HEALTH SERVICE JOURNAL hsj.co.uk

HSJ EFFICIENCY

AN HSJ SUPPLEMENT/29 SEPTEMBER 2011

OUT IN FORCE

MAKING THE NHS MACHINE RUN MORE SMOOTHLY

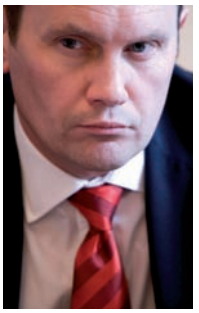
CONTENTS

INSIDE

Supplement editor
Daloni Carlisle
Sub editor
Amit Srivastava
Commercial director
Marie Rogers

ROUNDTABLE

The panel on procurement was unanimous that the NHS can make better use of its buying power to cut costs and improve care – but was also keenly aware of the challenges, such as the need to slash the number of buying organisations and bring procurement out of the back office to the top of managers' agenda. Page 2



OUTSOURCING

Most trusts have already outsourced the "easy" services such as catering. The next phase of outsourcing in the NHS will see them buying in expert help to cut costs and improve the quality of more complex services such as decontamination. Page 6

WORKFORCE

Traditionally temporary staff have been hired to help out in busy times such as winter flu outbreaks. But new thinking on workforce management means future flexible workers will support trusts through workforce redesign while costing them less. Page 10

REDUCING VARIATION

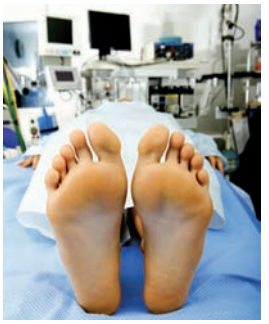
From stroke care to breast cancer operations, and diagnostic tests to home oxygen tanks, trusts are discovering how careful analysis of how they do things and spreading good practice can reap big savings, improve patient experience and save lives. Page 16

VALUE FOR MONEY

Private providers of residential mental health and learning disability placements have often charged the NHS and councils high fees without measurable outcomes. But commissioners are now mastering the art of tough commercial bargaining – and reaping the rewards. Page 20

EQUIPMENT RATIONALISATION

Procuring, maintaining and keeping track of all the equipment in a modern hospital is a huge, time consuming job. Outsourcing equipment management can deliver the latest devices and relieve trusts of a managerial burden. Page 24



FOREWORD

The holy grail of delivering more for less

Efficiency has to be the name of the game in today's NHS and in this supplement you can read about some the innovative ways in which NHS organisations can achieve the holy grail of delivering more for less.

As our roundtable participants agreed, much of this effort has to focus around reducing variation, flexing the NHS's not inconsiderable buying power and making sure that "back office" items are firmly on the agenda. This supplement will show you how to do that.

NHS Improvement's work to reduce costly variation is one example. By applying a consistent approach of testing new pathways and providing clinicians with the tools to take up new ideas, NHS Improvement has helped primary care and acute trusts save millions while improving outcomes and patient experience.

With redesign of pathways comes redesign of the workforce. NHS Professionals outlines how trusts can use their flexible workforce to support workforce redesign. This is a new way of thinking about flexible workers and one that will challenge trusts to consider how they view their entire workforce.

This supplement also features some of the less "sexy" areas ripe for efficiency improvements such as laundry, sterilising services and equipment.

These are areas that, when poorly managed, consume an inordinate amount of clinicians' valuable time but, when well managed, free clinicians to do their jobs. A true partnership between the NHS and outsourcing companies can allow each to reap benefits.

We also look at one of the most difficult areas faced by commissioners: how to get the best value out of contracts with the private sector when it comes to meeting the needs of those with complex mental health needs, acquired brain injury and learning disabilities.

The feature argues that the NHS needs to develop better commercial skills. As it points out, "money" is a dirty word to many in the NHS. In these days of tight finances, it's time for that to change. ●

Daloni Carlisle, supplement editor

JONATHAN WEDGBURY ON GOOD BUYING

HSJ ROUNDTABLE: PROCUREMENT

IT'S TIME TO USE OUR MUSCLE

Exploiting the NHS's potential buying power could make a big contribution to the £20bn savings target – without damaging frontline care or cutting staff. By Alison Moore

***HSJ* Editor, Alastair McLellan, hosted the roundtable debate with six of the industry's most influential healthcare procurement experts, including group purchasing organisations HealthTrust Europe and HealthTrust Purchasing Group, the NHS Confederation, University College London and Royal Free hospitals, and PriceWaterhouseCoopers.**

The theme of the discussion was very much centred around looking at procurement from the outside in – taking the "bigger picture" view with much of the discussion focusing on rationalisation and how larger orders from fewer NHS customers would result in a far more efficient system and enormous savings for the government. To achieve this, NHS trusts would need to work together, in a less competitive and more trusting arrangement, to leverage their position and realise the power they could bring to bear in the procurement process.

'The panel was unanimous procurement should not be a back room function but a board agenda item'

In a world full of spiralling choices, it was mooted that reducing the number of suppliers to the NHS, without compromising patient care or quality of goods supplied, would be a sensible way to achieve the keenest prices.

Information and systems were also topics for debate – how the provision of market intelligence can support the move to more uniformity in the healthcare sector.

Incentives for more efficient buying and making sure the procurement function is led from the top were all considered important. The panel was unanimous in the belief that procurement should no longer be a back room function but a board agenda item. With strong leadership and careful strategy, procurement is certain to play a big part in reducing government spend over the coming years.

Jonathan Wedgbury is chief executive of HealthTrust Europe

→www.healthtrusteurope.com

ROUNDTABLE PARTICIPANTS

Alastair McLellan editor, *HSJ*, and chair
Mike Farrar chief executive, NHS Confederation
David Sloman chief executive, Royal Free Hampstead Trust
Sir Robert Naylor chief executive, University College London Hospitals Foundation Trust
Jonathan Wedgbury chief executive, HealthTrust Europe
Jim Fitzgerald president, HealthTrust Purchasing Group
Joe Ippolito PwC global partner

Many chief executives and senior managers now realise the potential of better purchasing – but must overcome a barrage of structural and cultural problems to make savings.

Despite these hurdles, participants in the *HSJ*'s recent roundtable on procurement were clear about the tremendous opportunities for better procurement, both to save money and improve patient care through reducing variation.

University College London Hospitals chief executive Sir Robert Naylor set the scene by describing the National Audit Office's findings that not all trusts use a framework agreement to procure costly equipment – despite evidence that savings of 10 to 15 per cent could be made. Some trusts paid much more than others for equipment maintenance – tactics such as entering into a contract for maintenance at the time of purchase could reduce costs. But the biggest difference was in how equipment is used, with substantial variations between trusts.

Although costly equipment – such as CT and MRI scanners – was only a small part of overall procurement, the NAO report echoed a previous Public Accounts Committee hearing that had also criticised other aspects of NHS purchasing decisions.

Panel members felt the NHS potentially has enormous power as a purchaser, which it did not exercise. NHS Confederation chief executive Mike Farrar said the size of the NHS could give it an enormous competitive advantage "to use the muscle of the supply chain... we have latent potential which we have never fully understood or mobilised".

But the health service managed to "create a logistics that defeats many external suppliers".

Jonathan Wedgbury, chief executive of group purchasing organisation HealthTrust Europe, said the NHS had not invested in good commercial practice. His organisation had a different model to many in that it levied a charge on the supplier, but in return brought compliance and one contract, which would reduce the supplier's costs.

Mr Wedgbury pointed out the NHS had generally "chased the savings in-year to support cost improvement programmes". "Investment is key to systems technology and people so you can employ people who understand the market and drive the best deal," he said.

Jim Fitzgerald, president of the HealthTrust Purchasing Group, added: "Sometimes the NHS is not a good customer. If you don't commit for a number of years to a supplier that you want to develop services in a certain way then what is someone like Jonathan able to do?" Longer-term contracts would help companies to invest, knowing they had a stable revenue stream.

Buyers' problem

The large number of organisations individually procuring basically the same service or goods was quickly identified as a major issue, both for the NHS obtaining the best price and for the suppliers dealing with hundreds of small orders rather than a few large ones. Sir Robert said: "One of the reasons why we don't get the value is that we

CONTINUES OVERLEAF ▶

Buying time: joining the debate about procurement were (clockwise from top left) David Sloman, Robert Naylor, Alastair McLellan, Jonathan Wedgbury, Mike Farrar, Jim Fitzgerald and Joe Ippolito

don't aggregate purchases or manage distribution effectively. We don't work together." Better procurement could make a major contribution to the £20bn efficiency savings the government was looking for, he said.

PwC partner Joe Ippolito stressed the importance of having a procurement strategy if suppliers were to be influenced. "It is really understanding how you want your procurement function across the NHS to work. It is the balance of power between the buyer and the supplier and how we influence it." As a massive buyer, the NHS potentially has the power to influence both price and quality. David Sloman, chief executive of the Royal Free Hampstead trust, said there were issues around compliance – even when there were policies around what should be bought – and also around collaboration between NHS organisations. "There are too many individual institutions doing this badly."

But, if the current number of purchasing organisations is too many, what is the right number? Sir Robert suggested sub-national collaboration with England organised into 10 or 12 areas.

Private collaboration

UCLPartners – established as an academic health science system – planned to improve procurement across perhaps 10 per cent of the health service. It had become a vehicle for collaboration between organisations, shaping the market by its purchasing decisions. Reducing the number of suppliers of some products could help the collaboration partners get a better price. But Sir Robert doubted that NHS organisations could do this alone and added: "I think it has to be done in collaboration with the private sector."

Another driver for collaboration is the shortage of staff with the right skills to procure effectively. Mr Ippolito said: "The

'The fundamental issue is that the NHS can't afford to have 650-plus procurement organisations. There are just not enough skilled procurement people and there never will be'

fundamental issue is that the NHS can't afford to have 650-plus procurement organisations. There are just not enough skilled procurement people and there never will be." He agreed that these skills needed to be consolidated into around 10 organisations, while still recognising the need for local presence and input.

The suggestion of 10 to 12 organisations won general support – but there was concern that the devolution of commissioning to clinical commissioning groups would lead to greater fragmentation.

The NHS is not alone in facing these issues. Mr Fitzgerald, who has worked in the US healthcare industry for 30 years, said that many of the issues were the same there. His company had worked with a large number of hospitals to reorganise their purchasing into 12 regional hubs. Improved productivity and compliance had resulted, as hospital chief executives were given incentives to comply.

Mr Farrar outlined the importance of deciding how any joint procurement would work and ensuring that everyone benefited. Problems with the original model of joint procurement in the north west – where he was SHA chief executive until earlier this year – had included suppliers doing deals with individual hospitals rather than through a procurement hub. There had been a need for clarity and commitment, and for each organisation to know how the arrangements would deliver benefits for them. The scheme was revised, with a core number of members given equity, which meant they had an interest in getting other

WILDE FRY

organisations involved, and improving information systems. "That approach has delivered better value and kept people involved," Mr Farrar said.

David Sloman said transparent governance was important so that all parties knew what they were getting into and what they got out of it, as was good information so people could see the benefits of involvement. But he warned that procurement expertise was "very thin".

But a key part of any collaboration would be improved information. Mr Wedgbury said: "There are still some trusts in the country which still don't know what items they buy." There was a lack of a common coding system which hampered this. Mr Fitzgerald said: "We are probably the only industry in the world which does not have a uniform product number system." This makes it difficult to aggregate information and the lack of information makes it harder to make good decisions – and to identify variability, which is known to be dangerous in healthcare. His organisation had introduced product numbering and now represents 1,400 hospitals, giving it the ability to influence suppliers.

"There is no doubt that if you can go to the marketplace through a competitive bidding process with buy-in and collaboration there is a significant financial opportunity." Suppliers would only offer the best prices if they knew the buyer had a significant market share, he said.

New technological approaches could also offer other benefits. Mr Fitzgerald said his company had made significant investments in a web-based catalogue, for example, and completely electronic transaction processes, including payments. There were 20 per cent productivity improvements just from the implementation of better technology.

Point-of-use technology – which automatically re-orders materials as they are used in a hospital – also drove savings as it had allowed hospitals to reduce the stock they held by 30 per cent.

But, while the way in which the NHS structures purchasing is important, so is the culture when it comes to the task of getting the most out of its money. *HSJ* editor and debate chair Alastair McLellan asked: "We have chief executives, people involved in procurement processes and people affected by this. How do they have to behave differently?"

Incentives to save

Some of the cultural issues inhibiting improvements are deep-rooted. Mr Farrar said NHS managers had trained as public sector leaders and consequently "we are inherently slightly suspicious of using the private sector. The NHS can't understand how it delivers value from another party".

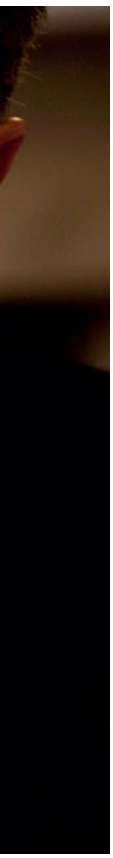
The NHS had always been forgiven for overspending as money had always been found to make up the shortfall. "It has been possible to mask our inability to engage properly with a supply chain. We are rapidly running out of road on that," said Mr Farrar.

He stressed the importance of taking a broader view of how purchasing goods and services fitted into overall care of the patient and the overall value it offered, rather than simply looking at cost.

Sir Robert said that in the past the users of supplies did not directly bear the cost, and therefore had little incentive to make savings. "If you wanted a new scanner, you went on the bottom of the health authority list and three years later, if you were lucky, you got a new scanner. Now you have to fund it yourself and there is much more incentive to get it right. It's a different mindset. A mature foundation trust board is more likely to be commercially minded and the strategy needs to be led by the board."

This was not just about individuals but about giving these issues priority at board level. "Chief executives have to stop managing and start leading," he said.

They needed to take a much more strategic view of their priorities, he added – a point echoed by Mr Farrar who said they needed to lift their heads out of the detail and learn from other sectors. Mr Farrar said that improving procurement could fit into the QIPP agenda through reducing costs and variation. Parochial approaches – "my job is around my hospital" – needed to be dropped and a wider perspective adopted. "We still see a lot of competitive behaviour between trusts when they need to trust each



other enough to get into a financial deal," he said. And the perception of procurement – traditionally seen as a back office function – needed to change.

But change needed to engage other staff, especially clinicians. This can be a challenge as clinicians may be used to particular pieces of equipment and may be reluctant to change. Sir Robert suggested that they needed to see the benefits of change in terms of releasing money to be spent on other equipment or aspects of care. "Engage clinicians and get them to take the decisions – but they need to have incentives. They need to be able to stand up and say if we stop buying 52 types of glove then we will be able to buy that piece of equipment or employ that specialist nurse," he said.

Mr Fitzgerald said change was very difficult for people and ways needed to be found to help them embrace it. Involving them in the process was helpful – for example, in his company, clinical boards advised on which products should be bought. "I'm an accountant by background, you don't want me picking out a catheter," he said. He said compliance in procurement could also be linked to the core business of good patient care.

Mr Farrar ended on an optimistic note. He felt that some of the examples of good practice were beginning to make an impact. He was concerned about what was happening in commissioning but the bulk of the costs lay in the provider side. "I think we have to apply some of the lessons we have debated today to the commissioning side. There is an opportunity for the National Commissioning Board. It could appoint to its board people with expertise in this area."

'The National Commissioning Board could distinguish between what should be standardised and what decided locally' – Mike Farrar

It could also distinguish between what should be standardised across the services and what could be decided locally.

Asked what would be the one piece of advice on "quick wins" the panel would give a chief executive, there was almost unanimous agreement that they needed to show commitment and leadership in improving procurement.

Mr Farrar said: "You need to frame this issue properly. It needs to be seen as a leadership issue, a strategic issue and a business critical issue in terms of the outcomes and quality of care you can deliver and your future solvency."

Mr Sloman urged chief executives "to be the first" and be prepared to be a leader, not a follower, in implementing change in procurement.

Several people pointed to quality and availability of information as being a key area. Sir Robert highlighted the importance of procurement staff producing data that was useful and understandable to the board.

In an echo of Donald Rumsfeld, Mr Farrar said: "We don't know what we don't know. If we knew what we did not know our starting point would be about who can come in and help us rather than assuming that we can do it all ourselves." ●

WILDE FRY

ADRIAN COWARD ON GOOD PARTNERS

With patient safety, choice and experience riding top of agendas up and down the country, trusts are weighing risk against cost, trying to ensure the scales remain perfectly balanced and deliver improved care at a lower cost. As the UK's largest provider of outsourced sterile and laundry services to the NHS, Synergy Health has partnered with trusts of all sizes and in all situations to help them achieve that balance.

We have considerable experience in working with trusts under pressure to deliver across many agendas, from compliance to service, safety to cost – and have the track record in helping them save in the region of 20 to 40 per cent of their budgets. We support our customers to find outsourcing efficiencies by working to a finely tuned formula that has evolved based on the experience of their peers.

The critical starting point for any trust is to select the right supplier and ask "can we work in partnership with them?" True partnerships are crucial, particularly where a service directly impacts patient safety. The smooth running of theatres, for example, depends on close partnerships, ensuring surgical instruments are delivered to the operating theatre fit for purpose, on time, every time. We urge trusts to closely examine the expertise, experience and record of potential partners.

A preferred partner should know and deliver

'A partner should know the outsourced service better than anyone else'

the outsourced service better than anyone else. They should be experts in delivering the service. After all, this is a critical service you are trusting to an outsider. Examine their healthcare experience. Can the supplier draw on experience, historical issues and solutions? Have they been recognised for best practice, innovation and for excellence?

One major benefit of outsourcing is transfer of risk and it is essential to explore whether accreditation, compliance and governance is as high on their agenda as it is on yours. Can you transfer the risk in total confidence? Once these elements have been assessed in terms of improved patient safety, the results must be set alongside the supplier's track record for cost leadership to achieve that perfect balance. Here efficiency parameters and economies of scale come in to play. Where significant investment in assets is required it is vital to select a partner with a pedigree of project delivery.

The decision to outsource is important and sometimes tricky to progress, balancing the scales even more so, but getting the formula right brings big rewards.

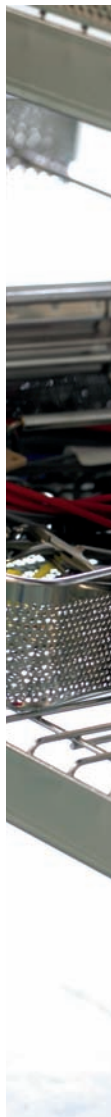
Adrian Coward is UK and Ireland chief executive of Synergy Health plc

➔www.synergyhealthplc.com

OUTSOURCING

CLEAN OUT THE WASTE

Trusts hunting for savings are being urged to go for 'higher hanging fruit' by contracting out more complex services such as decontamination. Daloni Carlisle reports on the next phase of outsourcing



In 2008 Barking, Havering and Redbridge University Hospitals Trust in Essex was in financial turnaround. Not only was it looking to make savings but also to explore what should make up its core services.

Among the services put out to tender at that time were decontamination and laundry. The trust had two acute sites, an in-house laundry and a nearly new sterilising unit built with Department of Health investment as a regional facility, providing services for three trusts and several primary care trusts.

"We started with an extensive review of our capabilities and a cost-benefit analysis," says Jackie Doyle, divisional manager for estates, PFI and facilities. This showed potential ongoing savings of around £900,000 a year. For sterile services the annual savings were £450,000.

"It was not just about the money, though," says Mrs Doyle. "There were questions around whether this was our core business, whether we wanted to manage the staff and whether we had the commercial acumen to get the best out of these services."

Synergy Health emerged from a competitive tender as the only realistic contender for the sterile services and won both contracts for five years.

"We have drapes and gowns that have to be laundered and then sterilised," says Mrs Doyle, "so using one company has ensured continuity of service. The volume of both businesses also gave us a better price."

Inevitably, the proposal to outsource raised all sorts of fears with the staff. "People were worried about the quality and about lateness," says Mrs Doyle. "These concerns proved to be unfounded."

She attributes this to two factors: a strong project team run by the trust that brought in nursing, infection control, the unions and trust managers plus the partnership developed with Synergy Health.

"You really do have to have a strong project team," she says. "The potential for damage if you don't get this right is pretty big."

In the end, the trust did not sell off the old laundry but refurbished it and moved in services that had been in leased premises. The laundry was relocated off site and Synergy Health took over the flagship decontamination unit at King George Hospital, running it as a joint venture with the trust.

"Wherever Synergy win third party contracts, the income is shared with the trust," explains Mrs Doyle.

The 68 staff members affected by the change were offered retraining and many of them went over to the newly outsourced decontamination unit with new qualifications and an upgrade under their belts. Others retrained as healthcare assistants or to other roles in the trust and only a small number were made redundant.

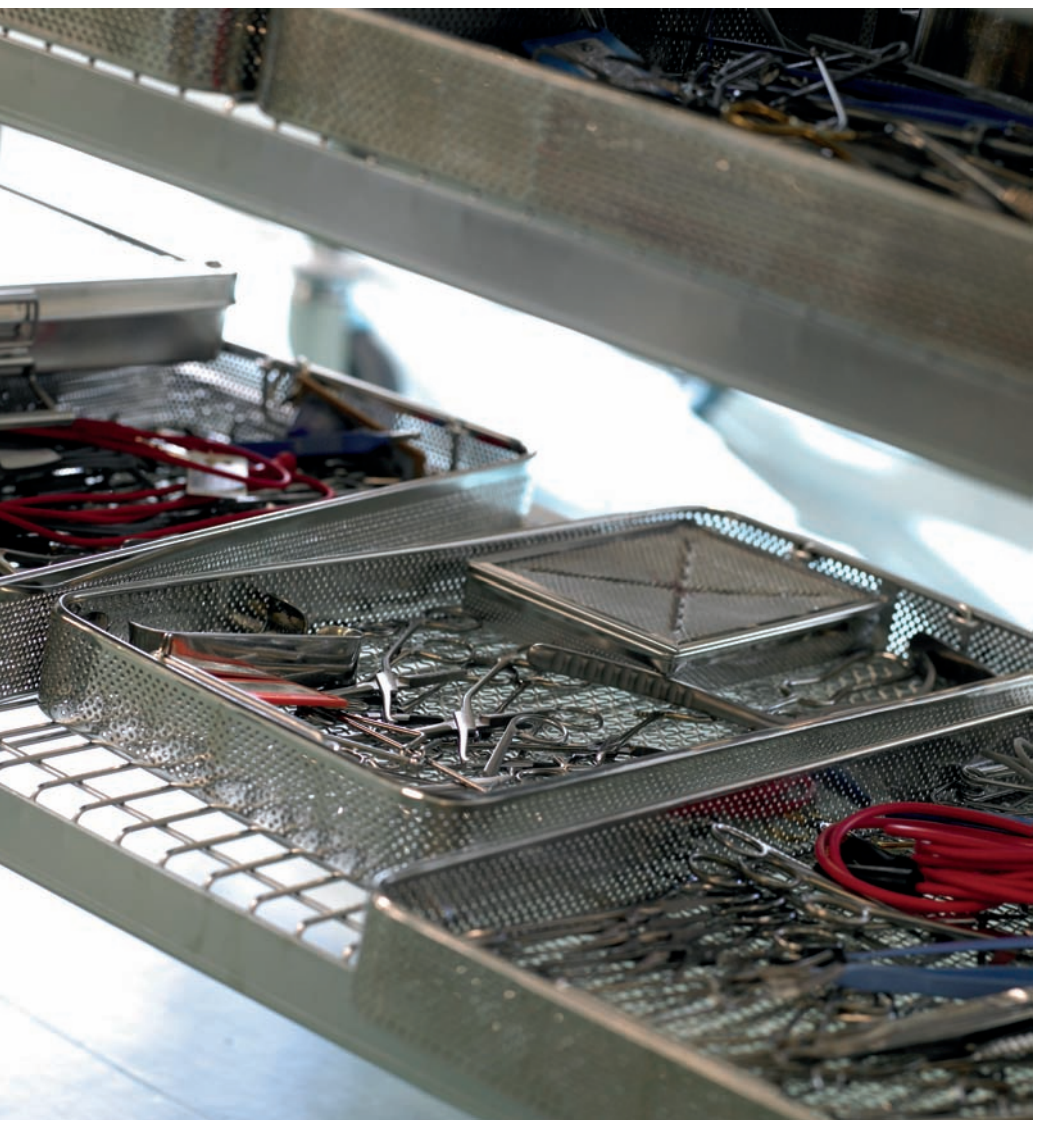
"It was hard work but very successful," says Mrs Doyle. "When I meet the staff now there is not one of them who does not say that this was the best thing that ever happened to them."

Two years on and the savings are being realised – not just for Barking, Havering and Redbridge but also for third party users – and the decontamination unit has generated some additional income.

The trust no longer has to consider compliance issues as these are Synergy Health's responsibility.

The trust has contact monitoring officers, user groups and holds quarterly meetings with Synergy Health to review services and take forward improvements, especially those that involve infection control.

CONTINUES OVERLEAF ▶



The new £3.5m, 16,000 sq ft sterilising unit (left and below) which serves Leicester hospitals

Adrian Coward, chief executive officer of Synergy Health in the UK and Ireland, says the complexity highlighted by Mrs Doyle at Barking, Havering and Redbridge is typical of what a trust faces when outsourcing decontamination. It is a scenario from which some trusts have shied away in the past.

"There has been a reluctance among some trusts who have viewed the potential savings as not sufficiently substantial to warrant going through what is a complex process," he says. "This is beginning to change in the current financial climate."

More trusts are now reviewing their core business and recognising that outsourcing of decontamination services brings not only economic benefits but also substantial benefits in terms of compliance, risk transfer and quality. "Trusts are now prepared to go for the slightly higher hanging fruit," he says.

The economic case hangs on two streams: revenue and capital. An outsourced service can often deliver more efficient use of staff – particularly cutting down the use of high cost agency staff and overtime. Typically, Synergy Health can save a trust £200,000 to £400,000 annually on its decontamination services and £200,000 to £500,000 on laundry.

Where trusts have good facilities, there is the opportunity to bring in business from neighbouring providers – NHS or independent. Where they have poor and ageing facilities – and the DH's national decontamination project has highlighted that many do – there is the opportunity to move services to more modern and

AREAS FOR OUTSOURCING

Most trusts have already outsourced the "easy" services such as catering and more are looking to more complex services such as decontamination. A handful of trusts have already gone ahead with outsourcing:

- **IT support**
- **Pharmacy production**
- **Pathology**

Cleaning out: Barking, Havering and Redbridge University Hospitals Trust's laundry services are now provided off-site

more efficient facilities.

When decontamination is outsourced, capital investment moves from the trust to the commercial provider.

"A lot of hospitals have ageing facilities that are non-compliant and would require many millions of pounds investment to bring up to scratch," says Mr Coward. "We have more available funds and outsourcing on a long term contract effectively transfers responsibility for making that investment to us."

A good example of this is the new £3.5m 16,000 sq ft sterilising unit at Meridian Park in Leicester, which was officially opened this month by NHS medical director Professor Sir Bruce Keogh.

Wholly funded by Synergy Health and staffed by 60 former NHS employees, it complies with the Medical Device Directive and international standards and is already serving University Hospitals of Leicester – Leicester Royal Infirmary, Leicester General and Glenfield Hospital. As well as state of the art sterilising equipment, it has track-and-trace technology that allows staff to ensure millions of items of surgical equipment are collected, decontaminated, sterilised, packed and returned to the correct client on time.

As ULH chief executive Malcolm Lowe-Lauri says: "This is an excellent – and timely – example of public and private sector working together towards the best possible outcomes for all parties, not least the patient and the multiple surgeons and clinical support staff who rely on safe, efficient and cost effective turnaround of the tools of their trade."

The issue of compliance is a particularly hot topic in trusts right now, says Mr Coward. "If trusts are not compliant this impacts on infection rates and in turn on the trust rating. Ultimately that impacts on the trust's economic and business status. As a commercial provider we are required by law to be compliant with the Medical Device Directive.

'Infection rates at the hospitals served by Synergy are roughly half the national average for post operative orthopaedics'

"With 18 facilities in the UK and two more due to open in the next nine months, we will have an audit at one of our facilities on average every two to three weeks. As we use shared processes across them all, we know that we are continuously compliant and always seek to share improvements highlighted by audits across all our facilities."

Mr Coward has looked at healthcare acquired infection rates at the hospitals served by Synergy Health. "They are roughly half the national average for post operative orthopaedics," he says. "Our services are not the only reason for that but they are certainly a contributing factor."

This is also an issue of risk transfer. With the outsourced provider responsible for compliance, trust managers have one fewer things to worry about during Care Quality Commission inspections.

At the end of the day, this is a partnership between the NHS and the private sector in which everyone does what they are best at.

"We are the experts in what we do," says Mr Coward. "Our core business is cleaning and sterilising, so let us worry about investing in IT, research and development, quality, people development and tracking of equipment. Then managers and clinicians in trusts can be freed up to do what they do, sure that the right equipment will arrive in the right condition, on time, every time."

And on the reverse side, Mrs Doyle adds: "Outsourcing has allowed managers to focus on our core business of improving patient care services and enabled us to reinvest cost savings in the front line."

RESEARCH

DO AS THE ROMANS DID

Outsourcing may date back to antiquity but research on how to do it successfully is surprisingly scarce. Nick Carley on efforts to plug the knowledge gap

In the current financial and political climate, it is not surprising to find that much of the outsourcing debate, particularly in the popular media, focuses on cost savings and the ideological imperatives as the main drivers for outsourcing in the public sector. However a review of the literature reveals a much more complex and sophisticated set of motivations at work.

Outsourcing is not new. It has been undertaken for centuries, dating back at least as far as the Romans, who employed mercenary armies to fight battles on their behalf. Manufacturing industries have regularly outsourced elements of their production process and recently many modern service industries have followed suit, with conspicuous examples in the finance and banking industry outsourcing their back office and customer service functions to companies in developing economies, most notably on the Indian sub-continent.

In the public sector, outsourcing has similarly focused on back office functions, IT and some other services seen as non-core business, such as cleaning, catering and refuse collection. Publications on outsourcing in the healthcare sector are relatively scarce and, where they do exist, contain little empirical research on performance models and measures.

Now a group of NHS organisations and their commercial partners are supporting independent research into current thinking and practice around outsourcing. Overseen by the University of Salford, it has two main elements: a comprehensive literature review; and in-depth interviews, which are currently underway with senior NHS managers, staff and union representatives, and executives in outsourcing companies. The full paper will be published in the autumn.

Manufacturing industries have outsourced elements of their production process

Examining arguments for and against the application of outsourcing to organisational processes in the public service sector reveals some evidence of a resistance, an unsurprising finding given what is potentially at stake, particularly in a health or welfare setting. The arguments put forward to support outsourcing include achieving best practice, cost discipline and control, improving service quality, and allowing a focus on core competences. The resistance is based on a general perception of outsourcing as damaging to the running of public services.

This resistance may go some way towards explaining the relatively slow move to the use of outsourcing in the healthcare sector. However, commentators note this is now seeing a shift in gear to make it one of the fastest growing service sectors for outsourcing.

Alongside the growth, competition has increased within the outsourcing market, increasing the pressure on prospective service sub-contractors to understand both the buying process and the decision making process of their target client.

One of the main current drivers of healthcare outsourcing is the continuing requirement to increase quality and productivity against a backdrop of tight public finance. However, other factors also come into play such as reducing risk, balancing sporadic demand, focusing on core activities and covering deficiencies.

The literature review shows that there has been much work around the drivers and barriers to outsourcing with a sophisticated debate that has moved well beyond a simple cost model, including a substantial body of publications pointing to the business relationship as being the major factor in the success or otherwise of outsourcing.

There is growing evidence of an increasing emphasis on the nature and quality of the relationship between principal and agent, which has seen outsourcing companies expand their roles in the areas of corporate strategy, information management, business investment and internal quality initiatives.

Such developments reflect a new way of thinking about outsourcing based on a model of partnership, rather than a simple client-contractor relationship. Outsourcing processes to a more capable provider is characterised as strategic sourcing, with the role moving from agent to partnering, so that the outsourcing company may be implicated in the task of helping the client to improve their strategic position.

However, with extended and overlapping responsibility across the client-contractor boundary come increased risks, and messages of caution in deciding what, how and to whom an organisation should outsource, are found in much of the existing literature in this area.

Such messages, and the fact that there have so far been few detailed studies that evaluate and compare outsourcing decisions, or which focus on the experiences of the main actors in the outsourcing process, highlight the value of this study.

The series of in-depth interviews which explore the issues outlined here in more detail with key players – from outsourcing firms, staff and trade union organisations, and client organisations – will address this knowledge gap to help the debate, and the sector, to move forward in this area. ●

Nick Carley is managing director of Alterline Research

REFLEXSTOCK

STEPHEN DANGERFIELD ON FLEXIBILITY

The need for NHS organisations to drive down costs and reduce expensive agency usage goes back many years. It was, after all, the reason that NHS Professionals came into existence in 2004.

But today's NHS has to take a wider perspective, looking at the whole workforce and delivering the most efficient strategy to maintain care and ensure safety while achieving substantial savings. It is a big change bringing a mix of uncertainty, risk and opportunity.

NHS Professionals is no stranger to change. In addition to undergoing the change in company status from special health authority to limited company in April 2010, we have also been through our own transition programme in recent years. We have gone from offering a relatively inflexible service that made heavy losses to a flexible organisation that makes sufficient profit to enable continued growth and investment in the business.

We have replaced manual processes with an online platform that provides web-based recruitment, online shift booking and placement, e-timesheets, full compliance and document management systems, and extensive management information delivered direct to our clients' desktops. All this with a headcount that has halved over the last three years.

We found it challenging and even painful at times but, as with all worthwhile

'We have gone from offering an inflexible to a flexible service'

transformations, it comes with huge rewards. We are no longer a supplier of temporary nurses but a genuine strategic partner for managed flexible workforce services. And we think there is even more work we can do, particularly driving benefits for our clients through the strategic use of a contingent workforce.

We have identified the "core/periphery" model in which a trust takes an overview of its workforce, activity patterns and patient acuity to inform its decision about what proportion of staff should be flexible. With accurate, timely management information, a trust can manage flexible staff to ensure efficient, effective and safe deployment at the lowest cost.

More recently we have begun to examine the contribution of the flexible workforce to NHS workforce redesign. This will be a new area to many and we hope that these pages will provide some thought leadership on how planned use of a flexible workforce can support trusts as they develop new roles, manage peaks and troughs of demand and ensure succession planning as "baby boomers" head to retirement.

Stephen Dangerfield is chief executive of NHS Professionals

➔www.nhsp.co.uk

Follow @nhsworkforce on twitter

WORKFORCE

POOL OF TALENT

'Virtual' or 'pool' wards are part of a revolution in workforce planning that is about much more than cutting the use of expensive agency staff. By Daloni Carlisle

It is a busy time for directors of workforce in the NHS. They are at the heart of helping to shape the workforce not just to meet the immediate financial pressures but also to develop a workforce fit for the future.

NHS Professionals' associate director of workforce strategy Jenny Hargrave (pictured below) believes that the flexible workforce can make a contribution to workforce transformation. This is not about the relentless drive to reduce agency costs – although that comes into it. Rather it is an approach that relies on understanding demand, spotting opportunities for innovation, developing new roles and using the flexible workforce to maintain safe staffing levels.

The drivers for change are, she says, fairly well understood. The impact of an ageing workforce, ageing population and the projected impact of lifestyle choices on health is changing demand for health services and requiring a radical redesign of services. This, in turn, demands a radical redesign of the workforce.

"What is very evident is that workforce redesign must be more population-centric rather than workforce-centric," says Ms Hargrave. "It is no longer a question of saying 'how many doctors, nurses and allied health professionals do we need?' but of asking 'what skill sets are required, do they exist in our workforce and if not, can they be developed?' New roles are already evolving."

So where does the flexible workforce fit in to this? Ms Hargrave's starting point is the "core/periphery" model, as described by Professor James Buchan of the Institute for Employment Studies in a report in 2010.

He wrote: "What is needed... is 'flexible and maximum use of substantive staff' with temporary staff providing a supporting role". It is a model of deployment that he contrasts with "the traditional NHS approach, where temporary and flexible staff have tended to be used in a short-term and reactive way to cover staff absence".

While there is no agreement on what the ideal balance might be between core and periphery, trusts that integrate their substantive and flexible workforce activity spend and utilisation analysis can quickly gain an understanding of when they have peak demands for flexible staff, where those staff come from, how much they cost. They can start to look at reducing the cost, for example by booking more shifts in advance to avoid costly, short term agency bookings.

Once trusts have started to get a grip on the demand management, they can move to more innovative ways of using the peripheral workforce to support the core during workforce redesign.

Now, traditionally, a trust might place the flexible workers to meet surges in need – for example to support wards in a winter flu outbreak. But is this the best way to do it?

Not necessarily, says Ms Hargrave. If a trust can predict winter pressures and understands the demand

A London nurse rushes to treat a patient and, left, nurse training. New nurses could gain vital experience acting as flexible workers

NEWLY QUALIFIED CAN LEARN WHILE DOING FLEXIBLE JOBS

Every trust faces a challenge twice a year – how to accommodate the next tranche of newly qualified nurses? From 2013, graduate-only training will mean double the number emerging once a year.

The problem is that too many nurses enter the job market at once and not all are willing, or able, to wait for vacancies to arise in the local NHS but instead turn to the independent sector. More often than not, they are then lost to the NHS.

Meanwhile, the NHS is also facing a predicted staffing gap as the NHS workforce ages and must now engage in succession planning. All this needs to be managed in the context of the £20bn savings plans and associated cost improvement programmes, which in turn is resulting in workforce reviews and redesigns.

Ms Hargrave suggests that one answer is to look at temporary workforce utilisation as a means to retain newly qualified nurses.

This will be anathema to many directors of nursing. Use newly qualified nurses as flexible workers? Impossible, they might well say.

But what about offering them the preceptorship, required of all newly qualified nurses, while they work as bank nurses? Ms Hargrave argues it should be possible to design such programmes – and has developed preceptorship guidelines that can be used in partnership with a trust. Trusts are already piloting this concept.

Essentially, the idea would be that a newly qualified nurse unable to find a job signs up to NHSP as a flexible worker, with specific governance and recruitment checks and a separate worker code identifying them as newly qualified. A partner trust agrees to provide preceptorship and regular work in a single, supervised setting ensuring that the worker meets agreed competencies.

The trust effectively gets additional staff, who may otherwise have been recruited through regular bank or agency routes, and also gains financially – NHSP workers are cheaper than substantive employees. They gain workforce flexibility and the nurse is provided with a supported route to substantive NHS employment.

‘Traditionally, trusts place flexible workers to meet surges in need. But is this the best way?’

pattern, why not develop core, substantive staff into highly responsive rapid response teams and “backfill” (fill the teams’ regular jobs) with flexible workers who have been booked in advance and are familiar with ward environments in the more stable areas (see case studies, overleaf)?

It is an idea that is already being explored in a number of trusts, she says. “The idea is to skill up a defined number of substantive workers into a rapid response team that can be redeployed at short notice in response to escalating demand,” she explains. “The trust would need to build in leadership skills, management skills and support these workers to be responsive and flexible to a changing environment.”

She believes such rapid response roles would be an attractive opportunity for career-minded people as they would give them the experience needed to move to the next band.

“To be a safe model, the trust would need some integral backfill plans in the more stable areas,” says Ms Hargrave. And this requires planning. As Professor Buchan’s work shows, there are some safety caveats about relying on flexible workers especially in making sure they are familiar with ward routines, policies and procedures. But where workers undergo proper induction and have time to build up an understanding of a work environment, they can bring benefits.

Ms Hargrave is now exploring how a “pool” or “virtual” ward can meet demands for a safer flexible workforce. This approach requires trusts to forecast demand for flexible workers based on historical patterns and known drivers such as existing vacancies and request 70 to 80 per cent of that need up to eight weeks in advance on a trust or hospital-wide basis (see case studies).

Trusts can thus guarantee work six to eight weeks in advance to their flexible workers – increasing their commitment to the organisation – and prevent over-reliance on expensive, short-term agency bookings.

“You build up a team of flexible workers who are likely to continue working for you,” says Ms Hargrave. “These are the people who then backfill for the rapid response teams.”

True, a trust can never predict 100 per cent accurately what future demand will be, but there are tools that will help refine the process, says Ms Hargrave. The use of models such as the NHS Institute’s Safer Care Nursing Tool, combined with real-time and historical management information (such as that delivered by NHSP’s information technology platform) is already helping trusts understand workforce demand.

“Aligning your substantive and temporary workforce plans based on dependency, acuity and management information about temporary staffing usage is giving trusts a view they have never had before,” says Ms Hargrave.

“It’s never been done well in the past but is now giving trusts a really powerful and holistic picture of the real situation. It is giving them the ability to forecast accurately and to plan, and therefore to be flexible, change and redesign.”

NHS Professionals

CASE STUDIES

READY FOR A BIG SHIFT

Daloni Carlisle takes a look at three trusts that are leading the way in changing the way people work in the NHS

UNIVERSITY HOSPITAL OF SOUTH MANCHESTER FOUNDATION TRUST

University Hospital of South Manchester Foundation Trust has worked with NHSP over many years, driving down the cost of the temporary workforce by more than £500,000 a year in the process. Now the emphasis of their partnership is changing as the trust looks at service leads and the relevant workforce requirements.

"Patient pathways are changing and the level of dependency of patients is increasing," says deputy chief nurse Alison Kelly. "We need to understand how to manage that, how to reduce costs and how to do this without compromising patient care."

NHSP now sits on the trust project board for this work while Ms Kelly sits on NHSP's client board, sharing information and best practice with other trusts. "Together we have come up with ideas that we are able to implement," says Ms Kelly.

For example, they have developed models that allow the trust to develop full time staff into new roles while backfilling with NHSP workers who are known to the trust and familiar with its wards.

"That's been particularly helpful around winter pressures," says Ms Kelly. "Apart from allowing our permanent staff to develop, it means we never put NHSP nurses in the vulnerable position where they are expected to be in charge of a ward."

Another strand of work is looking at using the Association of UK University Hospitals patient dependency tool to help understand how the workforce needs to change in response to changing patient acuity – and again Ms Kelly will be looking at how the flexible workforce can help support any transition.

Wythenshawe Hospital, part of South Manchester trust, which has slashed temporary staff costs

ROYAL BERKSHIRE FOUNDATION TRUST

Last year Royal Berkshire Foundation Trust developed a "pool ward" that allowed them to plan for the usual winter escalation much more efficiently.

Miriam Palk, clinical resourcing manager, explains how the trust used management information from the NHSP IT platform to predict need over the winter months and then set about booking a set number of NHSP nurses and healthcare assistants in advance, on the understanding that they could be placed in one of several wards.

At peak demand, they had eight nurses and eight healthcare assistants booked for all three shifts in a 24 hour period, allocated through bed meetings that involved the matrons, NHSP coordinator and Ms Palk taking place up to five times a day.

Royal Berkshire hospital is using a "pool" ward system to plan better for winter demand

It sounds simple – but it allowed the trust to overcome a whole set of familiar problems, not least the bank worker resisting a change of location for the shift.

If a staff nurse was absent through flu, the matrons knew roughly how long the nurse would be away from work and place an NHSP nurse in the ward for the duration, ensuring better continuity of care.

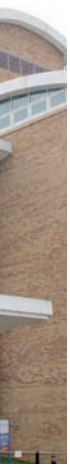
"It allowed us to flex up and down depending on staff absence," says Ms Palk.

With bookings made in advance, matrons and the NHSP co-ordinator could place NHSP nurses in wards that they knew.

"It was a good platform for recruiting staff," adds Mrs Palk. "They had a chance to work in different areas and get to know them."

Mrs Palk says the major benefit was the ability to plan. "For us this was not really a

New pathways: the NHS workforce must respond to changing patient needs while keeping costs down



means of saving money," she says. "It was about being able to plan. Applying some consistency has to be better for the patient experience and for safety."

BRADFORD DISTRICT CARE TRUST

In 2010, Bradford District Care Trust, an integrated community and learning disabilities service, budgeted £12m annually for its temporary workforce, making it the highest spender in England. By the start of 2011, this was down to £7.8m and dropping; the trust had gained transparency and control of its temporary workforce spend and provided a safer model for seeing it through ongoing workforce redesign.

Claire Rix, an HR consultant brought in to review flexible working options at the trust in early 2010, explains: "NHSP implemented their management information system not just for nursing and admin but right across the trust for all staff groups, giving us visibility of use of expensive estates staff, HR consultants or accountants, for example.

"It has challenged everyone in the trust to look at how they can reduce cost."

With all temporary shifts now visible via a website to all NHSP workers at the trust, and all temporary staff encouraged to register with NHSP, the trust plans to make future project opportunities available not just to permanent but also temporary staff.

"We have lots of project work going on from e-rostering through to the transition to foundation trust status and the transition of services to new providers as well as projects at ward level," explains Ms Rix. "Traditionally, the trust would have brought in expensive consultants. We now want to draw on the expertise that exists in our own staff including our bank workers."

The system is also helping the trust through a difficult transition as the local authority redesigns learning disabilities services and looks for new providers. It has inevitably meant vacancies have not been filled pending the changes.

"We have been able to fill these gaps using NHSP," says Ms Rix. "That's meant people recruited to NHS standards with all the risk management and clinical governance in place.

"It has not been easy; it is never easy for staff or managers when there is a high level of flexible workforce, but it has been managed in the best and safest way possible." ●

'For us this was not really a means of saving money. It was about being able to plan'

ALAMY, REPORTDIGITAL, REFLEX

JANET WILLIAMSON ON IMPROVING

NHS Improvement

NHS Improvement's strength and expertise has always been in practical service improvement. We have accumulated over a decade of experience in clinical patient pathway redesign in cancer, diagnostics, heart, lung and stroke services. NHS Improvement demonstrates some of the most leading edge improvement work in England.

We work closely with the Department of Health, trusts, clinical networks, other health sector partners, professional bodies and charities. Over the past year we have tested, implemented, sustained and spread quantifiable improvements across more than 250 sites across the country and provided an improvement tool to over 1,000 GP practices.

Our online resources have been accessed in over 140 countries and on average our website receives 15,000 new visitors each month.

Our current work programme is defined through the DH in line with the key policy areas of cancer, heart, stroke, chronic obstructive pulmonary disorder and diagnostics. We form part of the NHS medical directorate led by Professor Sir Bruce Keogh.

Applying improvement tools and techniques can help support NHS organisations in the delivery of the five domains outlined in the NHS Outcomes Framework 2011-12. The

'We have spread improvements across more than 250 sites'

improvement work falls into five categories:
1 Long term programmes of work to support delivery of a key national priority
2 Bespoke, time limited improvement work
3 Tailored support to assist delivery
4 Establishing, developing and supporting clinical networks
5 Advisory and development work.

NHS Improvement applies a framework for service improvement and clinical pathway redesign to ensure consistent and systematic work using the following approach:

- **Proof of principle: piloting and testing new ways of delivering services – redesign and quality improvement**
- **Testing wider applicability of pilots: prototyping new service models, innovations and improvements**
- **Spreading and disseminating learning and innovation more widely**

The following pages highlight just a fraction of our work. They show how redesigned pathways can deliver better care. We urge you to find out more about how we can support you to reduce variation and improve outcomes by visiting our website.

Dr Janet Williamson is director of NHS Improvement

➔www.improvement.nhs.uk

REDUCING UNWARRANTED VARIATION

The route to better stroke care in Nottingham took in simple road signs for non-local paramedics and a 'Bat Phone'. Catherine Blackledge reports

TURN LEFT FOR A

It's the simple things that sometimes get in the way of service improvement. And so it proved in Nottingham where a lack of road signs signposting the stroke unit at Nottingham University Hospitals Trust for arriving ambulances provided an unexpected hurdle in the trust's drive to improve stroke care.

This came to light during a project aimed at reducing the amount of time it took for patients to be admitted to the stroke hyper acute unit and start receiving thrombolysis. When work began, some patients were admitted directly, but more were taken to A&E – on a different site five miles across the city, or to the neighbouring emergency admissions unit.

So the stroke unit introduced a direct phone line – now known as the "Bat Phone". GPs and paramedics were asked to use the Bat Phone if they assessed a patient with stroke symptoms, giving stroke unit staff the opportunity to triage and provide advice on the appropriate care pathway needed.

Careful monitoring of the new system and continued communication with the ambulance crew also revealed the need for new signs. "Paramedics coming to the unit from out of area were having difficulties," explains Dawn Good, head of stroke services at Nottingham.

With the problem fixed, the direct access project is proving successful: all suspected stroke patients are referred directly to the stroke unit and there has been a fall in the number admitted via A&E. "Recent figures show 80 per cent of stroke patients are spending more than 90 per cent of their stay on the stroke unit," says Ms Good.

The Bat Phone initiative is one of over 40 projects led by NHS Improvement (see box, right), which, as well as providing guidance and support where needed, aims to keep the momentum going around improving stroke services in the wake of the 2009 National Audit Office report.

"I think stroke has moved significantly up the priority list, but it needs to move further," says Ian Golton director for NHS Improvement – Stroke. "Stroke is the third biggest killer and it needs the same weight as cancer and heart services."

WHAT THE CHIEF EXEC SAYS...

"It is critical that we continue to innovate for our patients as we design the health and care system of the future, ensuring we improve the quality of care for our patients, while making historic levels of financial savings to reinvest in frontline services. NHS Improvement working with and through clinical networks has been proven as an effective and productive model and it ensures that positive learning is spread more widely across the system."
Sir David Nicholson, chief executive of the NHS in England

'I think stroke has moved significantly up the priority list, but it needs to move further'

A set of nine indicators, devised by NHS Improvement as part of the Accelerating Stroke Improvement initiative, is designed to help trusts measure their performance across the whole stroke pathway. The indicators include direct admission to a stroke ward, as well as markers of care further along the pathway, such as timely access to psychological support; joint health and social care management; and access to and availability of an early supported discharge team.

CONTINUES OVERLEAF ▶

BETTER SERVICE

THE COMPUTER TOOL THAT COULD SAVE 3,000 LIVES A YEAR

Over 1,000 GPs practices in England are now using a computerised risk management tool to help manage atrial fibrillation and reduce the number of AF-related strokes.

The software tool – called Guidance on Risk Assessment for Stroke Prevention in Atrial Fibrillation (GRASP-AF) – is free and downloadable from NHS Information. It risk assesses all patients on a practice's AF register and then presents the clinician with a pictorial representation of how they are currently managing patients.

"Patients with AF are at a hugely increased risk of stroke; 4,500 strokes and 3,000 deaths a year could be prevented with optimum management of AF, representing a cost saving to the NHS of £53.5m in the first year following stroke, alone," says Julie Harries, director of NHS Improvement – Heart.

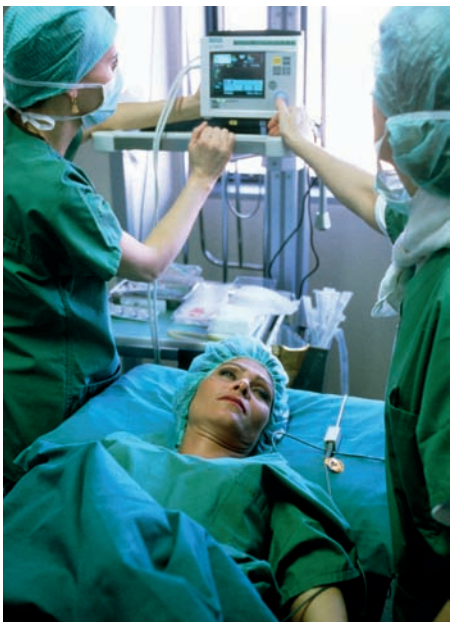
However, according to National Institute for Health and Clinical Excellence guidance published in 2006, a large proportion of AF patients are not prescribed an appropriate anticoagulant, such as warfarin, which can decrease the risk of stroke by 70 per cent if taken in a well managed way.

Recent data from 284 practices using the GRASP-AF tool reveals a modest increase in the number of patients prescribed warfarin: up from 52 per cent to just over 54 per cent.

Dr Richard Healicon, national improvement lead, NHS Improvement, estimates this small shift in practice has so far avoided 31 strokes, with an associated cost saving of £369,000 (based on the cost of a stroke in the first year following occurrence being £11,900).

He adds: "If all practices showed the modest effects of the use of GRASP shown in the 284 practices, we should avoid 787 AF-related strokes, but if all practices optimised the use of anticoagulation [with 85 per cent of patients identified as high risk on warfarin], then a further 4,480 strokes are potentially avoidable."

REDUCING VARIATION: CANCER



ALAMY, SPL

BREAST OP AND HOME IN ONE DAY

Patients undergoing breast surgery including mastectomies (without reconstruction) can now benefit from a day case or one night stay surgical care pathway at more than a third of hospital trusts in England.

The new pathway, developed by NHS Improvement in partnership with 13 national clinical spread networks is transforming breast surgery. Where once some patients stayed in hospital for as long as six days, now the majority are home the same day.

"It works, it's safe and patients like it," says Dr Ann Driver, NHS Improvement's director for transforming inpatient care in cancer. Others agree: NHS Evidence recommends the pathway while the British Association of Day Surgery has endorsed it.

It also has the potential to cut costs and improve efficiency. Dr Driver estimates that if the practice is taken up nationally, it could reduce the length of stay post-surgery by 50 per cent and bed days by 25 per cent, potentially saving up to £10m a year.

City Hospital, Birmingham, now follows the new pathway. The average length of stay is now less than one day and the trust is saving an estimated £300,000 a year.

NHS Improvement's work began five years ago. The first phase (2006-07) focused

on pulling together information: Hospital Episode Statistics data showed the national mean length of stay then was 2.4 days, however there were some places where mastectomies were being performed as a day case.

During the second phase in 2007-08, a small number of pilot sites tested the pathway and did work strengthening the proof of principle. In 2008-09, the project moved into the prototype phase: working with a larger number of sites and testing whether the pathway was transferable to other organisations.

Work is now ongoing in the final phase of the project – spread and adoption. A total of 72 hospital trusts, representing about a 41 per cent coverage England, are now using the pathway with more coming on board. Dr Driver is hopeful forthcoming data will show coverage has increased to 70 per cent.

Patient support for day case surgery has been unanimous. One patient, who had previously had a mastectomy involving a week's stay in hospital, said:

"At first the thought of day surgery felt a bit scary, but day surgery was even better due to the quicker recovery time and being back in your own environment. I went down to surgery about 8.45am and by 11.30am I was sitting up in bed and by 3.30pm I was having tea and biscuits. On the Saturday night I was out dancing at a party."

REDUCING VARIATION: HEART

MODELLING HELPS TO PROVE BLOOD TEST VALUE

Patients could avoid unnecessary referrals and procedures and the NHS in England could save up to £13m a year if all GPs used serum natriuretic peptide (NP) testing.

The simple blood test, which costs around £20, rules out the possibility of heart failure with 98 per cent accuracy and reduces the need for further investigations, such as expensive echocardiograms, by 30-40 per cent.

Despite this, serum NP testing is not widely available: in 2009, only 46 per cent of primary care trusts provided the test, according to a survey by NHS Improvement. "We found a lot of anxiety – commissioners thought the new test would increase costs," says Candy Jeffries, interim director of Bedfordshire and Hertfordshire Heart and Stroke Network.

In a bid to allay these fears and encourage the test's uptake, NHS Improvement provides computer modelling of different scenarios and pathways for primary care trusts and clinical commissioning groups to reveal the actual impact of the test's introduction. "Everywhere finds the modelling very helpful; commissioners want to have proof," says Ms Jeffries.

Trusts provide data including information such as local prevalence and incidence figures for heart failure and the proportion of patients following different pathways; if figures are unavailable, national averages can be used. It then takes NHS Improvement around half a day to a day to run the modelling and highlight a range of scenarios so that PCTs can pick a pathway to best suit their needs from both a clinical and financial perspective.

A total of 35 PCTs have requested NHS Improvement's help with scenario simulation and costing. So far, 25 have had their modelling completed revealing total estimated savings of between £1m and £3m (the lower figure represents the cost of an echocardiogram within primary care, the top end figure the more expensive cost of an outpatients appointment and echocardiogram).

Of the 25 PCTs to have completed modelling, 12 have commissioned serum NP testing and are estimated to be saving a total of between £675,000 and £1.5m a year. The remaining trusts have the ammunition to work with to make their business case for commissioners.

As a result of NHS Improvement's work, over 50 per cent of PCTs now provide serum NP testing. The aim is to get to 70 per cent, says Ms Jeffries.

Serum NP testing was shortlisted this year for a NICE Shared Learning Award.

Serum testing: a centrifuged blood sample in a test tube

'As a result of NHS Improvement's work, over 50 per cent of PCTs now provide serum NP testing. The aim is to get to 70 per cent'

REDUCING VARIATION: DIAGNOSTICS

FROM 20 WEEKS TO JUST 14 DAYS

A project to help ensure 98 per cent of women undergoing cervical screening receive their results in 14 days has shown how much more efficient a streamlined diagnostics pathway can be.

All ten NHS Improvement cytology pilot sites have achieved the 14-day turnaround time vital sign (sample taken to result received by women) integrated performance measure, and eight of the trusts now manage a turnaround time of just seven days for over 85 per cent of patients. At the start of the improvement drive in 2008, the turnaround time for some sites was 20 weeks.

Lean methodology underpins this dramatic transformation, says Lesley Wright, NHS Improvement's diagnostics director. Lean, which has its roots in the car manufacturer Toyota's efficiency drive to improve flow and eliminate waste, is the methodology of choice internationally for improving pathology services.

At each site, NHS Improvement taught lean concepts to a core team across the screening pathway: the nurses taking the samples in primary care, cytology lab staff and those in the recall centre sending out the results. In most cases, none of these people had ever sat in a room together before. "It was probably the first and greatest challenge," says Ms Wright.

The cervical screening process is getting faster

While the initial response to introducing lean was typically scepticism, attitudes quickly changed. "We've completely changed a culture," says Ms Wright, "Staff see the method as a way if improving quality, safety and even morale. Waste can be removed without the need for additional money, only occasionally is there a need to invest, usually linking a computer or such. Benefits can easily be quantified in terms of staff time, reduced duplication of tasks and elimination of certain steps."

She adds: "I think it makes people's working lives far happier. They are not wading in the treacle that is the waste in the system... you're taking out the waste."

The new system has also shown it can cope with an unexpected rise in demand. During the first year of the project, the reality television celebrity Jade Goody died of cervical cancer – prompting a surge in demand. Somerset and West Dorset cervical screening service saw a 30 per cent increase in patients at this point, but were still successful in achieving the 14-day turnaround time, and now return over 95 per cent of results in seven days – down from 22 at the start of the programme.

This quality improvement has also brought cost benefits – on average savings of £100,000 a year per site. Simon Knowles, lead cytopathologist at the service and national clinical lead for cytology, NHS Improvement, says: "When we used lean methodology we also found ourselves able to deliver a better, safer service with fewer staff. We weren't looking for a productivity bonus. It just fell out of the project."

NHS Improvement is now working with nine pilot sites applying lean methodology to histopathology and phlebotomy services and is working with all pathology labs in the East Midland. Early results are promising.

REDUCING VARIATION: LUNG

CASH SAVED ON UNNECESSARY OXYGEN

Initial work on improving the respiratory services pathway for patients with chronic obstructive pulmonary disease is highlighting the benefits of establishing and reviewing home oxygen services.

In England, £110m a year is spent on home oxygen services; the Department of Health estimates 30 per cent of people prescribed it either derive no clinical benefit from it or do not use their oxygen.

"Patients are being prescribed oxygen when it might not be clinically needed or they don't use it. There is a lot of waste," says Phil Duncan, NHS Improvement – Lung director. "It's a service not always seen as a priority for commissioners, but it's a very expensive service and could be made far more efficient."

Over the last year, NHS Improvement has worked with 12 national project sites across England helping transform home oxygen services by improving access to data, reviewing and validating patient lists and establishing assessment and review services.

Oxygen at home is widely overprescribed

Early results from nine of the sites show total annual savings of over £600,000. "This fits well with health economists' forecasts," says Mr Duncan.

Take NHS Hull, where a new home oxygen assessment and follow up service was commissioned in April 2010. Since its set up, monthly spend is down by £11,378 as a result of assessment and review.

Changing prescribing habits is still a major challenge: it's common for any patient with breathlessness to be prescribed oxygen. That's why one of the project's key messages, says Mr Duncan, is: "Oxygen is a drug and it's not for breathlessness, it should be prescribed on clinical need."

Patient education is needed as many patients are reluctant to stop using oxygen, seeing it as a treatment for breathlessness. "There's some work to be done to give consistent messages to patients and manage their expectations," adds Mr Duncan. ●

ALAMY, SPL

GRAHAM HALLOWS ON SUSTAINABLE COMMISSIONING

IN ASSOCIATION WITH COMMERCIAL AND CLINICAL SOLUTIONS

Commercial & Clinical Solutions Ltd

The commissioning landscape for complex, high cost, mental health and learning disability services is under considerable pressure. Why? Go back just 10 years and the imperative in the system was straightforward: to find a suitable provider and make the placement. The private sector had the luxury of market control as a result of this systemic inertia. Rarely was a meaningful conversation had about outcome related contracts, or value for money.

Once the placement had been made, the focus of reviews tended towards ensuring that it could be maintained: injecting little if any real pressure to achieve promised outcomes, step down, or to develop care pathways. Rehabilitative services were sold, and purchased, on aspirational clinical outcomes, yet here we are still seeing many expensive, often out of area, placements without any measurable outcomes having been achieved.

The new focus on value for money and measurement of outcomes is therefore welcome. Providers have to become more accountable in terms of promised outcomes; control of complex markets is extended to purchasers as well as providers; talk of value for money is no longer seen as a monetised discussion at odds with a caring system.

The irony is that while there is some short-term pain as all parties adjust to the new environment, in the medium to long term everybody can win. Through sustainable commissioning patients, or clients, whose care pathway is scrutinised in more detail (value for money being necessarily qualitative as well as quantitative) win as their visibility is raised; we all know that more attention has to be a good thing. Commissioners will work in an environment where they feel empowered, rather than the debilitating world they have endured of having to accept what the market has been willing to provide. Last but not least, providers benefit from sustainable marketplaces, where true partnership creates a healthier balance of power.

'We still see expensive placements without measurable outcomes'

A word of caution though: this paradigm shift in the market will only come about if led by commissioning teams. Strategic aims must be supported by skills development across the team. Bottom up and top down approaches are required to translate aspirations into measurable commercial and clinical solutions. Changes such as these require hard work and stamina but the outcome will be worthwhile.

Graham Hallows is founder and chief executive of Commercial and Clinical Solutions

➔www.ccslimited.org.uk

VALUE FOR MONEY

FIT TO NEGOTIATE

Consultants have been coaching commissioners to strike better deals with providers of complex mental health and learning disability placements – and have won huge savings. By Helen Mooney

All the talk of "any willing provider" has caused a political storm, with the BMA and others implacably opposed to introducing competition into the NHS.

But in one sector at least, the use of independent providers is longstanding: placements for people with complex mental health or learning disabilities needs. The independent sector already provides most of these services (see box, right). The issue is not whether the NHS should engage with providers, but of how the NHS and local authority partners should get the best value from these placements.

So says Graham Hallows, chief executive of commissioning specialists Commercial and Clinical Solutions. He argues that despite the efforts of successive governments, the NHS has never really benefited from the investment to enable it to be truly commercial. As a result it has not managed to develop the business acumen across the board to ensure that contracts with the private sector are the best value they can be, either in terms of cost or quality.

"NHS organisations don't get the best value out of placements because they generally don't have the business acumen," he says. Commissioning bodies need to "adopt a more commercial approach to service provision" that enables them to lower fees where appropriate while ensuring that existing levels of care are maintained or even improved.

Many in the private sector are delighted at the prospect of negotiating the highest prices and fees with NHS commissioners while providing services at the lowest costs to themselves. This is as true for specialist high cost, low volume services for people with acquired brain disorder, learning disabilities and other specialist mental health needs as it is for elective hip surgery.

These placements are commonly in residential care, residential care with nursing, and independent hospitals. Across both the NHS and adult social services, rehabilitation placements in private sector organisations represent one of the largest parts of the care system for adults with severe and enduring mental illness or learning disability with complex needs.

They are also often the most expensive. While local authorities have been fairly successful in encouraging third sector organisations to provide a diversity of supported housing both for learning disabled people and those with a mental health condition, this is not generally true of the NHS, says Mr Hallows, who has long experience of the sector.

The lack of NHS facilities for patients whose behaviours are intractably difficult to manage or who have unusual psychiatric needs has been seen as a market opportunity for the private sector. Over the last few years more than one third of beds in England for these patients are within privately owned institutions.

Patients often arrive in long-term private hospitals after lengthy, unproductive stays in acute psychiatric wards. Others come from prison, a special hospital or an NHS secure unit. Many have been moved from institution to institution since childhood. Some have a reputation for difficult to manage behaviour.

One problem NHS commissioners face is that the private facilities used by their patients are often out of area. Understandably patients dislike isolation from family and friends and are vulnerable to changes in the market.

The ability of primary care trusts and local authorities to develop a coherent approach to these types of placements is

CASE STUDIES OVERLEAF ▶

Eyes on the prize: large savings can be made on the cost of complex placements

'We explain to public sector commissioners how to cut to the chase to negotiate fees. They are shocked'

often challenged, especially when they are dealing with only a small number of such patients.

Mr Hallows says his own experience working within the private sector means he knows only too well the tricks of the trade when it comes to providing specialist services on behalf of the NHS. Market control often rests with providers rather than commissioners who lack the negotiating skills needed to take control, especially when patients are frequently placed out of area for a long time without effective monitoring.

NHS organisations need to develop better commercial acumen, he says. They need to "adopt a long-term, sustainable approach with contracted healthcare providers and, where appropriate, negotiate cost savings without compromising patient care".

He says: "There is definitely the capability [within the NHS and local government] to become more commercial but the systems do not encourage commerciality to develop, nor are individuals encouraged to work in a commercial manner."

And who better to help commissioners gain these skills than the people who know them already? Mr Hallows says it is time for NHS commissioners to turn to commercial expertise to get better all round value for money (see case studies, overleaf).

A good place for commissioners to start is with an honest review of the private provider market place, developing up to date understanding of market provision, market costs, service models and commissioning gaps that helps commissioners to effectively manage the high cost marketplace in the future.

It's an approach that CCS takes, and in doing so, the company claims to have saved the NHS commissioners and the local authorities it has worked with in northwest England a total of £3.1m since 2008, of which the majority is recurring annually.

Take CCS's work in Liverpool. Three years ago CCS was hired by Liverpool PCT and Liverpool City Council to review high-cost complex care placements, including mental health, learning disabilities and acquired brain injury services. The aim was to re-negotiate rates to get better value for money. In the first year, they achieved savings of £800,000 (see case studies).

It's not just about the one off initiative, though. Mr Hallows says that part of this work must be to ensure that skills remain once the consultants leave.

He calls this "sustainable commissioning": ensuring that staff build up a strong knowledge of the providers in their area and feel confident to negotiate and re-negotiate with providers and gain much needed control in the marketplace.

An example of this is the work the company have done with a group of PCT commissioners and contract leads in the north west providing them with a training day called "Dragon's Den meets The Apprentice" that involved asking public sector commissioners to design a commercial service (see case studies).

"Money often seems to be a dirty word for public sector commissioners," notes CCS chief operating officer Andrew MacGlashan. "We explain to them how they should go about negotiating and how they need to cut to the chase to negotiate fees. They are shocked. We are never impolite or unprofessional but we get to the bones of it immediately when we negotiate with providers," he adds.

He says that commissioners need to ask direct upfront questions about fees and what outcomes they are getting for their patients for the money they are spending.

Mr Hallows agrees. But he also cautions commissioners not to drive down costs so much they force providers out of the market. "We are always mindful of going into a provider and battering them to death because if we put a provider out of the market it may lead to a short term win for our customer but we have narrowed the market so other players will eventually have more control and, most importantly, we can't put the safety of a client or patient at risk."

He also says that there are times when they have to explain to commissioners that they need to do something to "stimulate" the market, for example by designing and commissioning new services.

"We are trying to help them change the balance of power," he says. "Commissioners should be able to affect the market and get more control over it."

VALUE OF THE INDEPENDENT SECTOR SUPPLY

Sector	Annual value of independent sector supply	Independent sector supply as % of total independent and public sector supply
Mental health hospitals	£1,133m (UK 2009)	27%
Care homes for learning disabled and mentally ill adults	£2,862m (UK 2010)	79%
Non-residential care for learning disabled and mentally ill adults	£1,613m (England, 2008-09)	57%

Source: Laing and Buisson

REFLEXSTOCK

CASE STUDIES

THE PRICE IS RIGHT

How commissioners in the North West negotiated remarkable discounts from private providers

SAVING AND LEARNING IN WARRINGTON

Last year Warrington Borough Council and PCT asked CCS to help them increase their commercial understanding.

The council's assistant director of adult social care Steve Reddy explains that he was keen to get CCS involved with the work of the council in order to secure better value for money from private sector contracts and also with the aim of developing the business acumen of council staff.

"What appealed to me was that they [CCS] have the skills and commercial background that gave a sort of injection of business acumen... it was also a message to both staff and the provider market that we had invited CCS in because in these tough times we are going to be scrutinising value for money in all aspects," he says.

CCS worked with both commissioners and contract leads across the council and PCT to teach and embed the tools and techniques needed to work more effectively with the private sector.

"Just inviting CCS in was sending a message to providers that we are focussed on value for money. They have also highlighted to us where we already have good quality value for money placements and also indicated where there are other providers we could be using," Mr Reddy says.

CCS have helped the PCT save £150,000 and the council £44,000 in high cost placement fees over six months.

Margi Butler head of commissioning for mental health and offender health at Warrington PCT agrees. "CCS have been

'Providers now know the PCT is looking very closely at how it does business with the private sector'

Liverpool's town hall and Alder Hey hospital and (opposite page) Warrington town hall and Royal Liverpool hospital. Commissioners in both areas have been helped to negotiate significant savings

able to tell me financially what I can negotiate on and they have supported our care co-ordinators to negotiate better deals," she says.

The collaboration has helped to give some providers a "wake-up call", she adds. "They now know the PCT is looking very closely at how it does business with the private sector."

ACTIVE PLACE MANAGEMENT IN LIVERPOOL

Three years ago CCS was jointly commissioned by Liverpool PCT and City Council to review high cost placements within its complex care placements including mental health, learning disabilities and acquired brain injury services.

PCT learning disabilities commissioner John Engwall explains that people with learning disabilities are often placed in high cost private hospitals and residential centres which are frequently out of the local area.

"When it comes to placing people out of area for years in private establishments and when you have things like the Winterbourne View Castlebeck scandal you have to be asking why are we doing it," he says, referring the abuse of people with learning disabilities uncovered by BBC's *Panorama* in May 2011.

"This population of patients is high cost and unpredictable in terms of when we have to make a placement for somebody. It would be ideal for everyone to be placed in the area so that family and care managers are able to visit regularly."

CCS helped the PCT and local authority to move patients and place them back in area by suggesting the PCT use local providers of which they were previously unaware. Savings amounted to £800,000 in the first year.

"When we deal with big private establishments costs are not individualised so they are harder to see and far less transparent," says Mr Engwall. "CCS have taught us some tricks in terms of understanding what is fair in terms of costs and what isn't."

DRAGON'S DEN MEETS THE APPRENTICE

A day's role-play based training for commissioners in NHS North West provided participants with some insight into how the commercial world works.

NHS commissioners were the "Apprentice" team and tasked with designing and managing a private-for-profit company. They then had to present this to the CCS "Dragon's Den" team to get the funding.

CCS chief operating officer Andrew MacGlashan says: "We modelled their business proposals and showed them that although they would have had the technical skills to run the service, they had made poorly informed commercial decisions which meant their new company would not succeed."

He gave the theoretical company and its directors a summary position of what would have happened over the next two years and explained that they would have been sacked because of the poor business decisions they had made.

It was a good lesson in how the private sector approaches commercial decisions, says Janet Collinson, assistant director of commissioning and strategy at NHS Northwest.

"They explained how to translate that understanding into achieving value for money within high cost, low volume markets through making staff more commercially aware of the areas they need to focus on and the work required prior to entering into contract negotiations."

As a result, staff now feel better equipped to carry out value for money reviews and active placement managements, both retrospectively and in the future – in other words, the day helped PCTs develop "more sustainable commissioning". ●

ALAMY

EQUIPMENT RATIONALISATION

DON'T FORGET YOUR KIT

The sophistication and sheer quantity of equipment in hospitals is staggering – and trusts often overlook how much can be saved by managing it better. By Emma Dent

Delivering efficiency while improving quality is not a straightforward proposition. Yet it is a very real issue that needs to be addressed by the NHS, and one that requires all trusts to think differently about the way it procures, manages and delivers services.

Achieving success during difficult periods almost always requires organisations to focus on what they do best. The NHS is no different.

The NHS delivers an exceptional service to its patients but now is the time to look at how specialist providers can enhance it, by reducing costs and delivering more efficient services.

In today's competitive environment, outsourcing of non-core services is becoming an important and attractive option for trusts. Over the last 12 months we have seen a marked increase in the number of trusts interested in outsourced equipment management solutions. There is good reason for this.

If high value medical equipment is not performing well, there is a direct impact on a hospital's ability to deliver patient care and generate revenue. It is therefore imperative that it is available and productive.

However, equipment and technology are advancing at such a pace that many trusts do not have the extensive capital required to provide patients with the latest equipment and most advanced treatments.

'Many trusts do not have the capital to provide the latest equipment'

Trusts also face changes to the patient mix, meaning demands on equipment are evolving. As a result, efficiencies in training, operations and maintenance need to be addressed as readily as equipment performance.

Utilising a specialist provider can help meet these challenges. When delivered correctly, the outsourcing of equipment management should provide enhanced productivity, reduced whole of life costs and improved quality. It should remove the day-to-day burden of managing non-core services. It should enable you to focus squarely on clinical services and patient care.

The addition of new procurement models means that outsourced solutions are now simple to acquire and quick to implement. This ensures that services are more accessible to all trusts, while also providing more immediate benefits.

At a time when the NHS needs to identify measurable efficiency savings, the outsourcing of equipment procurement, management and maintenance provides a genuine way of helping trusts meet cost improvement targets while freeing clinical staff to focus on what it does best – world class patient care.

Sean Williams is business development director at Asteral

➔www.asteral.com

A glance round any ward or department will demonstrate that the amount of medical equipment present in any hospital is staggering. And its presence is increasingly significant.

So advanced has even relatively basic equipment become that the average medical ward now compares to an intensive treatment unit of 25 years ago. Clinicians have become increasingly dependent on devices to aid diagnostic decisions. This significant shift is reflected in the increasing regulation that governs equipment use. And from devices used to peer into ears and throats to cutting edge MRI and CT scanners, the value of such equipment can vary from £50 to millions of pounds.

As wards, departments and directorates have traditionally each requested their own equipment for purchase, as opposed to stocks being centrally managed, keeping track of such a vast stock of equipment – including how long it has been in use, when it may need replacing and how to keep it maintained – can be massively time consuming for staff who would otherwise be engaged in clinical or managerial work. Equipment also represents a significant part of overall expenditure, yet such spending can be hard to track and control.

Stephen Hodgson, founder director and director of operations at independent provider of equipment services to the NHS Asteral, explains the purchase and maintenance of medical equipment suffers from not appearing on the radar at trust board level.

"Medical equipment does not always have a strong enough voice at board level and within the service there is a lack of transparency around equipment costs. This leads to decisions [about equipment] being made on a disparate basis, with one ward buying a box of X equipment while another buys box Y equipment and neither communicating with the other about their purchase," says Mr Hodgson.

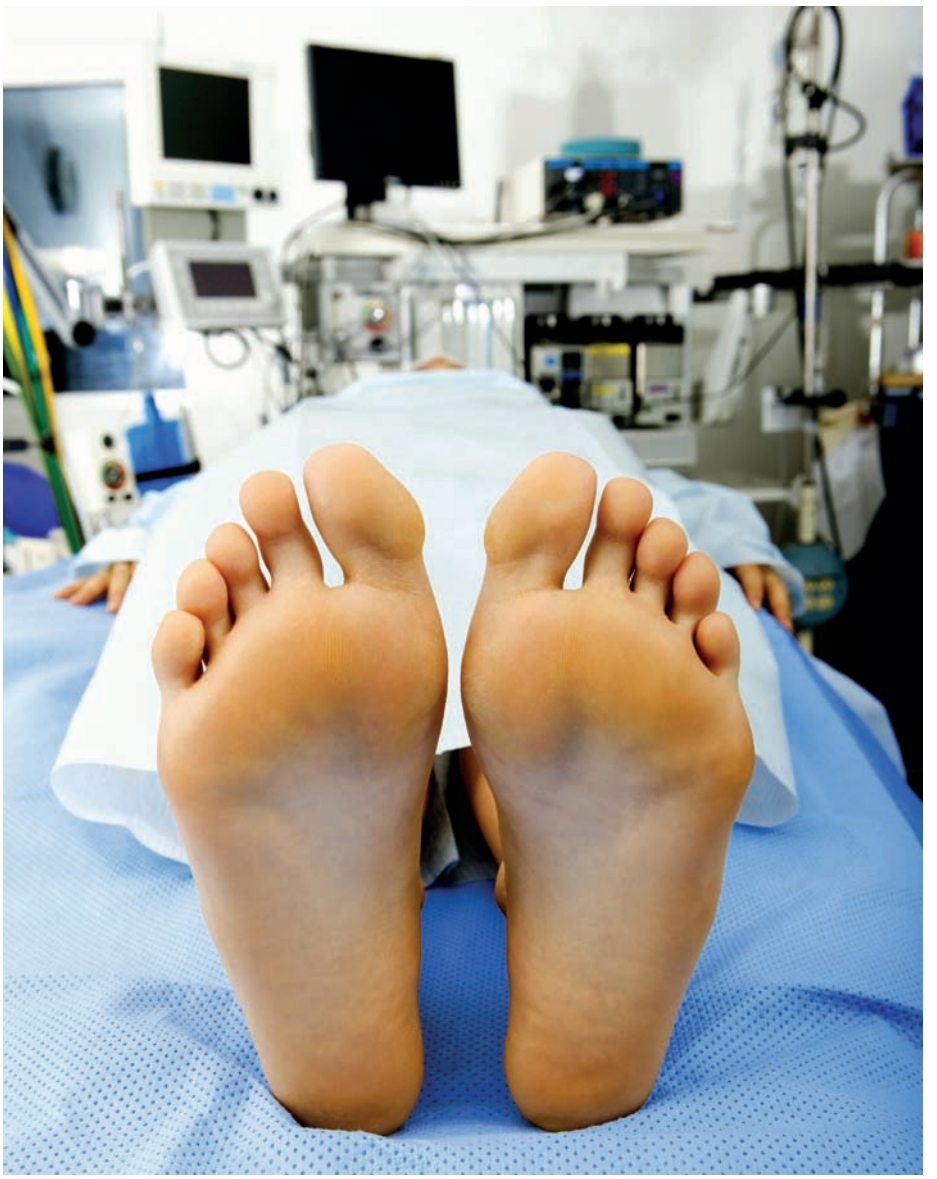
"It also means that ward managers and clinical leaders are having to manage equipment needs, which they may not understand and cuts into their time to do other things."

Asteral business development director Sean Williams adds that equipment purchases are often driven by clinicians requesting the latest, hugely specified, kit. And without a fixed grip on the situation it can be impossible to know what equipment is already in place, what is needed and how it can be most effectively used.

It is a state of affairs that can cost trusts considerable sums through equipment that is out of use because it needs repairing, equipment being unnecessarily replicated or not being used effectively (and equipment not being used is not generating income). One solution is to turn to a firm such as Asteral to manage equipment needs.

"As an independent service provider managing medical equipment we are able to identify the key issues and define a solution that is driven by best industry practice, ," says Mr Hodgson, who founded Asteral after a career in medical equipment management and lecturing during which he realised he was lecturing a theory but having to put into practice a rather difficult reality.

"The way trusts usually work is reactive. We are proactive. Trusts are able to plan financially at most two or three years ahead. We have stability and can plan financially seven or eight years ahead," he says, adding that with a substantial estate of equipment in its portfolio, Asteral is in a better position to negotiate prices than a trust buying one or two pieces at a time. Equipment is



Switched on: even ordinary medical wards today are packed with advanced equipment – but are trusts getting the best value out of it?

traditionally leased, purchased through the NHS Supply Chain agency, or bought after a tender advertised in the *Official Journal of the European Union*.

"The analogy we use is that it is like buying a car but we are fleet managers, not making a one off purchase, or hiring something," says Mr Williams. This enables Asteral to leverage its position to generate savings for the trust.

One service offered is the managed equipment service contracts [MES] used for diagnostic imaging – X-ray machines, MRI scanners, CT scanners and ultrasounds. The contract includes a number of Asteral staff being based on site to help maintain equipment, with engineers being brought in if a problem needs additional attention. Its longest contract is currently 33 years, although the average is around 15 years, which will involve at least two "refreshments" [replacements] of kit such as CT scanners, which typically have a seven-year effective life span.

"Diagnostics are the window of the hospital. It is important to get them right," says Mr Williams.

Asteral's other work involves contracts that cover the procurement, management and maintenance of what are known as electro-biomedical equipment (EBME) – items such as ventilators, defibrillators and pressure mattresses – but even in an average sized district general hospital this could involve between 3,000 and 10,000 items. Asteral will manage the whole inventory, replace equipment when required and provide fully-trained engineers on site to maintain the equipment to ensure faults are resolved quickly.

Asteral currently works with nine hospitals and had secured its latest customer – a district hospital on the outskirts of London with two sites, including maintenance of all diagnostic equipment and 5,000 pieces of EBME kit – on the day it spoke to *HSJ*. It describes six of those contracts as major and has a number of smaller contracts. Although the value of many cannot be revealed for commercial reasons, the largest contract being carried out by the firm is £150m, at a value of £10m a year over 15 years, while the smallest is £2m over seven years to maintain a CT department. Most however are around £20m or £30m over 10 or 15 years.

An advantage often cited by Asteral's clients (see case studies, overleaf) of dealing with a dedicated equipment supplier is its dedicated call centre in case of equipment failure – saving managers having to chase up manufacturers or engineers themselves.

However, Asteral do say they understand the cultural change trusts have to go through to take up such a contract. With trusts struggling with not being able to plan financially for the future more than at most two or three years ahead, Mr Williams acknowledges looking ahead 15 or 20 years can be a significant step.

"As a consequence, we are currently expanding our product portfolio to meet our customers changing requirements. We are rolling out a new product that provides managed services for a single equipment lifecycle, ensuring our customers receive immediate cost savings and much needed capital investment, while continuing to deliver the same productivity improvements that our longer term contracts provide.

"In addition we have recently launched a standalone managed maintenance product for trusts that don't require a fully integrated solution, designed to deliver significant cost savings while ensuring maximum equipment uptime through the use of OEM [original equipment manufacturer] engineers and spare parts," says Mr Hodgson.

REFLEXSTOCK

ASTERAL

CASE STUDIES

WE HAVE THE TECHNOLOGY

Trusts that buy in equipment services cite advantages including getting state-of-the-art devices and dealing with a single call centre for maintenance. By Emma Dent

UNIVERSITY HOSPITALS OF LEICESTER TRUST

Asteral's contract with University Hospitals of Leicester Trust covers all managed equipment services funded from existing medium term budgets and was not part of a later cancelled PFI deal.

"It covers a wide range of equipment, from all CT and MRI scanners, ultrasound and X-ray machines down to the injectors used with those devices," says Leicester's clinical business unit manager Nicola Leighton-Davies, who oversees departments including imaging and medical physics. "Each trust has a limited amount of capital to spend and the MES contract offers a way of ensuring this equipment will be replaced when it needs to be."

It took nine months for Asteral to install bespoke state of the art medical equipment and radiology facilities at the trust. Asteral also provide a full time, on-site engineer and radiographer and can supply performance data according to equipment type, hospital site and supplier. This means the trust can instantly see how equipment is performing and being used, and view an auditable trail of all supplier and maintenance activities.

Ms Leighton-Davies cites having a single point of contact (Asteral's call centre) as the single biggest advantage of the contract. "To have a single point of contact for all maintenance needs – instead of clinical staff having to liaise with dozens of manufacturers, which is a huge undertaking – means they can get on with treating patients," she says. Equipment uptime has improved since the contract began.

Ms Leighton-Davies admits that the arrangement did take some getting used to, and took some work to achieve.

"The contract took a lot of groundwork, financially, legally and from a procurement point of view, but from a service point of view now, it is difficult for an individual to see the difference in our everyday ways of working. And that's the way it should be."

WHITTINGTON HOSPITAL TRUST

In October 2005 the Whittington Hospital Trust in north London awarded a 15-year managed equipment service contract to Asteral. The deal was driven by a need to replace outdated technology.

While the hospital building was itself undergoing a major redevelopment, adoption of modern clinical procedures were becoming restricted due to the older technology and many pieces of equipment were getting close to their recommended replacement age. But the trust lacked the capital needed to buy new equipment.

"We felt from a financial point of view that the MES contract was the most affordable while also giving us an imaging department that was fit for the future," says imaging services manager Recep Suleyman, whose background is as a radiographer.

"It is a major department, with 22 imaging rooms, plus some mobile units, and finding the capital to fit it all out in one year would have been impossible, nor could we leave the environment as it was."

The first part of the MES scheme saw Asteral purchase and install a number of mobile ultrasound and X-ray machines to replace the most urgently needed and older equipment, followed by the refurbishment of an emergency department X-ray room.

Since 2006, when the contract was put into force, the number of radiology examinations carried out per year has risen from 99,000 to 150,000.

"This relates directly to the type of up to date equipment we now have that we could not have afforded otherwise, and was done without increasing manpower," says Mr Suleyman.

"For the first time since 2006 we do not have any equipment that is older than a member of staff. There is less equipment down time, and when something does go wrong, Asteral can be easily contacted."

Well equipped: (clockwise from top) Whittington, Peterborough, Leicester and Stamford hospitals have all renewed their equipment by signing contracts with Asteral

Mr Suleyman admits that, on paper, an MES deal may seem more expensive than standard equipment procurement and adapting to it can be a culture shock.

"It is a completely different way of working. But Asteral police their supplies very carefully. If you put all the gains into perspective it is worth it. Doing things the traditional way has hidden costs."

Although the trust enjoyed good relationships with manufacturers when its equipment was traditionally sourced, Mr Suleyman adds that when two ultrasound machines were purchased outside of the Asteral contract, the customer service received did not compare favourably and Asteral were eventually asked to take over their maintenance needs too.

'For the first time since 2006 we do not have any equipment that is older than a member of staff'

Knowing replacement needs are also included in the contract is another relief for Mr Suleyman. "You do not have to convince the finance director or go into battle with other department managers because the money has already been put aside. It is the easiest replacement regime I have ever worked with, and I qualified in 1975."

PETERBOROUGH AND STAMFORD FOUNDATION TRUST

Asteral manages around 6,000 items for Peterborough and Stamford Foundation Trust on one site that includes an acute hospital with 611 beds (including 16 critical care beds) and 18 theatres as well as a 102 bed mental health unit and 34 bed community hospital. The acute hospital's facilities were previously on three sites.

The new Peterborough City Hospital was financed and built through a 35 year £335m PFI contract, in which Asteral is a partner. Asteral manages and maintains all equipment and the contract covers room design and implementation and supply and future replacement of all imaging and anaesthetic equipment.

"From a value for money perspective it was the most appropriate way to go," says Greater Peterborough Health Investment Plan associate director Angela Broekhuizen. "It also meant we got some very good, state of the art imaging equipment. And a major advantage was that, at the handover of the new hospital, all the equipment had already been installed." ●

ALAMY