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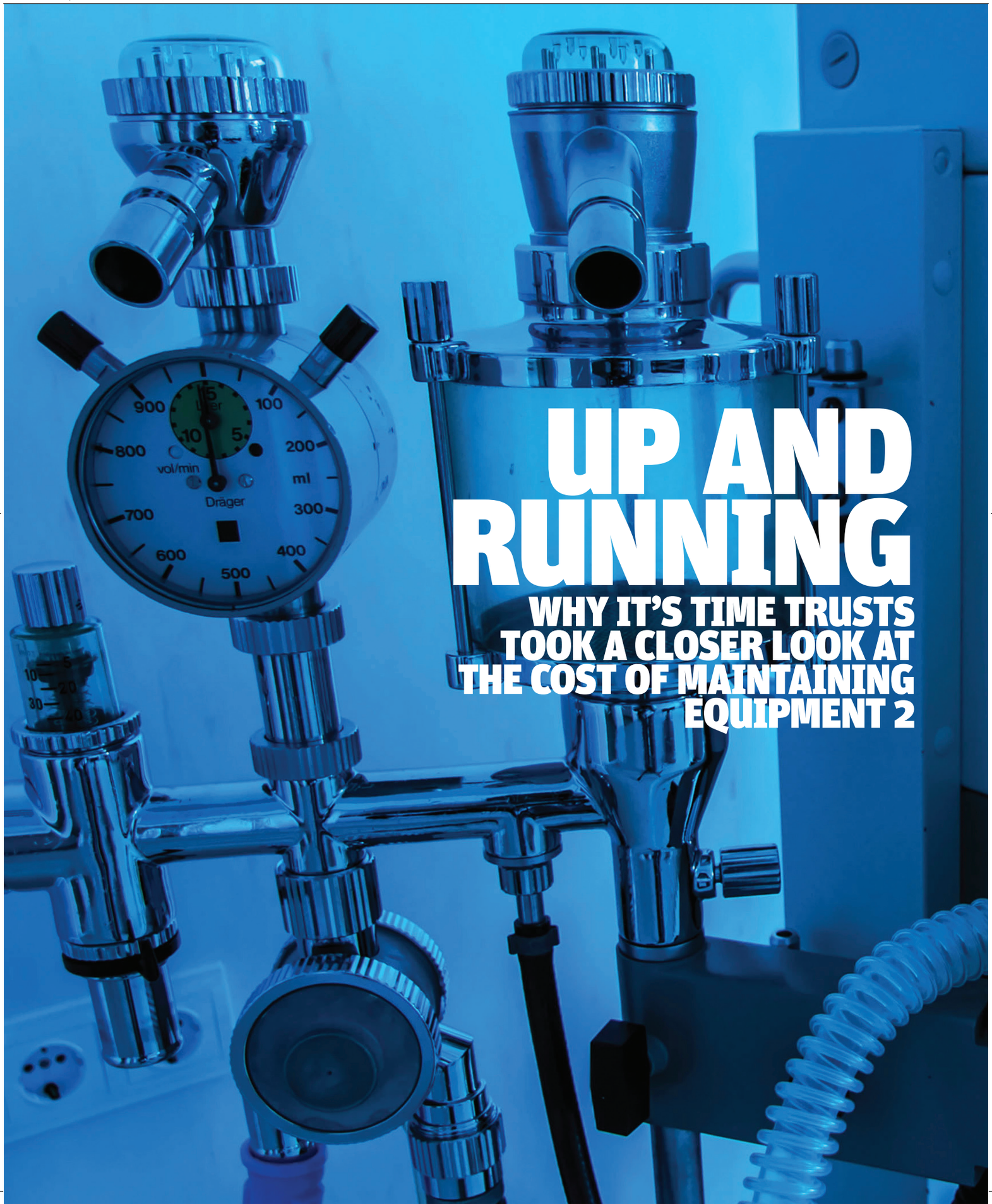

UP AND RUNNING

WHY IT'S TIME TRUSTS TOOK A CLOSER LOOK AT THE COST OF MAINTAINING EQUIPMENT 2

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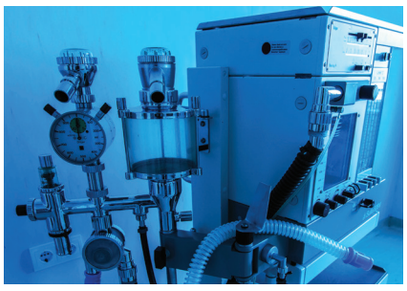
INSIDE

Supplement editor
Alison Moore

EQUIPMENT MANAGEMENT

With the focus on cutting NHS procurement costs, the bill for maintaining equipment can be overlooked. Barriers to getting better deals include the difficulty of keeping track of hundreds of contracts for a typical acute trust. Now some trusts are turning to outside specialists to review their maintenance contracts and save money through tactics such as bundling contracts together, switching service suppliers and renegotiating deals. Page 2



ESTATES MANAGEMENT

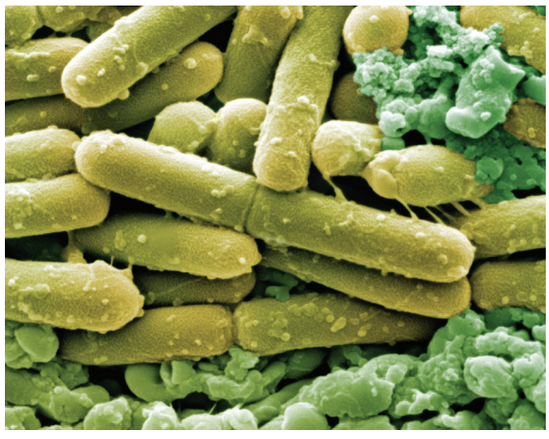
The Francis review and the DH's review of critical infrastructure have upped the pressure on trusts to tackle the huge buildings maintenance backlog. But with funds scarce, they may need to start thinking outside the box to find the income to do this – by, for instance, creating more retail space in hospitals or building hotels for friends and family on site. Page 18

WORKFORCE

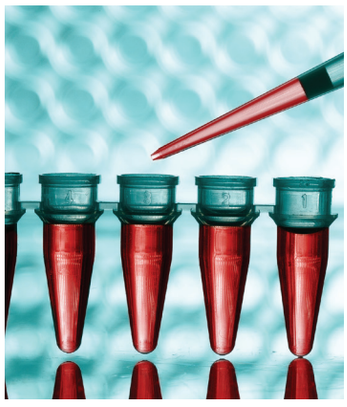
Trusts must ensure NHS staff at all levels have the skills needed to cope with increasingly demanding roles and avoid future failings in care. Now some are bringing in outside help to analyse and address the skills gap. Page 6

DIAGNOSTICS

As *C. Difficile* rates in the NHS have dropped in recent years, trusts have been hit with tougher targets for the number of cases – and big fines if they miss these. Some trusts are now looking at spending more on molecular tests that deliver quicker results, thus cutting the risk of a target-busting outbreak. Page 20



PATHOLOGY



Collaboration between trusts to provide more efficient pathology services has been growing. Many are looking to set up joint ventures to build economies of scale but in doing so must negotiate a regulatory minefield. Page 10

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An ageing population means rising numbers of atrial fibrillation sufferers, who face a high risk of stroke. But could the cost to the NHS of monitoring the drugs they take be reduced – and outcomes improved – through self monitoring? Page 22

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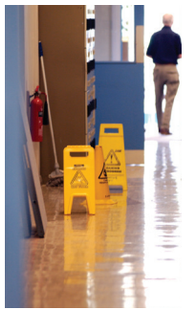
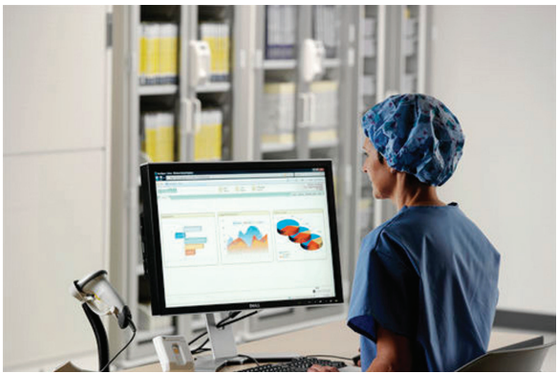
Trusts are looking to share or outsource a wide range of services, with a notable tactic being setting up joint ventures with the private sector. Such projects are not just about savings but can bring in extra capital. Page 14



INVENTORY MANAGEMENT

How trusts could save money through better systems to manage stock. Such systems can ensure that, for example, items are always ordered in the right quantities to avoid waste or shortages, are easier to find, and are used before they expire. Page 26



STUART JEFCOATE ON SAVINGS

The continuous need to generate savings is among the NHS's greatest challenges, and recent tariff reductions have extended that challenge still further. With much of the low hanging fruit having already been plucked, the NHS is having to dig deeper for new savings opportunities and to explore new approaches and new ways of delivering services that might never have been considered in a less austere climate.

Of course, there is a vast array of initiatives vying for the attention of most trusts – hundreds in some instances. But implementing most of them requires resource, and implementing a significant number far more resource than a trust will normally have available. And many require significant investment today to deliver savings tomorrow at a time where capital is in short supply.

So prioritising which cost improvements to focus on is a real issue – indeed probably the key issue for many finance or turnaround directors today. And there is a huge balancing act too – between satisfying Monitor's requirements for prudent financial performance on the one hand, and the need to meet the standards set by the CQC on the other. So ensuring that a cost improvement programme delivers savings without compromising patient care or operational efficiency is critical.

So what might an ideal cost improvement programme look like? It would clearly deliver savings – but without requiring front end investment. It would free up trust resource to focus on other initiatives, rather than demand scarce resource to implement. It would increase rather than compromise control and efficiency. And, finally, it would enhance patient care by reducing risk. We have worked hard to develop our Maintenance Lifecycle service to deliver all of these benefits – and to ensure that our systems and people are focused on this. "Savings, control and compliance" is more than just our marketing strapline, it defines our entire approach to implementing the service.

'Prioritising which cost improvements to focus on is a real issue'

With massive savings targets, we recognise of course that it is inevitable the focus will tend to be on the largest projects. And, while there are significant savings to be made from maintenance and service contracts, it's fair to say we won't solve a trust's financial problems single-handedly. But we can make a great contribution. And we will do so without using up trust resource – and deliver an improved solution at the same time. There probably aren't many cost improvement programmes that can tick all of those boxes.

Stuart Jefcoate is commercial director at Leaseguard

www.leaseguardonline.com

EQUIPMENT MAINTENANCE

RISE OF THE

Is your trust facing a rising bill for maintaining its equipment? A

Over the last few years there has been a great deal of focus on how the NHS procures equipment. It's recognised that trusts do not always get the best value for money when they buy expensive equipment.

But there has been much less focus on maintenance of that equipment once it has been purchased. Keeping the equipment running smoothly is critical for delivering diagnostic and other services, and trusts will normally have maintenance contracts in place to ensure that the risk of vital medical, IT and estates and facilities equipment suddenly becoming unavailable or malfunctioning is minimised.

Continued functioning of such equipment is often mission critical for organisations because of the impact on waiting times and quality of care if key pieces of equipment are out of action. But, while no one wants to skimp on the essential maintenance of such equipment, are there opportunities to reduce the cost of these contracts without reducing the level of service offered?

The National Audit Office suggested, in a landmark report in 2011, that trusts had no mechanism for deciding whether they had the appropriate maintenance for expensive equipment – CT and MRI scanners – and none of the organisations it questioned had assessed how they compared with other trusts. Yet the lifetime maintenance costs of such equipment were broadly equal to their purchase costs. Overall, they did not have the means to determine if they were getting the best value from either purchasing or maintenance of the equipment, and the NAO said trust boards should scrutinise existing maintenance deals.

There is no way of knowing how many NHS organisations have taken up this recommendation but the potential for savings is significant: a hospital with a turnover of £300m to £400m can easily have maintenance contracts of £5m a year.

And very often it can be hard to keep track of what contracts it has, whether the equipment is still in use, and whether the contracts offer the best value for money. Add to that the complication that the amount of equipment used in a major hospital is a moving target: over a year, some will be discarded, some will be replaced and other pieces will be entirely new.

Peter Mullin, managing director of Leaseguard, which delivers a Maintenance Lifecycle service to trusts, says acute trusts tend to be very asset-intensive organisations and will typically have 300 to 400 contracts across up to 200 suppliers. Very often the maintenance contract will have been bought as an afterthought, often with the original equipment supplier but will typically index

CASE STUDIES OVERLEAF ▶

MACHINES

? Alison Moore on a cost that can often be overlooked

ALAMY

up in costs year on year, he says.

This sort of historic agreement can often continue for years without being questioned or the value for money examined. And with many internal stakeholders with an interest in the maintenance contracts – from the clinicians who use the equipment through to the finance and electro-biomedical engineering departments – changing specifications or supplier sometimes just feels too difficult.

'Often the maintenance contract will be an afterthought and typically index up in costs year on year'

The end result is opportunities for the cost of contracts to be reduced may be missed. Trusts may not even know how many contracts they have – let alone have an eye on when they are all due for renewal and the opportunities that forward planning of renewal could offer.

"It becomes hard to look at it from a holistic point of view when the pressure is simply to renew the contract in time, let alone plan a portfolio-wide strategy," he says.

One of the first things that Leaseguard will do is find out exactly what contracts are in place in a trust – which is not as easy as it sounds. Once trusts know what they are paying whom and for what, there can be opportunities to make savings – although he is clear there is no silver bullet which instantly saves all organisations large amounts of money. Instead, solutions have to be tailored to an individual trust's position and preferences.

One approach which can reduce cost is to bundle together a number of maintenance contracts for similar devices which can then be put out to tender. This offers economies of scale which can reduce overall cost. In some cases, negotiating with service suppliers can reduce the cost – although this can be challenging if there is no threat of competition to encourage the supplier to reduce prices.

Another option is looking beyond the original equipment manufacturer for a service contract. When buying a complex and expensive piece of equipment, it is easy to opt for the manufacturer's service contract simply because if feels "safe". But there can be significant savings for trusts prepared to look elsewhere.

So what can trusts save by adopting a different approach to maintenance contracts? Mr Mullin says he has seen savings of up to 70 per cent on some contracts, but savings of over 15 per cent over the term of the contract are more typical.

In theory, trusts could do this all themselves but Mr Mullin says that what Leaseguard brings is a level of expertise in this field and a proven ability to deliver savings, which trusts are unlikely to have in house simply because maintenance contracts are unlikely to be a focus for their business.

And another aspect is whether the contracted maintenance is actually carried out. When equipment is in regular use, it can be difficult for a contractor to actually carry out the maintenance as planned.

Staff may be reluctant to release it for maintenance in busy periods and, inevitably, sometimes contractors go away without being able to carry out the planned work. Mr Mullin estimates that between 5 and 10 per cent of maintenance work which is paid for may not be carried out

Mr Mullin says that one contractor told him that they had not managed to service a particular piece of critical theatre equipment for three years because it was continually in use when they turned up for booked appointments.

Regardless of why it happens, not carrying out necessary maintenance work means that money is being wasted and potentially increases the risk that equipment will break down, impacting on services, or will malfunction – which can have implications for patient safety.

Leaseguard has introduced a managed service – OPTIMiSe – which allows service sheets to be uploaded to a central repository and the work done reconciled with what should be happening. This allows planned maintenance to be tracked and offers proof that it has been carried out.

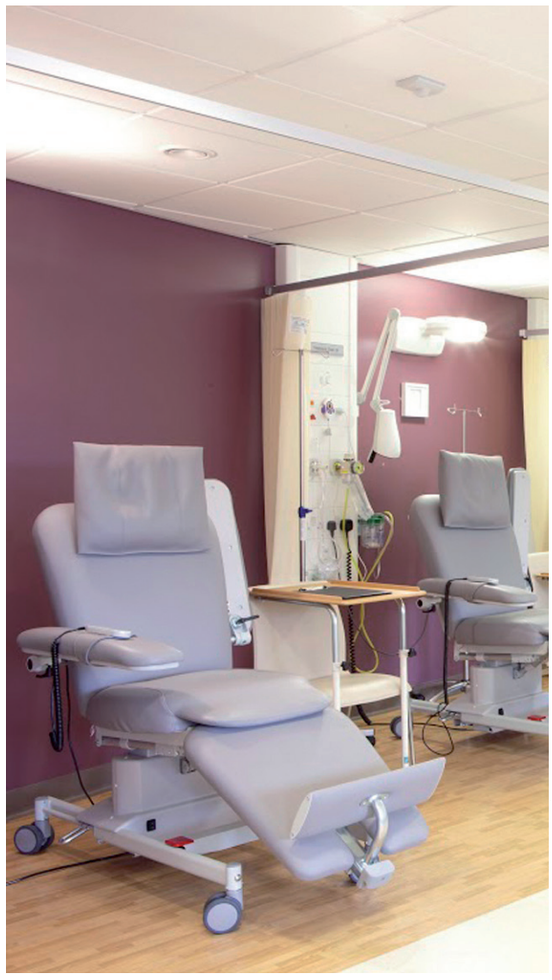
Ensuring NHS equipment is running smoothly and is available when it is needed has never been more important than in the current climate: but the challenge for trusts is to do that while also looking for savings which can help their bottom line. ●

LEASEGUARD

EQUIPMENT MAINTENANCE: CASE STUDIES

DON'T JUST TICK THE RENEWAL BOX

How moving responsibility for managing contracts from busy frontline staff has paid dividends for three trusts



ALAMY

THE CHRISTIE

The Christie Foundation Trust – a specialist cancer centre in Manchester – relies on a vast range of technology to provide its services. Keeping that equipment running is crucial – but like other trusts it does not want to spend more money than it has to on maintenance.

So over the years it has tried to trim the cost of maintenance contracts as much as possible, using its inhouse staff. A few years ago the trust felt it had made all the savings it could – and called in Leaseguard.

Ian Moston, until recently the trust's finance director, says he was pleasantly surprised when Leaseguard were able to make extra savings. "We had picked all the low hanging fruit. We did not put anything with them until we had got all the savings out that we could," he explains. "We are technology heavy as an organisation compared with the standard hospital. The bulk of our business is theatres, imaging... and so on. It is about being able to ensure that we have the equipment available to use when we need them and the patients are not waiting.

"I am convinced that there is a lot of opportunity for the NHS to get greater value out of its supply chain. This is where the NHS is getting to grips with the sort of changes that have happened elsewhere in other industries. We choose to partner quite carefully as an organisation. We are quite picky and that's a good thing. We only want to work with people who will give us their A team and are there for the long term."

Like many trusts, the Christie had multiple contracts across the organisation and found it hard to keep an eye on all of them. One of the things it discovered was that it had three contracts with one supplier who was offering different levels of discount on each of them.

Leaseguard says it is now managing around £1.6m of medical and IT equipment maintenance contracts for the Christie and has generated savings of at least £290,000. Tendering for one contract, with an estimated cost of £140,000, reduced the price by £50,000. In another case, it was able to negotiate down the cost of a contract with a single supplier.

The trust is also introducing the "OPTIMiSe Service" system which monitors service delivery to ensure it is as specified in service contracts.

Monitoring delivery of these contracts can be difficult, says Mr Moston. A contract may specify four service visits a year – but if one slips a little it can easily fall into the next year and be counted against next year's total.

Effectively, OPTIMiSe Service makes the supplier do all this work to ensure they get paid. It provides an accessible audit trail to show that the work actually has taken place – which can be important for the trust if there are issues around liability.

But it can also prompt trusts to look at what they are getting out of repeated service visits and question whether they are setting specifications at the right level. Mr Moston is hopeful the data from OPTIMiSe will inform future decisions and give a better picture of what is happening across the trust.

ROYAL BROMPTON

Managing the Royal Brompton and Harefield Foundation Trust's vast portfolio of maintenance contracts would require a team of several people – and even then it would be hard to provide the expertise which would drive down costs and justify the investment, according to head of procurement Steve Williams. He sees "outsourcing" the management of contracts as a sensible

Keep on running: The Christie and (below) Royal Brompton are rethinking their approach to maintenance

solution which allows the trust to capitalise on someone else's expertise while making substantial savings.

The Royal Brompton, like many trusts, has hundreds of maintenance contracts with different organisations, differing lengths and differing end dates. Historically, decisions on contract renewals were often devolved to frontline staff who would get little notice that the contract was due to end and had little time to do anything but tick the box to renew for another year.

In such circumstances it is easy for trusts to end up with more expensive options and a "gold standard" of service which does not really reflect the impact of equipment breaking down for the organisation.

But managing the system more closely from the procurement team would be a huge administrative task and Mr Williams did not have the manpower available to do so.

So the trust turned to Leaseguard in 2010, initially using it to manage an annual total of £3.1m – and now £4m – of contracts. Mr Williams says that a specialist team can look across the market and exploit its knowledge and experience to drive savings which an internal team would struggle to get. Contract renewal is now a planned process with finish dates being known and plans drawn up well in advance. "We would not get anywhere near the value they are achieving," he adds. "We have saved enormous amounts of money."

'Trusts can end up with an expensive "gold standard" service that does not reflect the impact of equipment breaking down'

He is particularly pleased with the overview he now has of his contracts across both trust sites – information Leaseguard assembled from bits of paper in filing cabinets and by looking through invoices to discover what the trust was paying for.

"Four or five years ago we would have been hard pressed to know how much we were spending on maintenance contracts. Now we can look up online absolutely everything that is under contract – what the status of the contract is, when it is going to be renewed and what it costs. It is indispensable."

Leaseguard calculates the savings to the trust to be over £1.9m over the term of the contracts. For the trust there is also less anxiety about contracts – that they may run out without being noticed or that money may be being wasted because an unnecessarily high level of support has been purchased.

NORTHERN LINCOLNSHIRE AND GOOLE

Providing hospital care across thinly populated areas such as Lincolnshire inevitably means that trusts end up running services in more than one site.

But that can be an extra challenge for facilities departments trying to keep track of equipment and ensure that it is maintained.

With three sites, Northern Lincolnshire and Goole Hospitals Foundation Trust has found one benefit of working with Leaseguard is that it has helped to keep the trust's asset register up to date as well as save money.

The trust has also started to work with the neighbouring United Lincolnshire Hospitals Trust, which also uses Leaseguard, in a collaborative project. United Lincolnshire has three main sites so contracts covering all six sites offer economies of scale. Three contracts covering piped medical gases, lifts and CCTV and intruder alarms, across all six sites have been tendered with the help of Leaseguard: Leaseguard says the savings from these alone amount to £435,000 over the contract period.

Nigel Myhill, director of facilities and information at Northern Lincolnshire and Goole, says savings add up to £400,000 in the last three years (including United Lincolnshire's). "That is money we could not have released," he says. "We don't have the resource and the specialist knowledge.

"For example, they have lift contracts across lots of other trusts and therefore have an ability to talk to big lift suppliers about whether they are going to come into a tender."

One challenge for Mr Myhill's team has always been the timing of contract renewals: many end in March or April at a time when facilities staff are often preoccupied with the end of the financial year, getting projects underway for the new financial year – and also it is holiday time. This meant that unless prices had risen dramatically there was a temptation to just roll the contract over. Now, he says, Leaseguard will start to talk to his team as early as September or October, allowing plenty of time for a tendering process before the old contract expires.

"But it is not just the money it is about ensuring the maintenance contracts that are let are up to date and meet the latest statutory requirements," says Mr Myhill. From a governance point of view, this means that he can offer reassurance to the board that the trust is compliant with relevant guidance and requirements. ●

CHRISTINA POND ON INVESTING IN YOUR STAFF

Making cost savings is far from the only major challenge facing health sector managers and clinicians. The Francis report stressed the importance of ensuring quality, safety and the right organisational culture, highlighting the damage when things go wrong. Leadership has been put in the spotlight with managers and clinicians facing tougher scrutiny than ever before.

Considerable strategic shifts are taking shape in the demand on the sector, associated with an ageing population and the need for greater integration between health and social care. We know too that there are skills gaps within the workforce and that out-of-date working practices based on traditional roles and models of services often exacerbate inefficiencies and affect the quality of care.

The best health organisations understand that workforce development is the single most important issue which underpins the changes necessary to meet so many of these wider challenges; they also recognise that workforce represents their greatest investment. Despite the scale of the challenges, forward thinking organisations have shown they are able to tackle them and are reaping the rewards in the form of major cost savings, productivity improvements and enhanced health outcomes.

Skills for Health has worked with many of these trail blazing organisations, often helping them achieve astonishing results. Locally, nationally and internationally we have a reputation for excellence and expertise and a ten year track record of supporting employers to manage change. Employers trust us to make a difference and to help them with reliable, sustainable, value for money solutions that drive up skills, productivity and quality and which reduce costs.

‘Out-of-date working practices exacerbate inefficiencies’

Whether it’s our bespoke consultancy or workforce planning services; products such as Doctors Rostering tools, role redesign or ‘WIRED’, which helps to revolutionise compliance reporting; e-learning delivered to over 250,000 people; or apprenticeships and leadership programmes – our results speak for themselves. An independent report found we add around £150m of value to the health sector each year. We are licensed by the government as the Sector Skills Council for health and, as a registered charity, we’re non-profit-making, unlike other commercial providers.

Our goals place health sector employers at the heart of everything we do. Ultimately, we help you develop your workforce, transform services and improve the care you deliver.

Christina Pond is executive director at Skills for Health

www.skillsforhealth.org.uk

WORKFORCE

MIND THE SKILLS GAP

With the demands on NHS staff changing fast, how can we ensure they have the skills to cope? Alison Moore on analysing and tackling skills shortages

The NHS is at heart a people business with workforce costs taking up 70 per cent of its budget. So it is not surprising that it is under tremendous pressure to get the best out of its staff and to ensure they can deliver high quality healthcare.

But NHS staff may not always have the skills they need to cope with their increasingly complex and evolving jobs. In many cases these are not specialist skills but may be required by most staff: skills such as team working, problem solving and dealing with patients and public.

The consequences of this for organisations can be profound – including the impact on patient care. Lack of appropriate skills has been a factor in many failings in the delivery of care such as Mid Staffordshire and Winterbourne View.

Christina Pond, executive director for products and services at Skills for Health, points out that what has come out of the Francis report into the failings at Mid Staffordshire is not new learning: the broad issues around the need for appropriate skills have been around for a long time. She says: “There are very demonstrable impacts on quality of care.”

In 2011, healthcare employers were asked by the UK Commission for Employment and Skills what they saw as generic skills gaps in the workforce. Team working skills were cited by just over half of those who identified gaps, followed by customer handling skills, written communication skills, strategic management skills and problem solving. Most of these were identified more often in the health sector than in other parts of the economy.

There is ample evidence on how gaps in these generic skills directly influence the quality of care for patients – for example, research has shown that good communication skills can lead to reduced patient pain and improve recovery times because patients get better information about diagnosis and treatment.

But Ms Pond points out that the current challenges for the NHS make equipping staff with the right skills even more important. “If you look at the overall impact of skills gaps per se, it is much harder to encourage the take up of new working practices when there are identified skills gaps involved. That is important for the NHS as a whole if we are to achieve better services by getting people working in different ways,” she says.

“We know that, although we have some excellent areas of practice, there are also areas where we lag behind our European counterparts. If we are seeking to achieve change and transformation in services and care, then we have to get people doing things differently.”

So that means understanding the skills a workforce needs and what skills it already has is crucial. At a very basic level this means ensuring that staff have the core skills to operate effectively. Skills for Health’s core skills training framework aims to standardise what is required from statutory and mandatory training.

This should help reduce duplication in training but can also be used to drive up the numbers of staff who have completed the necessary training and have these vital core skills. This is already being demonstrated at many trusts, who are working with Skills for Health on a project to streamline both training and the checks new employees have to go through.

But organisations may also want to carry out a training needs analysis to identify both the skills they are going to need to deliver care in this new environment and also to map the skills staff already have.

CASE STUDIES OVERLEAF ▶

Good preparation: staff need to be taught new skills – and given the chance to use them

SPL

Linked to this is the need to think about how services will look – as they are increasingly built around patient pathways. Roles are likely to be redesigned around this – and new roles may need to be developed in response to identified gaps in skills and competences.

And skills gaps are found everywhere in organisations, not just among the lower banded staff. The Francis report revealed that leadership and management skills can also be in short supply – and the impact of this. There is evidence that the majority of employees in healthcare are effectively supported by their managers but a significant minority of staff work under managers who are not managing effectively.

But as trusts face an ever tighter financial situation what makes the case for investment in training? Ms Pond points out there are many central initiatives around ensuring the workforce has the skills it will need but the issue is that they are not necessarily taken up, translated and implemented consistently at a local level.

One of the levers that could be used is commissioning: commissioners could stipulate required training and skills development in contracts. "How do you commission for value that is both financial and qualitative?" she says. "There is a benefit in developing the clinical commissioning role so that it considers value in terms of both the outcomes of treatment and the cost."

'Commissioners could stipulate required training and skills development in contracts'

The impact on quality of care is also part of the return on investment. There can be tangible benefits for organisations from better trained staff – such as shorter length of stay for patients who have received better care – but there can also be longer term impacts, such as on reputation and how an organisation scores on friends and family recommendations. And staff who feel supported to develop new or enhanced skills may be less likely to move on.

But that is likely to require investment in staff throughout their careers and for this training to be closely linked to the wider organisational objectives. In particular, she points out that those on bands one to four of Agenda for Change get fewer opportunities for development through training – even though this group is seen as being crucial to the delivery of care.

However, training by itself is not enough to deliver transformational change. What is needed is for individuals to be given the skills they need – and then be put in an environment that allows them to use those skills, says Ms Pond.

"People can go on training courses and come back feeling totally enthused. But if you put them back into the same working environment where they don't get the chance to use these new skills then it is a wasted investment. It is about creating a context for change." ●

WORKFORCE: CASE STUDIES

SAFE PAIRS OF HANDS

How skills gaps – and inefficient training systems – are being tackled on the ground as the NHS seeks to build a workforce it can rely on

ALAMY

CHESHIRE AND WIRRAL PARTNERSHIP

Providing end of life care for patients in their own home is a challenge many NHS organisations aspire to meet.

But many staff may feel a little trepidation about offering support to a patient and their family and carers at this sensitive time and may feel they are not well equipped to do so. And they may be reluctant to raise the issue of dying with people in advance and therefore find it hard to discover their preferences around place of death.

As the NHS increasingly supports more people to die in a place of their own choosing, ensuring that everyone involved in their care has the right skills and competences to deal with these issues is growing in importance.

That was the position the provider arm of Western Cheshire PCT was in two or three years ago when it decided to look at what skills and competences its staff in district nursing and crisis and reablement teams in the western Cheshire area had around end of life care. It was supported by Skills for Health and NHS North West in this work.

The aim was to identify any skills gaps and how to remedy them, and to establish what was needed to use the model more widely across the organisation. It would also enable the organisation – now part of Cheshire and Wirral Partnership Foundation Trust – to meet the required standards for quality improvement payments from its commissioners.

Operational transformation lead Sandra Birnie said this was driven by a desire to provide "the right care at the right time".

Key staff involved in this were likely to be district nurses but also community occupational therapists and physiotherapists, and some of the rapid response teams in the area. Many of these staff would be professionally qualified but some would be healthcare assistants whose basic training would not have covered this.

The first challenge was to find out how staff assessed their own skills – it was seen as important that they felt confident in delivering this sort of care. This was done through workshops and self-assessment questionnaires for both individual and teams. Training events covered communication skills and how to support patients in expressing their preferences around end of life care.

The skills needed varied according to role. For example, therapists may not be involved directly in end of life care but may be caring for people as they approach the end of their life. The Skills for Health website was a valuable tool in developing a competency framework relevant to the project.

The outcomes of the project were measured through a set of metrics. For example, the proportion of patients with a recorded preference for place of death increased from 32 to 78 per cent from April 2010 to April 2011. The proportion of those dying where they chose rose from 79 to 88 per cent over the same period – and was 100 per cent in May 2011. The proportion of patients supported by the community teams who died in hospital fell dramatically – a sign that the team were confident in supporting them at home or in the community.

Staff also said they felt more confident in enabling people to make choices around their care and in discussing their preferences with them, including preferred place of death.

Ms Birnie believes the positive outcomes of the project have been sustained over time, and through a period of organisational change – though she points out with an ever changing workforce there is a need to go back and train new starters. Most importantly, patients and those around them are being supported to express their preferences around place of death and to die where they choose.

And it has been part of a bigger piece of work the trust has done around district nurses and the competences they need. This has led to a redesign of their services so that their skills are used when necessary but other staff used when appropriate. The work has also strengthened the evidence for a band four assistant practitioner role.

The potential for saving is substantial: the cost of the service could be reduced by 11 per cent by changing the skill mix and the indicative saving through more people dying at home was around £160,000 a year for the area covered by the scheme.

Although this sort of skill and competence matching can be time-consuming and intense, the lessons learnt from the process and the approach have been valuable and could be applied across the organisation to support further change.

STREAMLINING STAFF MOVEMENTS

Anyone joining the staff of a hospital or community service in the NHS is likely to have to go through an induction process covering some basic statutory and mandatory training and often have a criminal records and identity check.

No one would argue with the importance

‘One nurse had four identical training courses in six weeks... all delivered by the same tutors’

of that: but when staff move around frequently – for example, if they are junior doctors on rotation – that can lead to wasted time and effort as records are rechecked and training redone for each new employer. At the same time many NHS staff fail to complete mandatory training for a variety of reasons.

There is clearly a need to streamline processes and reduce duplication while ensuring that compliance with mandatory training increases. And that has been the aim of the Streamlining Staff Movements programme in London, where Skills for Health has worked with partners including the former NHS London, and HR for London, which includes human resources directors from London trusts, and now NHS Employers.

There was a recognition that ineffective systems cost large amounts of money and led to unnecessary duplication of training because hospitals did not recognise what others had done. In extreme cases this could lead to junior doctors being made to repeatedly apply for criminal records checks but, more commonly, it meant new employees having to sit through training sessions which they had already covered at their old employer or during placements. One nurse undergoing advanced practice training in critical care had four identical training courses in six weeks... all delivered by the same tutor.

“Analysis identified that inefficiencies in that system just in London alone would cost £40m a year in duplication of training, employment practices and litigation,” says Sam Gallaher, executive director for business development and consultancy at Skills for Health.

Yet, at the same time, compliance with mandatory training could be as low as 40 or 50 per cent and the growing number of necessary pre-employment checks which staff needed might not have been carried out. This meant many staff might not have had up-to-date criminal records checks, their immunisation status might not have been checked and their rights to work in the UK might not have been established.

“When we started to spell out what the economic cost was there was a recognition this needed to be done,” he says. Potentially the savings could average £1m a trust. The majority of HR directors were happy to sign up to a memorandum of understanding to engage with the process.

Four workstreams were set up, looking at statutory and mandatory training; pre-employment checks; occupational health; and the electronic staff record’s intra-authority transfer. Skills for Health has led the statutory and mandatory training workstream.

To recognise each others’ training, trusts needed assurance. Part of this involved agreed standards for training and agreeing how recent training needed to be before being refreshed.

Skills for Health has produced a core skills training framework which looks at the 10 key areas which frequently feature in statutory and mandatory requirements – such as fire safety and infection prevention and control – which provides a means of standardisation. Getting trusts to adopt this framework was important – around 80 per cent signed up to it within the first year.

As a first step it was important for organisations to establish what their level of compliance with training actually was and software from Skills for Health was used to extract data from the trusts’ HR systems and create compliance reports. Compliance reporting is often a difficult task, but is important if robust data is to be available.

Knowing who was compliant and who wasn’t has enabled trusts to improve compliance rates: from around 55 per cent to more than 65 per cent.

Part of this may be because of greater use of e-learning – which may suit many staff, especially those who work shifts. Around 35 per cent of the trusts involved have increased their use of this.

Organisations should also have greater confidence that their staff are appropriately trained – something which ultimately could affect their premiums with the NHS Litigation Authority. If all trusts achieve the highest level, there could be savings of more than £9m a year. “For a marginal investment you can get a significant economic and qualitative benefit,” says Mr Gallaher. As a first step, the levels and review dates for all London trusts have been mapped.

In other areas of work, 5,000 new recruits have had identity checks carried out through passport scans and potential savings in occupational health have been identified.

London may have a more fluid workforce than other areas but Mr Gallaher believes similar issues could be tackled elsewhere. “It is just about taking the time to look at current practices across a local economy,” he says. ●

MARK FITZGIBBON ON THE REGULATION MINEFIELD

In this economic climate, NHS providers and commissioners have to explore much more innovative options across a swathe of clinical and support services to deliver efficiencies while improving standards.

Pan-pathology services are a natural target. You have a specialist qualified workforce providing what amounts to a relatively standardisable and commoditisable service albeit highly technical and heavily regulated, for a variety of clients including trusts and GP practices. The providers of kit are already geared up to provide all technical equipment required on a managed service basis (or otherwise as required); this part of the jigsaw has been relatively active in the marketplace for many years. But you also have multiple sites with multiple support requirements which, in many instances, can be more readily and effectively consolidated in some form (and there are a wide variety of models under discussion) as a means to rationalise and avoid unnecessary duplication of costs. So what's stopping them thinking laterally and pursuing innovative solutions more rapidly?

Well, there is still a high degree of uncertainty in the sector around the exact landscape which will emerge once the exercise of pushing the remaining NHS trusts through the "FT pipeline" has been completed; this naturally militates against longer term planning

'The regulatory framework is potentially a significant hurdle'

if the size or make-up of trusts is uncertain at this critical time.

In addition, care is going to be needed to be exercised at a commissioning level by NHS England and clinical commissioning groups, particularly in light of their obligations under new NHS procurement, patient choice and competition regulations which came into force on 1 April, and by foundation trusts, who have similar provisions around anti-competitive agreements and behaviours under the new Monitor licensing regime. How will they facilitate coordinated (and more efficient?) activities while still remaining in compliance with the regulations? And how will trusts meet their licensing obligations at the same time as procurement obligations under the Public Contracts Regulations 2006?

The regulatory framework is potentially a significant hurdle, whether in reality or as perceived by those subject to it, to this thinking. Clearly effective and clear guidance is needed from NHS England, Monitor and or the DH urgently to avoid a choice between inertia or alternatively acting in good faith, but stumbling into minefields of regulation.

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PATHOLOGY

GOOD NEIGHBOURS

Pathology joint ventures can deliver lower costs and improve services while sidestepping procurement rules for foundation trusts. Ingrid Torjesen reports

Collaboration between trusts is nothing new, but the extent to which trusts are working together to provide good quality pathology services has been growing as they become more aware of the potential benefits.

Trusts don't have the capacity to do every kind of test, so trusts have always referred some specialist tests to others, but then Lord Carter's reports on modernising pathology spelt out the benefits of collaborating more formally. His 2004 report advocated the establishment of managed pathology networks and then his 2006 report called for "the creation of stand-alone pathology service providers". "This would enable commissioners to focus on what is required for the local health economy as a whole and for such care-specific pathways as for cancer and coronary heart disease," the report said. "This in turn could be linked to a more fully developed nationally defined tariff."

Dr Rachael Liebmann, registrar at the Royal College of Pathologists, says the existence of pathology networks has further encouraged trusts to specialise in specific areas and take work from their neighbours. A few are even entering more formal collaborations, including Ashford and St Peter's, Frimley Park and The Royal Surrey County Hospital Foundation Trusts.

"That model is catching on. It is becoming much more attractive to do something in that more formal partnered way, but within the NHS," says Dr Liebmann.

The need to make efficiency savings to meet the Nicholson challenge is providing that push. Furthermore, if trusts wish to grow their pathology business having a partner is essential because of the sheer magnitude of the tenders available, illustrated by the recent ones for the East and West Midlands and East of England. Dr Liebmann says: "A single pathology service serving a single district hospital would not be playing in that marketplace with any kind of clout so banding together makes sense." This could be with another trust or a private sector partner.

The upside of having a private sector partner will be access to additional capital for investment, but the downside will be that the private partner will be looking to take profit out of the system. The benefits of partnering with another trust include keeping the initiative entirely within the public sector where there is likely to be easier access to more senior medical staff.

Dr Charles Alessi, GP and chairman of the National Association of Primary Care, says GP commissioners are looking for a quick and efficient response for their tests and occasionally want to have a conversation with someone so that they can get advice. "One of the commonest referrals is for someone with abnormal liver function tests," he explains. "There are many times in which one would not need to send a referral letter if only one could have a conversation with somebody."

As an NHS pathology service is attached to an acute hospital, pathologists will not only oversee laboratory testing but will also usually have other clinical roles within the hospital, Dr Liebmann says. "That is why it may look as if there is more input from senior medically qualified individuals." For example, haematologists will see patients with clotting disorders and cancers. If a trust went with a standalone laboratory service, it would need to contract for those additional clinical services separately.

Clinical commissioning groups appreciate the clinical facets of the service that they are buying, because they are clinically led, she adds. "They don't want to buy just a results only service where there is no interpretation and there is no one who can help them deal with actually managing the patients. The last thing that a GP would want is to have to make a formal referral when what is really needed is to understand the output of the pathology investigation so that they can manage them in the community."

But she adds that the tariff system does not recognise that. "It doesn't separate the clinical support from the testing support.

CASE STUDIES OVERLEAF ▶

ALAMY

That is a risk and it is a risk if there are tenders and there are commissioners who don't understand the detail."

Historically, the health sector has not been very good at complying with the public procurement rules. Sometimes contracts have simply been renewed with the existing provider rather than being put out to tender.

Acute trusts buying services from each other and entering into shared agreements have been able to circumvent procurement rules because they are entering into non-legally binding contracts with other NHS bodies. However, the concept of the non-binding NHS contract doesn't apply to foundation trusts.

"Over the last few years trusts have drifted into FT status and their procurement practices haven't necessarily kept pace with the legal framework of the regulations," Mark Fitzgibbon, a partner at law firm Hill Dickinson, says, and providers are increasingly prepared "to threaten and sabre rattle" now if the rules aren't followed and they are locked out.

One way that foundation trusts can continue working together is to set up a joint venture company. Mr Fitzgibbon says: "Before the advent of foundation trusts normal acute trusts couldn't hold shares in separate companies without the secretary of state's consent so it wasn't really an avenue they could explore."

'Councils have saved more than £250m by teaming up to deliver frontline services'

Those entering into a joint venture own a share of the company – which provides services back to its parents without having to contract because the company is treated as if it were an internal department of each trust. As well as reducing duplication and sharing staffing, there are economies of scale for the trusts involved, for example through only having to procure equipment through one managed equipment service agreement, Mr Fitzgibbon says.

And the NHS needs to look no further than local government to see how pressure to generate revenue and make cuts has driven collaboration. According to the Local Government Association, councils have saved more than £250m by teaming up to deliver frontline services, such as adult social care and waste disposal, and by sharing back office functions such as HR.

Councillor Peter Fleming, chairman of the LGA's Improvement and Innovation Board, says: "Over the last five or six years, councils have really developed the concept of sharing services as way of improving efficiency and saving money. In the last year alone we have seen the number of councils sharing services grow by 65 per cent, bringing the total savings for council taxpayers to more than a quarter of a billion pounds."

Mr Fitzgibbon predicts that pathology services could be "a Trojan horse" in terms of joint ventures by encouraging them to be considered for other services. "Ultimately we may reach a point where it might make sense to merge clinical functions as opposed to the support functions," he says. ●

HILL DICKINSON

PATHOLOGY: CASE STUDIES

TUBE CONNECTION

How trusts in the north west are leading the way in working with NHS and other partners to build more efficient pathology services

UNIVERSITY HOSPITALS OF SOUTH MANCHESTER

University Hospitals of South Manchester (UHSM) Foundation Trust, Tameside Hospital Foundation Trust and Stockport Foundation Trust have been collaborating on pathology services to improve efficiencies for around two years. Currently the collaboration is conducted under a memorandum of understanding supported by a series of service level agreements between the organisations.

The initiative has been created to realise the benefits identified by Lord Carter, including reduced costs and improved quality in pathology, and specifically the target adopted by the Greater Manchester Pathology Network and the Commissioning Cluster to reduce the cost of delivering pathology services by 20 per cent while achieving an improvement in service quality.

Jayne Wood, associate director of operations (clinical support services) at UHSM, says Carter described a model that could be deployed to deliver efficiencies by looking at both the size of population and where services might naturally work well together. In addition, the foundations to allow service change in pathology were already in place. Increasingly services could be automated and some were already not delivered on every hospital site, although most clinicians did not realise that.

South Manchester, Tameside and Stockport are one natural grouping in the South Sector of the Manchester area. Another natural grouping where a reconfiguration has already occurred is the North West Sector (Salford Foundation Trust with Wrightington, Wigan and Leigh Foundation Trust).

The aim is to progress the South Sector arrangement by appointing a senior manager whose salary will be split between the three trusts. Ultimately, the goal is to provide services through a formal joint venture, owned jointly by the three trusts. There will be a single microbiology service for the sector, a single histopathology service and a hub and spoke model for blood sciences with the GP direct access work pooled on one site.

Ms Wood says: "Histopathology can be provided from one site. You might need some outreach if there are frozen sections and other urgent tests, but most of it is going to be in one place. It doesn't really matter where that is as long as we can ensure that our clinicians receive a high quality result within the timescale required so we can provide a good service to our patients."

Asked whether clinicians are likely to notice any changes as a result of the initiative, Dr Gill Burrows, associate medical director for diagnostic and clinical support services at Stockport, replied: "By working as one team in the South Sector we will be able to deliver quality improvements by standardisation and sharing of best practice as well as delivering a number of efficiencies."

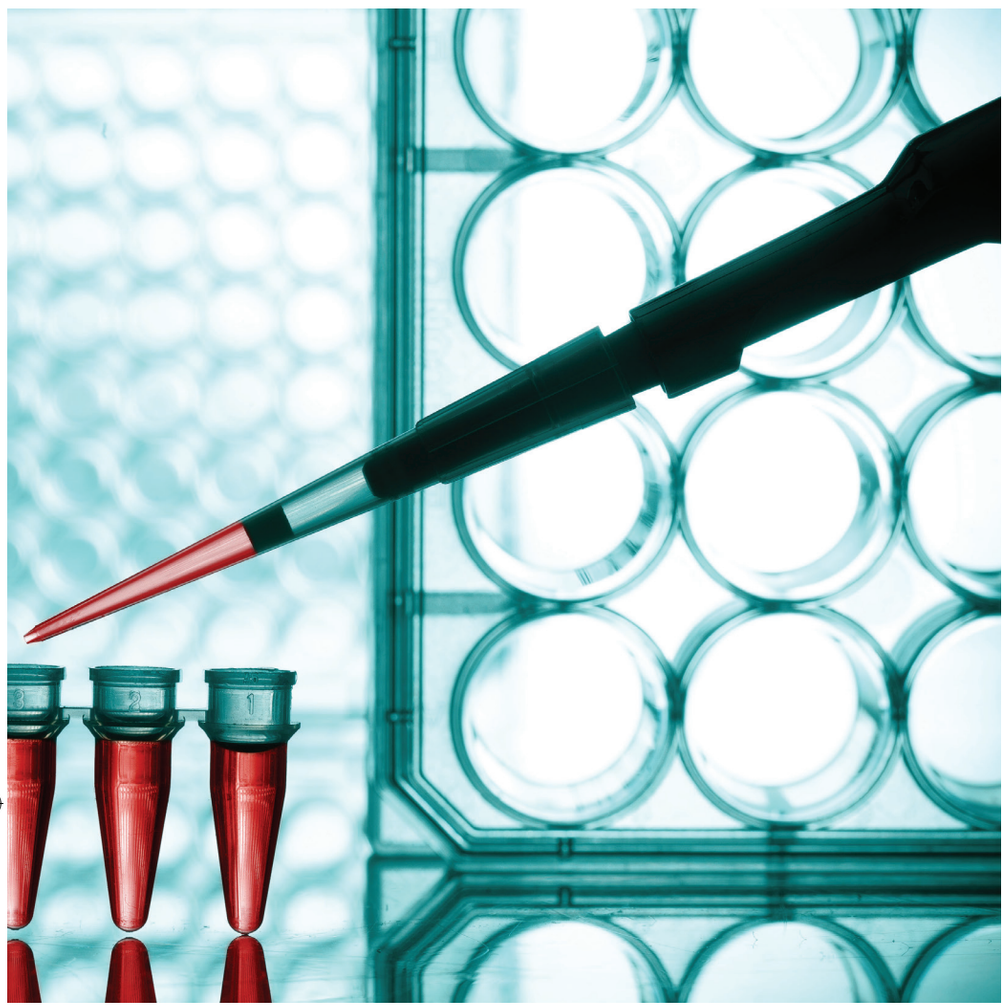
Collaboration by the three trusts in pathology over the past two years has delivered savings of 8.5 per cent on the 2009-10 baseline, and as the arrangement develops further, efficiencies are expected to rise.

Nigel Humble, diagnostics manager at Tameside, says working together can help achieve efficiencies in numerous ways, including greater purchasing power in the procurement of equipment and reagents, and greater volume and critical mass as services come together. There is also the potential to rationalise transport and estates by disposing of unnecessary buildings and reconfiguring transport routes and contracts.

In terms of workforce, there are potential savings to be made through reduced management costs, and ensuring that the workforce is fit for purpose going forward in terms of the right numbers and banding. The collaborative approach also offers more resilience in terms of medical on-call rotas where workforce numbers are small, such as haematology, where joint rotas are being explored.

Standardisation of processes and harmonisation of reference ranges across the trusts can reduce confusion over testing procedures and results for commissioning GPs and other clinicians working across wide geographical areas. An integrated IT system is planned that will also enable GPs and clinicians to access results from tests conducted at all three trusts, reducing the need for duplicate tests being undertaken in primary and secondary care.

The South Sector did contemplate entering a partnership arrangement with the private sector, but opted against it and went for a fully NHS-delivered service instead. "Both the management and the staff felt that this was the model that we wished to pursue," Penny Martin, associate director for diagnostics and clinical support services at Stockport, says: "There are advantages in partnering with the private sector and some sectors have taken this option but we all felt



‘An integrated system will enable clinicians to access results from all three trusts, reducing duplicate tests in primary and secondary care’

strongly that we wanted to provide the services ourselves.”

Mr Humble went on to say: “What you have got to look at is the value for money in terms of working with your local provider. For example, if patients are treated in one hospital and the pathology tests are done somewhere else then often the test will be repeated and it will cost twice as much, especially as we currently do not have good IT links between pathology services. In terms of efficiency, the future needs to be about the whole patient journey as opposed to looking at the price per test.”

A very important part of the pathology service is the medical staff, who are always available to answer questions from GPs and other clinicians about the tests and their results. “Provision of clinical interpretation is a key part of the service that we provide to our local GPs.

“Given the tough financial challenges ahead of us, going forward there will be more organisations working together as well as changes in service configuration,” Ms Wood predicts.

AINTREE UNIVERSITY HOSPITAL FOUNDATION TRUST

Aintree University Hospital Foundation Trust is in the second year of its Managed Equipment Service (MES) contract with Roche Diagnostics after tendering in 2011 jointly with Southport and Ormskirk Hospital Trust.

The initial aim was to appoint a primary contractor to manage multiple pathology contracts over a 10 year period with the emphasis on chemistry and haematology.

Prior to tendering, both trusts were dealing with multiple providers and had a diverse range of equipment that was either purchased or leased; some equipment was also provided on a reagent rental basis.

Sue Colbeck, head of procurement and supplies at Aintree University Hospital Foundation Trust, says: “Both trusts were in a position where we needed to put a solution in place and agreed to work collaboratively to achieve the benefits of commitment and volume. One of the directions nationally from the Department of Health emphasises collaboration between NHS organisations where possible.”

Aintree wanted a solution that would provide equipment for the trust’s existing requirements, but that would also adapt to the trust’s needs and changing service requirements over the term of the contract. An MES enables this, she says.

MES contracts have many advantages, including not having to put up capital for equipment up front, which frees up money for investment in other areas, Ms Colbeck explains.

Also, it is up to the supplier contracted to ensure equipment is always fit for purpose and in working condition to ensure the trust can provide continuity of service. Part of the MES requires the contractor to provide robust training, education and support on an ongoing basis; it is in their interests to ensure that staff can use the equipment competently.

Having one contractor, even though there may be multiple providers of equipment, is another benefit, she says. The primary contractor takes responsibility for the service. Another benefit on MES contracts is the reduction in back office costs because there are far fewer invoices to deal with.

It is also written into the contract that the company must seek continuous improvement and cost saving opportunities, she adds. “They review our data and processes working with our operational teams and feed back various ideas at regular review meetings or via the dedicated support team in place to provide technical support.”

The trust is continuing to assess how further efficiencies can be brought into pathology services.

“This is not just about what we are buying and how we are buying it, but this is about how we deliver services,” Ms Colbeck explains.

Aintree University Hospital Foundation Trust and the Royal Liverpool and Broadgreen University Hospitals Trust are in the process of amalgamating their pathology services as a shared service called Liverpool Clinical Laboratories under some form of partnering arrangement.

“That in my book is true collaboration because that is looking at all the services across the two hospitals, all the demand requirements across the Liverpool region and then agreeing service models to deliver outcomes,” Mrs Colbeck says.

It is early days for the initiative. The focus at the moment is on implementation. ●

ALAMY

SHARON RENOUF ON OUTSOURCING

IN ASSOCIATION WITH BEVAN BRITTAN

Bevan Brittan
The public services law firm

The NHS must make big efficiency savings amid increasing demand for its services, a rising drugs bill, incremental pay increases for staff under Agenda for Change and impending National Insurance increases.

Outsourcing of property and hotel management services has been tried and tested by a good number of NHS trusts and the challenge for second and third generation outsourcings of these services is how to secure further savings without compromising on quality and efficiency.

For many organisations though, it is necessary to look beyond the traditionally outsourced services at business areas (HR, patient administration) that five years ago would never have been considered for delivery outside of the NHS as well as those (pathology, IT) where the private sector brings the benefit of additional investment for service transformation.

For those trusts considering which services to outsource and how, it is well worth considering a structured approach to soft market testing. Sessions with private, not-for-profit and/or other NHS organisations, prior to formal advertisement, can be invaluable in helping the board and senior managers to understand the extent and nature of support that is available from outside the organisation. This also enables a smart, efficient procurement process to be run

'The NHS body buying services needs to change its ways of working'

at the correct time.

Careful consideration must be given to the amount of internal change that will be engineered by an external provider with a mandate to drive service transformation. In order to maximise efficiencies, the NHS body buying the services will need to be ready to change its ways of working and to enable its staff to do so, so as to achieve the benefits as quickly and comprehensively as possible.

Having taken a decision to outsource, a typical trust will be keen to do so in a short timeframe, ideally one which will allow savings to be generated "in year". While due procurement process must be followed, we are seeing robust competitive dialogue competitions concluded in about seven months and restricted procedures more quickly.

Most notably there has been a policy decision to allow private sector service providers to access the NHS pension scheme ensuring that NHS employees who transfer to a new provider will be able to retain their pension benefits. This promises to remove further cost and time from the process of selecting a service delivery partner.

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SERVICE REDESIGN

SHARE DIVIDENDS

Alison Moore reports on the potential benefits of joint ventures and shared services

For many years NHS organisations have tended to carry out many of their functions for themselves. Then came outsourcing of areas such as cleaning which were not seen as core to the organisation's purpose and offered the possibility of savings.

But the current financial position is causing trusts to develop radical solutions to drive savings and improve services. These range from shared services with other organisations to utilise economies of scale, through outsourcing, to a range of joint ventures with the private sector.

And boards are thinking again about what is their core business and where they can add value – and where other solutions would be most appropriate.

Sharon Renouf, head of major projects at law firm Bevan Brittan, suggests the shared service model is popular with trusts that want to keep services within the NHS and feel they can grow and develop services themselves. "The most common problem that we see and the reason they stall is that they try to be too ambitious," she says. "They are looking at the 10 year picture and not at how they get through the next six months. They need to take it more in bite-sized chunks." Agreement on how liabilities are shared is also important.

Outsourcing remains popular and is increasingly seen in clinical support areas as well as back office functions. But timescales are important: Ms Renouf says trusts are often thinking of three or five year contracts, which may be too short if providers are going to transform a service, make substantial investment and then start seeing a return. "TUPE and redundancy costs are sometimes quite prohibitive without a longer term contract," she says. Resolving issues around pension costs for staff who transfer can delay contracts.

Simon Scrivens, managing director of services company Sodexo, says short contracts make it difficult for companies to make a good investment case, unless they are for simple outsourcing that is mainly transactional. More complex and specialist services which require investment and often redesign will need longer to make a return for the partners, both NHS and private.

"It is very hard for short term contracts to drive efficiency because you can't make the right investment," he says. "Within reason, the longer the contract the better."

The NHS also needs to ensure it can produce output-based specifications for outsourcing contracts – which can focus on quality of service, says Ms Renouf – and also incentivise the provider to produce what it wants.

The Anglia Support Partnership has moved from being a shared services vehicle for providing back office services to trusts in the area to being run by Serco, following a competitive selection process.

The NHS organisations which founded it will retain an interest and benefit from its success: and other NHS organisations can buy an expanded range of services from ASP. This can avoid the need to go through a European-wide procurement – the ASP framework is already compliant with this – and means services can be set up within a few weeks in a relatively simple process, says Jonathan Simons, director of market development at Serco Health. Staff remain on NHS terms and conditions – and within the NHS pension scheme.

'Trusts see joint ventures as a way of bringing in extra capital to help developments'

Outward bound: trusts have moved on from just outsourcing simple services such as cleaning

ALAMY

John Myatt, strategic development director for Serco Health, says ASP was an attractive proposition because it already had a track record with existing clients but needed investment to take it to the next level. One aim is to standardise processes where possible, bringing down costs.

Joint ventures are beginning to become more prominent in trusts' thinking, especially as they realise that they may not have the business expertise and skills in-house needed to develop services.

But Ms Renouf cautions that trusts have to understand they may need to contribute capital in some form (though this can be in the form of land if the joint venture is estate-focused) and to take risks, which may be alien to them.

But they can provide a vehicle for trusts to start providing services over a wider area – such as pathology for neighbouring trusts. But she says trusts need to be realistic about their areas of strength – not all trusts can grow their services in this way.

Taunton and Somerset Foundation Trust and Yeovil District Hospital Foundation Trust set up a joint venture with Sodexo and Labco to deliver pathology services to the two trusts and serve local GPs. This was structured in a way which allowed other trusts to join if they wished. It has allowed investment in a new hub laboratory.

Unusually, the Southwest Pathology Services venture is envisaged to last 20 years – something which Mr Scrivens welcomes as it encourages investment to improve services.

But it is not just about making savings on costs: trusts see joint ventures as a way of bringing in extra capital to help development. Lancashire Care Foundation Trust formed a joint venture company with Ryhurst two-and-a-half years ago to develop new units and run its current estate. The move has given it access to capital for the new developments.

Ryhurst managing director – and former NHS trust chief executive – Stephen Collinson – says the partners have an equal number of seats on the joint venture board.

But many trusts look at the different opportunities available to them and feel they don't know where to start. "It is about spending a little time as a trust finding out what the market can offer and finding the right solution to meet whatever drivers they have," says Mr Collinson.

He encourages trusts to think about values and relationships so they have a partner tuned into their needs. "The aim is that we are working to a shared business plan which is productive to both of us."

Mr Scrivens says there is growing interest in joint ventures from NHS partners. Properly constructed, they can offer the opportunity for other partners to join – as is possible in the Yeovil/Taunton pathology project – or for services to be offered over a wider area. "I would encourage NHS organisations to think carefully about what they are procuring and how they are describing it as they start any sort of procurement process," he says.

Joint ventures offer a way to share both risks and benefits, he says, and also can provide the transparency of governance that NHS organisations like.

So what should trusts do if they want to go ahead with such changes? Ms Renouf suggests they need to be clear about what they want to achieve – is it cost savings or do they need capital? Do they regard themselves as pioneers or leaders in a field or do they need help to improve their own services? An honest assessment of strengths and weaknesses will help decide what route will best deliver their ambitions. ●

SIMON CORBEN ON INFRASTRUCTURE

“When you walk into a run-down and unkempt clinic, surgery or ward, you don’t feel, as a patient, that you matter... A clean, tidy, safe and warm environment makes us feel welcome and cared for. Health is about the whole experience, not just the quality of the clinical care.”

So says Angie Usher, patient ambassador at the Expert Patients Programme Community Interest Company.

The 1,700-page Francis report on the performance of the Mid Staffordshire Hospital Foundation Trust makes 290 recommendations grouped into themes. The key aim of the report is to foster a common culture, shared by all in the service, of putting patients first. The NHS Constitution (Section 2a) also pledges that: “The NHS commits to ensure that services are provided in a clean and safe environment that is fit for purpose.”

In December 2012, the Department of Health asked every NHS trust to initiate a review of critical infrastructure risk, as failure to tackle an estimated £1.2bn of backlog maintenance could be breaking this pledge and putting lives in danger. To address this, estates teams must report backlog maintenance figures accurately and develop action plans to tackle areas needing immediate attention due to risks posed to patients. Suitably resourced teams should then immediately implement these plans,

‘Health is about the whole experience, not just clinical care’

providing assurance to executive boards that risks are being managed appropriately.

NHS trusts, learning from other sectors, are beginning to differentiate their offer by not only dealing with concerns such as infrastructure risk, but also by improving wider estates and facilities – often via innovative solutions for funding such as joint ventures and commercial partnerships.

Overall, the key role of healthcare estates professionals has to be to provide cost-effective healthcare in an environment that it is exemplary in terms of patient safety and experience ratings. Estates teams need to play their part in ensuring there is never again a need for a Francis report.

Simon Corben is business development director in Capita Symonds’ health team.

Capita Symonds works with trusts through all stages of asset management, from identifying, managing and clearing high and significant risks, through to innovative solutions for funding, to implementation of improvements to estates and facilities that deliver tangible benefits to both patients and staff. The company is also at the forefront of developments such as welcome and retail centres and associated hotel facilities.

www.capitasymonds.co.uk/health

ESTATES MANAGEMENT

FRANCIS HITS A NERVE

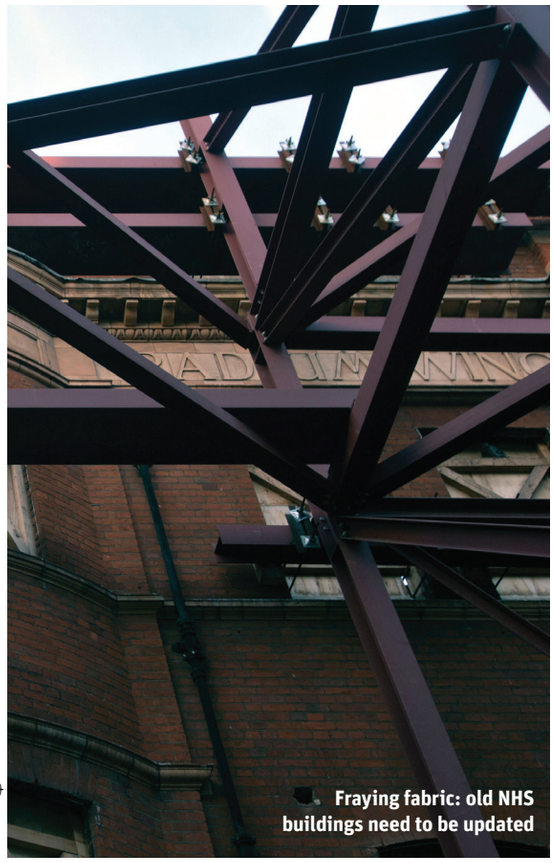
Daloni Carlisle on how the NHS should respond to the report’s recommendations on buildings and to the new DH infrastructure agenda

A great deal has been written about the ideal hospital environment. It should provide a good therapeutic environment, for example, and be cost-effective to run while being flexible in its use. It should be easy to clean, safe and secure.

But we all know that too often the NHS falls short of that ideal. Now two factors are raising the profile of estates.

The first is the Francis review, which highlighted the poor fabric of the buildings at Mid Staffordshire Hospital. Recommendation 72 makes sombre reading for aspiring foundation trusts.

It says: “The assessment for an authorisation of applicant for foundation



Fraying fabric: old NHS buildings need to be updated

trust status should include a full physical inspection of its primary clinical areas as well as all wards to determine whether it is compliant with fundamental safety and quality standards."

Renata Drinkwater, director at Capita Symonds, chief executive of the Expert Patients Programme Community Interest Company and a non-executive director of The Princess Alexandra Hospital in Essex, says: "For an aspirant foundation trust, recommendation 72 is fundamental."

"Dilapidated, run-down buildings can compromise patient safety – think of examples like asbestos in the roof, cockroach infestations or hard-to-clean corners and their impact on infection control."

But often the effect is subliminal. "Even if the care is exemplary, patients tend to think it's not if the buildings look and feel neglected," she says. In an era of patient choice, this matters.

The second is the DH's review of critical infrastructure risk, ordered by David Flory, the deputy chief executive of the NHS. This will begin to investigate for the first time how big the maintenance backlog really is – and how much of it is actually critical.

In January this year, he wrote to English NHS trust chief executives announcing that Peter Sellars, head of profession at the NHS Estates and Facilities Policy Division, will lead this review to decide whether the £1.2bn worth of supposedly "critical risk" backlog maintenance reported as being necessary by English NHS trusts is actually putting lives in danger.

If this were the case, Mr Flory warned, the NHS "may not be fully meeting its commitments under the NHS Constitution to provide services from a clean and safe environment that is fit for purpose based on national best practice".

It may also be risking regulatory requirements to ensure "service users are protected against risks associated with unsafe and unsuitable premises".

Ian Daccus, chair of the Health Estates and Facilities Management Association in London, says the NHS had a poor track record on maintenance.

"The NHS hadn't historically taken life cycle cost improvements properly into account, in the 70s and 80s, and now we are trying to catch up on a deteriorated estate with a backlog of asset renewals which is where the term backlog maintenance originates," he says.

"It was historically underfunded or underinvested locally, which has created the challenge we see now. Improving the quality of the estate alongside developing the estate so it better supports the aims of the NHS is the challenge."

This supports the analysis that Mr Sellars spelt out at a conference last year where he reportedly said: "A total of £4.3bn of backlog maintenance is reported and we are investing between £500m-£600m a year addressing this, but the overall figure diminishes by only £20m-£30m, and in some cases it goes up. We have to ask ourselves is the money we invest being targeted at true backlog, or is the rate of deterioration happening at a greater rate than the investment?"

So right now, trust estate managers are busy reviewing and asking: how much of our backlog is critical – and how, in the current financial climate, can we find the money to bring estates back up to safe standards?

Ms Drinkwater says: "Trusts have to focus on patient safety issues first, but they also need to consider design and the way buildings and services impact clinical responsiveness and patient wellbeing."

Capita Symonds business development director Simon Corben says this is increasingly happening. Many trusts are now carrying out patient-led assessments in which trained patients work alongside staff to inspect the estate for cleanliness. "That's the soft end," he says.

The second is a harder edged "six facet survey" in which teams of qualified people systematically inspect the estate for backlog maintenance issues that are likely to impact patient safety and quality of care.

"They assess the risks, score and cost them," says Mr Corben. Typically, this will allow estates managers to identify which issues are most critical, cost them and put their case for funding to the board.

'Even if the care is exemplary, patients tend to think it's not if the buildings look and feel neglected'

"If you go to the board with a £50m plan, they will not consider it realistic," he says. "But a £5m costed plan with the risks to patient safety scored is something the board can address and that the trust can deliver against."

But even £5m is challenging. Capital budgets are tight and, while many in the estates world hope that the critical infrastructure review might leverage some funds for maintenance, no one can be sure until an announcement is made.

For a start, trusts need not only to make sure they have identified the critical maintenance risks but also to ensure that they have the right expertise to hand to ensure good project management.

Beyond this, Mr Corben argues that trusts should start thinking outside the box particularly when looking for ways in which their estate can start to generate income that can be reinvested in maintenance and front line services.

"I would urge foundation trusts to look to outside third parties to see how they can best utilise assets," he says.

Increasingly trusts are looking at how they can involve retail on site, using the income this generates to refurbish entrances and provide long term rental income.

"Creating a welcome centre – where there is a reception desk as well as a range of shops and outlets offering food at the front of hospital creates a focal point for staff and patients," he says.

In the primary and community care sector, retail pharmacy is playing a similar role, adds Mr Daccus.

Some hospitals have begun exploring turning old nursing accommodation into hotel accommodation, providing a place for families and friends to stay while a loved one is in hospital. Not only does this generate income but also potentially increases the catchment area for the hospital, says Mr Corben.

Yes, backlog maintenance is a hard nut to crack – but it is one that might be easier if trusts began to engage with third parties at all levels – from project management through to income generation. ●

ALAMY

DANIEL WHITE ON RAPID DIAGNOSTICS

Healthcare-associated infections such as *Clostridium Difficile* are a universal problem, placing a significant burden on medical resources. Rapid diagnosis and an efficient patient pathway are essential to minimise length of hospital stay and ensure isolation beds are used appropriately. Consideration of the pathway as a whole, rather than as a series of individual segments, is vital, along with an acceptance that extra spending in some areas may be necessary to provide the best care and make significant overall savings.

Historically, laboratories have relied on enzyme immunoassays (EIAs) for the diagnosis of *C. Difficile*. However, amid concerns about EIA effectiveness, new guidelines were introduced last year requiring the use of a two-step algorithm – such as the glutamate dehydrogenase (GDH) test or nucleic acid amplification testing followed by a "sensitive" EIA. Faced with financial constraints, providers often adopt the seemingly cheaper GDH/EIA option, yet this may be a false economy. Time to result can range from eight to 24 hours or more, depending on the assays chosen. During this period, a costly isolation bed may be occupied and unnecessary treatment initiated. When the clinical picture does not concur with the test result, repeat tests may be performed at additional expense. Ultimately, by the time a definitive diagnosis is achieved, the patient

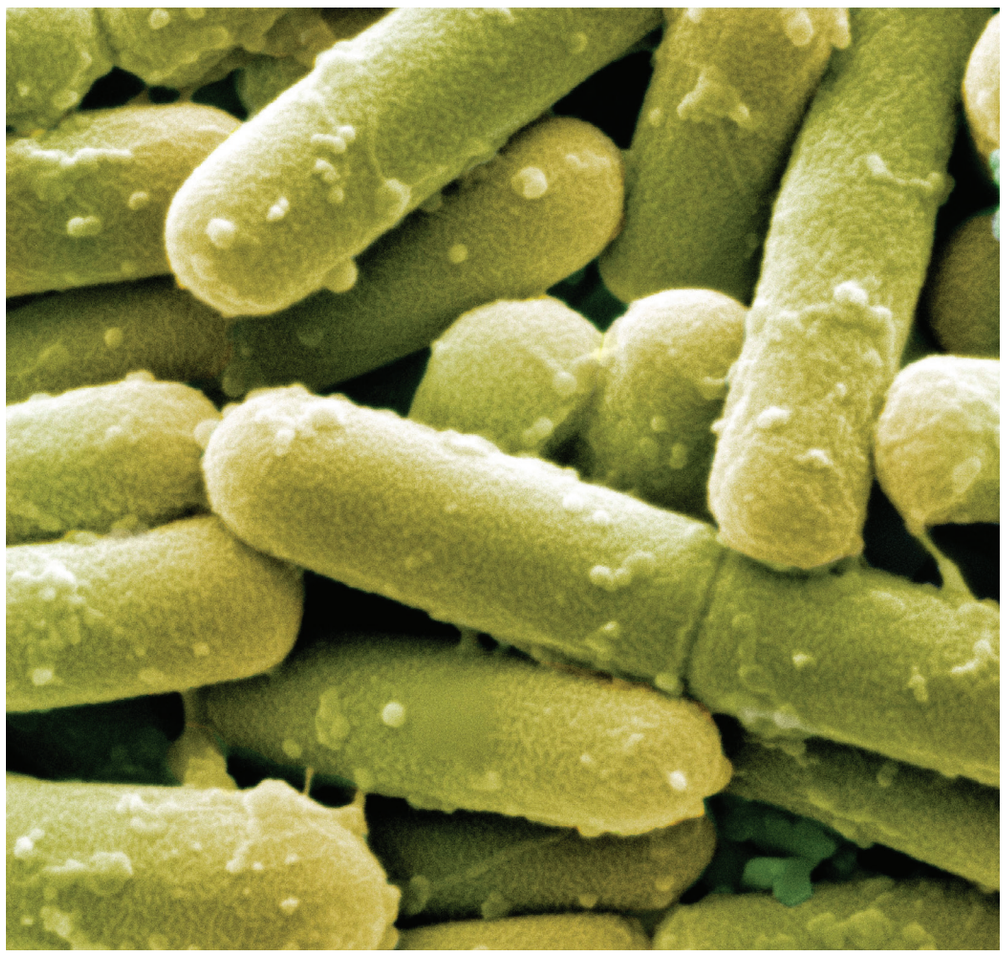
'It is vital to look at the bigger picture, rather than cost per test'

may have drastically deteriorated, or been discharged. Either way, the cost to both patient and hospital is considerable.

Rapid real-time diagnostics using molecular technology is drastically reducing turnaround times and delivering a rapid and accurate diagnosis in just 45 minutes. The benefits are tremendous; infected patients can receive immediate and appropriate treatment to reduce the onset of more severe symptoms, and the correct bed can be allocated from the start to minimise infection risk to others and eliminate subsequent costly transfers. Expensive repeat testing may be reduced, while the faster turnaround time is reflected in shorter hospital stays, potentially generating substantial overall savings, despite the higher cost per test[1]. The message is clear; it is vital to look at the bigger picture and consider the hospital and patient burden per episode, rather than the cost per test, to provide the best possible patient outcome at the lowest overall cost.

Daniel White is UK managing director at Cepheid
www.cepheid.com

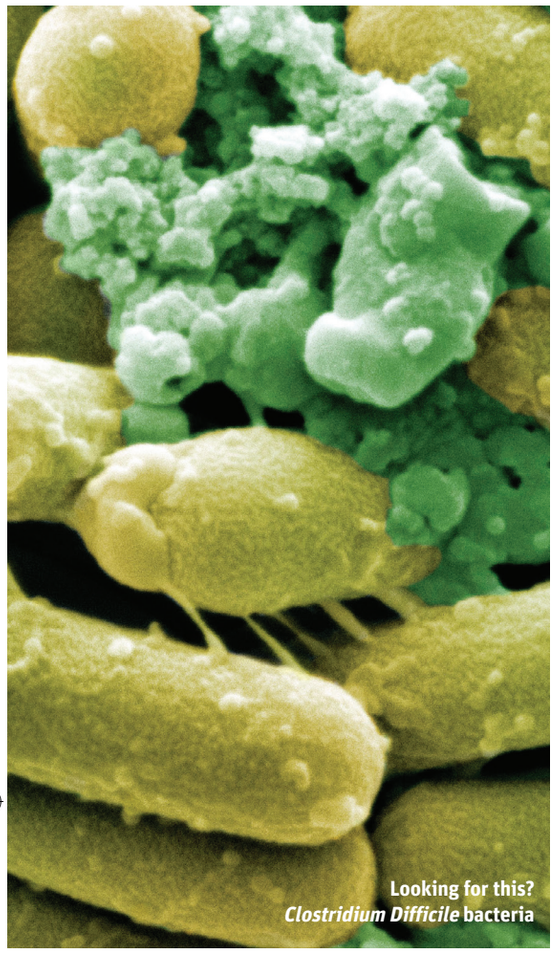
[1] Bernadette Sewell *et al*, *Impact on patient length of stay and cost-effectiveness of rapid molecular testing for Clostridium Difficile*, 22nd European Congress of Clinical Microbiology and Infectious Diseases, London, 2012



DIAGNOSTICS

TESTING TIMES

Control of the *C Difficile* infection is still a top priority for hospitals – not least because of the threat of huge fines. Alison Moore reports on the case for using tests that can identify cases far more quickly



Looking for this? *Clostridium Difficile* bacteria

C. Difficile rates across the NHS have been reducing after enormous efforts by infection control teams over the past few years.

But despite this it is still proving a headache for many hospital trusts. As rates have reduced, trusts have been hit with ever tighter targets for the maximum number of cases – and threatened with substantial penalties if they miss these.

The Foundation Trust Network warned last year that these could be destabilising – at up to 2 per cent of turnover – and has pushed for the penalties to be "proportionate", something which the Department of Health has so far resisted.

Maidstone and Tunbridge Wells Trust – where *C. Difficile* infection is a particularly emotive topic because of a severe outbreak in the last decade – risked a fine of £5m for exceeding its trajectory by just 10 cases in 2012-13 – although it has now reached an agreement with commissioners on how that money can be reinvested. And other trusts have been in a similar position or have had to keep funds available in case they do go over target.

Monitor can also downgrade trusts which fail to hit *C. Difficile* targets and trusts which are still struggling to achieve foundation trusts status are acutely aware that a poor record on infection control counts against them.

So it is no surprise that management of *C. Difficile* is still a priority for many organisations – even when their record is relatively good and the number of reported cases has dropped significantly.

Royal College of Nursing adviser on infection control Rose Gallagher says: "There has been tremendous improvements if you look back to where we were in 2005-7. But infection control teams continue to strive to reduce these numbers even further."

So it is not surprising that trusts are keen to diagnose patients with *C. Difficile* quickly so they can be treated and isolated. Guidance on reporting cases changed last year and now stresses a two stage testing process to try to improve sensitivity.

Many trusts use a glutamate dehydrogenase (GDH) test to detect *C. Difficile* antigens and then an enzyme immunoassay (EIA) toxin test to determine if the patient is producing toxins associated with *C. Difficile*.

However, some clinicians have become concerned that patients with a negative second stage test can still go on to develop *C. Difficile* within a couple of days. Confirmation of the test results can also take 24 to 48 hours – during which time a patient should be isolated from other patients and treated as an infection risk.

Stopping transmission between patients is crucial if an isolated case is not to become a target-busting outbreak: DH advice is that patients suspected of having *C. Difficile* should be isolated within two hours.

But this takes place against a backdrop of increasingly pressurised hospitals where isolation facilities are often at a premium. The risk for trusts is that isolation rooms are taken up by patients who are awaiting test results: at busy times this may mean that other suspected cases can't be isolated in a single room.

Ms Gallagher says that isolation facilities are very variable from hospital to hospital and it is important that they are used appropriately. Risk assessment of patients should be used to decide whom to test, she says, bearing in mind that there are many causes of diarrhoea, not all of which are infectious. There are also known risk factors for developing *C. Difficile* which ought to ring alarm bells when accompanied by diarrhoea.

Waiting for a test result can also mean that patients risk not being given the most appropriate treatment. But quicker tests are available. Molecular tests can be carried out as near patient tests with results available within an hour.

Daniel White, UK managing director of Cepheid, which makes the Xpert *C. Difficile* test, says that it is often used as a third stage test when clinicians want to be sure whether a patient – who may have been negative on the second test but still have symptoms of *C. Difficile* – has the condition.

'The risk for trusts is that isolation rooms are taken up by patients who are awaiting test results'

However, he suggests hospitals are missing out by not using it as a first line test – allowing certainty about patients' diagnosis within 45 minutes and for them then to be treated appropriately.

With a negative test, this could mean patients don't need to be isolated, freeing up facilities for others. A study has suggested that Xpert is more sensitive than the GDH and EIA tests.

And quicker treatment can mean reduced length of stay. Research in Swansea, presented as a poster at the European Congress of Clinical Microbiology and Infectious Diseases last year, looked at reductions in length of stay, and therefore cost, for patients who were suspected of having *C. Difficile*.

For both patients who turned out to be positive for *C. Difficile* and those who were negative the average length of stay was reduced compared with those diagnosed through a cell culture cytotoxin neutralisation assay. Using a value of £285 for a day in hospital, this produced savings of over £1,200 per positive sample or £1,900 per negative sample.

The cost of testing with Xpert *C. Difficile* is potentially more than with the two step approach. However, it can be used either in a laboratory or in a near patient setting, at any time of the day or night.

Mr White says this means the test is very popular with frontline clinicians and also managers who have to struggle with bed capacity. It is important to look at the wider picture and savings across the whole patient pathway rather than just the unit cost of the test, he says.

"The money is being saved on the wards but it is the laboratory budget that often has to cover the cost," he says.

And there is the effect on the patient of a quicker diagnosis – being treated appropriately and being reassured about their condition and care.

Hospitals will probably never be able to eradicate *C. Difficile*: but controlling the use of antibiotics which can promote it, combined with good testing regimes and appropriate isolation of patients, should enable the number of cases to be further reduced. ●

SPL

The patient mantra "no decision about me without me" describes a new healthcare climate where the patient is an active participant in their own care, empowered to make informed choices that reflect their needs. A big part of this in the modern NHS is self care, where patients are supported to take responsibility for their own condition.

With the NHS groaning under the weight of increasing demand and a flat budget, health professionals must innovate. This is brought sharply into focus for the growing number of sufferers of atrial fibrillation, many of whom live with the challenge of taking daily warfarin, and the interruption of frequent visits to clinics for blood tests. For those who work, attend school or travel abroad regularly, this can present a real challenge, yet the alternative is poor warfarin control, which can lead to bleeds or stroke.

However, an innovation is available. The CoaguChek XS enables patients to test their blood at home and provide INR readings by telephone, taking away the need for time-consuming trips to the clinic, thus easing the burden on themselves and healthcare professionals, who can devote time to complex cases. Additionally, there is strong clinical evidence that patient self testing leads to better health outcomes, including stroke, bleeds and mortality, as well as providing a cost saving to

'There is strong evidence that self testing leads to better outcomes'

the NHS. This treatment pathway supports the NHS Outcomes Framework across three specific areas:

- **preventing people from dying prematurely;**
- **enhancing quality of life for people with long term conditions; and**
- **ensuring that people have a positive experience of care.**

Furthermore, 2011's *Innovation, Health and Wealth* report, led by Sir David Nicholson, states: "A finger-prick blood test device enables patients on anticoagulation therapy to self monitor their blood clotting time, saving regular visits to blood clinics.

"This is clinically effective and substantially more convenient for appropriate patients; but less than 2 per cent of the 1.25 million people in the UK on long term anticoagulation therapy self monitor, compared to an estimated 30 per cent who could benefit."

An opportunity lies in the wider uptake of this simple, innovative system; Roche Diagnostics is committed to working with the NHS and, in particular, academic health science networks to spread the use of patient self monitoring to those who would benefit most.

Roche Diagnostics
www.roche.co.uk/portal/uk/diagnostics

SELF CARE

DO IT YOURSELF

Atrial fibrillation will rise as the population ages. Many sufferers need regular blood monitoring to determine drug doses. Could patient self monitoring improve outcomes and cut costs? By Alison Moore

An ageing population will bring many challenges for healthcare. But while rising incidence of diabetes, dementia and other long term conditions are widely known about, the impact of more people suffering from atrial fibrillation (AF) has had much less attention.

Around 1.5m people in the UK are already thought to suffer from AF – many of them undiagnosed. This disturbance of the heart rhythm increases the risk of a blood clot developing which can lead to a catastrophic stroke – frequently leaving the victim dead or disabled.

Patients with AF are six times more at risk of cardioembolic strokes than the general population, unless preventative measures are taken. But Martin James, consultant stroke physician at the Royal Devon and Exeter Foundation Trust, adds: "The hidden tragedy when there is a stroke secondary to AF is it is also more severe than other strokes. It has a higher risk of being fatal and among those patients who survive there is a higher chance of requiring residential care."

A US study found that AF was uncommon in adults under 55 at just one in 1,000 but among the over 80s the rate was 9 per cent. With an ageing population, the UK is likely to see more cases of AF and associated strokes – half of whom will die within 12 months of having that stroke. The AF Association says the number of people with AF could double by 2050.

This will present the NHS with many challenges around financing the care of these patients. And that raises questions of whether solutions which put patients more in charge of their own care could both reduce the burden on the NHS and offer a chance to improve care.

Improvements in care of people with AF fits within the NHS domains and the aim of preventing premature death, ensuring people have a positive experience of care and improving the quality of life for people with long term conditions.

Many AF patients will be on warfarin, which requires regular monitoring at either hospital clinics or GP surgeries. Warfarin can reduce the risk of strokes but too much can lead to an increased risk of bleeds so the time taken for patients' blood to clot needs to be monitored and kept within tight limits as much as possible.

But the evidence suggests that, even with this monitoring, patients are not necessarily achieving good control and are only achieving international normalised ratios (INR) levels within the ideal therapeutic range about half the time.

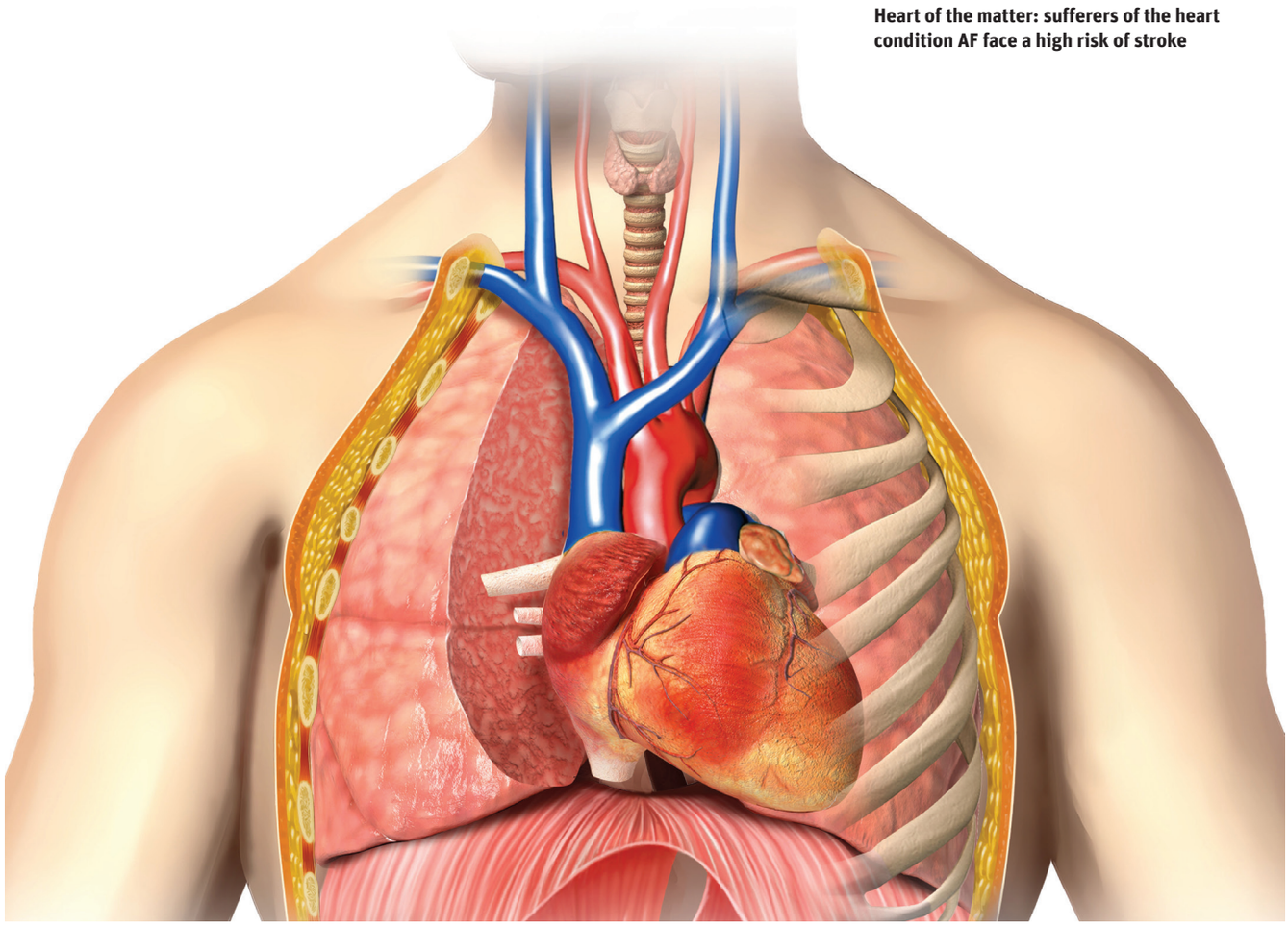
Could offering patients the opportunity to self monitor change that? Self monitoring equipment is available although patients currently have to pay for it themselves, but can get the consumables such as testing strips on prescription.

Dr James says self monitoring has proved to be a good alternative for some patients. Crucially, patients who self monitor can keep their INR within the right therapeutic range for more of the time. Time within therapeutic range is seen as an indicator of good care: a study in *The Lancet* in 2006 suggested that the time spent within therapeutic range with weekly self monitoring was 85 per cent. The same study suggested that thromboembolisms were reduced by 55 per cent and mortality by 39 per cent (although a later meta-analysis suggested mortality fell by less – 26 per cent).

Dr James is enthusiastic about the potential for self monitoring: "Scientific studies show that the control of their anticoagulation is much improved."

It is also less intrusive for patients, allowing them to continue to lead their lives with minimal interruption – Dr James

CASE STUDIES OVERLEAF ▶



Heart of the matter: sufferers of the heart condition AF face a high risk of stroke

ALAMY

knows of one patient who spends a lot of time abroad, which would be difficult if he had to make regular monitoring trips to his surgery or clinic. And elderly patients in rural areas find it difficult to travel to surgeries or clinics for monitoring, while regular visits can be disruptive to younger patients' education and employment.

And when patients' anticoagulation control is most at risk of being disrupted – for example, during illness – they can opt to monitor themselves more regularly.

Self monitoring is not for everyone but Dr James says the evidence from studies shows that four out of five people could test themselves and about half take the next step and make the adjustments to warfarin dosage (others would need to contact their surgery or clinic to have a new dose calculated for them). "In the past we would have been uncertain of the benefits... but the research more recently gives greater confidence that it is an effective intervention," he says.

NICE AF guidelines support the option of self monitoring, subject to certain conditions, when patients prefer it.

But there could also be financial benefits for the NHS. Dr James points out that a large practice may have hundreds of patients on warfarin treatment. That can amount to a monitoring workload equivalent to much of a practice nurse's time.

'The AF Association says the number of people with AF could double by 2050'

If those patients are still not achieving the right clotting times much of the time, there will be increased risk of strokes or bleeding. This is likely to lead to costly emergency admissions; strokes associated with AF may be particularly costly because patients may need long term care afterwards.

And keeping patients on warfarin, but ensuring that they are achieving good control, could help reduce the overall costs of pharmaceuticals for AF patients.

Three new anticoagulation drugs have been accepted by NICE which are effective treatments without the same burden of monitoring. However, these cost more than warfarin and have no current antidote – and, as the number of people requiring treatment for AF increases, so will the bill for the NHS.

Maintaining patients on warfarin and ensuring better control could reduce costs by reserving the newer drugs for patients with a clinical need for them – such as those contraindicated for warfarin or who are unable to self monitor (for example, because of cognitive difficulties) but don't achieve

sufficient control with normal warfarin monitoring.

Inevitably some clinicians are sceptical about this shift towards self monitoring – even though one of the benefits is likely to be reduced numbers of patients attending clinics for monitoring, allowing doctors and nurses to spend more time with patients who are having difficulty with their condition.

Dr James points out that when it was suggested that diabetics should monitor their blood glucose levels themselves this was treated with similar scepticism. Now it is seen as the norm. And many patients with other conditions such as high blood pressure are buying monitors to use at home.

He is hopeful that the academic health science networks – whose remit includes promoting dissemination of research – could have an impact. "If you can improve the screening and detention of AF, improve the management [of AF] and prevention of strokes then we are talking about a substantial impact on costs of stroke and the personal tragedy that it is."

He also suggests that the percentage of time patients spend within therapeutic range could be made public for individual surgeries – for example, on a noticeboard. "There is no excuse for poor warfarin control," he says. At the moment, there are incentives for doctors to prescribe anticoagulants but not around achieving good levels of control.

But to treat people with any drug they first have to be diagnosed. It is thought that around half the people with AF don't realise they have it.

Dr James points out that most people at high risk will be in an age group which tends to visit their GP seven or eight times a year. Simply monitoring their pulse and checking for irregularities during one of these visits can give the GP a strong indication of whether AF may be present. NICE guidelines suggest this is the most cost-effective method of testing. Irregularities can then be followed up by an ECG and heart monitoring if appropriate.

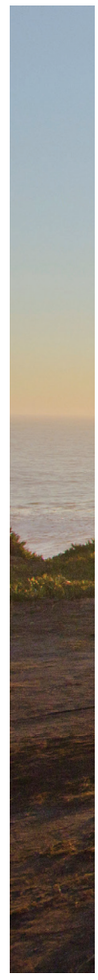
A tool called GRASP-AF allows GPs to quickly calculate whether patients are at risk and decide what treatment is indicated.

This opportunistic monitoring is supported by organisations such as the European Society of Cardiology, the Royal Society of Physicians of Edinburgh, and the AF Association. "Screening for AF is win-win for both the patient and the health service," says Dr James. "It is a cheap way of identifying people with the condition."

And from the NHS's perspective, early diagnosis and intervention, combined with a testing regime which helps the patient keep their condition under control and reduces the risk of a catastrophic outcome, has to make sense. ●

SELF CARE: CASE STUDIES

AMERICAN DREAM



Needing continual blood monitoring hasn't stopped one Nottingham patient from taking his camper van across the States – thanks to a self monitoring programme

Travelling around the US in a camper van is an ideal way to spend part of the year: and that is what one of the patients at Nottingham University Hospitals Trust likes to do – despite being on warfarin.

Thanks to an innovative scheme to support warfarin patients who want to self monitor, he is able to email back his INR results and receive advice on whether to adjust his warfarin dose from the hospital team, if necessary. And, says specialist anticoagulation nurse Debbie Duffin, he normally sends a few holiday pictures along with his readings – just to show the team where he is.

Emails like this from patients who are enjoying a "normal" life show the success of the anticoagulation team's approach – that it is for patients to control their warfarin, not for the warfarin to control them.

Around 210 warfarin patients registered with the clinic are currently self monitoring their INR levels. It is mentioned to all patients as an option as they start with the clinic and those who are interested will be assessed for suitability.

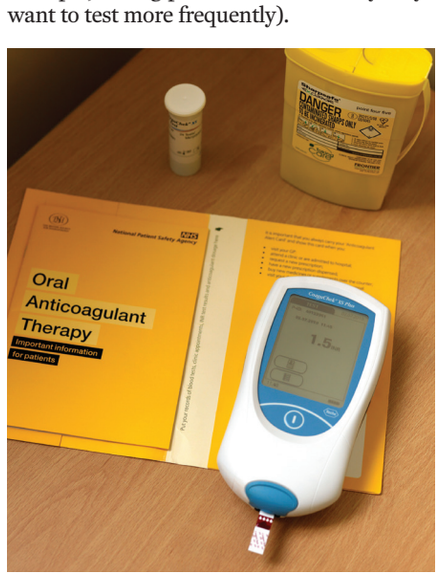
Ms Duffin says it is important that either the patient or someone involved in their care would be able to use the CoaguChek machines and take the readings. If they are suitable and want to self monitor, a letter is then sent to their GP explaining this and asking them to prescribe the necessary testing strips and lances. Most GPs are happy to do so but the team can provide extra information if they have concerns.

A patient who wants to go ahead then has at least three nurse-led training sessions – the nurse is funded by Roche to come into the hospital once a week – explaining how to use the machine and take readings. Patients then sign an agreement which sets out their responsibilities around taking readings regularly.

Results are then either phoned through to a dedicated answerphone or can be emailed to the staff – a generic email address is being set up to ensure that patients can send their readings to just one address which is always monitored. If the readings are of real concern, the staff will get back to the patient on the same day.

Once a year, patients will be called back to the clinic for their CoaguChek machine to be checked and for the clinical staff to ensure it is being used correctly. But if their testing technique is good and the INR results don't present any problems then they will not need to be recalled for other checks or to visit their GP, apart from collecting prescriptions. Patients who are not supplying their readings regularly will also be contacted.

Patients' lives no longer have to fit around clinic and GP surgery appointments, and they can adjust the frequency of testing to reflect what is happening to them (for example, during periods of illness they may want to test more frequently).



ALAMY

And Ms Duffin believes the outcomes are good. The opportunity for patients to test more frequently than they would be with traditional clinic care may improve the amount of time spent in therapeutic range. "I am sure they have fewer bleeding incidents and risks because their INRs are more controlled," she says. Preliminary results have shown that patients with AF and other conditions who self monitor achieve significantly more time within therapeutic range.

Ms Duffin can't think of anyone who has started self monitoring using a CoaguChek machine who has later had to abandon it, though this may be because of the initial assessment before they are accepted for self monitored, and the training given before starting.

She says one of the barriers to more people self monitoring is that they have to fund the cost of the CoaguChek machine themselves. Warfarin patients also have to pay for their regular prescriptions – unlike some other long term conditions patients.

Patients who are expected to be on warfarin for a relatively short time may decide the investment in the machine is not worth it, and others may simply struggle with the cost. However, some charitable funding has meant that under-18s who are on warfarin can be supplied with a machine free of charge.

'For those who travel for work or pleasure, self monitoring offers freedom from having to always think about arranging their next INR test'

Ms Duffin says that having to take warfarin can interfere massively with youngsters' lives – especially as puberty can affect control and many young patients would otherwise have to come out of school for regular appointments.

And for those who travel for work or pleasure, self monitoring offers freedom from having to always think about arranging their next INR test. "You can get an INR done anywhere in the world but it is the inconvenience and the cost – and they worry about where they are going to get their next INR taken," she says.

Patients who self monitor – and therefore don't need so many appointments either in an outpatients' clinic or in their GP's surgery – may, of course, be saving the NHS money. They are likely to be achieving better control and reducing the risk of, for example, a catastrophic stroke. But that has still to be recognised in funding streams, meaning that some patients continue to miss out on self monitoring and the improvements to their lifestyle it can bring. ●

TONNY PEDERSEN ON OPTIMISING ASSETS

At Stanley Healthcare, safety, security and efficiency are more than just words. Together they represent our mission. We provide a comprehensive suite of solutions to help transform safety, security and operational efficiency. Our portfolio ranges from patient and staff security and protection to supply chain and asset management, patient safety, environmental monitoring, and optimisation of clinical operations and workflow.

Our solutions reach across departments to optimise and monitor assets, supplies, patients, staff and other resources. Stanley Healthcare offers asset management, inventory management and storage solutions to increase staff productivity, reduce inventory and eliminate waste from expired products. We offer a wide variety of storage solutions such as cabinets, racks, trolleys and RFID automated cabinets. We combine smart storage solutions and software to link supplies to physicians, patients, and procedures. Solutions can be customised for different areas of the hospital, maximising usable space and driving efficiency of care.

Stanley Healthcare has a strong heritage. We are part of Fortune 250 company Stanley Black & Decker, have been working with hospitals for 100 years and have carried out more than 15,000 implementations worldwide. We developed the most comprehensive modular system which optimises the flow of supplies from central storage through to the point of use. The Health Technical Memorandum 71 (HTM 71) as published by NHS Estates is based on Stanley Healthcare's Scan Modul products, introduced in 1972. The system is being continually refined in close cooperation with users, so that our customers benefit from a constantly evolving, innovative range of highly customisable products.

'Nurses report spending up to an hour per shift searching for equipment'

Our inventory management solutions can save hospitals millions of pounds annually through optimised inventory levels and higher caregiver efficiency – 8 to 10 per cent of items expire annually and over 40 per cent of nurses report spending up to an hour per shift searching for equipment.

Using Stanley Healthcare's asset tracking and management, trusts optimise high value assets such as infusion pumps, specialty beds and crash carts. This solution automates the manual processes most hospitals have for managing and maintaining equipment. In this way, equipment utilisation is increased, while operational and capital expenses are reduced.

Tonny Pedersen is senior marketing manager Europe at Stanley Healthcare

www.stanleyhealthcare.com

INVENTORY MANAGEMENT

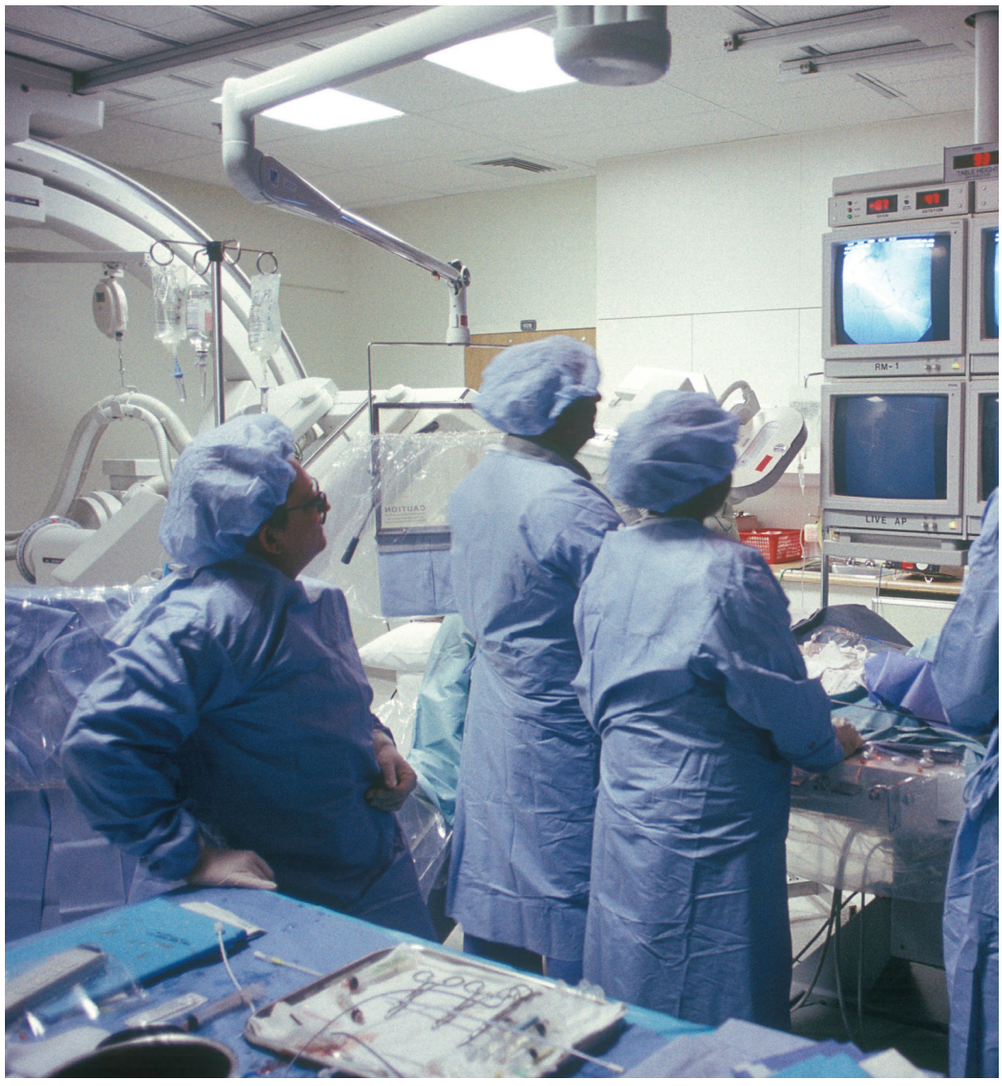
TIME TO TAKE

Savings from better management of items after they have been bought are often overlooked. By Claire Read

With the imminent publication of Sir Ian Carruthers' procurement strategy, the efficiency savings which could be realised were trusts to improve performance in this area will once again receive significant attention. Less commonly discussed, however, is what happens to stock post-procurement. Is it always managed effectively? Is it always ordered in the right quantities to avoid waste or shortages? Is it always used before it expires?

For many organisations, the answers to these questions will be no. Procurement may gain many of the headlines but inventory management is often just as big an issue – and often offers a similar potential for cost and efficiency savings.

Ask Kenton Madge why trusts have not grasped this, why they still struggle with effective inventory management, and he takes a moment to think. "Why do healthcare trusts still struggle with it? That's a very good question," he reflects. "I really see it coming down to the fact that it's



CASE STUDIES OVERLEAF ▶

STOCK SERIOUSLY

no one's responsibility. You have strong procurement – everyone's got a procurement department – but procurement's specialty is to procure; to make sure they get the best deal for their hospital.

"But the management of that item once it's procured and put on the shelf is left in the hands of the clinical staff in that department. Now those clinical staff didn't go to university to learn to care for patients to then come back to a hospital and manage inventory. I don't think that was a module on nursing courses, but that's where it falls – it falls to the senior nurses and sisters to take responsibility for it."

It is an issue which Mr Madge sees regularly. As commercial director for Stanley Healthcare, which offers a range of solutions in supply chain and asset management, he frequently talks to clinical staff struggling to manage inventory alongside managing patients.

"They've been given this job and they've got no tools to be able to do it," he explains. "Some people do actually manage it quite well, but it's taking 50 per cent of their time. You see them using spreadsheets, pen and paper, see people having to do inventory checks every month and doing stock takes."

Keeping track of the inventory used, and that which needs to be ordered, is challenging enough in a small clinical area. But start to look at a department and the true scale of the issue becomes clear.

"We have probably somewhere in the region of over 1,600 lines active at any point in our cath labs," explains Glen Sibbick, operational manager for cardiology at University Hospitals of Leicester Trust. "We currently run five labs, so there's a lot of turnover of that stock on a day to day basis, and no single person gets to see all the equipment being used.

"A group of nurses in one room won't see what's being used elsewhere – they only get a feeling for what's being used in their room and not everybody else's. To manually monitor those 1,600 lines is very difficult."

Since September 2009, the cath labs at Leicester have therefore been using a software system to automate stock management. SpaceTRAX Point of Use is a web-based system which uses barcodes to precisely track stock. Items are scanned as and when they are used, at which point the software tracks that the inventory has been reduced and judges whether that article needs to be reordered.

"Every item within the system will have what's called a par level – a par high and a par low," explains Mr Madge. "As soon as an item hits the par low, you automatically run a reorder report and the system will tell you to reorder to the par high. So you can capture the demand for reordering that item without the need to go to the shelf, look at the items, and say I need to order two more stents, more 10ml syringes, and so on."

The resulting efficiency benefits and financial savings can be significant: through reducing wastage, decreasing the amount of time clinical staff spend on inventory management, ensuring stock is at the right level at all times, and having detailed data on stock usage, University Hospitals of Leicester reported a 1,103 per cent return on investment within the first year of using SpaceTRAX. And the data the system generates is giving staff the information they need to identify yet more efficiency and cost savings.

'Clinical staff didn't go to university to learn to care for patients to then come back to a hospital and manage inventory'

"Once our systems are embedded they give you very clear statistics of which items you're using; very clear analytics to show where you're spending your money," explains Mr Madge. "That goes right down to patient-level data. In one simple scan of a manufacturer's barcode, you've recorded an item against a procedure. So trusts can compare their tariff cost to what it's actually costing, and see where they need to make savings."

"We get an idea of the exact cost per case which can then feed into patient-level information and costing systems (PLICS)," reports Mr Sibbick. "So we can understand exactly where our costs are for each patient episode and, since we can see what we're using, that gives us better bargaining power with the companies we purchase stock from."

The benefits seen by organisations such as Leicester are such that Mr Madge argues all trusts should be looking at better inventory management as "a simple win".

"The NHS needs to adopt, or at least open its mind to, supply chain automation," he suggests. "It's about taking the people out of the supply chain and automating what you can automate.

"An efficient supply chain is one that doesn't really need that much interference from people," he continues. "When a nurse goes to get her 10ml syringe, there should be one there. And when she later comes back for another one, there should be another one there in its place. And that should be her whole involvement in the supply chain. Because that way she gets back in front of her patient quickly to do her job – and that job is not managing inventory." ●

Extra monitoring: clinical staff often look after stock as well as monitoring patients

ALAMY

INVENTORY MANAGEMENT: CASE STUDIES

NOW WHERE DID I PUT THAT?

How trusts here and in Sweden are tackling stock problems, including staff wasting time running around hospitals trying to find things

UNIVERSITY HOSPITALS OF LEICESTER TRUST

Glen Sibbick has a simple way of explaining how inventory management software has improved the situation in cardiology at University Hospitals of Leicester.

"We're now to the point where we are managing the stock rather than the stock managing us, which is where we were at before," says the operational manager for cardiology. "I think a lot of other centres are in a similar boat to the one we were in: you're running around trying to manage stock, and find an item has run out."

The department has reported significant cost and efficiency savings since introducing Stanley Healthcare's SpaceTRAX system in September 2009. An important reason for those savings has been less wastage. Through barcodes being scanned when a product is used, SpaceTRAX precisely tracks the use of items and then recommends maximum and minimum levels. Mr Sibbick says that has removed the problem of overstocking.

"We did have a system in place previously that kept an eye on some of the stock but it wasn't detailed enough to be able to do what SpaceTRAX can do for us now – it constantly monitors lines, looks back, and checks the frequency of us using that stock, and then suggests levels.

"We have five cath labs, and so previously the idea had been that we should have five of everything, because we needed one in every lab," he continues. "But we can now say, well, actually, we only use this once a month or once every two months, so we don't need to stock it in every room; we can have a central area for it or just stock it in certain rooms because we know it's only going to be used in those rooms. You might find an item is being used particularly by one room by one particular operator but not so regularly by another operator in another room. SpaceTRAX auto-adjusts levels to reflect that."

With computer software monitoring the situation rather than an individual, it is proving much easier to get a precise and timely picture of the labs' inventory.

"We work on about three weeks' supply on some of these items," Mr Sibbick explains. "If we've only used one in the last three weeks, SpaceTRAX will reduce the levels whereas if we'd used 10 it would say we need to increase the levels. So it's far more responsive than any person could be doing this manually – there's just no way anybody would be able to respond that quickly. I think that's probably where we've made a lot of the gains from; adjusting the minimum and maximum levels so we're not holding too much or not enough."

Certainly it is a major reason that the percentage of items expiring has fallen by 52 per cent since the introduction of SpaceTRAX. Important too is the system's ability to record precisely when an item is due to expire. The initial scan of the barcode when an item comes into stock records expiry information, and it can be easily viewed at any future point. "Most of the products we use in the cath labs have at least a year's shelf life, and that goes out to four or five years depending on the product. Keeping track of which ones are going out of date is very difficult," says Mr Sibbick. "If you've got no way of seeing the expiry dates on products, you're working blind all the time.

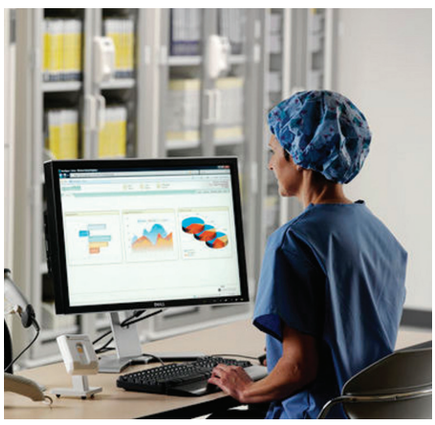
"But now that I'm able to see what stock is going out of date, we're able to move it to areas where it's more likely to be used, or flag it up to make sure that it is used. We also have swap out clauses in the agreements we have with providers, so if we've got nine months left on the product and we don't think we're going to use it we send it back, and they swap it out for stock that we think we will use.

"It's about us managing stock rather than the other way around."

SKÅNE UNIVERSITY HOSPITAL

Torbjörn Harlenbäck took an interesting route to the challenges of inventory management in healthcare.

"My background was in international logistics – I'd been with DHL for more than



Good view: stock statistics on screen

10 years," he explains. "I was headhunted back in 2005 to come and see what I could do with the flow of material here at Skåne University Hospital [SUS, a two-site hospital in Sweden]. They knew they had a problem, but they weren't sure how to solve it and it hadn't been a prioritised question."

The exact nature of the problem is one which Mr Harlenbäck says is common to more or less any healthcare provider.

"I've looked at a lot of hospitals in Sweden and in other countries as well, and the storage of items is normally as far away from the patient as it could be," he reports. "There's no order, they have a lot of material, too much stock and no standardisation. There's no control whatsoever."

Introducing that control at SUS meant introducing a new software system and moving all supply and ordering to central management. Wards are no longer responsible for judging how much stock they need and when. Instead a central department uses barcodes and SpaceTRAX software to monitor stock levels, usage, and to order more supplies as and when needed.

The stock level in a standard department has been reduced by 40 per cent: departments now have exactly what is needed rather than holding large amounts of stock – "that 40 per cent was probably thrown away when it got too old to be used, so we were throwing away a lot of money." Notable too is that the range of articles has been reduced by 25 per cent.

'We have five cath labs, and so previously the idea had been that we should have five of everything'

"The normal thing is a department gets a new doctor who tells the staff: 'I need this item to be able to work'. So they buy it and put it on the shelf. But what we've found is that a fourth of everything departments had they actually could do without," says Mr Harlenbäck.

But the efficiency improvements go beyond those secured through better management of stock. SUS combined the introduction of the SpaceTRAX software with a complete overhaul of stock storage arrangements. Stock is now much closer to the patient, and by definition to the staff member who needs to use those items.

"Three metres from the patient we have the 30 most commonly used items: mostly clothes for the patient, linen for the beds, and so on," explains Mr Harlenbäck. "And then not more than 20 metres away from the patient, we have main storage – in a standard department that's about 300 articles. Then we have one other store, which is more than 30 metres away from the patient and there we store the things that are not so commonly used – clothes for very small or very large patients, for instance. That storage is normally shared between departments."

It means that staff no longer spend time walking long distances back and forth to get hold of the items they need for their patients.

"We save 1.2 full time employees in every department by doing this," says Mr Harlenbäck. "There was a half time employee who did nothing but unpacking stuff, putting it into storage, handling orders and so on. And the other 0.7 per cent you're saving is everybody else – all the time they spent running around looking for things.

"So it's very much easier for clinical staff. It makes their lives a lot less stressful: everything turns into a much calmer environment because they are not running around any more – what they need is right beside them. And if you work in one department one day and then the next day in another department, you will find your way around the storage because it's standardised. It is a real benefit for a hospital like ours."

Mr Harlenbäck has encouraging words for any other organisation considering improving their inventory management and addressing storage issues.

"It's not as hard as it might seem, actually. We implement while the departments are fully up and running – they don't have to leave or anything like that. We kind of sneak in the system within three weeks and then they are up and running. The return on investment is very fast. We are talking about less than a year in some places." ●