian are long term professional investors in the NHS, not short term speculators looking to turn a quick profit and exit. We retain ownership of the projects we develop, managing and maintaining the assets on behalf of our shareholders for the length of the lease.

What if the hospital entrance is not big enough for a retail development?
There are other options. In some hospitals we have added value to the staff restaurant by bringing in new food retail outlets.

Where are the efficiencies?
In addition to gaining an income, the trust has the opportunity to make better use of its existing estate. For example, by replacing the staff restaurant with a food court used by members of staff and the public, the trust can release estate. It is hard to back this up with data but, anecdotally, there is evidence that patient perception of the trust increases when the entrance is welcoming and provides the high street brands they know and love – and that staff satisfaction increases when they can do a top-up shop on site. ●

‘Anecdotally, there is evidence patient perception of the trust increases when the entrance is welcoming and provides high street brands they know and love’

ALAMY

LOUISE HAMILTON ON LEASING

IN ASSOCIATION WITH SINGERS HEALTHCARE FINANCE AND OLYMPUS

Singers Healthcare Finance

Over recent features in *HSJ* exploring the issue of leasing, there has been a consistent message: that although leasing has been around as a financing option since 1996, the way it has been utilised by the NHS has not always resulted in the best possible outcomes. Too often, it is only towards the end of the procurement process that the question of how the equipment will be funded is considered.

Here we propose a more strategic approach, with pre-tender discussions involving clinicians, finance and procurement experts from the trust, the equipment supplier and their leasing partner taking place much earlier in the procurement process.

This article discusses laparoscopic surgery, where there is widespread variation in the age and quality of equipment used across the NHS.

Laparoscopic procedures have superseded the old style "open" operations in many cases. Today, 90 per cent of all gall bladder removals and over 30 per cent of all bowel cancer operations are performed laparoscopically.

Yet currently less than half of all hospitals meet the gold standard for theatre equipment, as set out by the Association of Laparoscopic Surgeons of Great Britain and Ireland.

A July 2012 press release from the ALSGBI about their second annual audit of theatre equipment ran the headline "Financial constraints on the NHS could lead to doctors operating on patients with outdated equipment". It went on: "Laparoscopic technology is advancing rapidly. However there is a fear, borne out by the audit, that theatres are lagging behind by not being equipped with the technology to enable more efficient operating standards. With the NHS under pressure to save £20bn by 2015, the ALSGBI is concerned that necessary investment in pioneering surgical techniques and technology is in danger of being overlooked."

'Less than half of all hospitals meet the gold standard for equipment'

The response from the suppliers and funders to the fears voiced by the ALSGBI is that, when considering how to future-proof equipment, there are alternatives to diminishing capital. Leasing can help trusts procure the highest quality, best performing equipment, in order to achieve the most efficient clinical outcomes.

The stark warning relates specifically to the expensive, high-tech equipment used for carrying out laparoscopic procedures, but could apply to other high-tech equipment used throughout modern hospitals. The goal remains delivering the best patient care possible, in the most efficient and affordable way.

Louise Hamilton is head of NHS sales and marketing at Singers Healthcare Finance
www.singersaf.co.uk/healthcare-finance

FINANCE

KEY CHANGE

Keyhole surgery equipment is hugely costly. Can leasing help trusts get the latest kit? By Graham Clews

Every trust and every clinician wants the best for patients and with medicine increasingly reliant on technology that often means using the latest equipment. But with capital funding severely limited, how can trusts afford this?

The evidence is that they can't if they use traditional procurement methods – but they could if they changed their thinking and looked at alternatives such as leasing not as passive customers but as active partners.

Upgrading laparoscopic – or keyhole – surgery equipment is a good case study in how trusts can use alternatives to capital funding to replace, update and even maintain their assets and in the process release efficiencies and improve services for patients.

The apparatus needed for laparoscopic surgery is some of the most complex and expensive available, with a high obsolescence rate. Surgeons using the equipment highlight the difference that the very latest equipment can make to patient outcomes (see case studies, overleaf).

But currently, less than half of all hospitals in the UK meet the gold standard for the quality of equipment used by their laparoscopic surgeons.

The second annual audit of theatre equipment carried out by the Association of Laparoscopic Surgeons of Great Britain and Ireland this year found that only 49 per cent met the association's gold standard, with almost a quarter of hospitals surveyed having no maintenance contract for replacement or repair of broken equipment.

There was no programme of "upgrade, replacement or maintenance" in 17 per cent of hospitals and 7 per cent had neither maintenance or procurement programmes in place, the audit discovered.

The ALSGBI put the blame for this squarely on the NHS financial situation, heading their press release: "Financial constraints on the NHS could lead to doctors operating on patients with outdated equipment."

There is, says Mike Parker, immediate past president of the ALSGBI and the man who initiated the audit, a "stark contrast" between image quality of new high-definition technology and that from equipment more than five years old.

"If you go to a shop you can't even get a non-HD TV these days, so surgeons can't be expected to work without that level of quality," he says. "Most of what we, as consumers, use is computerised and most people change or upgrade their computer every two or three years, so we should be doing the same thing in surgical practice."

He accepts that NHS trusts may not have the capital that was available a few years ago, but he believes there is a solution to the need for costly high-end tools when financial times are hard: leasing. And to his mind, the possibility of trusts leasing high-spec laparoscopic theatre equipment is "very attractive".

"In my time in the NHS [he now works in private practice] I spent a lot of time persuading managers in the NHS of the benefits of leasing, but to no avail," he says. "Maybe they see it as more complicated, maybe they like to spend the money, and then it's done, I don't know."

It's likely that a combination of entrenched historical behaviour coupled with 15 years of capital flowing into the NHS has meant that if trusts wanted to buy something, they often could, and owning assets has long been the favoured position within many trusts.

In some cases, for example non-technological equipment such as standard hospital beds or simple surgical instruments that can be written down over a number of years, there would be little advantage in leasing. But for technical equipment with a high rate of obsolescence, of the sort highlighted in the ALSGBI audit, it's different.

Mr Parker argues that the high obsolescence rates for equipment used in laparoscopic surgery should drive managers

OLYMPUS

To let: trusts can now lease an entire theatre system

to consider leasing packages that can incorporate updates and upgrades, particularly if clinicians play a part in those leasing decisions.

This is where leasing companies and medical equipment providers come in, working together in new ways. An example of this is the partnership between Singers Healthcare Finance and Olympus Medical. Singers work with Olympus, as their preferred finance partner, to provide a lease offering on their equipment solutions for trusts, helping them meet the ALSGBI's gold standard.

Louise Hamilton, head of NHS sales and marketing at Singers Healthcare Finance, says getting the best solution requires a tripartite approach with supplier, NHS trust and lease funder, identifying the trust's specific challenge and then producing a solution that will enable the trust to procure that equipment without the need for vast sums of capital.

"Rather than just tendering for chunk of equipment here or there, what we really want is for trusts to talk to us with our supplier partners early on in the procurement process about the whole solution they would like to achieve. Together we can develop a bespoke equipment solution that can deliver from a clinical and technical perspective, with Singers structuring a finance offering to enable trusts to have it and pay for it over the working life of the equipment rather than needing a significant outlay of capital," she says.

'High obsolescence rates for equipment should drive managers to consider leasing packages that can incorporate updates and upgrades'

According to Ms Hamilton, where trusts miss out on accessing the bigger equipment and cost benefits available from this approach is by leasing only a chunk of what they need.

"Don't put a prescriptive tender out for a small piece of what you would like," she advises trusts. "Talk to the supplier about all of your needs and we can give you alternatives that might be achieved by committing to an affordable revenue spend each month rather than a prohibitive capital spend up front."

A maintenance service could be included in a leasing package on top of warranty, and

Singers Healthcare Finance

Ms Hamilton says a bundled finance and equipment lease would mean trusts could then enjoy one, known, fixed payment, which can be hedged against inflation for the term of the lease.

Upgrades could also be built into the package. Olympus generally bring out a new model of camera used in laparoscopic surgery every four to five years, and they acknowledge that, while every surgeon would love to have the newest equipment as soon as it is available, that is probably not realistic.

Alison Westney, senior product manager for imaging and gynaecology at Olympus says a close relationship between supplier and the trust can identify when upgrades are available and required and the lease can then be amended to incorporate the upgrade.

"There is no limit really to what trusts could lease," she says. "People tend to think in little silos of leasing, they think they could lease the camera or the scopes, but when you think of an integrated theatre there's no reason why they can't lease the whole system."

It's not just laparoscopic surgery to which this scenario applies. A House of Commons public accounts committee report last year suggested that around half of all NHS CT scanners, MRI and linear accelerators needed replacing.

The National Audit Office's report, *Managing high value capital equipment in the NHS in England*, put the bill to replace this outdated equipment at £460m over three years, and a further £330m within six years.

Ms Hamilton says: "The joint approach that we as a funder take with our manufacturer and supplier partners can be applied across many clinical and technical modalities, from endoscopy to oncology, sterilisation to anaesthesia, infusion services to cardiology and beyond."

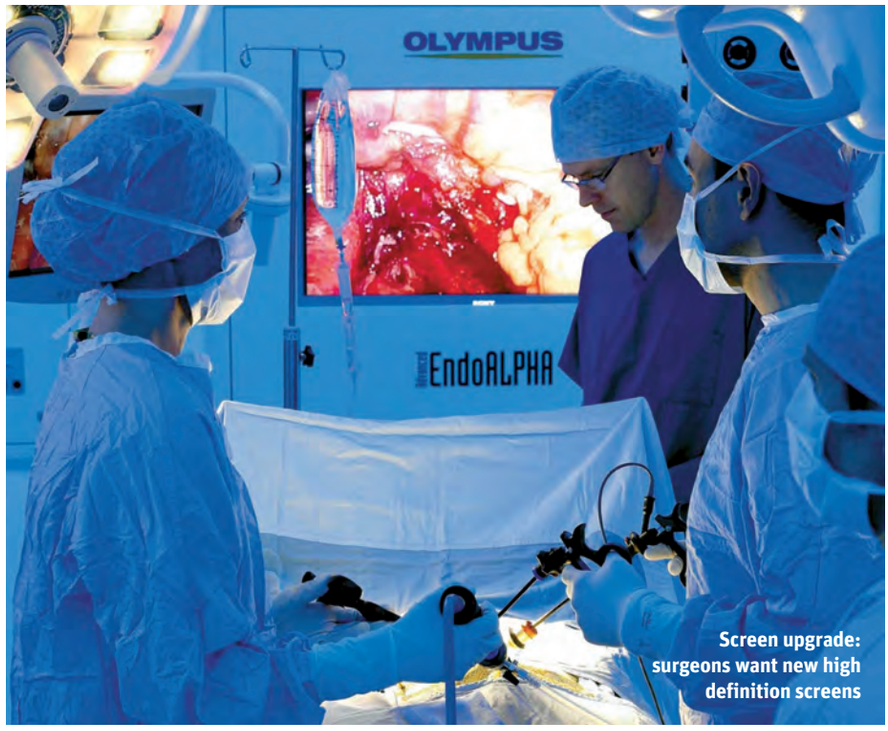
Julian Rose head of asset finance and data policy at trade body the Finance and Leasing Association, says leasing is a logical way to provide expensive cutting edge technology to the NHS.

He argues that NHS finance directors have assumed that the private sector is not going to beat public sector funds in financial terms.

"We say 'do the sums and if it's cheaper then do it, if not then don't'," he says. "Members are telling us that a lot of trusts are taking a fresh look at leasing and how the numbers come out."

In its response to the Department of Health's call for evidence in its ongoing review of NHS procurement, the FLA argues that commissioning changes mean trusts are likely to need more flexibility to upgrade or replace equipment after just a few years.

This collaborative approach finds echoes in current DH thinking. In his letter calling for evidence for the DH's procurement review, chief executive of NHS South of England, Sir Ian Carruthers, who is heading the review, says more innovative procurement processes are needed within the NHS.



Screen upgrade: surgeons want new high definition screens

'People think they could lease the camera or the scopes but there's no reason why they can't lease the whole system'

"By harnessing relationships with suppliers, the NHS can adopt existing innovations, and stimulate new innovation to deliver quality and value for both NHS patients and taxpayers," he writes.

"It is vital we have a procurement function that is responsive to creative ideas from suppliers and we support their adoption and diffusion at scale and pace across the service."

And the need to improve partnerships between NHS trusts and between trusts and providers is one of four categories included in the DH procurement guidance *NHS procurement: raising our game*, which was published earlier this year.

It says that engagement with other trusts should be "proactively pursued to maximise value for money for the trust"; that trusts should "optimise the benefits of working with procurement partners"; and that "key suppliers are considered partners and relationships are suitably managed".

Ms Hamilton says: "Cost savings flow from economies of scale and committing to the supplier. It is about developing a partnership and a relationship rather than just buying boxes from someone.

"The difference in behaviour we are trying to introduce is to have the conversation about what trusts would really like. NHS people often don't talk about the service they would really like to deliver, but instead talk about what they can afford.

"We can go in and look at equipment they have, look at budgets, look at what they are spending on maintaining older equipment, because that will come from revenue budget and that same money could be used to pay lease rentals on new equipment."

Ms Hamilton argues that there is an imperative at least to explore alternatives models of finance and to do the sums. "The idea that trusts are sitting there with the kind of shortfall of equipment and technology that's been identified by the ALSGBI survey when there are means out there – and leasing is one of those means – to have it is a crying shame," he says.

"Everyone knows that, whatever way the government tries to wrap it up, real time funding to the NHS is decreasing and the pressures on the efficiency savings targets are growing. We don't want to see the advances in NHS equipment that have been made disappear because of the financial situation, because there are alternative methods of procuring it out there other than just buying through capital." ●

OLYMPUS

FINANCE: CASE STUDIES

CUTTING EDGE

Surgeons at two pioneering trusts explain how using the latest technology improves outcomes. Graham Clews reports

MAIDSTONE AND TUNBRIDGE WELLS TRUST

Professor Amir Nisar is a general, laparoscopic, oesophagogastric and bariatric surgeon at Maidstone and Tunbridge Wells Trust in Kent. His operations can be long and complex, among the most complex in general surgery, he says, taking anything from six to 10 hours for one procedure.

Having worked for more than 15 years as an educator in laparoscopic surgery, which involved practising across a number of different sites, the variation in quality of equipment and the efficiencies it could produce became apparent.

So, along with other surgeons, theatre staff, and trust management, Professor Nisar looked for suppliers who could transform the existing laparoscopic theatre capability.

A decision was taken to work with Olympus, which has developed a fully integrated theatre system that includes boom-mounted viewing screens, a central touch-screen control panel, and a sophisticated software system that can retain surgical footage for future use and live-stream it to other venues for teaching purposes.

The early involvement of clinicians in planning the acquisition of Olympus's Endoalpha OR Theatre, was key, Professor Nisar says, to ensuring patient outcomes were the best they could possibly be.

The results of using the cutting edge theatre have been, Professor Nisar says: shorter operation times; quicker set up; fewer complications; less bleeding; fewer conversions to open operations; less strain and fatigue on surgeons and theatre staff; and faster recovery times.

'This kind of technology is sometimes seen as a luxury but it is a necessity'

Figures from his surgery bear this out. Conversion to open operations has fallen from around 1 per cent to 0.5 per cent; operations that were taking up to nine hours now take about five hours; camera cleaning has gone from 35 to 40 times in a five-hour operation to 10 to 15.

"This kind of technology is sometimes seen as luxury, not necessity, but it is a necessity," says Professor Nisar. "If you do not have the best possible visibility then it is not feasible to carry out the operation."

Leasing such a complex installation could be possible if trusts work with suppliers and lessors to look for solutions and, although the Kent theatre is not leased, Professor Nisar estimates the cost per patient of the integrated theatre at between £10 and £15.

"But if sub-optimal vision costs £8 per patient and optimal vision will cost £12, then surely you will always pay £12," he says. "There is only one focus, to take the patient through the episode as safely as possible. There can be no compromise and no second best."

ST MARK'S HOSPITAL, NORTH WEST LONDON HOSPITALS TRUST

Robin Kennedy, consultant surgeon at St Mark's Hospital in north west London, says that it is vital that the introduction of substantial new equipment is "clinician-led and management-facilitated". "Enlightened hospitals will see that it benefits patient care," he says. "Obviously you can't have every new toy, but it does make a significant difference to clinical outcomes."

In laparoscopic surgery, there was a huge leap in quality between standard and high definition images, he says, but things have moved on significantly since then and he says: "Every two to four years there is a development that could make a significant difference."

He and other theatre staff were involved from the start in building an integrated theatre at St Mark's. He interviewed three manufacturers and a decision was made after three interviews and feedback sessions to use Olympus's integrated theatre.

He accepts that many hospitals don't get that latitude, but he presents his surgical statistics as an example of what can be achieved with cutting edge technology.

Mr Kennedy began colorectal surgery in 1994 and between then and 1998 around a third of his cases were done laparoscopically. Now he attempts 97 per cent of his cases laparoscopically with between 5 and 10 per cent converting to standard surgery.

The result? A "massive improvement in recovery" with post-operative length of stay roughly half what it was. ●

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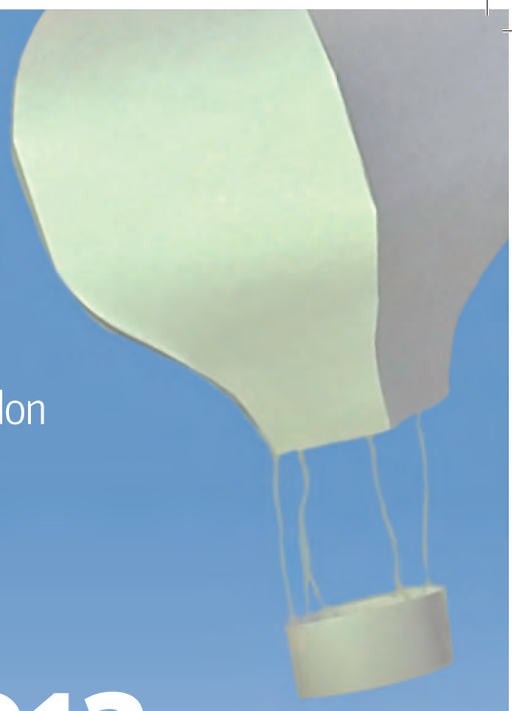

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