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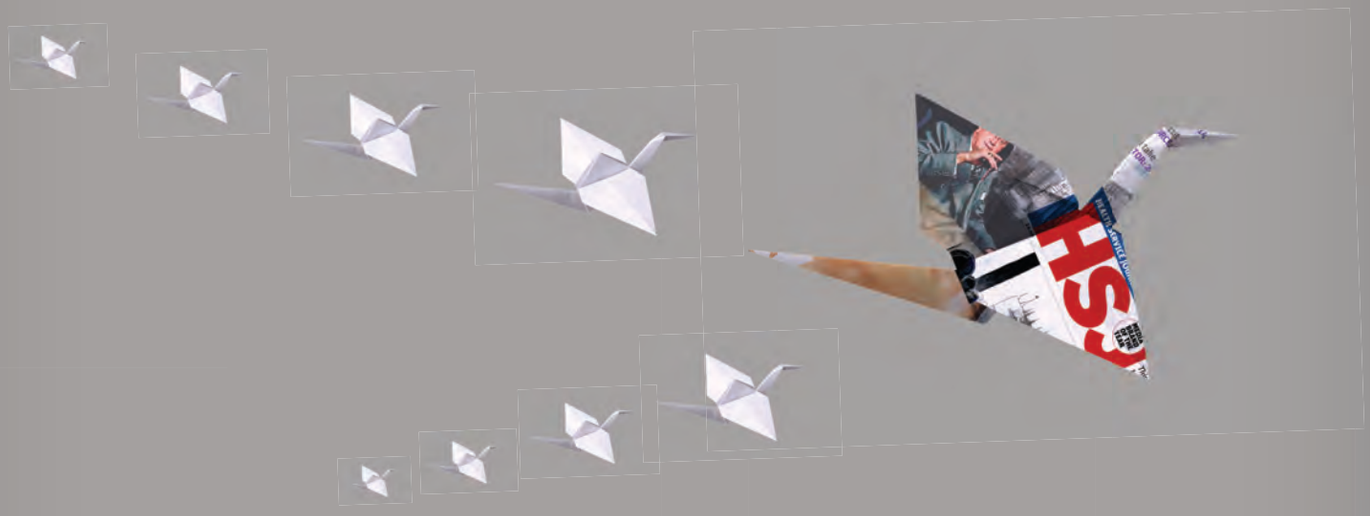
PLANNING FOR YOUR FUTURE NEEDS



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EVE GREGORY ON THE PRINCIPLES OF SUCCESS

Planning your estate in the medium and long term is not easy in the current climate. Uncertainty over renewal of services contracts in the brave new world of commissioning and any qualified provider, the lack of central capital funding and, in most places, a sluggish property market limiting the once significant capital returns for surplus property, all make planning for growth and improvement a significant challenge.

However, the basic principles are still sound:

- **Plan to succeed: Plan your estate strategy to meet the needs of your clinical services strategy, and input into your clinical services strategy to ensure it can be achieved. The two are mutually interdependent and can't stand alone.**
- **Maximising capital return: When considering premises to release as surplus, make sure you consider whether they will give you the best capital receipt versus any spend you might need to make to house the relocated services (if any). For those inheriting community estate assets, these come with a clawback arrangement in the event the premises become surplus, but there is nothing to stop you locating other services in former community premises and releasing your own assets (that have no clawback) for disposal.**
- **Think outside the box: Commercial lenders are gradually becoming alive to the fact that foundation trusts are no longer constrained by protected asset principles, have greater autonomy to enter into arrangements and have clearer insolvency regimes – all of which makes it easier to understand and lend to you.**
- **Working with others: Shared services are flavour of the month, but even if shared estates services are not something you are able to consider, sharing facilities with other NHS bodies or even other public sector bodies will be – and can help you to reduce your costs and overall premises liabilities.**
- **Function over form: Don't be tempted into thinking that one solution fits all needs. Just because a competing trust has entered into a joint venture in respect of their estate, doesn't mean it's right for you. Remember, form follows function: the legal structure of a solution should be shaped to meet your needs and these will not necessarily be the same as your neighbours'.**
- **Don't feel you have to come up with all the answers on your own: To devise a robust and informed estate strategy you will almost certainly need input from others, both in terms of your local property market and likely interest in your estate or services, and in terms of how you might structure any framework for the implementation of your strategy.**

'Don't be tempted into thinking that one solution fits all needs'

Eve Gregory leads the health estates team at DAC Beachcroft
www.dacbeachcroft.com

PLANNING

PLAN FOR TOMORROW

A clear clinical strategy is the first step in planning to make the most effective use of a trust's NHS estates

NHS organisations are facing big questions about what to do with their estates going forward. While some have sparkling new hospitals funded by private finance initiatives, others will have a collection of buildings that are perhaps outdated and in need of refurbishment or that don't match the pattern of services the trust is planning to deliver. Still others are in the process of taking on additional buildings as they start to provide community services.

Estates directors face challenges as well as opportunities in this process. Along with other board members, they must make strategic decisions about how to manage and develop their estate to match clinical needs while ensuring costs are kept down and any potential windfall from disposing of surplus property is maximised.

Eve Gregory, who leads on health estates for law firm DAC Beachcroft, suggests the starting point has to be those services an NHS organisation sees itself providing in going forward. Only when the clinical strategy is clear can the estates team start planning. "Often we meet with an estates team who are keen on taking steps forward but they are fettered because the clinical strategy has not been fully developed," she says. In many cases this will mean trusts will need to talk to their commissioners – or, increasingly, clinical commissioning groups – about their longer term intentions.

A vital part of this discussion is likely to be around the drive towards services being provided in the community rather than in a district general hospital. While the future extent of this shift is far from clear, it does raise the possibility of hospitals being left with significant unused space – for example, as a result of providing fewer outpatients appointments or reduced length of inpatient stays. While some will have in mind alternative uses for this space, it may not be easy to dispose of if it is no longer needed.

But these appointments and other services, such as diagnostics, will have to be provided somewhere. And that could mean hospital trusts need to think about operating them from new locations if they hope to remain as providers. Many surgeries will struggle to accommodate additional services, at least in the short term. Community hospitals may be better placed, but may not have capacity.

Trusts that have taken on community services face additional issues, as they take on the buildings used to deliver these services from next April. Many trusts will be going through the process of accepting properties from primary care trusts and sorting out the documentation around their use. PCT property that does not transfer to other provider organisations will revert to the new NHS Property Services company, which is expected to move to a more commercial approach to letting, potentially charging higher rents to help fund itself.

Taking on community services premises may be a mixed blessing – the buildings effectively only come with the contract for the services, which means that in around 18 months they could have to be handed back if the contract is not renewed. The trust's freedom to do what it wants with them will be restricted – if they are sold off then the secretary of state can retain half of the profits, for example.

Ms Gregory points out this will be a dilemma for trusts, especially if they acquire premises that need significant refurbishment – do they invest in improving these buildings if there is a risk they will lose the contract?

"Do you need to think more strategically about whether you use it to invest in those services? Maybe putting additional services in there?" she says. This could release other buildings owned by the trust, which could be sold off and all the proceeds used to improve services or the existing estate.

"Even if you have not got community estates coming through, for acute trusts there is still a drive to get people out of hospital and treated in the community," she says. This shift will pose questions: will they

CASE STUDIES OVERLEAF ▶

A vital area to the future of estates management is the drive towards providing services in the community

ALAMY

'Trusts that have taken on community services face additional issues, as they take on the buildings used to deliver them'

need all the space they currently have in their main hospitals? Will they need to acquire a more widely spread estate to enable them to deliver care closer to home for patients?

In extreme cases, trusts could find they don't need all of the buildings on their current sites. But disposing of them can be challenging. And for many trusts that have identified that services need to remain on site, but whose present estate does not support the provision of high quality services in the future, there is the issue of how to fund new builds or major refurbishments. How are acute and mental health trusts going to be able to improve their estate against the backdrop of ever decreasing funds for capital investments?

Where trusts are with regard to their thinking is very varied. "Some trusts are beginning to see it as a big strategic issue," says Ms Gregory. One option that some are beginning to consider is a joint venture which brings in a private sector partner. This model has been used by some local authorities that have a regeneration scheme requiring significant capital investment and upfront costs. Often the local authority would contribute not only the land for the redevelopment site, but also other parcels of land that could be sold or used as security to help fund the scheme.

"This has started to be thought about for the NHS estate," says Ms Gregory. "Organisations should ask themselves whether they have surplus land or other estates or services of value to put into a pot."

But, she cautions, not every trust is going to be in that position and this may be only one possible solution. "I think there will be a range of different answers depending on the nature of the trust, the size of the funding gap and the key priorities and values of each trust... It will be very much what is the solution for your trust?

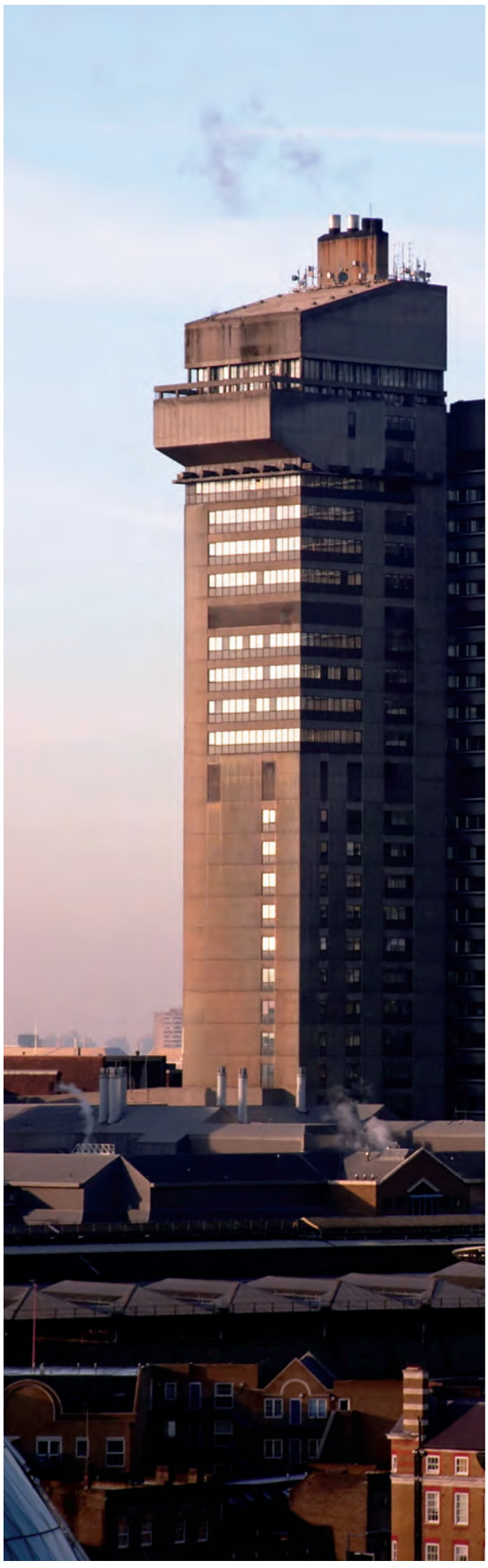
"While you will know most about your estate and your own clinical strategy, as with most strategic projects, it is important to take the benefit of professional advice from both a surveying practice that has expertise in large estate strategy planning and the local planning background and market conditions, and from legal advisers who can advise on the right way to structure the framework or projects forming part of the strategy."

The key, she says, is using advisers with specialist health estates experience to ensure trusts receive advice aligned to their own strategy that helps them achieve their objectives in the most advantageous way. ●

CASE STUDIES

TO EACH THEIR OWN

The need for estate plans to suit individual requirements is exemplified by two trusts that have taken separate approaches and have both achieved excellent results



LANCASHIRE CARE TRUST

Lancashire Care Trust is a mental health and community services trust covering the entire county. Like many countywide trusts, it operates from hundreds of different sites, not all of which are well suited to the healthcare needs of the 21st century. Some of these date back to Victorian times and others from the 1960s and 1970s. While the most modern of these facilities are generally fit for purpose, the older ones simply aren't.

A few years ago, the primary care trusts covering the county carried out a review of the buildings used for mental health services and their ability to be used to deliver a modern service. Even with adaptations, many would not be able to deliver the therapeutic and clinical care the trust wanted to provide. With inpatients treated at 15 sites, clinical staff were spending a lot of time travelling rather than seeing patients, says Alistair Rose, project director for the trust's capital programme. Clearly, this was a poor use of their time.

The trust adopted a service driven approach, looked at what its ideal model of care would be and what the estate to deliver it would look like. It identified four main conurbations that would require an inpatient unit. Investment in these units would cost £150m over a period of a decade. But the question was how best to fund this. "One of the options was not to do it all ourselves but to do it in some form of partnership," says Mr Rose.

The trust already had a range of arrangements for its existing estate – a private finance initiative, leasehold and sites it owned outright. The aim was to take the best elements of each of these types of tenure and create a model of what an ideal approach would look like.

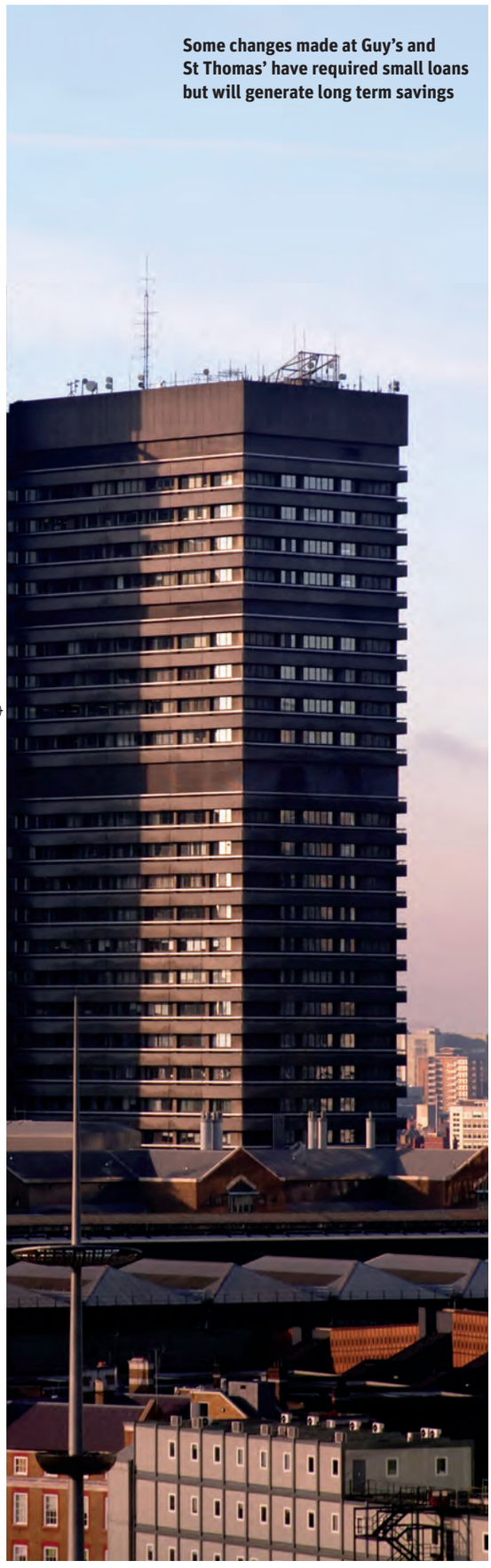
The trust advertised in the Official Journal of the European Union and entered into competitive dialogue with a number of potential partners. Eventually it formed a joint venture – Red Rose Corporate Services – with Ryhurst, a property services and development company.

The partnership has not been just about developing new units, however; it is much more holistic than that. "It looks at all the things that we would want to do as an organisation," says Mr Rose. That has included various aspects of hard and soft facilities management. "It is a wider joint venture than just building new buildings. It provides us with additional capacity and to move faster." Nor is it exclusive. The trust can choose what it does when it wants to build – it could do it alone if it could secure the funding, or it could use the joint venture with Ryhurst. As a foundation trust, it has access to a number of different funding sources. This, Mr Rose suggests, keeps everyone on their toes: the joint venture partner can't take the trust's business for granted and, in this, it is different from other funding arrangements, such as the Local Improvement Finance Trust, where organisations are tied in.

"It keeps the pencils sharp," he says. "It incentivises the joint venture partner. If we are not in the controlling seat, we are at least in the equal stakeholder seat, which you certainly are not with LIFT or PFI."

The joint venture development company owns and provides the full services and managed accommodation that the trust then occupies. "What it gives us is control over exactly what we want. The expertise that our partner provides is around property development," says Mr Rose.

But the trust is unlikely to have done so much in the same time scale without the joint venture. Mr Rose suggests building work would have had to be sequential rather than simultaneous, which would have meant the trust could not have delivered service improvements so quickly or had the same opportunity to rationalise its estate.



Some changes made at Guy's and St Thomas' have required small loans but will generate long term savings

'It was a plan to do the right thing for the organisation and its patients, but also to put right some longstanding infrastructure issues'

The building programme is ongoing at the moment and will reduce the trust's footprint as well as its costs. It reflects the move towards more "agile" working for corporate functions. Staff may not need an office all the time.

Already, the trust has seen savings in its corporate headquarters caused by redevelopment and changes to the way it is used. The trust has target savings of £4m on its facilities management costs by 2015 and this is on target. A review of hard and soft facilities management has led to renegotiated contracts, for example.

Work on one of the four big units will start next year, another is at the point of finalising designs, and a third and fourth are at feasibility and site selection stages. "It is making sure it is service driven rather than building driven."

Mr Rose says funding has to be "horses for courses". Joint ventures may not work for every organisation, but they are certainly worth considering.

GUY'S AND ST THOMAS' HOSPITALS

It's hard to imagine a bigger redevelopment programme than the one embarked on at Guy's and St Thomas' Foundation Trust, which has a budget of £450m over five years. But this level of investment is part of a careful plan that has involved looking at the trust's estate and its emerging clinical needs – with the interests of patients at the heart of the strategy.

Steve McGuire, director of capital, estates and facilities at the trust, says the process started around six years ago with a wholesale look at the estate. This showed the trust could improve efficiency; it could retain the same buildings environment and use it to provide more services, or it could shrink its estate and do the same.

"We started to think about how we would use the assets better," he says. An estates strategy was drawn up, which was presented and accepted by the board. It could see this investment in the trust's infrastructure would pay dividends in the future by improving efficiency and patient care.

The trust identified two sites it could sell off – and this happened at the top of the property market, netting a significant sum. It also identified some significant and very expensive maintenance that needed to be carried out, including repairs on the concrete hospital tower at Guy's Hospital – the highest in the world – which had started to shed bits of its cladding.

Others initiatives centred on redesigning services and providing the estates infrastructure to support this. At St Thomas', outpatients have been centralised and new technology used to speed up the patient journey through the system. Appointment letters are scanned as patients arrive, giving consultants up to date information on who is waiting to be seen and enabling them to choose who to call in.

"We have ended up with a building that is smaller than we had before, but we can see more patients," says Mr McGuire.

Completing this work has enabled the trust to start work on redesigning the accident and emergency department in the hospital, which will allow improvements to the emergency care pathway.

Investment in combined heat and power plants to serve both hospitals has cost £10m but is expected to be recouped in savings within five years – with the added bonus of reducing the hospitals' overall carbon emissions. The trust has funded the work through surpluses and a small loan; the upgraded facilities are expected to generate more surpluses, however, which in turn can fund more work.

Patient involvement in the project has been key. Even the children's hospital at St Thomas' was informed by the views of patients. They wanted to see curved corridors and pull-down beds so parents could easily stay overnight: these were incorporated into the design. Cancer patients have helped design the chemotherapy suite.

Few trusts have taken this sort of long term strategic approach to their estates. Having this overarching strategy has proved its worth. Mr McGuire says the trust would not have achieved so much without it.

Despite the trouble in the wider economy and the funding constrains in the NHS, everything the trust committed itself to in 2006 is being delivered. "We would not have been in that position if we had not had a five year plan," he adds. "It was a plan to do the right thing for the organisation and its patients, but also to put right some longstanding infrastructure issues that needed to be addressed."

And he urges the NHS to be brave on investment decisions. "The NHS is full of portable buildings and phase ones," he says. Part of this is articulating the wider benefits and measuring them once changes have been made – a key part of the approach taken by Guy's and St Thomas'. ●

ALAMY

RICHARD ASHCROFT ON MEETING THE ESTATES CHALLENGE

IN ASSOCIATION WITH FULCRUM

In the midst of major reorganisation, how can the NHS deal with the estates challenges it faces? It must transfer services out of the acute sector, yet the quality of the primary and community health estate remains varied. Addressing this challenge will be a key enabler to transforming the financially constrained NHS.

There are many new high quality Local Improvement Finance Trust (LIFT) and third party developer primary care facilities, but much of the rest of the estate is poor. There is still spare capacity in some newer primary care buildings and it is vital that utilisation is optimised. This should be the priority so services can transfer into the community, allowing a reduction in acute capacity.

The LIFT programme is over 10 years old and has delivered over 300 primary and community healthcare facilities. Fulcrum is the private sector partner in four LIFT projects and has developed 34 new primary care buildings with a value of over £250m. The 50-plus LIFT companies have been established on a public private partnership model in which the public sector owns 40 per cent of the equity and shares in the returns produced.

The LIFT sector is fully aware of the financial challenge facing the NHS and delivery of the quality, innovation, productivity and prevention challenge. At Fulcrum, there are three main elements of our support for our NHS partners.

We have reduced construction and rental costs of new buildings for the NHS over the past seven years by driving better value from our supply chain. We are also now helping our public sector partners optimise use of new buildings and rationalise their estate. Our team is delivering strategies, utilisation reviews, environmental and sustainability support and helping to optimise value from the disposal of unneeded buildings. We have developed a model to help our NHS partners get better value and use from their facilities.

'We developed a model to help get better value and use from facilities'

The true value of our partnership model will only be realised when the parties work in close collaboration to share their objectives and jointly develop innovative solutions, improving patient care through increased efficiency. One of LIFT's key benefits is it has already been procured and deemed good value; the public sector can use it to provide support without needing further costly and lengthy procurement processes.

Finally, we are supporting interagency working to help the NHS deliver more integrated models of care. Optimal NHS solutions can only be provided when they are truly integrated with acute care, social care and other key stakeholders. Our new buildings will support this through excellent design, creative project structuring, financing, and flexible lease and tenure arrangements.

Richard Ashcroft is chief executive of Fulcrum Group
www.fulcrumgroup.co.uk

PARTNERSHIPS

A LONG TERM PERSPECTIVE

LIFT partnerships provide expertise that allows trusts to make the most out of new builds and existing factilities

Many areas have seen extensive investment in primary and community care buildings over the past decade, often through the Local Improvement Finance Trust (LIFT) programme. As new schemes become harder to fund, it is increasingly important for buildings to reflect commissioning intentions and for trusts to get the most out what they have, or can afford to build.

This could mean some areas will have to look at rationalising their estate, adopting a system wide approach to which buildings will be essential in the future and which could be disposed of at some point. Many NHS organisations will struggle to find the skills and capacity internally to approach this sort of work.

Fulcrum, which has partnered with many NHS organisations in LIFT programmes, has developed a suite of products and interventions to help review primary and community estates, identifying opportunities to realise capital savings and reduce ongoing costs. This can contribute towards quality, innovation, productivity and prevention savings.

"Historically, there has always been a misalignment between estates and commissioners. We have been working to bring these functions closer together and talk intelligently to both sides," says Adrian Wallace, Fulcrum's head of strategic asset management. "Estates are a key enabler in delivering all of these system changes that are needed going forward and leads to improved quality, cost reductions and increased efficiency."

But, as a starting point, organisations need to understand what property they have, under what sort of tenure and how it is used. This baseline should allow them to identify spare capacity and also see how future commissioning intentions, and the effects of a changing population, can be accommodated.

Fulcrum suggests organisations think about their physical estate as being core (sites they envisage using for the next 25 years or more), intermediate (5–10 years) or short term (no longer than five years). Fulcrum's estates planning process can then drive a range of decisions from refurbishment to length of facilities management contracts.

South West London Health Partnerships, a LIFT company of which Fulcrum is the private sector partner, carried out a review of the estate implications of the cluster's commissioning strategy. Ian Brown, who leads on strategic asset management for NHS South West London, says: "They were particularly able to bring skills from the interface between commissioning and health planning to the debate. These technical skills are not readily available and the use of the partnering services meant that the cluster primary care trusts did not have to spend any significant time on tendering as the rates under partnering services have been previously agreed."

But organisations may also need to "sweat their assets" and look at how much of their space is used and for how long. When this approach was applied in NHS Halton and St Helens, it identified the potential for a 32 per cent increase in utilisation and a 16 per cent reduction in the operational cost of estates as a whole. It highlighted the opportunity to reduce the size of the estate by 47 per cent while releasing £5m in capital receipts.

In NHS Merseyside, LIFT programmes have led to a core of very high standard buildings, but work is under way to ensure they are fully utilised while others are disposed of.

"If you build a £5m facility there is no point in having it 50 per cent occupied," says John Garrett, head of estates at NHS Merseyside. Disposing of buildings in need of repair can also reduce the amount of backlog maintenance needed and enable any funds to be spent on other sites that are better suited to clinical use.

PCTs can also seek savings on running costs. Mr Wallace says PCT owned buildings

LIFT programmes undertaken in Merseyside have resulted in buildings of a very high standard

ALAMY

often have their own cleaning, gas and electricity contracts with little attempt to bundle these together to get better prices. This fragmentation can mean organisations are paying over the odds for services.

By working across two PCTs, Renova, a LIFT company of which Fulcrum is a partner, was able to cut energy costs by 20 per cent across the non-LIFT buildings by using this collective buying power. A similar bundling approach can be used for cleaning services and security. Savings could also be made on waste management contracts.

"There is a role for a LIFT company to work closely with the commissioning support units going forward so all of these issues can be addressed," says Mr Wallace. "We want to be the estates partner of choice for our local health economies. We have a long term strategic partnership in place through the LIFT companies so we are keen to work with our partners to help them deliver their objectives of improving healthcare."

Looking forward, flexibility in use will be important. Buildings offering space that can be easily adapted for several uses could help to accommodate the anticipated shift of healthcare into the community.

'As resources become even tighter we are going to have to think about how we use these assets even harder'

The LIFT programme in Merseyside has created flexibility. "The buildings are designed in such a way that allows them to change. It is future proofing – whatever comes along we can use our facilities," says Mr Garrett. "It allows us to start to move things out of the acute setting."

Ian Davies, director of strategy and programme coordination at NHS Knowsley, says simple changes can facilitate flexible use, such as making certain there is a pipe running through an administrative room in case it needs to be adapted for clinical use.

Changing work habits has also opened up opportunities. "We have a lot more mobile and flexible working. We can take some of the administrative space out of buildings," he says. This has enabled space to be made for additional dental services."

Greater use of IT could also reduce demand for office space, suggests Mr Wallace, but will require a cultural change and for staff and managers to move away from territorial behaviour.

The LIFT company has embraced the QIPP ethos, says Mr Davies, and has helped the PCTs review and change the use of buildings. "It has brought its overall estate management expertise. As resources become even tighter and as we look to provide more services out of hospital we are going to have to think about how we use these assets even harder."

As the NHS seeks even more savings, the role of companies like Fulcrum is changing. Mr Garrett says: "They have become much more than just the people who built us a new building; they have become the people who help us manage and develop the estate to move forward." ●

STEPHEN OUTHWAITE
AN ENVIRONMENT FOR RECOVERY

IN ASSOCIATION WITH ST ANDREW'S HEALTHCARE

St Andrew's HEALTHCARE

There is no doubt our surroundings affect our overall sense of wellbeing. When someone is physically or mentally ill – or perhaps both – the contribution the environment can make to the speed and quality of recovery is significant. For employees, the working environment can also make a big difference to the time and commitment they can dedicate to their role.

At St Andrew's Healthcare we provide national specialist secure care and regional centres for people with mental illness, learning disabilities, brain injuries and neurodegenerative conditions such as Huntington's disease. We employ almost 4,000 people across four sites.

Throughout almost 175 years as a charity, we have always believed that excellent care in the right environment speeds up recovery, thereby enabling people to move on to more independent living much more quickly. That is not only a great benefit for them but it also benefits wider society because it reduces the costs of care, now and in the future.

We have successfully combined both old and the new buildings within our integrated care philosophy. We have an outstanding Palladian-style building on our Northampton site, built with remarkable foresight by the original founders in 1838, which is still accommodating around 200 patients. This is complemented by our newest hospital, William Wake House, which mirrors the

'We have combined old and new buildings within our care philosophy'

style of the original while leading edge design and construction provide facilities that former health secretary Andrew Lansley described as "state of the art". We also take the outside space very seriously. In Northampton, our facilities are set in 135 acres of parkland, which includes woodland and sports pitches; all of our facilities are designed to make sure our living spaces include access to outside areas.

By managing our diverse 2 million sq ft of estate inhouse we are meeting the needs of our service users and taking a sustainable long term view of our whole asset. This also ensures our expenditure is contributing directly to the quality of the care we provide, rather than funding administrative overheads. Because we are a charity we also take a long term view of our investments in facilities – both old and new. In this way we can continue to do what we have always done: improving the quality of life for people who are very ill.

In an environment where investment in healthcare – and especially mental healthcare – is under continual pressure, we are still in a position to plan major new investment in specialist facilities.

Stephen Outhwaite is director of estates and facilities at St Andrew's Healthcare
www.stah.org

MENTAL HEALTH

INTEGRATED APPROACH

Providing high quality mental health services has many implications for estates staff unique to this sector

Mental healthcare is always likely to be a balance between providing an environment that promotes recovery and wellbeing and keeping the service user – and sometimes others – safe. Finding that balance is a challenge for all providers, whether NHS or independent, in a cash strapped system where commissioners may be reluctant to pay over the odds for treatment, and funds for development may be hard to come by. At the same time, however, the standards of accommodation expected of mental health inpatient units has continued to rise.

Low secure facilities are an integral part of a recovery pathway for service users on their way to more independent living. "What we mean by 'low secure' is a good question. It's often said that it is somewhere where you lock people up and then give them lots of leave," says Tim Exworthy, clinical director of services for men at St Andrew's Healthcare.

This emphasises the dual function of such units – providing a therapeutic unit that is secure while also promoting the reintegration of the service user back into the community. This is done through the regulated use of leave from the unit prior to the next step of their moving to live in a supported hostel.

Low secure standards have been developed by the Royal College of Psychiatrists. They cover the clinical aspects of care but also have significant impacts on estates – and will mean many existing units will struggle to meet these standards.

The college's standards include ensuite rooms that are "homely, light and bright" and allow for "appropriate personalisation", despite the fact that the requirement for single ensuite rooms was not included in the Department of Health's own draft standards, issued for consultation earlier this year.

Security is addressed through external fencing and the internal design, although for many mental health units the emphasis on avoiding fixtures that can be used as weapons or ligatures will be familiar, as will the unrestricted lines of sight the standards emphasise.

Units should have de-escalation and seclusion facilities, meeting the same standards as those set when the provision of ensuite rooms was specified. Overall, the units should take into account how design and the environment affect both the therapeutic environment and safety.

Dr Exworthy says such units are not just about the physical environment but also encompass relational and procedural security. Relational security is about knowledge of service users, the environment and group dynamics, while procedural security involves the processes and policies a unit follows. "Security is a composite between the three aspects and, to an extent, each complements the other two."

"It is hard to know how you can have lower physical security and still deter someone from trying to leave. Does that mean the relational security is proportionately more important in low secure units? I think it does."

In such units the physical constraints and external control on the service user are being replaced by the unit's own internal controls, which will enable service users to ultimately live outside the unit with no physical barriers. Building up to this requires both a less restrictive environment and the opportunity for the service user to experience the outside world.

Dr Exworthy believes commissioners will take the new low secure standards seriously and will look to commission services from organisations that can offer compliance.

'It is hard to know how you can have lower physical security and still deter someone from trying to leave'

CASE STUDY OVERLEAF ▶

ALAMY

Nationally, the picture is likely to be fairly mixed. Many NHS trusts have new builds or recent refurbishments that could be compliant but others are using older buildings that probably won't be.

Helen Killaspy, chair of the faculty of rehabilitation and social psychiatry at the Royal College of Psychiatrists, says: "It's completely different to 20 years ago when people just had a sleeping area in a ward. There is much more attention to privacy and dignity."

Standards can be higher in low secure units than those to which service users are moved as part of the rehabilitation pathway, she adds.

Paddy Cooney, interim director of the Mental Health Network for the NHS Confederation, says trusts will be at different points in their refurbishment cycles, but that single rooms and ensuites are becoming more common.

Dr Exworthy also points out that, over time, standards tend to be increased – as has happened with the current medium secure standards.

"I think there will be tremendous pressure on hospitals to meet these standards, whether they are enforced or not," he says. "It is relevant to the wider agenda about dignity and care, which the Department of Health has promoted in recent years. Just because these patients have lost their right to liberty does not mean they lose other rights, such as a right to dignity.

"It helps them to retain a degree of autonomy over their lives. Providing a more than adequate level of accommodation is a positive message, which contributes to the way these patients value themselves. Often their self esteem is very low and that can be reflected in their behaviour. It aids recovery."

"Units that address some of the environmental issues don't have to rely on the other aspects of security so heavily," he adds. "And while a less than ideal environment can be compensated for in other ways, this can affect both the quantity and quality of the time staff have with patients."

A better environment could also help with staffing, he suggests. It will be more pleasant to work in – overcrowded units can lead to conflict, for example. Better environments might help attract staff to work in what can be a demanding setting.

So what do state of the art modern mental health facilities feel like? Stephen Outhwaite, director of estates and facilities at St Andrew's, says: "Our aim is to provide a secure hotel type service rather than a hospital. My objective is to raise the standards bar higher so we become the private provider of choice."

While the aim of the charity's four sites is to help service users recover – which in many cases means moving along a pathway through secure environments to ultimately living independently – there will be some for whom their stay in hospital is likely to be long term.

At its Northampton site, St Andrew's has a chapel and has hosted weddings for service users and christenings for their children. But hosting long term service users, who would be disturbed at a sudden change of scene, does have its challenges. Commissioners sometimes want to stop funding and move them to a different setting; in some cases, the charity's trustees have stepped in to continue funding for people who would otherwise be uprooted.

And some aspects of care, which might be relatively insignificant for patients in an acute hospital for a matter of days, take on a new importance. With many patients spending more than a year in its care, St Andrew's has looked very carefully at the food it provides. It has been highlighted by the Soil Association for the quality of food and its catering service has won a number of national awards.

Chief executive officer Professor Philip Sugarman said: "We know that food plays an important role in the lives of the people who use our services and it makes a real difference to them if they can look forward to meals that they enjoy.

"We also have a unique approach to assessing people's dietary needs when they come to one of our facilities and to reviewing their nutrition over time so that we can make sure that the food they receive meets their needs."

A significant challenge is providing optimal services within the constraints of the main listed building on the Northampton site. Mr Outhwaite says that getting listed building consent for changes is a long process and operating from a historic building can sometimes inhibit what the trust wants to do.

This is certainly the case with the low secure standards, where making accommodation in the main building compliant looks impossible because of the requirement for ensuite bathrooms. Instead the charity is planning new builds in the 135 acres of ground on its main site as part of a £50m redevelopment.

A new phase of development would provide accommodation built to medium secure standards. "It gives us absolute flexibility for the site," says Mr Outhwaite.

The new low secure standards do not differ significantly from medium secure standards, other than in areas such as the height of perimeter fences. This will mean the upper floor of the historic main building might no longer be used for service user accommodation. Alternative uses, such as academic accommodation and some treatment zones could be considered.

Providing high quality mental health services has many implications for estates staff. Mr Outhwaite says: "It is very different from the provision of a other types of estates service." Contact with service users to understand their experience is important – he sits on a service user group, for example.

One of the initiatives at St Andrew's has been keeping all auxiliary services inhouse. By not outsourcing services such as cleaning and catering, it has retained control over who is employed, which helps to keep continuity. Mr Outhwaite suggests this is particularly important for service users who may become distressed by frequent changes of staff.

But, from the charity's perspective, it also avoids being subject to VAT from its supplier, which it would be unable to reclaim. It also means St Andrew's can offer a more holistic approach to what constitutes recovery, offering work experience in estates functions for some service users, for example, which an outside contractor would be unlikely to do.

"As an estates department we are totally integrated with operations; the clinical side and the estates and facilities side report together," he says. This fosters joint approaches to working and a recognition that all staff – whether clinical or support functions – are working together to help service users.

Looking forward, Mr Outhwaite thinks mental health services will see more standards coming in, for example, around medium secure adolescent units where there are currently no recognised standards, despite the special needs of the service users. "I spend more time in my adolescent unit trying to work out what the future is than anywhere else on site," he says.

'Food plays an important role and it makes a real difference to service users if they can look forward to meals they enjoy'

St Andrew's is the largest charitable mental healthcare provider in the UK, with around 1,000 inpatient beds. However, in spite of this, Mr Outhwaite suggests the issues it faces with estates will be similar to those of NHS colleagues. St Andrew's is fortunate, he suggests, in having an all-freehold estate, which means the charity is in a better position to plan for the unexpected. However, it faces the same cost pressures.

"We have a really good relationship with some of our NHS colleagues. We do brainstorm and swap ideas."

And for Professor Sugarman the aim is clear: "It's our ambition to provide mental healthcare facilities and services that are second to none, both regionally and nationally." ●

The refurbishment of St Andrew's care facility in Essex has improved therapeutic areas for staff and service users

ST ANDREW'S, ESSEX

The emphasis on the right environment to provide care and support service users is obvious in the refurbishment work carried out at St Andrew's facility in Essex. The 18 month project costs £5m and will enhance the unit's low secure provision for both men and women. Mark Morris, clinical director for the hospital, says much of the work has been around creating a brighter and newer environment for service users. People are more likely to respond well in a nice environment and will engage better than in the traditional psychiatric hospital, he suggests.

"In general we want open settings," he says. "Part of the dilemma is that, on the one hand, it should feel homely and personal but, on the other, we have to keep in mind the security requirements and the need for visibility to see from one end of the ward to another.

"In some buildings there can be an oppressive emphasis on observation and control and it fosters a 'them and us' attitude. Here it is more about the ambience, there is a feel factor to it.

"Part of it is around comfortable chairs and seating, and things like carpeting, so it does not feel too institutional."

One of the focuses of the refurbishment was around art work with much thought going into choosing artwork that was both safe and inspiring.

But the refurbishment has also had to look at how staff work. "There are capacity issues – we want to use as much space as possible for patients but space is also needed for professionals," he says. "Whereas you can get professional silos, we have moved to across the board hot desking. As far as possible, we get people to do their computer work on the wards so they are visible and accessible. There is a lot of work space on the wards.

"You don't have to come and find me – I'm sitting there. We become part of the everyday discussion."

The critique of old style treatment was that clinicians often came into the ward and left, and were therefore quite detached and difficult to contact for both other staff and patients. By being that much more visible, clinicians have started to break down some of these boundaries.

As well as providing good homely accommodation to aid recovery, however, service users also need to start the process of moving back into a community outside the hospital. This can be a difficult step. Reintegration can start with very normal activities such as using a local gym or preparing food in the kitchen.

"It is around focusing on a sense of optimism and enabling people to see we are on the same side as them, trying to achieve the same ends – for people to move on and out," Mr Morris says. ●

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- Dr Sanjeev Nayak, University Hospital of North Staffordshire Trust
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- Professor Siobhan Quenby, University Hospitals Coventry & Warwickshire Trust
- Professor Jason Gardosi, West Midlands Perinatal Institute

Commissioning Organisation of the Year
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- NHS Blackpool Clinical Commissioning Group
- NHS Nene Clinical Commissioning Group
- NHS Nottingham City Clinical Commissioning Group
- Warrington Clinical Commissioning Group

Enhancing Care with Data and Information Management
- Barts Health Trust
- Birmingham Prostate Clinic
- East Midlands Ambulance Service Trust, National Ambulance Clinical Quality and Research Groups and University of Lincoln
- NHS London
- NHS North West London
- North of England Cardiovascular Network
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- Bradford Teaching Hospitals Foundation Trust
- Derbyshire Community Health Services Trust
- Liverpool Primary Care Trust and Liverpool Clinical Commissioning Group
- Northumberland, Tyne and Wear Foundation Trust
- Sandwell and West Birmingham Hospitals Trust
- Sussex Community Trust
- Yorkshire Ambulance Service Trust

Improved Partnerships between Health and Local Government
- The Ayr Clinic (Partnerships in Care) & Scottish Government
- Christchurch Locality Commissioning Group
- NHS Blackpool
- Norfolk Community Health & Care Trust
- South Essex Partnership University Foundation Trust
- The Gateshead Housing Company and Gateshead Primary Care Mental Health Team
- The Healthy Urban Team, Bristol
- The Merton, Kingston and Sutton Multi Systemic Therapy Team
- Torbay and Southern Devon Health and Care Trust

Improving Care with Technology
- Cornwall Partnership Foundation Trust
- EMIS
- NHS Bolton and d2 Digital by Design
- NHS Midlands and East
- NHS South of England
- Nottingham University Hospitals Trust
- Oxford University Hospitals Trust
- Saxmundham Health
- University of Stirling, Dementia Services Development Centre

Innovation in Mental Health
- Avon and Wiltshire Mental Health Partnership Trust
- Birmingham and Solihull Mental Health Foundation Trust
- Cornwall Partnership Foundation Trust
- Hertfordshire Partnership Foundation Trust
- Kent and Medway NHS & Social Care Partnership Trust
- Pennine Care Foundation Trust
- South London and Maudsley Foundation Trust
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- Ashford and St. Peter's Hospitals Foundation Trust
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- Isle of Wight Trust
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- NHS Nene Clinical Commissioning Group
- Tameside & Glossop Shadow Clinical Commissioning Group
- Royal Borough of Kensington and Chelsea
- SEQOL
- Southern Health Foundation Trust and Portsmouth Hospitals Trust

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- Stockport Foundation Trust
- The Ipswich Hospital Trust
- The Royal Wolverhampton Hospitals Trust
- University Hospital Southampton Foundation Trust
- West Midlands Perinatal Institute

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- Birmingham Community Healthcare Trust
- GP Care
- Imperial College Healthcare Trust
- NHS Blackpool
- NHS Nene Clinical Commissioning Group
- North Bristol Trust
- Partners4Health and West Cheshire Clinical Commissioning Group

Progressive Research Culture
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- NHS Bradford and Airedale
- Nottingham CityCare Partnership
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- Sussex Partnership Foundation Trust
- University Hospital Southampton Foundation Trust
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- Birmingham Community Healthcare Trust
- Derbyshire Community Health Services Trust
- Liverpool Heart and Chest Hospital Foundation Trust
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- Tees, Esk and Wear Valleys Foundation Trust
- Torbay and Southern Devon Health and Care Trust

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- Fulham Road Collaborative
- Isle of Wight Trust
- NHS Blood and Transplant
- NHS Erewash Clinical Commissioning Group
- NHS South Essex
- Oxford University Hospitals Trust
- South East Coast Ambulance Service Foundation Trust
- South Tees Hospitals Foundation Trust

Secondary Care Service Redesign
- Great Western Hospitals Foundation Trust
- Hertfordshire Partnership Foundation Trust
- NHS Greater Manchester
- NHS South West London
- Oxford University Hospitals NHS Trust
- University Hospital Southampton Foundation Trust
- The James Cook University Hospital
- University Hospital of North Staffordshire Trust

Staff Engagement
- Birmingham Women's Foundation Trust
- Blackpool Teaching Hospitals Foundation Trust
- Bolton Foundation Trust
- Hull and East Yorkshire Hospitals Trust
- NHS Merseyside, Development of the Merseyside Commissioning Support Service
- NHS Merseyside, Leading our people through transition
- NHS Nottingham City Clinical Commissioning Group
- Sandwell and West Birmingham Hospitals Trust
- The Walton Centre Foundation Trust
- West Hertfordshire Hospitals Trust

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- 5 Boroughs Partnership Foundation Trust
- Advanced Training Practices Pilot
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PETER SELLARS ON A CORNERSTONE OF NHS STRATEGY

Far reaching change is taking place in health. Since we last published a supplement in *HSJ*, the NHS has been tasked with delivering significant cost savings, productivity improvements, innovation and, above all, high quality healthcare outcomes. Since then ProCure21+ has demonstrated its leading role in supporting NHS clients to achieve these requirements.

The quality, innovation, productivity and prevention (QIPP) initiative is now integral to NHS strategy. There is a recognition that effective estates strategy can help NHS clients meet the challenging QIPP agenda and we are now seeing our principal supply chain partners being appointed to develop estates strategies with NHS clients that optimise care quality and efficiency over the long term.

Principal supply chain partners and their supply chains can have far reaching positive effects for the NHS including not only an enhanced patient experience, but also increased productivity, reduced operational costs, reduced infection rates, diminished maintenance and cleaning costs, improved team working and the promotion of best practice among clinical professionals.

The Government Construction Strategy calls for all public sector clients to drive through cost efficiencies. We are responding by developing initiatives that will help deliver significant cost savings for our NHS clients, but it must be a collaborative effort. The Department of Health is creating an environment where principal supply chain partners and NHS clients can work together to ensure the development and implementation of these cost saving initiatives are seen through, and the benefits they bring can be measured.

We know the NHS is one of the construction industry's largest clients and we are working to encourage it to use its influence to identify best practice, increase standardisation and lower costs for all. We have a royalty free licence under the framework for the NHS to share any information, including standard designs. There are significant savings to be made here – not everyone needs a "bespoke landmark building" and therefore we have an opportunity to spend public money in a way that will produce more benefit for our patients. The principal supply chain partners agree with this and have signed up at the highest level to deliver it. However, the NHS must take advantage, understand where efficiencies can be made and drive them through their capital schemes.

In this new era of improved quality set against a climate of cost consciousness, the ProCure21+ framework is proving itself as a cornerstone of estates strategies, helping trusts to deliver improved standards of patient care and a high standard of clinical outcomes – all within a tightly managed framework geared to giving best value for money.

Peter Sellars is head of profession, NHS estates and facilities policy division at the Department of Health

www.procure21plus.nhs.uk

IN ASSOCIATION WITH PROCURE21+

INFRASTRUCTURE

THE SMARTER WAY TO BUILD

The ProCure21+ framework can help the NHS to engage in faster, more efficient and cheaper building schemes

Getting the most out of capital investment has never been more important in the NHS. This squeeze on capital is combined with a government-wide push to reduce the costs of public sector building schemes.

The Government Construction Strategy seeks to reduce the cost of construction by up to 20 per cent by the end of this parliament. That won't be easy, but health must play its part. And for trusts planning new buildings in a tight economic climate, cost savings and better value for money will be among the core requirements of the Treasury and the Cabinet Office.

The ProCure21+ framework and procurement process is a vital tool available to trusts that are looking to invest in NHS capital schemes, such as building new infrastructure or undertaking refurbishments. It enables trusts to avoid going through the time consuming Official Journal of the European Union tendering process by selecting from six pretendered principal supply chain partners.

ProCure21+ has built on the experience of the previous framework, ProCure21, which ran for seven years and was used to develop 560 NHS buildings. But as finances tighten, its unique position will provide some solutions for NHS organisations looking to trim costs and contribute to the reduction targets.

ProCure21+ has identified three main areas where savings could be realised. The first is around cost targeting and benchmarking. "We are challenging our principal supply chain partners to reduce costs. We want three per cent savings on every single scheme," says Ray Stephenson, ProCure21+ programme manager. The ProCure21+ supply chains are putting in place a method to record their cost savings. But trusts will also need to play a part in that: they must engage with the supply chain they select under ProCure21+ around how to reduce costs and be clear about requirements for cost savings. That could involve cutting out some of the frills found in some schemes or reducing specifications slightly but, in return, getting a building that is more efficient to run in the long term.

Standardisation and bulk buying could also offer a way to reduce costs. The principal supply chain partners have identified areas where they can bulk buy specific components that are common to all construction projects, reducing costs for the NHS organisations involved. This is a novel approach for many in the NHS and can challenge some of the objectives set for their construction process.

"Potentially there are significant gains to be made by specifying single components and designs," says Mr Stephenson. "We have information from our supply chain that says using a standardised design for multiple schemes could cut costs by up to 24 per cent for each scheme. Few in the NHS are likely to realise this, and many trusts go through the unnecessary process of designing their scheme from scratch when their clinical needs may be little different from other hospitals that have already paid for a similar design."

'Potentially, there are significant gains to be made by specifying single components and designs'

Understanding the impact of such decisions and where extra costs lie is key to driving down costs without compromising quality or functionality. "We are starting to make the effects of these decisions much clearer than we have before," says Mr Stephenson. "Specification of schemes is a local decision, but the costs need to be clearer and the principal supply chain partners can help with this."

ProCure21+ is setting up a database of design information that could help

CASE STUDIES OVERLEAF ▶

organisations collaborate and take advantage of the royalty free licences that exist under the framework. This allows clients to share design and specification information at no cost.

And this is where senior managers can get involved. While many board members won't be involved in the detailed design of new builds or refurbishments, they do have a role to oversee and challenge work. This means they are well placed to ask the questions about what is being done within the trust to drive down costs and look at using standardised designs.

One way costs could become more transparent is through increasingly using specialist software that can dig deep inside a proposed building and show the effects of various choices. Building information modelling can provide information on additional costs associated with particular components, such as installation requirements, health and safety, maintenance and lifecycle. ProCure21+ is using this on all schemes and many component manufacturers now offer discounts for its use, as it enables them to coordinate production and supply of components more effectively.

Ultimately, trusts should be looking at getting more for their money through being both a better client and driving the construction industry to provide better value. "ProCure21+ is in a unique position to help create an environment in which better value can be secured," says Mr Stephenson.

Money spent on estates needs to deliver improvements in patient care and outcomes, as part of representing good value for the taxpayer. But he adds there is often little attention paid to measuring the outcomes of this investment – what is achieved as a result of it?

"These sorts of questions are becoming more important and the only way to address them is head on – and that's exactly what ProCure21+ is trying to do." ●

HOW PROCURE21+ WORKS

ProCure21+ is a procurement framework for designing and delivering capital schemes for the NHS in England. It has six principal supply chain partners, selected in compliance with European tendering law, with which organisations can work without having to go through the usual tendering process – cutting six to nine months off the time it takes to get a project under way.

NHS organisations and their supply chains develop schemes based on standard principles, processes and contracts, which have been proven to deliver quality schemes on time and within budget. Behind the principal supply chain partners are supply chains of hundreds of small and medium sized enterprises that can offer advice, design and construction services. Since the original ProCure21 framework was set up in 2003, 93 per cent of schemes have been delivered on time and 95 per cent on budget.

One surprising consequence is that the NHS will end up spending less on lawyers' fees. Traditional procurement methods often mean the two parties end up in court arguing who pays for cost overruns: the fees associated with this are significant. ProCure21 and ProCure21+ have delivered 580 projects, worth £3bn and so far none have resulted in a court case.

FOTOLIA

CASE STUDIES

TRUSTED TO DELIVER

ProCure21 has been successfully implemented to transform two hospital emergency departments into modern facilities with minimal disruption to patients

UNIVERSITY HOSPITAL LEWISHAM

Few construction projects are more difficult than building a new accident and emergency department amid the hustle and bustle of a hospital. But Lewisham Healthcare Trust has managed to work with its construction partner to deliver a department capable of handling the 130,000 people who seek its services each year.

And by using the ProCure21 framework the trust and its principal supply chain partner, Kier Health, have managed to keep the scheme on track despite difficult weather and the inherent problems of doing work in a busy hospital.

The old department had served its time. Trust project manager Guy Pocock says: "Having been designed originally in the 1950s to handle an annual throughput of 70,000 patients, it was latterly handling around 130,000. To add to that, it was situated in two locations on either side of a main road with complicated access arrangements, and it was not cost effective or energy efficient to run."

The redevelopment would give the hospital a new adults' and childrens' A&E department and an urgent care centre, and bring some diagnostic imaging facilities into the emergency department rather than leaving them on a different floor. Providing quality care in this environment would be easier and the confidentiality, privacy and dignity of patients would be improved.

Staff who would work in the new department were able to contribute to the design ideas. One of the aims was to create a more relaxed and calming atmosphere that would deter aggression.

"The new building brings everyone to a central reception desk, where they are assessed and streamed to the urgent care centre or the emergency department," says estates and facilities director Keith Howard.

"That means faster treatment for everyone and less risk of minor cases delaying major ones."

The new design also offered the possibility of different working arrangements. Nurse practitioners could be used for minor cases, freeing up senior doctors, and all staff would enjoy a calmer atmosphere.

To generate these positives, however, the trust had to accept a period of disruption while the work was carried out. And the joint working with Kier Health, engendered by the ProCure21 approach, was crucial in keeping this disruption to a minimum.

The trust and Kier spent considerable effort planning how the construction period would be handled. One obvious issue was that services would have to be decanted – but each decant would add to the cost and would also be unsettling for staff. The trust, working with Kier, decided to create a temporary emergency department in the ground floor of one building, to make the process easier.

With construction material sharing the emergency access to the site, timing became important for deliveries. Deliveries were staggered so only one was happening at any time, a compound to store materials was created and the clinical team worked with the construction team to ensure deliveries could go ahead and clinical services maintained throughout.

The trust had got certainty over its maximum cost through the ProCure21 process – something that was important in enabling the project to get off the ground – but found it did need to make some adjustments as construction progressed. The most extensive of these was developing a two storey modular building with integrated link corridors.

"The principal supply chain partner and ourselves worked together to get maximum value from the budget," says Mr Howard.

'The joint working with Kier Health, engendered by the ProCure21 approach, was crucial in keeping disruption to a minimum'

Some work also had to be rescheduled when extreme weather affected progress on the roofing. Heavy frosts made it too dangerous for work to be continued but by reprogramming work at a later date, the contractors managed to keep to the overall schedule. The scheme was completed in April.

Mr Howard is a fan of the ProCure21 approach. "As a result of the pre-qualification, procuring contractors is more efficient and that gives reassurance," he says.

"It also means that you work together to plan the scheme and thereby deliver the best outcome for all stakeholders while progressing the scheme smoothly. Using ProCure21 allows for greater engagement far earlier in the project."

Work on University Hospital Lewisham meant diagnostics could be carried out in its new accident and emergency department

BASILDON UNIVERSITY HOSPITAL

Working through ProCure21 has enabled Basildon University Hospital to keep the cost of its new emergency department down, while also delivering it on time and with minimal disruption to normal working.

Its accident and emergency department had remained largely unchanged since being built in the 1970s. Facilities were cramped, of poor quality and did not meet the trust's aspirations to enhance patients' privacy and dignity.

Basildon University Hospital needed a modern A&E unit to cater for increased patient numbers

"We needed to make significant changes, because not only has clinical practice moved on since the original build, but also patient numbers have increased," says Jenny Galpin, former director of estates and facilities for Basildon and Thurrock University Hospitals Foundation Trust.

It needed a new department that would not only be larger and have better facilities, but would also offer additional areas to meet modern clinical needs. These included a dedicated children's A&E, a fracture clinic, a "majors" clinic and a resuscitation suite. It would also need office space and a major incident room to enable coordination if the trust had to take multiple casualties. Some of this space was designed for more than one purpose to keep costs down. The major incident room doubles as a training facility for staff and can be subdivided to make two smaller rooms suitable for seminars.

Balfour Beatty was appointed, under the ProCure21 framework, as the principal supply chain partner for the £11m project. The level of work to be carried out was always going to present a challenge within a hospital environment where it was essential to continue providing high quality care for patients throughout the building works.

'There was careful control of cost, starting with the guaranteed maximum price'

The three year construction phase was broken down into 18 phases. An area was temporarily vacated and then used to house different parts of the service as the phased work continued. This helped control costs.

Services had to be kept running even as two large cranes were manoeuvred onto the site and during work on the electrical system. Careful scheduling kept disruptive work to quieter times for the department. Yet, at the same time, the construction work had to be kept progressing to ensure the project was delivered on schedule and within budget. Work was halted on just one occasion – due to patient needs rather than construction issues.

A wealth of tiny details were incorporated to ensure the new building would deliver better value for the trust and support improved clinical outcomes and efficiency. Natural light inside was maximised with the use of 445 roof lights. The internal design supports the passage of patients through the department within four hours, meeting the A&E standard. Careful planning avoided additional costs through unnecessary out of hours working.

The phased work also enabled learning from early parts of the project to be incorporated into later work. Teams from the trust and principal supply chain partner met fortnightly to ensure the project remained on schedule, and the three year programme was eventually finished slightly earlier than planned.

"ProCure21 encouraged us to work very closely with the principal supply chain partner, to highlight and deal with issues before they became problems, and work together to find creative solutions in an open and collaborative way," says Ms Galpin. "There was also careful control of cost, starting with the guaranteed maximum price."

She expects many of the benefits of this way of working to continue. Working so closely with an experienced partner has helped drive cost efficiencies in the construction and should have a longer term effect over the whole working life of the unit.

"The principal supply chain partner had an enormous amount of experience and had seen many schemes to succesful conclusion – and they brought all that to bear on working with us to provide expertise, experience and engagement," she says. ●

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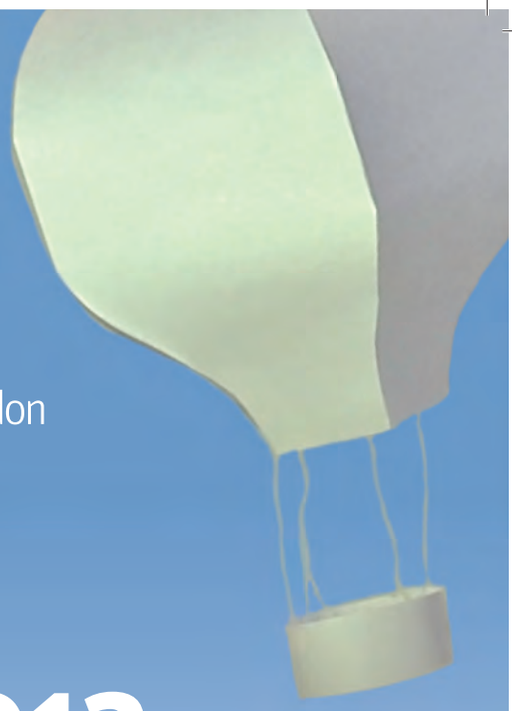

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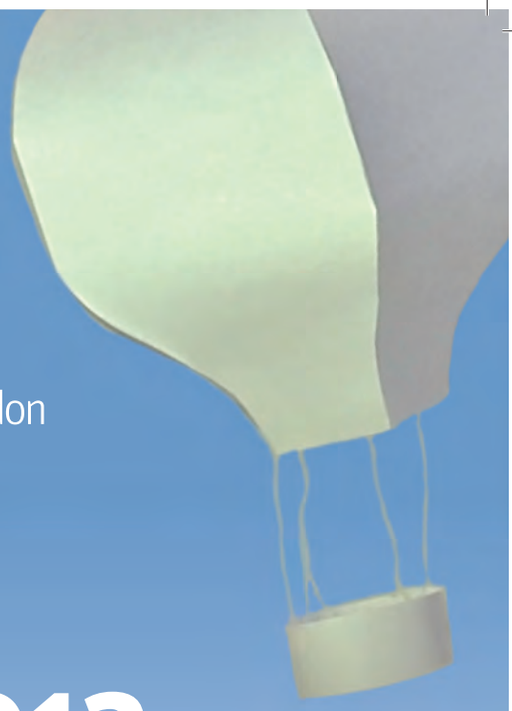

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Greg Quinn, Health Policy Manager, Boehringer Ingelheim

Source: 1. Footfall at HSJ Awards 2011

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