HEALTH SERVICE JOURNAL FOR HEALTHCARE LEADERS

HSJ EFFICIENCY

AN HSJ SUPPLEMENT/29 MARCH 2012

CONTROL SHIFT

HOW TO SAVE ON AGENCY STAFF – AND GET THE MOST OUT OF THOSE YOU DO HIRE 16

The London Clinic: Managing Rising Levels of Data Whilst Reducing Costs

The upsurge in the volume of digital information created and used by hospitals is immense. With the move towards a total electronic healthcare record and a massive increase in the number of clinical images, it is now crucial for a hospital's IT organisation to successfully and cost effectively secure, protect and manage that data, both now and in the future.

The London Clinic is no exception, and having experienced rapid growth in these critical areas, they required a solution that would enable them to back up their existing hospital information systems' data, and also enable administrative information to be protected. This would include finding a way to store the data cost effectively and without detriment to the day to day running of the hospital.

Managing the Proliferation of Data

BridgeHead Software acted as The London Clinic's advisor to scope a solution that met these requirements. The first step was to archive older data from the Clinic's Patient Administration System (PAS), freeing up important space on the Storage Area Network (SAN) infrastructure, and managing that content on less expensive storage, whilst maintaining its availability to the user if required.

By implementing BridgeHead's Healthcare Data Management (HDM) solution, the Clinic would be able to ensure that patient records are quickly and easily accessible, and that point-in-time replicas of that data are intelligently distributed, in line with hospital policies, to the appropriate secondary storage (e.g. tape, disc, Cloud, even VTL), as well as geo-dispersed for disaster recovery.

The Results in Action

The London Clinic has been able to reduce costs and increase availability of critical data across the Clinic simply by using one application that provides them with a single point of storage for all their clinical and administrative information.

The BridgeHead HDM solution provides a Vendor Neutral Archive (VNA) where clinical data (PACS, other DICOM and non-DICOM images) as well as administrative data (file and email) are stored. As content is written into the archive, it is indexed (both meta-data and full-text indexing), making it easier for the Clinic to ensure clinical staff can search for and access patient records when and where they are needed, without delay.

One common issue the Clinic had previously been experiencing was the management of emails. The IT department had received frequent calls asking about the capacity of their mailboxes and retrieving old mail. By implementing BridgeHead's HDM solution the Clinic has saved both time in accessing information and the considerable cost of maintaining and upgrading storage.

The Clinic is now able to manage business continuity in the face of disaster much more efficiently than before. Their data recovery programme enables them to restore and access patient information quickly so that in the event of an outage, system loss, or corruption, they can recover at a rapid rate minimising the effect on patient care.

Working in Partnership

The BridgeHead HDM solution delivers significant benefits to the Clinic; both in terms of more effective management of its data, as well as infrastructure cost savings in the future. Having virtualised their storage, the Clinic is now able to prepare for making use of the IT Cloud. This will enable the business to grow and outstrip the resources required to sustain it.

Additionally, the Clinic is looking at possible directions in supporting other hospitals in the London area by exploring further developments in the archiving of their medical images.

> *"It's nice to find a supplier that can both listen and help you realise a vision. BridgeHead Software is one of the very few organisations that really do understand the problems that face most IT directors in managing storage and archive. Their software is robust, highly scalable and has done an excellent job in protecting our core application data. BridgeHead Software is a strategic solution for the clinic and I look forward to continuing our partnership into the future."*
>
> **Mike Roberts,**
> IT Director at The London Clinic

For more information on how BridgeHead Software can help lower the cost and administrative burden of managing your healthcare data, contact us at: **info@bridgeheadsoftware.com** or visit us at: **www.bridgeheadsoftware.com**

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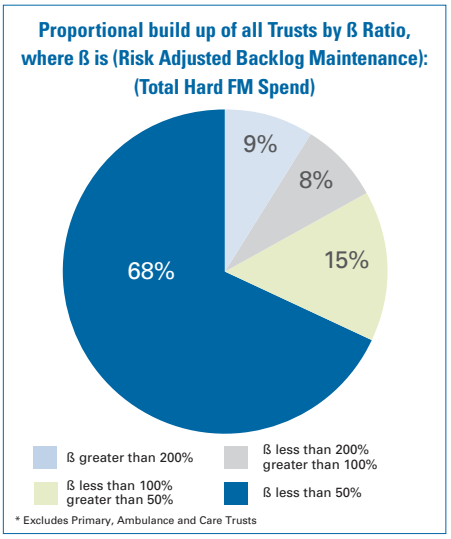


The NHS is experiencing unprecedented cost pressures and it is clear worse is to come. The NHS estate varies considerably in quality and condition, with Risk Adjusted Backlog Maintenance (RABM) levels reaching lows that are seriously compromising Trusts' ability to deliver safe and effective clinical services that achieve the high levels of patient satisfaction that we should all expect.

The cost of maintaining this estate is rising inexorably. The relentless increase in energy costs (77% since 2004) is expected to continue rising a further 81% over the coming decade. This indicates that by 2021 energy inflation will have added £8.4 billion per annum to the fuel bill of UK commerce and the public sector combined.

Energy Cost Increases 2010 to 2021	2010	2021	Change (%)
Electricity p/kWh	7.8	14.7	88%
Gas p/kWh	3.4	5.4	59%
Electricity £*	£78,000	£147,000	88%
Gas £*	£30,000	£48,000	59%
Total £	£108,000	£195,000	81%

* Energy price forecast for a typical large office building.

The Balfour Beatty Asset & Energy Programme

The Balfour Beatty WorkPlace (BBW) Asset & Energy Programme has been created to specifically address these energy and backlog maintenance needs and is designed to support the NHS through medium-term flexible partnerships. Put simply, we propose to provide the capital required to improve your estate, invest in energy-saving measures and to reduce carbon output; all of which have a direct and positive effect on patient care and patient satisfaction. Balfour Beatty, with its expertise in whole lifecycle management, will oversee that investment programme and underwrite savings (in truth, cost avoidance) and provide the Trust with a greater level of budget and cost certainty.

The Asset & Energy Programme is a comprehensive approach to improving clinical environments; delivering immediate savings by replacing or refurbishing critical infrastructure that is no longer efficient, reliable or safe. It continues to reduce costs by intelligently maintaining your estate whilst optimising energy demand and procurement.

This combined approach allows BBW to create better environments for staff and patients, as well as reducing expenditure.

Turning Risk into Reward

Backlog maintenance is a very significant risk to NHS estates. Our research shows that one in six NHS Trusts have RABM that is greater than their total annual estates expenditure. Aside from the practical problems associated with infrastructure or asset failure, the cost of an unplanned repair or replacement is often significantly higher in comparison to planned expenditure.

Unlike traditional approaches to Estates Management, The programme provides immediate investment to eliminate 'High Risk' backlog maintenance and substantially reduce 'Significant Risk' elements, while also delivering savings. Some measures are introduced quickly, and will be prioritised in the early stages of the partnership. Others require more planning and will be implemented later on.

Examples of the types of measures that might form part of a partnership include:

- Installing a combined cooling heat and power (CCHP) unit
- Using voltage optimisation technology to stabilise levels of electricity and reduce unnecessary waste
- Installing efficient glazing and shading systems
- Generating energy from waste
- Upgrade to fabric or infrastructure in clinical settings to enhance the patient experience.

Managing Energy Consumption & Carbon Reduction

The Asset & Energy Programme will help a Trust manage energy costs by introducing measures to reduce the energy demand of your estate. We will reduce a building's energy consumption through a combined lean, green and clean approach that not only reduces costs, but offers significant environmental benefits.

Lean Use less energy through measures such as enhanced metering and building management systems, better thermal insulation and auto daylight dimming controls.

Green Use renewable energy, for instance by installing a biomass boiler.

Clean Provide energy more efficiently, for instance by generating energy from waste.

Procuring Energy Efficiently

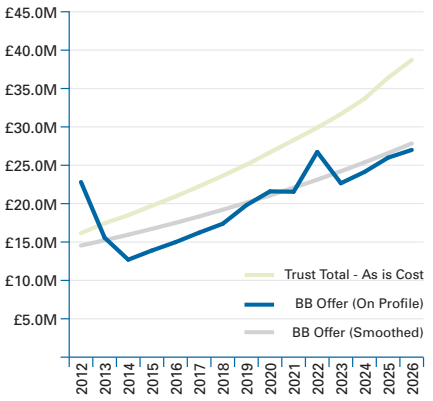
As well as helping to reduce energy demand, BBW offers a range of procurement strategies to lower costs and minimise the impact of energy price rises. These include fixed or flexible deals, each of which can be adopted across a Trust or on a site-by-site basis. Our procurement team purchases from the wholesale energy markets, focusing on delivering best value from the various market suppliers. By installing smart meters, we can evaluate and plan your energy consumption in real time. By accurately forecasting your future utilities consumption we are then able to match your base and peak energy demands to the appropriate energy tariffs, thereby reducing expenditure and minimising your exposure to volatile energy markets.

A Unique Proposition

We have analysed data submitted by NHS Trusts through the Estates Return Information Collection (ERIC) process for the ten years to 2010 and we model this data with forward projections on consumption and price to provide you with an initial estimation of future operating costs. We input our capital investment and cost savings assumptions and use this initial exercise to mutually determine if there are meaningful and acceptable high-level cost savings. Assuming there are, we then undertake a very detailed survey to establish accurate and current energy usage and asset condition and use this to prepare a detailed commercial proposal that includes guaranteed savings.

The Balfour Beatty investment, coupled with our experience in managing healthcare estates, lead us to be confident that The Asset & Energy Programme can reduce a Trust's hard FM costs (building engineering and maintenance, total energy and backlog maintenance investment) by up to 20% over 15 years. This saving will, in part, be guaranteed and net of a smoothed annual financing charge. Our model also assumes that the Trust benefits from a Year 1 budgetary saving of up to 10% of current operating costs. The programme is flexible and unlike PFI does not have a fixed annual charge, but instead adapts to the inevitable changes that will occur in a Trust's estate during the life of the partnership.

The Asset & Energy Programme has the potential to save an NHS Trust 20% over the life of the partnership



Total savings summary		
Trust 'AS Is' 15 year cost		**£389.0m**
Energy saving		(£34.5m)
CRC Tax saving		(£ 5.5m)
Lifecycle saving		(£18.4m)
Maintenance cost saving		(£46.4m)
BB Investment		£17.2m
TOTAL GROSS SAVING	(22.5%)	**£87.6m**
Smoothing cost		£6.5m
BB Offer (Smoothed)		£308.0m
SAVING to TRUST	(20.8%)	**£81.1m**

Using the example of our average NHS Trust, the AIM returns a smoothed annual charge that delivers a year 1 saving of 10% and a potential 15 year saving of 20.8% to the Trust.

What the programme offers:

- Better environments for patients and staff
- Lower operating costs over the life of the partnership, some of which will be guaranteed
- Elimination of high risk and reduction of significant backlog maintenance
- Reduced annual maintenance costs
- Reduced energy costs
- Reduced carbon emissions.

Fundamentals of the programme

- Based on a long-term strategic partnership
- Includes investment in infrastructure and assets to improve performance; reducing both risk and cost
- Unlike PFI, the programme uses a flexible commercial model that will accommodate a changing estate profile
- Reduces operating costs from day one
- Hard FM transfers to BBW

Contact us for further details:

We would welcome the opportunity to discuss the programme with you and to develop a bespoke proposal based on your estate's ERIC data and other current survey information. This will provide a clearer picture of the potential cost savings and environmental benefits. For more information, please call **Kevin Holder** on **07772 817 715**.

Balfour Beatty
WorkPlace

HARRY KEENAN ON DOING MORE FROM LESS

The NHS is going through a period of unprecedented change. Despite all the media noise about the twists and turns of the Health and Social Care Bill, the stark reality is that it's already a hugely challenging environment for all who work in or alongside the NHS today. The proposed £20bn of efficiency savings must be found in an already cash constrained environment. Doing more for less, but maintaining quality care for patients, is a regularly heard mantra.

We at Baxter have found that this is a real opportunity to work differently as a supplier to our main customer. Our broad portfolio of products and services allows us to have the unique ability to see a whole patient pathway, and there are real opportunities for us to work in true partnership with NHS clinicians and managers to deliver their QIPP targets with a win-win scenario for all including, most importantly, the patient.

David Nicholson in his *Innovation health and wealth: accelerating adoption and diffusion in the NHS* report says that "we need an entirely new relationship with industry based on partnership, not just transactions".

Through our Evolving Health Programme we aim to do just that. Nothing is off the table. We want to work with our customers as problem solvers, as consultants, who can work with the trust, GP consortia or clinical commissioning

'We need to remove the "silo budget" mentality'

group to help them to realise greater efficiency but also to ensure that they continue to deliver high quality care for patients.

We find that we are having different conversations with new and different customers within the NHS who are wanting to find solutions to the challenges that they have within their health economy. This could be anything from reducing emergency admissions, cutting bed days, reducing transport budgets or getting more patients treated in their own homes. To help them to solve these problems we have to look at funding streams differently. We need to remove the "silo budget" mentality, and review where efficiencies can be made across the whole of a trust.

The importance of innovation within this efficiency drive is absolutely key. Innovation is not just about using new technologies, although innovative medicines and devices do have an important part to play. Many of our examples of innovation often derive from innovative and different ways of working or the creation of strategic partnerships that have truly benefited patient outcomes.

Harry Keenan is general manager of Baxter UK and Ireland

www.baxterhealthcare.co.uk

PARTNERSHIP WORKING

THE INSIDE

The new breed of supplier no longer just delivers at the front door and leaves but is looking to help trusts make savings and improve care from the inside – as an integral part of the care team. Alison Moore reports

The NHS has always worked closely with a large range of suppliers of goods and services. But these relationships are taking on an added impetus as it tries to save £20bn and improve quality.

Whereas suppliers were once the people who delivered to the front door of the hospital and left, now they are increasingly being invited in to use their expertise to everyone's benefit. And they are effectively becoming partners as NHS organisations try to deliver savings and improve quality of care.

These longer term relationships often focus on services as well as products and look across whole patient pathways rather than focusing on one point.

Aaron Cummins, chair of the finance directors forum at the Foundation Trust Network, says it is important that the NHS look at the whole picture of these arrangements – including added value offered as well as the bottom line. "How cheap can you go is really quite dangerous," he says.

"We recognise the financial and quality challenges that NHS trusts are facing," says Amy Pott, market access director at Baxter Healthcare. "When we go in to speak to hospitals now it is about trying to join up the dots to all the linkages in the pathway.

"We try to work with trusts to really understand what is going on inside the organisation. Sometimes, because we can see the whole patient pathway, we can go and bring people out of that 'it's my budget' conversation into one around the whole effect on the hospital."

She believes that it is critical to put the patient at the heart of this and to focus on the outcomes for them. Understanding the local health economy is also important.

She can see a shift in what the NHS is looking for. "We are seeing more and more managed services tenders coming out – be it for the provision of renal or pathology or pharmacy. Hospitals are recognising that these things can be outsourced and run very effectively and they can focus on their own core strengths."

One effect of this is that some investment in upgrading facilities and adding equipment can come from the company, rather than having to be found out of a hospital's stretched capital budget.

Suppliers can also bring knowledge and skills which organisations don't have in-house. This can be helpful when new ways of working are being introduced – such as shifting care into the community or helping patients self manage.

Often working with suppliers can be about sharing risk – as when cancer specialist

CASE STUDIES OVERLEAF ▶

TRACK

‘It’s not a provider-client relationship – it’s a partnership’

Christie Foundation Trust and Baxter reorganised their chemotherapy supply route (see case study, overleaf).

Baxter now takes the risk of the drugs it supplies not being needed at the last minute, explains Michelle Rowe, aseptics and clinical trials manager at the Christie. But it also now has more control over how those drugs are kept – reducing the chances that they have to be thrown away. And because it is involved in re-manipulating drugs which are not needed, it does have a slightly increased income stream – but at the same time pressure on the hospital pharmacy has been reduced.

Projects such as this take a more collaborative approach. The supplier does not just deliver and leave; they are part of a team, often taking part in department meetings. “It’s not a provider-client relationship - it’s a partnership,” says Ms Rowe.

And that close working helps understanding. Ms Rowe says staff now understand that the staff at Baxter are working hard to resolve any problems with chemotherapy drugs: “We know that people do their utmost to make certain treatment is there for that patient.”

At St George’s in London, staff from Baxter providing outreach services to patients attend meetings in the trust and are seen as part of the care team.

Mr Cummins stresses that clinicians need to be engaged. “When you are talking about end-to-end value projects the key people are your clinical leaders.” He says procurement needs a multidisciplinary approach.

So what are the barriers to setting up these mutually beneficial relationships? An obvious one at the moment is that some parts of the NHS are experiencing rapid change and instability. “It’s a very fluid and dynamic environment,” says Ms Pott. “A lot of people are interviewing for their jobs and can’t plan more than six months ahead.”

Organisations may also be looking for quick savings – something which companies have to factor into their plans. “We have to recognise that they need to find savings quickly,” she points out. “We have to prove the value of the product or service.”

And silo funding is always an issue. There is a need to look across the patient pathway to see where changes can bring overall benefits to the NHS – but organisations may be concerned about the impact on their own budgets. Some kind of benefit sharing may be needed. Ms Pott says Baxter often works with NHS organisations to develop a business case which shows the benefits which can be realised.

“That is where we come in and take a step back and work with all of the sides to find that ideal solution.”

But whereas organisations might have “salami sliced” in the first year or two of the Nicholson challenge, there is now more realisation that sustained transformation is what will deliver the ongoing savings. This can open people’s minds to more radical change – and may help overcome the remaining pockets of resistance to working more closely with commercial companies.

Trusts are also individual, they work in different ways and a “one size fits all” approach does not work. This means that companies that work with them will need to tailor solutions to their problems and situation rather than offer an off-the-shelf solution – and that can be more expensive. However, with continuing pressure to make efficiency savings, close working with healthcare firms looks set to increase. ●

FOTOLIA

Baxter

PARTNERSHIP WORKING: CASE STUDIES

CONTROLLED RELEASE

How partnerships have cut costs and improved care, including two groundbreaking projects that let carefully selected patients leave hospital to be treated at home

Cutting waste: more chemotherapy drugs are now saved and reused at the Christie

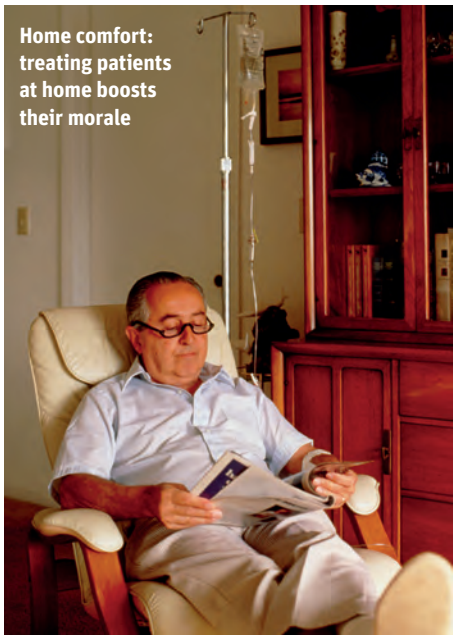
GIVING INTRAVENOUS ANTIBIOTICS AT HOME IN TOOTING

Many hospital trusts are likely to have a small number of patients who need long-term intravenous antibiotics but are otherwise well.

In an ideal world, those patients could be at home with their families, receiving care from a visiting nurse and only going to hospital for routine appointments.

In reality, many spend weeks – or even months – in a hospital bed because it is too difficult for them to be sent home. That's expensive for the hospital and means the bed is not available for other patients. And it can be frustrating for patients.

A scheme at St George's Healthcare Trust in Tooting, south London, is enabling a carefully selected group of patients to get care at home. In 2010-11 this saved the hospital 2,300 bed days and this year it is expected to save around 2,700.



Home comfort: treating patients at home boosts their morale

Patients receive antibiotics at home for between five days and five months. All are medically stable and are assessed for social factors before they are accepted for outpatient parenteral antimicrobial therapy. Around half of the patients referred are rejected – either on medical or social grounds, or because they can be switched to oral antibiotics instead, or simply don't need continuing antibiotic therapy.

Once accepted, patients are fitted with a peripherally inserted central catheter line to allow them to receive antibiotics and each patient's prescription is drawn up and checked by the hospital pharmacist, then sent to Baxter Healthcare.

Baxter provides both the medication, which is delivered to the patient's home, and nurses to infuse the drug once or sometimes twice a day. During the visit the nurses will also take observations, deal with dressings and are obviously aware of the risk of central line infections. They take the patient's bloods once a week so the results are available for the patient's appointment at hospital. Some patients can self-administer drugs and some of the training for this may be undertaken by the nurses as well.

Dr Matthew Laundy, the consultant running the project, describes it as a "win-win" for everyone. The trust has more beds while the patients are at home. "One should not underestimate the morale sapping effect of being in hospital," he says. "Some of our patients have been able to return to school or work." Infusion typically takes half an hour to an hour so, carefully timed, it need not interfere too much with a patient's life.

Dr Laundy says that a district nursing service could undertake this work. But with St George's offering specialist TB care and also acting as a regional trauma centre, that would involve working with many different teams. His multi-drug-resistant TB patients, for example, have come from as far away as Bristol and Brighton.

"We have 10 to 12 PCTs feeding into us. Each district nursing team has a different way of doing things, some people can do things, others can't. It becomes impossible to manage," he says. Given this, a private provider with a small team of nurses seemed a better option: and the trust tendered out the service last year.

Clinical governance is ensured through regular audit and weekly meetings to discuss patient progress. Urgent matters are immediately and patients also have access to on-call consultants.

But joint working is important: "It is very important to establish a rapport with the nurses so they are not some anonymous group," says Dr Laundy.

CHEMOTHERAPY DRUGS MANAGEMENT IN MANCHESTER

Chemotherapy drugs are notoriously expensive but often can't be administered because the patient is discovered to be too unwell to receive them after they have turned up for treatment.

This can sometimes lead to drugs having to be thrown away because they have not been kept at the right temperature and can't be reused for other patients.

Three years ago the Christie Foundation Trust – a specialist cancer hospital in

Good move: research suggests patients dialysed at home have better outcomes

Manchester – was having to throw away £600,000 worth of chemotherapy drugs a year because of this problem.

Baxter Healthcare was already working with the hospital to supply pre-ordered drugs from a site a few miles away. Once the drugs were ordered and arrived they were in the care of the hospital – meaning the hospital had to take the risk that they were not used.

When compounded drugs were not needed at the last minute, the hospital pharmacy would try to reuse them – but because the drugs had been issued by Baxter, it was difficult to guarantee they had been kept in the right conditions. This issue of the missing link in a controlled temperature chain meant they had to be discarded.

In addition, the work associated with reusing drugs that had been kept under controlled conditions was also putting a strain on the pharmacy department.

The solution was to work with Baxter to ensure that the drugs were only issued once the patient was in the clinic and blood testing had shown they could have chemotherapy. This meant that the company needed an on-site hub which could react quickly once it was clear treatment was going ahead.

An email system was set up to alert the Baxter team that a patient was going to be treated and the drugs would then be released to a nurse; up until this point, the drugs would have been kept under controlled conditions and could be reused for another patient if not needed.

Any manipulation to allow reuse is now done by the company's staff, reducing strain on the hospital pharmacy.

In a second development, the on-site hub was moved closer to the area where chemotherapy is carried out, which has encouraged better relationships between the Baxter team and the staff giving the treatment. "We are getting collaborative working with staff on the ward," says Michelle Rowe, aseptics and clinical trials managers. "They are in the middle of it. The nursing staff can go straight to the room and ask for a treatment – it reduces a lot of delays."

'The Christie hospital was throwing away £600k of chemotherapy drugs a year'

An email system of ordering is still used – it provides an audit trail – but the teams can work together to resolve any issues. Where drugs can be reused the hospital is only charged an additional handling charge.

The effects of the changes have been a significant saving in wasted drugs – down from £600,000 a year to £240,000 in the first year of operation – but also shorter waiting times for patients to commence treatment once they are judged suitable.

"What we are seeing now is less than £10,000 a month wastage," says Ms Rowe. "And the staff are a lot happier as well."

DIALYSIS AT HOME IN NORTH STAFFORDSHIRE

Enabling people to have dialysis at home can give them more of their life back and reduce the pressure on hospital units.

But patients may often be nervous about the process – especially if they are new to dialysis and are not expecting to start it. And nurses need to feel equipped to help such patients both practically and with additional information. The University Hospital of North Staffordshire has been working with Baxter Healthcare to ensure that suitable patients are able to benefit from home dialysis. The company has funded a home dialysis course looking at patient suitability, access and assessments.

It also helps the hospital see how they can develop their home service more and is an opportunity for idea sharing and innovation. On the final day of the course a planning session is held to look at the current mix of peritoneal dialysis patients there are within the hospital's existing patient population and how changes can be made which will enable it to grow this.

A second course concentrates on how to insert the catheter, which is crucial to this treatment, with the aim of disseminating knowledge through a department. Patients often need daily help when they start on this form of dialysis and nurses have to be equipped to do this, as well as deal with any queries patients have.

Renal nurse Liz Cropper says Baxter has also helped with patient education material, such as decision aid cards.

The department has seen the number of people treated at home increase to around 90. Although this is still only 25 per cent of the patients undergoing dialysis, it represents patients being given a choice of where they want to be treated and is a significant shift in patient pathways.

"A lot of research points to people doing a lot better if they are dialysed at home. There's research showing they live longer and do better," says Ms Cropper. But the switch to more treatment at home has also helped the trust deal with more patients. ●

ALAMY, REPORT DIGITAL, REFLEX

DAVID LAWRENCE ON A CHANGING ESTATE

The NHS has to transform the way care is delivered while seeking productivity gains and savings. The traditional hospital based model of care itself has come under scrutiny. But what will this mean for the NHS estate?

The NHS estate has grown by 2 per cent since 2009-10 to 29 million square metres at a time of fiscal challenge. With occupancy costs for hospital double that for community facilities, delivering care closer to patients' homes produces significant savings.

Radical changes to the way estates are utilised will require new thinking, investment and commercial expertise. All trusts should have a programme of estate rationalisation; our experience points to this targeting 10 to 15 per cent of the estate. Moving care closer to home, our models suggest, can also lead to a further 5 to 15 per cent gain in estate efficiency. This, however, depends on the pace of change and investment and the following factors:

- **the ability of trusts to reduce clinical capacity by increased productivity alongside moving care closer to home;**
- **access to capital, which will act as an enabler for transformation, and seeking out new and innovative ways of income-generating opportunities to "sweat" the estate;**
- **understanding the true cost of the estate by service line to ensure income can fund the use of space; and**
- **innovative solutions in times of austerity that recycle estate to generate good returns.**

'Moving care closer to home could lead to a 5 to 15 per cent gain in estate efficiency'

The NHS needs innovative and commercial leadership to drive estate change. It is no different to other major corporates in that the expertise base has been downsized, and sourcing expertise will be needed to deliver estate solutions.

The NHS will always require a good quality estate in the right place at the right price, offering a clean, safe, secure and warm environment. Estate solutions need to accommodate the changing models of care – they must provide quality accommodation, minimise revenue expenditure and offer a more commercial approach to gear in additional income streams.

Failure will see properties not fit for purpose, underutilised and without the investment to maintain them to ensure compliance to statutory standards. Estate efficiencies offer real opportunities to support and deliver QIPP for the NHS.

David Lawrence is a director at Capita Symonds
www.capitasymonds.co.uk

ESTATES MANAGEMENT

WATCH THIS SPACE

With so much NHS space underused and more services moving into the community, estates managers are going to have to take some hard decisions. By Alison Moore

Ask anyone what comes to mind when they think about the NHS and it is likely that buildings – hospitals and health centres – will feature fairly highly.

But the NHS estate may not be what is needed to provide healthcare in the future. As services are increasingly provided close to home, we may need fewer big hospitals and some existing hospitals may find they have redundant floor space.

A recent report suggested that the NHS has 1.9 million square metres of underused space. If this was reduced by half, the NHS could release £1bn in capital and save on revenue budgets, the report adds.

But as care becomes more integrated between acute and community settings there may be increased demand for services in health centres, community hospitals and GP practices – including access to diagnostic equipment and outreach clinics. At the same time, stretched capital budgets are making it hard to refurbish buildings and the NHS has a backlog of repairs and improvements.

The changing structure of the NHS has contributed to the pace of change, with many primary care trusts looking to rationalise their estate, and community services estates transferred to new providers such as foundation trusts. What's left of the PCT estate will be held by a new property company: NHS Property Services.

Such issues are concentrating minds on how the NHS can best use its massive estate efficiently to produce both cost savings and improve the quality of care. This is likely to happen in an environment when capital spending is limited and changes may need to be self-funding.

"You need to think about service solutions that are less reliant on bricks and mortar and ensure you have a plan to invest in the best and most appropriately located premises, and redevelop or dispose of the rest," says Capita Symonds head of health David Lawrence.

This new thinking is already starting to permeate through the NHS. "Every square metre we have needs to be contributing something to the organisation," says Paul Mears, chief operating officer of South Devon Healthcare Foundation Trust. "If it is not needed, what are the opportunities to use it to generate revenue? It is about maximising the benefit."

Nigel Myhill, spokesman for the Health Estates and Facilities Management Association, acknowledges that it is hard to get people to think beyond the bricks and mortar of well loved hospitals.

"Most organisations are trying to reduce their estates so we can make the savings but keep the quality of service up for the patient," he says.

"The quality lies in the service we provide, not in the bricks and mortar. But changes are very difficult. Patients should feel they are getting a better deal if services are close to home."

Mr Lawrence agrees: "The key is effective public and patient involvement in service change and working together to develop new services that are far less dependent on bricks and mortar: we call it healthcare without walls."

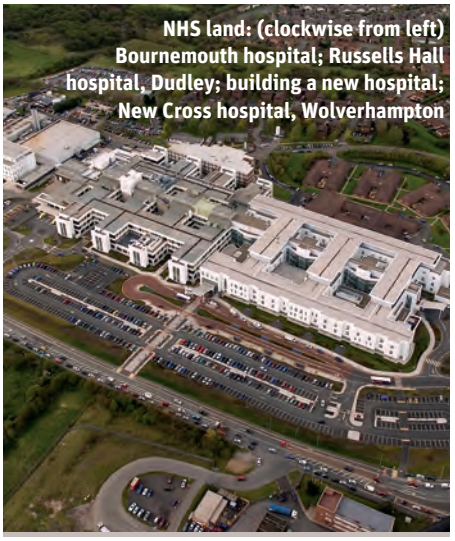
Managing these public perceptions will be important as the impact of some long term changes works through the NHS and affects its estate needs.

Nigel Edwards, senior fellow at the King's Fund, says that some people believe hospitals will only be needed for those undergoing surgery or who require ventilation. This could mean fewer hospitals beds – but a different configuration inside hospitals, with added equipment meaning each patient would require more space. More rehabilitation beds might be needed.

The shift of specialist work into the community could also change requirements for space in primary care and outpatient departments.

Mr Myhill foresees a point where smaller

CASE STUDIES OVERLEAF ▶



NHS land: (clockwise from left) Bournemouth hospital; Russells Hall hospital, Dudley; building a new hospital; New Cross hospital, Wolverhampton

‘Some people believe hospitals will only be needed for those undergoing surgery or who require ventilation’

acute hospitals are needed, as care moves into community settings. The footprint that an acute hospital needs to deliver its clinical services will reduce, he says.

In extreme cases trusts may have surplus assets which they can sell off and use the money to build or equip new purpose-built buildings. That’s the position in Kent, where Maidstone and Tunbridge Wells Trust has closed two old hospitals, moving into a new PFI hospital on one of the original sites.

This is enabling it not only to work from better premises but to sell off the site of the old Kent and Sussex Hospital in the middle of Tunbridge Wells. Proceeds from this 11 acre site, which could fetch close to £20m, will help fund equipment in the new hospital.

But not all trusts are in that fortunate position: in many cases hospitals could be left with spare space. If this lies empty it can be expensive, often still requiring maintenance and security – and sometimes heating and cleaning, depending on how integrated it is within a hospital. Mothballing spare space is not always a viable option.

But space offers opportunities. It can be used in a different way or it can be rented out – for example to house complementary organisations or services, or to provide retail space to serve a hospitals’ staff, patients and visitors. The hospital setting – with thousands of people passing through each day – can be attractive to retailers because of the high footfall.

At the Bristol Royal Infirmary, for example, a refurbishment of the entrance area is planned which will offer enhanced retail space. But the money generated from this can be used to provide other hospital services – in Bristol’s case, extra welcome space and services for visitors (see case study, overleaf).

Finding tenants for unused parts of hospital sites can be challenging. Western Sussex Hospitals Trust has been trying to rent out surplus space at Southlands Hospital and concentrate inpatient acute services at its other two sites. The trust recently had to extend the timescale for this as it has had little interest.

Mr Mears suggests it is worth thinking about what fits best in a hospital environment. “What are the services that are complementary to the business of the hospital? People like care homes, GP practices and pharmacies.”

Spare space in hospital grounds – or completely vacant buildings – may have different uses from space within a hospital. There can be opportunities for staff accommodation or even hotel space, and in some cases packets of land could be sold off. Reducing the size of the estate may also help NHS organisations drive down their carbon emissions and hit targets, adds Mr Myhill.

But the move from acute to community may increase demand for space in community hospitals and GP surgeries or health centres – not all of which are ideal for this work.

Mr Myhill suggests that such sites will need to move away from a 9-5, Monday to Friday, model of care to start providing more facilities round the clock. And they could also add new services, such as diagnostics. This sort of “sweating” of assets could offer efficiencies with the costs of running and maintaining a single site being spread across a range of services.

Where hospitals are in their thinking on this will vary. Some will face greater restrictions than others. Private Finance Initiative hospitals and Local Improvement Finance Trust (LIFT) projects in particular may find it difficult to vary use or mothball space without the agreement of the owners. Trusts may have to pay for any adaptations which are needed to deal with changing models of care. Mr Myhill says that some trusts with PFI developments have managed to cut the costs of services provided under the PFI agreement but changing the physical space can be more difficult.

But whatever situation estates managers find themselves in, there seems to be no doubt that they will have to make some hard decisions about how to get the most of their sites.

Mr Lawrence sums up this approach: “Now more than ever healthcare estates and property professionals need to think like entrepreneurs, by becoming more agile and creative to promote innovative property solutions that will make a real difference to patient care.” ●

ALAMY

ESTATES MANAGEMENT: CASE STUDIES

DRAMATIC ENTRANCE

An impressive new reception area in Bristol and a rethink of where patients should be in Devon show how trusts can get more out of their estates. By Alison Moore

NEW RETAIL AND WELCOME CENTRE AT BRISTOL HOSPITALS

First impressions count – and that applies to buildings as much as people. Patients and visitors coming to Bristol Royal Infirmary are greeted by an unimpressive entrance area.

Deborah Lee, director of strategic development at University Hospitals Bristol Foundation Trust, says: "At the moment it is a really unattractive building. We want the quality of the environment to match the quality of the care ... There is not an obvious point of reception. You just find yourself right in the heart of the trust – it's a bit of a rabbit warren."

Patients and visitors can find it difficult to find where they need to go and there is little space for services to help them. There are a couple of small kiosks but little else in the way of services for the trust's 8,500 staff, visitors and patients.

"With so many demands on our resources the trust took the decision to create a modest new entrance area, as part of the larger redevelopment of the hospital," says Ms Lee.

"But then we were approached by Capita Symonds with a really well worked up proposal demonstrating how we could move away from that kind of modest scheme by turning the main entrance into a combined retail and welcome centre," she says.

"They had spoken to retailers and the planners so were a good way down the line of demonstrating how it could be developed, with the revenue generated from the retail servicing the capital required for a more ambitious project. It was a good simple idea and, while we had explored something similar, we didn't believe it would fly in the current climate and hadn't pursued it."

Shane Dineen, Capita Symonds associate director of health, says: "We could see this highly successful foundation hospital ... with a really poor and disappointing shop window. We therefore saw a great opportunity to come up with an innovative and more ambitious welcome centre project that will provide an environment for patients that will match the clinical care provided."

Way in: computer-generated images of the new reception area at Bristol Royal Infirmary

As well as a substantial reception area, this allows for a patient information centre and liaison point where patients can pass on compliments and concerns. "Navigator" staff will point patients in the right direction or help them to get where they need to go.

The retail units – likely to include a pharmacy, newsagent, café and other shops – will provide a useful service for staff, patients and visitors. The income from renting them out will help to meet the capital cost of the development and, in time, provide a valuable income stream for the hospital.

"We are not trying to draw people into the hospital for the shopping," says Ms Lee. But essential needs for patients, visitors and the staff could be met through this scheme. Her personal gripe, she confesses, is never being able to get to a post office because she is at work typically from 8am and often after 5pm. When she aired this view at a staff consultation event, she was staggered by how the problem resonated with most of them. It is hoped that the planned newsagent may be able to provide some post office services.

She believes the spacious reception will help patients feel less anxious and promote a positive image of the trust from the minute they arrive – as a clean, efficient, well organised place.

Part of this is about making the trust the patient's first choice. Although relatively few patients exercise choice, preferring to use their local hospital, the trust is keen to offer an experience people would recommend to friends and family.

"Capita Symonds understood how to connect with the retail sector – the players who were trying to develop their offering in the health sector. They helped us build the business case which demonstrated to the board that this stacked up both commercially

Changing climate: on the beach in Torquay, South Devon, where older patients will see service changes

but equally importantly that it would contribute to delivering the trust's wider strategic objectives."

The board then decided that, rather than working with a developer who would effectively put up the cash for the development, it wanted to fund the £5m plans from trust resources. This would give it more flexibility and control – for example, over the length of leases for the retail units.

Final approval was given by the board in January and construction should get underway in July, with visitors being greeted in the new welcome centre from next April.

INTEGRATED ESTATES AND FACILITIES SYSTEM IN SOUTH DEVON

As the NHS shifts more care closer to home, its need for buildings is changing. And that can provide a challenge for trusts and PCTs.

South Devon already benefits from a more integrated model of care than most areas. Torbay Care Trust offers an integrated approach to health and social care which has led to relatively low admission rates for the frail elderly at its local acute trust, South Devon Healthcare Foundation Trust.

But the thrust towards care closer to home is so strong that further changes are likely. As well as the acute trust, the area has 11 community hospitals and – with a high proportion of elderly people – a lot of nursing and care homes.

The acute trust and the care trust (which has recently extended the area it covers) have started to look at what some of these changes could mean in estate terms. Over the last few months they have been looking, with Capita Symonds, at opportunities for an integrated estates function.

Part of this would be back office efficiencies – things which could be more cheaply provided across the two organisations rather than separately.

However, a more significant piece of work is an integrated estates and facilities function to support the future model of care. That involves looking at what care pathways are likely to be in the future and how the acute and community hospitals will fit into them.

"We want to make certain the estate is supporting a shift in care," says Paul Mears, chief operating officer at South Devon Healthcare Foundation Trust. "It is about looking at what is the total bed stock we have across the community and acute services. We know that we have a certain number of patients in a facility which is not the best one for them."

This is usually because a patient is in too acute a bed for their condition: in the acute hospital when they ought to be in the community one, in a community hospital when they ought to be in a nursing home, or in a nursing home when they ought to be at home with a support package.

"How do we make sure that at any one time every patient is in the most appropriate place? The ideal for many patients would either be that they managed in their home or are on a pathway which takes them back there," he says.

"We have started to look at where we have our bed resources. We probably have more than enough beds but there is an opportunity to look at how we reconfigure some of these beds."

This could involve moving beds into the community or looking at the role nursing homes play in the patient pathway. As many care home operators are under financial pressure, there may be opportunities emerging which were not there in the past.

"We should not forget nursing and residential homes. They are not part of the NHS but they are a very big resource out there," Mr Mears says.

"There are opportunities to work collaboratively with these providers to think about how we are mutually supporting each other."

One option would be for some community hospitals to take a more specialist role. One is already used as part of a stroke care pathway where patients receive their immediate stroke care in the acute sector and are then moved onto a community hospital for rehabilitation.

A looming challenge is how changes could be funded. Money for capital development or significant refurbishment has become much more scarce. "The question is then how do we make the best use of what we have. We have to think very carefully about how we manage any change of use of community hospitals.

"Part of this will be around the public perception of change – whether it is a different and better pathway of care which requires changes to the estate or simply a loss of beds."

What Capita Symonds has been able to bring to the process is expertise in working with different partners and in the commercial world, and a different perspective, he says. For example, a joint venture might be a way of drawing in some capital from other areas.

Lesley Powell, Capita Symonds health director, who has been working closely with the trust for a number of months, says: "The trust has a fantastic reputation for the standard of care but the built environment and patient experience could be improved whilst at the same time maximising opportunities for a more commercial use of assets. We have been exploring a number of really exciting alternative uses for potentially surplus land and assets that would bring big improvements to patient care.

"It's all about coming up with complementary solutions that maximise and sweat assets and generate income that can be used for direct patient care." ●

'The ideal for many patients would either be that they are managed in their home or are on a pathway which takes them back there'

ALAMY

LOUISE HAMILTON ON LEASING

As the financial pressure on trusts increases, they are having to make more decisions about current and future equipment procurement. Equipment is just one of many areas where trusts are looking to achieve savings and efficiencies – but it is a key one.

As the comments in this supplement show, as budgets are being stretched to their limits, more and more trusts are having to consider alternatives to capital purchases. Leasing can offer a genuine alternative, which should be part of their evaluation when procuring equipment.

A well structured equipment lease can help a trust meet patient requirements and keep up to date with the latest technology. The two often go hand in hand, as new technology tends to provide the best clinical outcome.

A key part of our most successful leasing solutions have involved discussions at an early stage of the procurement process. Understanding what a trust wants and needs to achieve from equipment investment can offer a funder the opportunity to devise a bespoke solution that addresses these important requirements.

In this new era for the NHS, where efficiency has to be balanced against delivering more services and utilising the latest technologies to ensure the best patient care, new thinking and approaches are needed. Leasing is not a new option, having been around since 1996, but the current challenges present an ideal opportunity to rethink how it can be used to the best advantage of a modern NHS trust.

'Quality of equipment will impact on how many patients a trust can attract'

At the same time we now have competition to attract patients – a relatively new phenomenon for NHS providers but something that is becoming more important as the reforms loom. Without doubt the quality of equipment a trust has will impact on how many patients, and therefore the income, it can attract.

Making sure the need for greater efficiency in equipment is not superseded by "sweating assets" – ending up with ageing, underperforming equipment – is one of many challenges. Leasing offers a tried and tested solution, it just needs to be integrated into a trust's everyday approach to equipment procurement and lifecycle management.

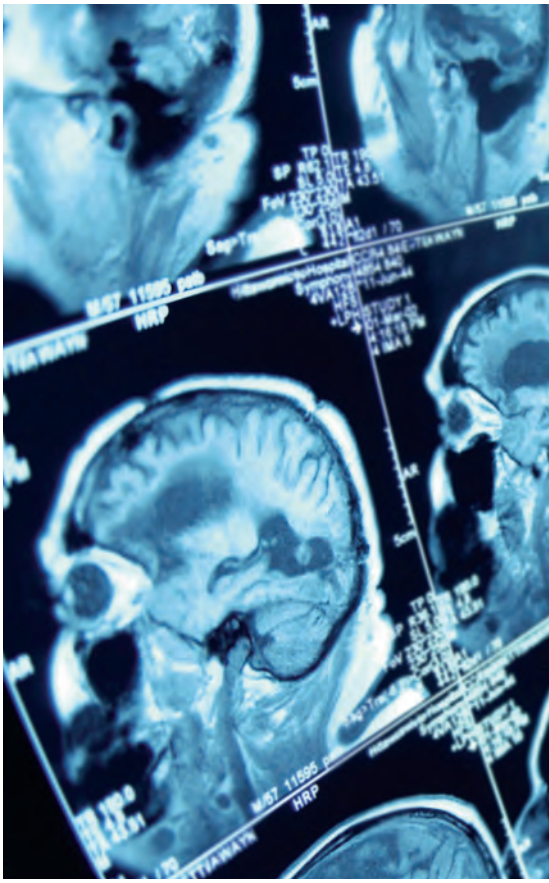
Trusts with equipment requirements hitting difficulties finding capital funding can expand their options by talking to leasing companies.

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

EQUIPMENT RATIONALISATION

TO BUY OR NOT

The latest equipment can be costly and cash-strapped trusts are increasingly looking at leasing as a cost-effective way to improve care. Alison Moore reports



Many NHS services rely on high value equipment. Demand for MRI and CT scans is increasing rapidly, as is the number of courses of radiotherapy given. Endoscopy is becoming more common as a diagnostic and screening tool – and quick access to diagnostic equipment such as endoscopes can be key to getting patients through their care pathway speedily.

Trusts are increasingly facing a dilemma. New equipment can often aid productivity – it can be quicker to operate, offer a higher standard of image, making it less likely that the screening will need to be repeated, and is likely to have less downtime than older equipment. This can all ensure patients are treated swiftly and at lower cost. And modern equipment and easy access may drive patient choice.

But replacing or buying additional equipment is a challenge for NHS organisations, especially when the equipment involved is costly.

With budgets squeezed, finding the money to invest in new equipment has been tough for many trusts. While new income may follow the equipment, it can still be difficult to make the initial investment.

Many trusts have been stuck with old equipment, already at the end of its projected lifespan. This can have high maintenance costs, be unreliable – which can have knock-on effects across an organisation – and may be costly in terms of staff time.

A report from the National Audit Office, *Managing high value capital equipment in the NHS in England*, published in March last year, highlighted how acute this problem is becoming.

It calculated that the NHS would face a £460m bill over three years if it bought new equipment to replace the stock of outdated linear accelerators and MRI and CT scanners. Much of this equipment was purchased in the years of plenty in the early 2000s and was centrally funded.

But, as the report pointed out, trusts are in a very different position now. There is no central programme to purchase this equipment and they will have to fund any new or replacement equipment from their own resources.

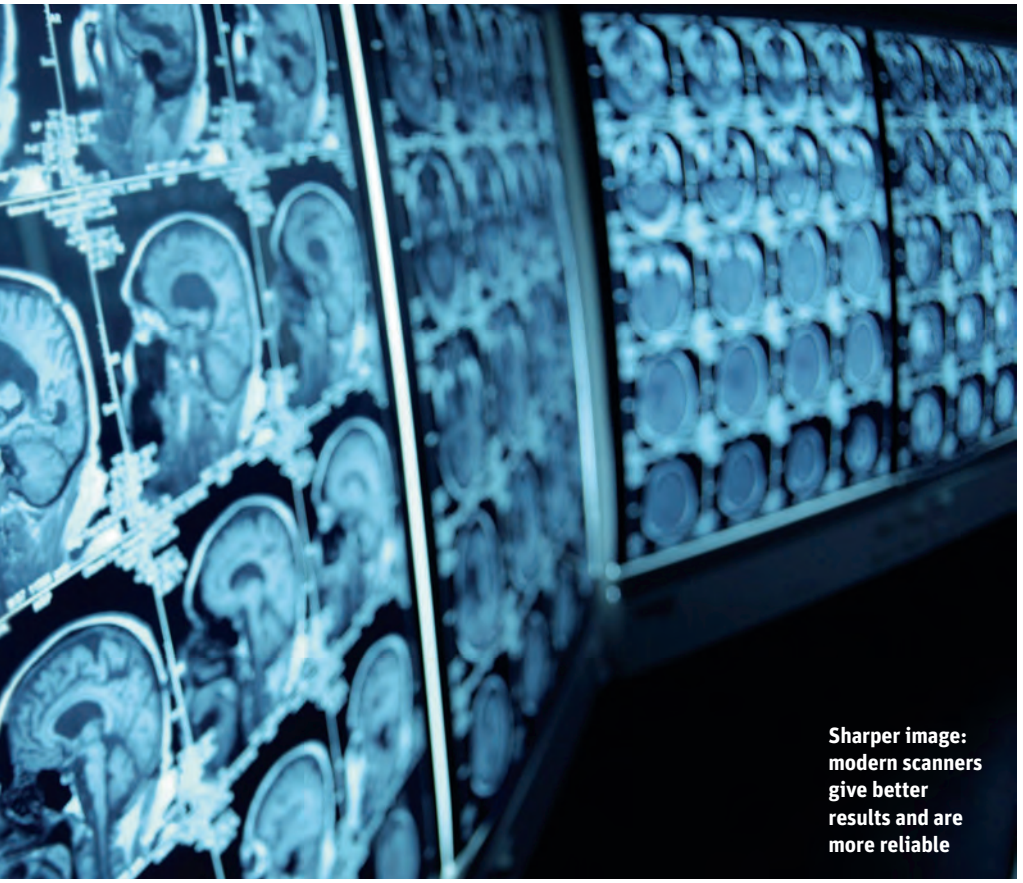
The report was blunt about what continuing to run outdated equipment could mean: "Although machines may be used for longer than their expected working life, they become more expensive to maintain and may not be capable of delivering the latest techniques required by clinicians. They may also suffer more downtime when they cannot be used for the benefit of patients."

While NHS organisations have traditionally bought equipment, leasing is another option – and one which the NAO suggested they should consider, having assessed what the demand for equipment was likely to be in the future.

"Clinical and finance teams within trusts should assess the costs and benefits of

CASE STUDIES OVERLEAF ▶

TO BUY?



Sharper image: modern scanners give better results and are more reliable

'Replacing outdated linear accelerators and MRI and CT scanners would cost the NHS £460m'

purchasing, leasing and outsourcing when replacing machines, and check for alignment with their planned levels of activity," it suggested.

Louise Hamilton, head of NHS sales and marketing at Singers Healthcare Finance, says leasing is an option worth considering. "It's not a panacea," she says. "But it is a weapon in trusts' armoury which should be considered alongside other options, such as outright purchase."

Chris Calkin, media officer for the Healthcare Financial Management Association, agrees that leasing is a viable option in many cases and can help trusts get new technology into place. He suggests that trusts should always weigh up leasing against outright purchase for equipment costing more than £25,000.

"You need to look at each individual item as to whether it is appropriate for leasing and whether it will deliver the benefits of going down that route," he says.

At the moment very low interest rates can make leasing attractive, he adds. Changes to the way capital is provided in the NHS – with trusts increasingly having to rely on generating income to fund capital investment – have affected trusts differently. Some will still have capital available for substantial purchases, others will be more strapped.

Leasing can be a solution to a shortage of capital that is stopping investment in a worthwhile service. The improved productivity and extra patients can create a flow of income the trust can use to help meet the leasing costs, and it transfers risks to the leasing company.

At the end of the lease if the equipment is handed back then it is up to the company to sell it on for whatever it can get. The trust does not have to take the risk that technological advances have reduced the expected residual value of the equipment.

Ms Hamilton says it is worth having conversations with leasing companies at an early stage before a trust goes out to tender.

This can help shape thinking about what is needed and what may be a more cost-effective way of getting it – for example, a single tender for several bits of equipment rather than multiple tenders as each comes up for replacement. "We are a resource which is there to support these organisations," she says. ●

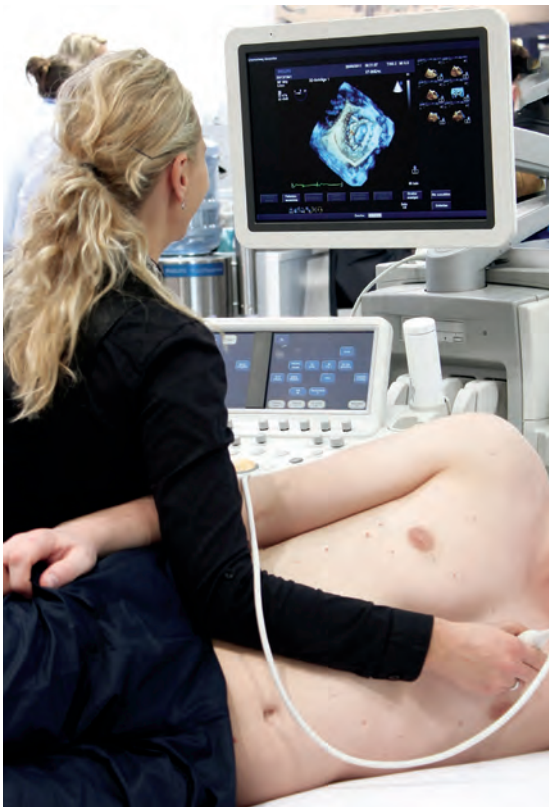
BUY OR LEASE? SOME THINGS TO CONSIDER

- **What are the costs and benefits of both approaches over time?** It's important to know what you want out of a piece of equipment and its impact on costs, income and care pathways.
- **How is the lease treated in accounting terms?** Some leases are "on balance sheet" while others aren't.
- **Is there capital available to buy outright?** Some organisations are finding it hard to make investments, even when they generate sufficient income or savings to pay back the cost over a relatively short period.
- **Are there advantages to bundling together equipment and leasing them together?** You may get a better price if you are buying five endoscopes rather than one, so bundling may be worthwhile if you need several pieces of equipment at roughly the same time.
- **What happens at the end of the term?** Trusts have a range of options when the contract comes to an end, including returning the equipment or continuing for a shorter period.
- **Are there opportunities to upgrade mid-lease?** Sometimes technological advances can leave older models looking obsolete; some leasing arrangements allow you to upgrade.
- **What about maintenance?** Maintenance can become a considerable expense with older machines and downtime can impact on the ability to provide timely patient care. Maintenance contracts, either as part of a leasing contract or as a separate contract, are worth considering.

REFLEX STOCK

EQUIPMENT RATIONALISATION: CASE STUDIES

CAPITAL GAINS



How two trusts have used leasing to get around the continuing squeeze on equipment spending

ROYAL SURREY COUNTY HOSPITAL, GUILDFORD

The current lack of capital for medical equipment in the NHS is making many organisations look for alternative ways of funding.

At the Royal Surrey County Hospital in Guildford, head of procurement Richard Woodage says: "In the past we just got handed a lump sum from the PCT but it is now funded differently."

Because of this the trust has turned to leasing, he said: "We lease when we don't have the capital budget to buy. If we can buy the equipment out of capital we do, and if we can't we look at the leasing route. We would not have a lot of the equipment we have got if we did not have the lease option available."

Mr Woodage says new building developments – particularly housing pathology and endoscopy – over the last few years have meant heavy calls on the trust's capital budgets so leasing has been a way of getting the equipment needed.

"The projects are £3m to £5m schemes – that's a big chunk out of your capital budget," he says. "The capital cost of a linear accelerator can be £1.2m – we just don't have that money.

"Over the last couple of years we have leased everything from ultrasound and ventilators to linear accelerators. We have just leased some audiology equipment for that department. And we have leased some ophthalmic equipment and a couple of spectrometers."

And although the trust sets aside a certain amount each year for clinical equipment, the need for new equipment can be unpredictable – and is affected by problems with older equipment which can break.

Leasing can also be a means to getting more up-to-date equipment, which can offer significant productivity improvements or can drive a revenue stream.

Managing leases well can also keep costs down, something Mr Woodage prides himself on.

He says he often gets calls from companies claiming he can save money by consolidating leases with them but they end up saying that they can't offer a better deal.

The deals on offer are closely analysed. He always asks for the interest rate implicit in the lease and will check against what market rates are for borrowing over that period.

Part of this management is ensuring that the expiry dates of leases are flagged up well in advance, allowing discussions with clinicians about what is needed.

"Almost without exception at the end of the lease period we send the equipment back. We don't extend the lease," he says.

"We can see what the expected residual value is."

The responsibility for disposing of the equipment then falls on the leasing company, which may sell it on for what it can get.

And he always feeds back to leasing companies about why they lost a tender. Overall he says leasing has enabled the trust to access equipment it would not otherwise have been able to afford – but that trust procurement managers need to do their sums and manage leases well to ensure they are getting the best possible deal.

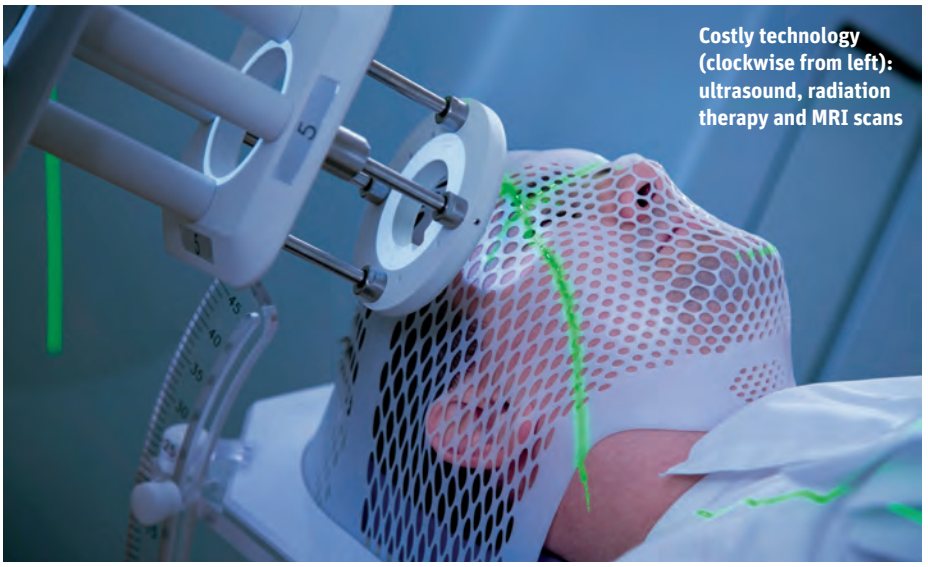
MID-CHESHIRE HOSPITALS

Buying up-to-date equipment is not always easy for hospitals. But Clive Mosby, head of procurement at Mid-Cheshire Hospitals Foundation Trust believes that leasing has provided a way for his trust to get the equipment it needs without depleting its capital budgets.

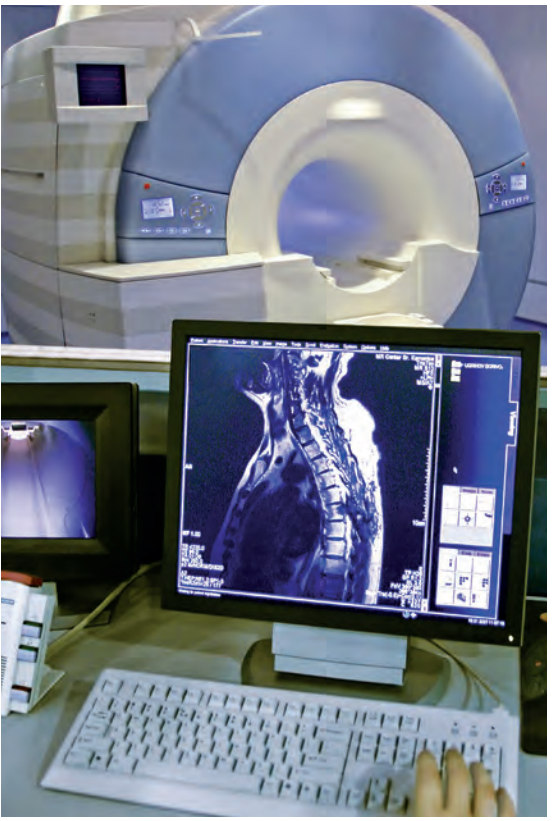
The trust has a portfolio of around £20m of equipment – both clinical and non-clinical – which is leased. This is done through around 100 leases which are spread around a number of companies and last for between three and 10 years depending on the equipment involved.

It has been using leasing as a means of getting new equipment for around 15 years. This has helped the trust deal with expansion and changes in its facilities. For example, it opened a day surgery unit about six years ago which was fitted out with leased equipment.

One of the key advantages has been that risk is effectively transferred to the company leasing equipment to the trust. The trust can simply hand back the equipment at the end of the period and it is then up to the leasing company to get what money it can out of it. This can involve selling it on, but in some cases technological advances mean the equipment has little residual value. If the trust owned it, it would then have to replace it with a more up-to-date model and accept that there was less value than had been



Costly technology (clockwise from left): ultrasound, radiation therapy and MRI scans



expected in the old one. With a lease, the company takes that risk.

Leasing costs come out of revenue so the trust can use its capital for other things – such as improving the hospital infrastructure. And because Mr Mosby and the clinical departments don't have to go through the capital approval process they have a degree of freedom in what they buy.

Leasing can also mean that the constant temptation to keep old equipment running past the best years of its life is avoided. "There are some pieces of equipment like ultrasound machines that you would not want to keep more than five years because there is always something coming up," says Mr Mosby.

"It assists with planning and with procurement. We know what is coming up – we are never hit with any big surprises. We don't have end-of-year spending sprees."

Mr Mosby does end up extending some leases and keeping equipment for an additional time but this is often equipment which is not becoming outdated – hospital beds, for example, tend not to change dramatically.

"You still have complete control of what you are using. When it comes up to renewal we have made the decisions on whether to return the equipment, replace ... or get an upgrade."

He believes there are benefits for the trust in having the most up-to-date equipment in a competitive marketplace. "When it is all about choice and patients being able to choose where they want to go then if you have the latest MRI or CT scanner it helps. It helps us to be competitive."

So what has worked for Mid-Cheshire? Mr Mosby strongly recommends grouping equipment in order to go to suppliers with a larger order, rather than buying bits piecemeal. This has significant financial advantages, he says. "If a trust gets its act together and bundles like equipment it presents an attractive proposition to suppliers," he says. "We have seen big discounts as a result of this."

"It's important to have a flexible approach from the trust and the leasing company," he says.

He also stresses the importance of organisation. He will start planning about 12 months before a lease comes to the end of its term, talking to clinicians and other users about whether to extend the lease or hand back the equipment and get replacements – and if so what specification.

"It takes management. You need to keep on top of it and push for decisions from clinicians. But it is advantageous – we are able to renew our key assets on a regular basis. Otherwise we would have to take our place in the queue and hope it will be prioritised.

"I don't think that other trusts have this long-term planning in place. With a lot of trusts it seems quite sporadic. We have been able to look at our asset base and plan how that is going to be dealt with."

To look at costs, he uses a whole life approach which also includes maintenance costs. Much technology becomes cheaper and better over time so replacement does not necessarily mean costs increase.

Mr Mosby does not see the trust going back to purchasing large pieces of equipment outright. In a difficult financial situation, the money would be hard to find, he says. ●

'The constant temptation to keep old equipment running past its best years is avoided'

FOTOLIA, GETTY IMAGES

STEPHEN BURKE ON BETTER INFORMATION

HCL Workforce Solutions is the largest provider of temporary staff to the NHS and draws on long experience working with just about every hospital in the country to develop innovative and measurable outsourcing and staffing solutions aimed at supporting the NHS in these times of austerity and reform. Staffing agencies need to be part of the solution, working in partnership with trusts at a strategic level to plan workforce needs, identify skill gaps and respond quickly to meet demand.

Many trusts would struggle to put their hands on that information quickly, making it more likely they will fill a vacant shift with an agency worker who may not be needed. Tackling the issue can feel like an impossible task and trusts often don't have the capital or staff to implement the technology to do this properly.

HCL has linked up with healthcare technology partner Skillstream – which is powering recruitment for the Olympics at London 2012 – to develop a platform tailored to meet the needs of the NHS. The result is HCL Clarity, a holistic managed service giving transparency across the healthcare workforce through real-time management information. It is the result of a significant investment by HCL and was developed with the guidance and support of the Royal Free Hampstead in London which achieved £2m savings in its first eight months.

HCL Clarity allows engagement with the

'Many trusts would struggle to put their hands on agency staff information quickly'

contingent workforce in an efficient, compliant and cost-effective way, as the technology gives complete visibility and control. In real time managers are able to find out who and where their contingent workforce are and how much they cost. With this complete and accurate picture, cost reductions and control can be realised through strategic engagement with agency partners.

However, HCL doesn't just install and leave the trust to get on with it, a dedicated support desk managed by HCL is placed on site.

No investment is required by the NHS. HCL makes the investment and, by entering into a gain share agreement, both partners are equally incentivised to make significant savings. Users can be confident that temporary staff are fully compliant, risk is managed and payments through PAYE and limited companies identified and processed. This typically achieves agency spend reductions of 15 per cent, the equivalent of £1.2bn over three years across all trusts – and a massive 5 per cent contribution to the NHS £20bn savings target.

Stephen Burke is chief executive of HCL Workforce Solutions

www.hclclarity.com

HCL Workforce Solutions

WORKFORCE MANAGEMENT

Cutting the cost of NHS agency workers has the potential to deliver huge savings – and better staffing data will be vital

TEMPORARY

Staffing accounts for nearly two thirds of the annual NHS budget, and its 1.3 million workers make up by far the largest single cost in healthcare in England. Yet we still haven't cracked the management of our most valuable asset in terms of optimising attendance, skill mix and demand.

The fixed costs of maintaining a high quality workforce are an enormous burden on trusts, on top of which comes the added stress of fluctuating demand and unpredictable seasonal pressures.

Layer on top of this NHS funding cuts, redundancies and wider issues in the economy such as rising childcare costs and spiralling fuel costs, and it is little wonder that the workforce is groaning under the strain and that NHS absenteeism remains firmly above the private sector average.

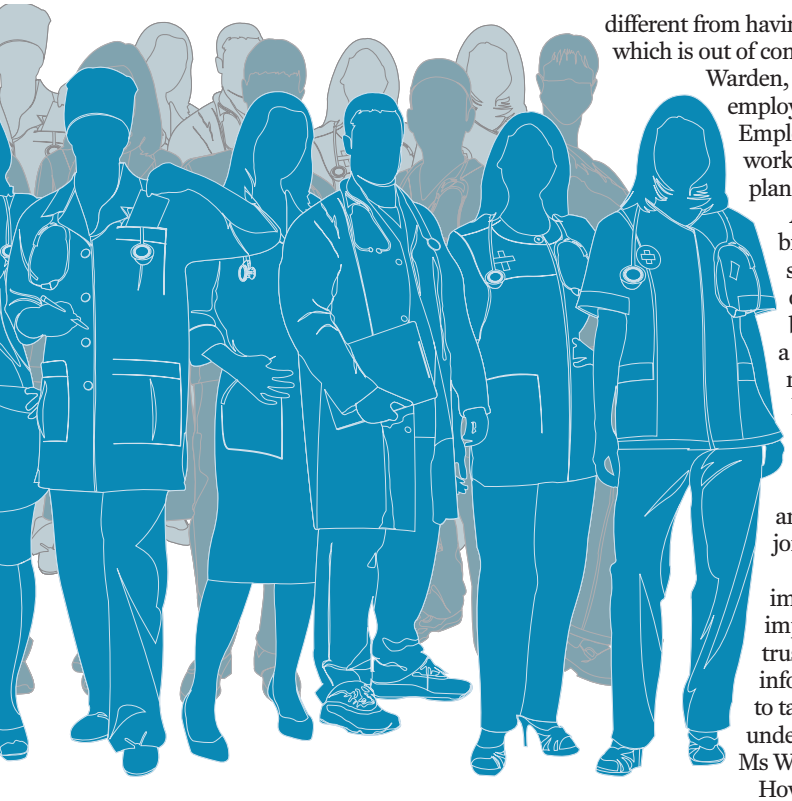
An inevitable constant in the NHS is fluctuation in demand and the workforce needs to be able to flex up and down to accommodate this. Annual leave, training and sickness absence place further pressure as does demand for specific skills to meet patient needs. Get this formula wrong and we risk compromising patient safety as well as wasting valuable budget filling staffing gaps at short notice.

In 2005, the DH identified temporary staffing costs as one of the 10 high impact workforce changes and a year later the National Audit Office highlighted the potential for cutting temporary nursing costs. It found trusts would be able to make savings of between £13m and £38m through better procurement, and highlighted poor management information and a lack of

CASE STUDIES OVERLEAF ▶

SHIFT

'Agency staffing is always going to be integral to delivering high quality care'



understanding of what drives demand for temporary nurses.

Responding to the challenge thrown down by the £20bn savings plan, many trusts have gone for the low hanging fruit of reducing reliance on temporary staff. Agency spend can be under board-level scrutiny, internal banks of workers have sprung up and "contingent workforces" established. More recently, a quality, innovation, productivity and prevention workforce workstream was established as part of the £20bn savings initiative, with a target of reducing spending on temporary staff by £300m by 2014. Last year there was a fall of £130m.

Temporary staff are always likely to be part of any trust's approach to staffing gaps. "There are times when it is absolutely legitimate and under control and that's very different from having an agency spend which is out of control," says Ruth Warden, deputy head of employment services at NHS Employers. "Agency workers are part of a planned workforce."

An NHS Employers briefing from 2010 stresses that an organisation's own bank staff may often be a cheaper option and many trusts have put a lot of effort into improving banks, ensuring they work across different units and encouraging staff to join them.

E-rostering is also important and is being implemented by many trusts. "It gives you information but you need to take that and understand it," points out Ms Warden.

However, few trusts find they can fill all the gaps with bank staff. Agency staffing is always going to be integral to delivering high quality care.

Most organisations have established an authorisation process for temporary staff, in some cases right up to director level. This can dramatically cut costs although it risks being time-consuming and human error can mean that systems are bypassed and temporary staff engaged without approval.

Electronic systems can simplify these processes and protect from error. "They help trusts in following process and protocol and getting information," says Ms Warden. "They give transparency to the problem but do not solve it."

"One of the main barriers to getting on top of the substantive/flexible workforce balance in the NHS is lack of knowledge around where and when gaps in workforce are likely to arise," says Stephen Burke, chief executive at HCL Workforce Solutions. "Cutting edge management information is critical to understanding activity, planning in annual leave and training and predicting the likely level and shape of staff absence.

"To put it in perspective, as one of the world's biggest employers the NHS will have to make a significant capital investment in the management information infrastructure required or partner with providers for whom this is their core business if it is ever to realise the levels of workforce efficiencies it aspires to."

Ms Warden acknowledges that different trusts have different issues and therefore the solutions which work for them will differ.

But she detects that many trusts are now taking the issue of managing temporary staff very seriously. "People will be at different points in the journey in trying to reduce this,"

FIVE WAYS TO IMPROVE TEMPORARY WORKFORCE MANAGEMENT

NHS Employers has produced five high impact actions to improve trusts' management of the temporary workforce.

- Increase understanding of the issue – this requires better data and understanding the likely demand for extra staff
- Manage the process and take control – ensure there is an authorisation process in place for booking temporary staff
- Manage your workforce and create a sustainable supply. Understanding what staff are needed can highlight ongoing areas where permanent recruitment or training up staff is needed. E-rostering can cut agency spend by ensuring the right mix of staff are on duty
- Work collaboratively both within the organisation and more widely. That way some departments don't have surplus staff when others are short; working with other local trusts can enable better deals to be struck with local agencies
- Manage with staff. They may need to change their working practices or accept more restrictions on booking staff

HCL Workforce Solutions

WORKFORCE MANAGEMENT: CASE STUDIES

HOW TO SAVE £2M

How one London trust used new systems to understand and take control of its spending on agency workers

THE ROYAL FREE HAMPSTEAD

The Royal Free Hampstead Trust in London has around 900 beds and sees about 700,000 patients a year. It employs around 5,500 people and has a turnover of about £550m. Voted Dr Foster's "large trust of the year" in 2010, the organisation has been recognised for its patient safety and infection control record.

With such a large workforce and wide variety in case mix, the trust wanted to explore various workforce management options with healthcare technology partner Skillstream and HCL's latest offering HCL Clarity – and ended up with a solution that saw its agency spend drop by £2m in the first eight months.

Founded in 2002, Skillstream powers recruitment for some of the world's biggest brands and is known for resolving challenges, complying with relevant legislation and delivering industry-tailored solutions. Its investment in the healthcare industry has produced a web-based recruitment system that connects the trust's own staffing supervisors and managers with approved government framework agencies.


The Royal Free Hampstead

The end-to-end solution manages the entire recruitment cycle from shift creation, compliance and vetting through to e-timesheeting of all agency workers. It then automatically generates and presents the agency's invoice to the trust's finance department. This process is underpinned by management reports that provide real-time visibility of headcount, spend including overtime, framework deviation, ESR (electronic staff records), and compliance with AWR (agency worker regulations).

Jasvier Boyal, former director of workforce at the Royal Free, decided to use Skillstream to achieve savings on agency spend while maintaining a high standard of care. The system went live in March 2011.

Adrian Newman, former resourcing and project manager at the Royal Free and now interim project manager at HCL, helped implement the system at the trust. Mr Newman says the trust initially thought its annual spend on agency staff was around £13m. However, when it was analysed using Skillstream it was actually £18.9m.

"Like many trusts, the Royal Free tried to fill shifts with bank staff before turning to agencies. By interfacing the bank management system with Skillstream it could continue to do this so that bank availability was checked before a shift was made available for agency staff," he explains, "The process also meant that the staff trying to fill a shift from either bank or agency workers did not have to enter the same details twice."

Skillstream was interfaced to the Royal Free's own bank management system, which ensured that HR policy was adhered to. Before agency staff were requisitioned the bank could be explored for available staff before converting the requirement to be filled by agency partners.

The new system also enabled the trust to work with its preferred suppliers, reducing these from around 180 to a more manageable 40 approved government framework agencies. "The benefits were multiple with a significant increase in quality candidates which were generally available quickly thereby enabling consistency in patient care," says Mr Newman.

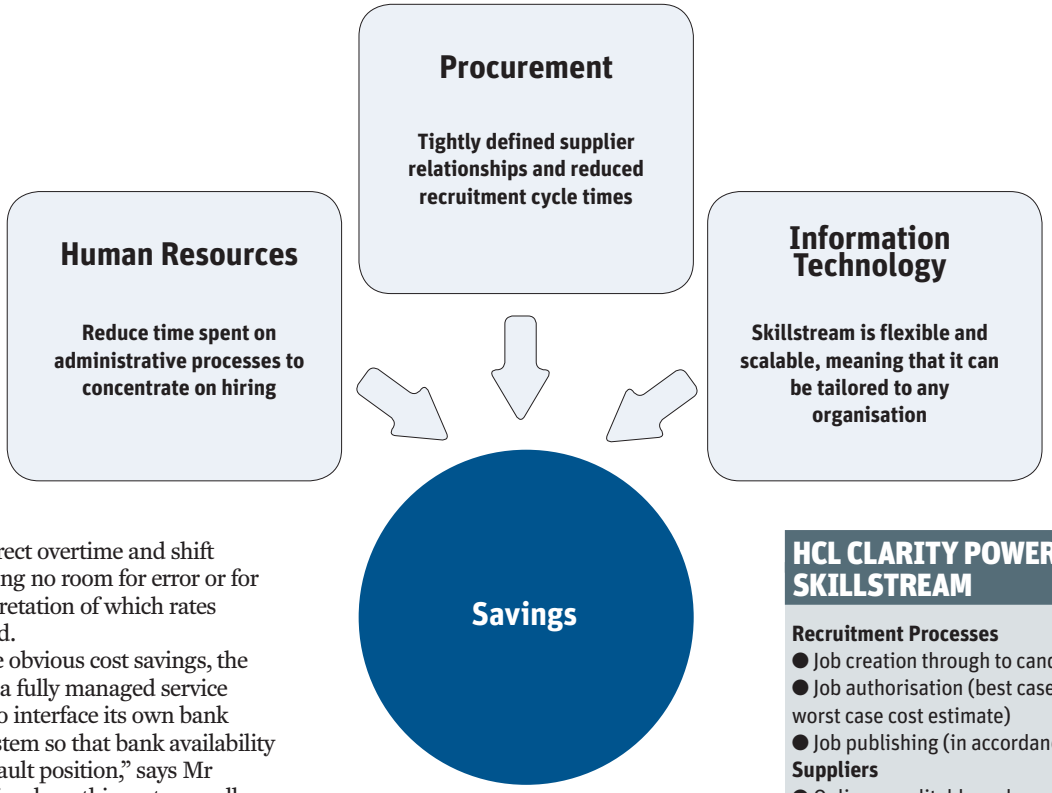
"The trust was also able to flag up candidates who had worked there before – which meant they would have had training and any necessary security checks as well as knowledge of the organisation and how the individual wards worked. This also generated an accurate audit trail on meeting security and skills requirements – critical to helping trusts reduce their insurance premiums and supporting Care Quality Commission audits."

Ensuring authorisation

In an attempt to restrict agency expenditure, trusts have introduced high level authorisations (at least two or more layers) but these are sometimes bypassed and bookings made outside established protocols. This can lead to potentially having to cancel a booking (which can incur penalties) or having to pay for unnecessary temporary staff. Skillstream eliminated this by ensuring that the protocols could not be bypassed nor could bookings made without nominated sign off.

From an agency worker's perspective, this was good news. Once offered a shift they knew it was pre-authorised, with less chance of last minute cancellations, and they were paid swiftly and at the right rate. This encouraged consistency and loyalty with experienced workers able to hit the ground running and be immediately useful.

Time management was enabled through the electronic timesheets which automatically



calculate the correct overtime and shift allowances, leaving no room for error or for subjective interpretation of which rates should be applied.

"As well as the obvious cost savings, the trust is enjoying a fully managed service which allows it to interface its own bank management system so that bank availability is always the default position," says Mr Newland. "This is where this system really comes into its own as most trusts have invested heavily in establishing their own banks – in terms of time, effort and finances – and don't want to lose this resource and investment. Skillstream takes this investment and maximises its potential by absorbing it into a holistic platform."

He continues: "The Royal Free has also enjoyed some substantial administrative benefits since automatic invoicing has meant there are far fewer queries over invoice payments. Queries have reduced by 95 per cent and invoices are typically processed in a couple of days, rather than more than two months – allowing yet further savings through discounting for early settlement."

Since moving over to HCL Mr Newman notes that the real benefits of partnership come to life at the implementation and support stage. "Many trusts elect to move to automated systems from the simple e-rostering platforms right up to a fully outsourced managed service but we need to recognise that this is a people business and that there are unique situations in every hospital in the country.

"What we have developed in HCL Clarity is to take the Skillstream platform and then build in the 'people' element because we know that installing a system and hoping it will be used to its full potential is a big ask of any busy hospital.

"In placing a dedicated and experienced project implementation team to work alongside our clients, designing their managed service and the process and organisation that underpin it, we are able to deliver – together – a solution that is truly bespoke and effective from the outset." ●

HOW THE BENEFITS ADDED UP FOR THE ROYAL FREE

- **The trust now only buys agency supplied resources in line with government framework rates and it controls agency spend in line with human resources and finance policy**
- **Reduced cancellation penalties, as all roles are approved from the outset**
- **Control and compliant processes have helped the trust achieve QIPP initiatives and lower insurance premiums due to improved CQC audit**
- **Conformance to agency worker regulations is enabled through the automated recruitment cycle**
- **Online timesheeting and invoicing means correct overtime and shift allowances in line with the framework and agency terms**
- **Reducing suppliers from 180 down to 40 means service and timescales have improved and higher quality candidates are supplied**
- **Previously top performing staff are now flagged up on the system as being preferred. This has led to better patient care – the most critical benefit**

HCL CLARITY POWERED BY SKILLSTREAM

Recruitment Processes
- Job creation through to candidate placement
- Job authorisation (best case cost estimate/ worst case cost estimate)
- Job publishing (in accordance with SLAs)

Suppliers
- Online – auditable and accountable
- Manage agency plus SLA tiering centrally
- Agency performance can be tracked
- Rate compliance in accordance with the government frameworks

Candidates
- Vetted/reference/CRB checked
- Online timesheeting (one central place for all agency candidates)
- Actual hours worked vs booked hours comparison

Reporting and management information
- Headcount report
- Spend report
- Accruals and invoice report
- Exception report

Invoice management
- Self – bill functionality
- Prompt payment discount
- Volume based discount
- VAT efficiency (reclaim/concessions)

Rate management
- Candidate rate
- Charge rate
- Overtime rate
- Simplify the ambiguity of PAYE/Limited/ WTR/National Insurance charges

Budgetary control
- Spend per division, directorate, specialty, department/ward

Administration efficiencies
- Centralise recruitment/back office
- Digital signature – timesheet authorisation

Pricing frameworks
- Adherence to government frameworks
- LPP, AHP/HSS, medical and buying solutions

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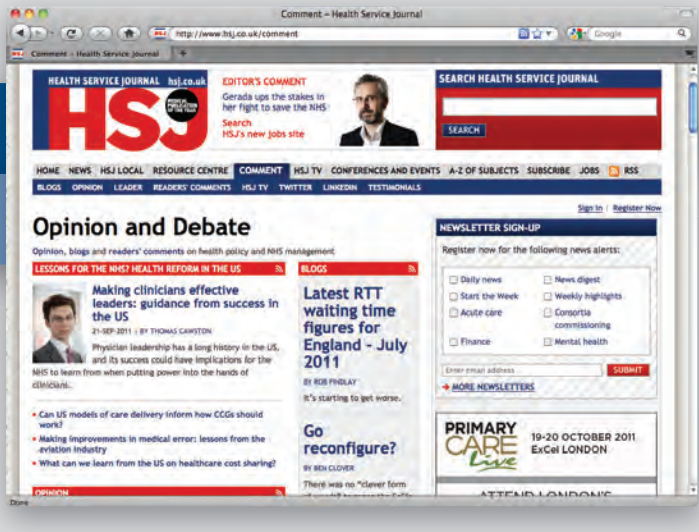

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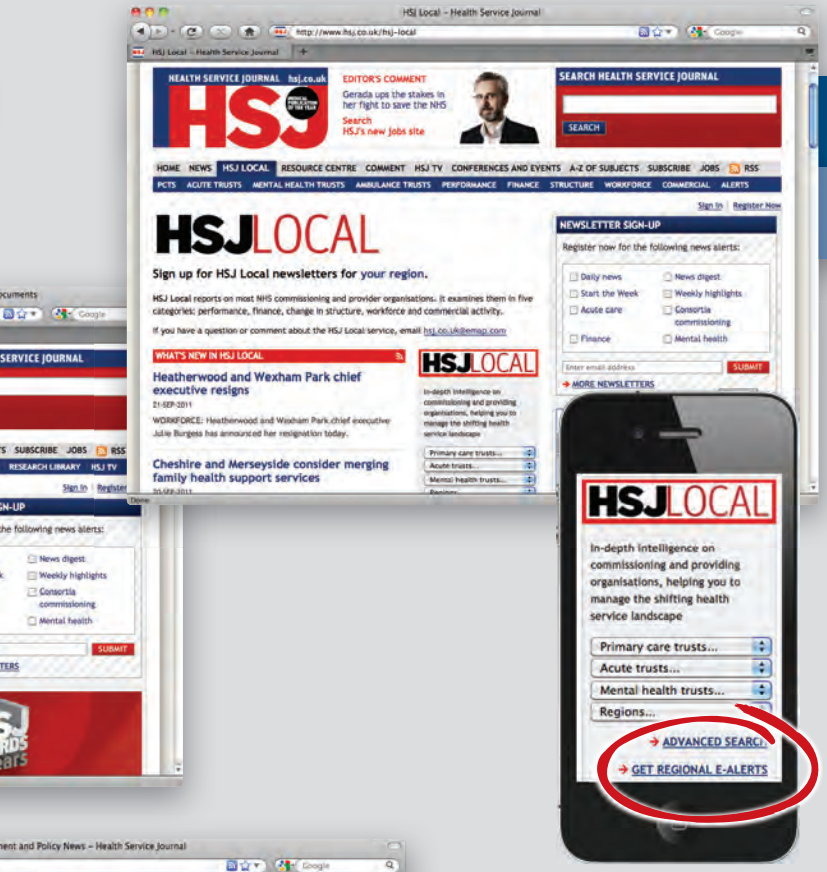

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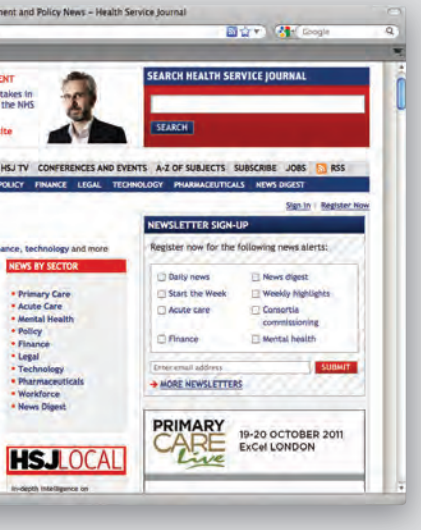

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CHRIS LANGLEY ON MANAGED SERVICES

There is huge pressure on NHS provider trusts to deliver procurement savings, but this is no simple task – it calls for a fresh approach to update existing practices and thinking. As outlined by the Commons Public Accounts Committee (PAC) in its review of public expenditure in health and social care, marginal changes in NHS procurement are unlikely to achieve the £1.2bn procurement QIPP target.

To meet savings targets while improving patient outcomes, innovation is key. Rather than just buying goods, trusts are increasingly looking at procuring services, which provides a focus on outputs and outcomes rather than seeing the purchase of equipment, consumables, or services as separate entities.

Clinicians play a pivotal role in the successful adoption and implementation of a service based model. Services must meet clinical requirements and the involvement of senior clinical stakeholders in procurement decisions ensures that agreements are ultimately driven by the need to improve patient care.

Not only does this deliver an enhanced patient experience and superior outcomes, but it also reduces costs by ensuring that appropriate equipment is in place to support patient services both now and in the future.

Trust planning groups, involving clinical, financial and technical teams, need to evaluate existing equipment portfolios, looking at current capacity, utilisation and future demand. This relies not only on accurate information – lack of which was referred to in the PAC report – but also in-depth understanding of comparative asset performance.

'Clinicians are pivotal in the successful adoption of a service based model'

Obtaining this specialist knowledge of high-level medical equipment across manufacturers needs full-time attention, a luxury that very few NHS procurement professionals can afford.

Independent expertise and support will enable trusts to make the leap from procuring goods to adopting a service-based approach. The PAC report highlighted a lack of strategic planning and coordination that contributes to a highly inefficient approach to procurement. Although decision makers can benefit by sharing intelligence and group buying mechanisms, each trust has different circumstances that need a bespoke solution.

Robust, independent challenge can ensure that decisions have been made for the right reasons to deliver the most appropriate equipment to meet clinical requirements.

Christopher Langley is chief executive of Asteral

www.asteral.com

ASTERAL

PROCUREMENT

HOW MUCH FOR THE CT SCANNER?

Short of capital to buy cutting edge equipment? Trusts are looking to outsiders to buy, maintain and upgrade it via 'managed service' contracts

The NHS has around £1bn's worth of high value equipment, including CT and MRI scanners and linear accelerators for cancer treatment. According to a House of Commons Public Accounts Committee report, *Managing high value capital equipment in the NHS in England*, half of this equipment is due for replacement within the next three years.

Published in October last year, the report states that if trusts were to replace these machines they would collectively need to find £460m. However, with the NHS challenged to make £20bn in efficiency savings – including £1.2bn from procurement – in the next three years, trusts need to look closely at how they acquire new and replacement equipment.

A separate report by the National Audit Office report, published in February 2011, said that: "The NHS in England could save £500m every year through efficient and effective procurement."

One of the problems, says Christopher Langley from Asteral, a vendor-independent provider of medical equipment services, is that simply focusing on the cost of equipment at point of purchase isn't going to achieve the £1.2bn procurement QIPP target. Significant changes are required in the way trusts approach and measure procurement.

He explains: "The PAC report highlights a number of issues which give rise to the concern that many trusts are not achieving value for money when purchasing equipment. The report focuses very much on the mechanism of procurement itself but trusts need to place far greater emphasis on the whole-life cost of equipment and ensure that outputs – such as productivity and reliability – are measured against set objectives."

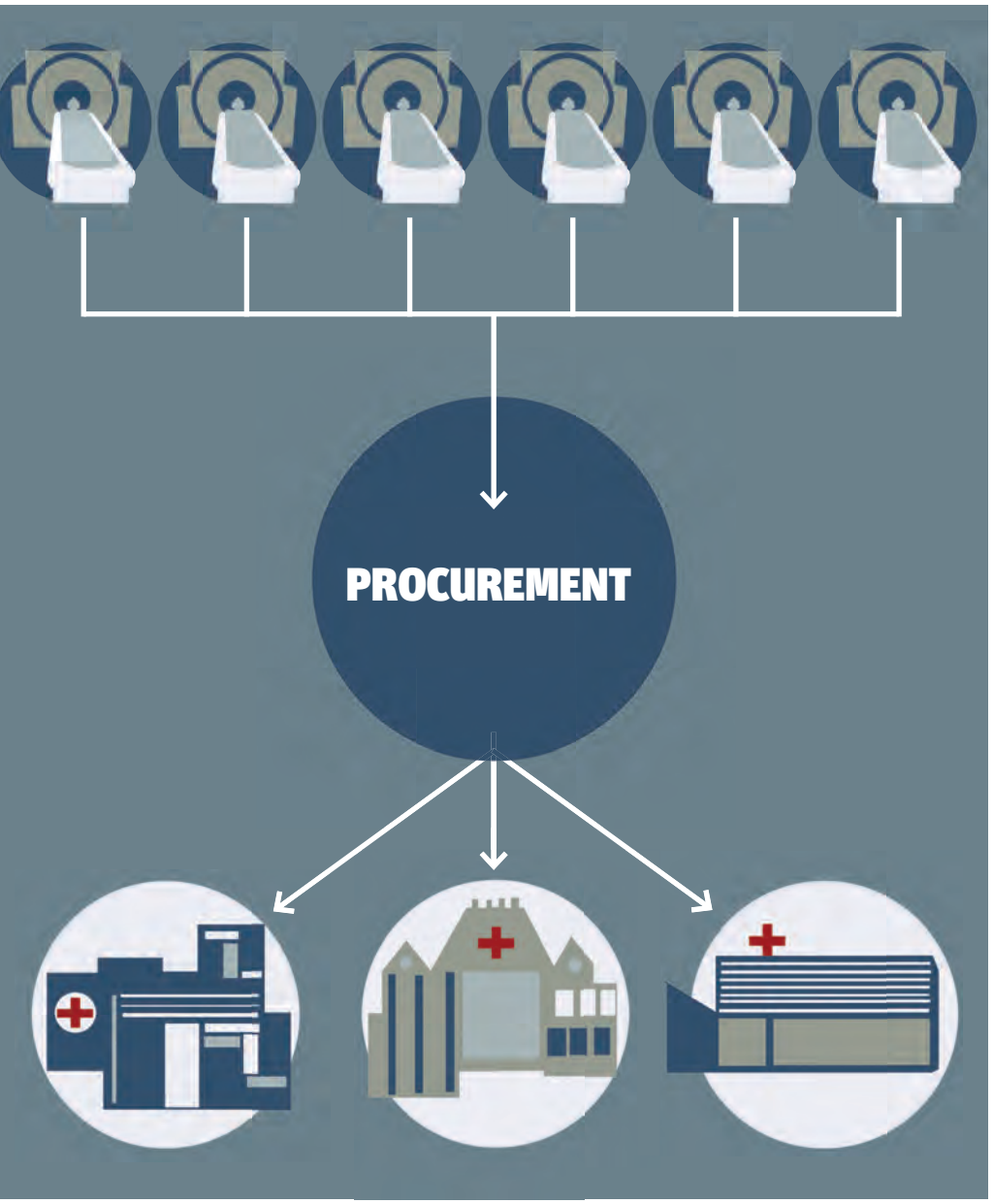
Mr Langley believes that, when it comes to reducing costs in procurement, the focus is too often just on capital expenditure. "By considering the whole life costs, including depreciation, floor space, staff training, maintenance and consumables, trusts can gain a more accurate cost comparison between different types of equipment and procurement methods. When considered alongside overall value and performance, this information can be used to drive true efficiency savings and increase equipment performance resulting in a better service for patients," he says.

David Lawson, director of procurement for both Guy's and St Thomas' Trust and King's College Hospital Trust, supports this theory and says procurement teams are doing much less buying of nuts and bolts. Instead they are moving towards buying in services, securing investment for new equipment or buildings or partnering with external companies to develop and expand clinical services.

He explains: "You are essentially transferring the risk to a third party to make sure that (a) they provide the right equipment and (b) it is maintained and operational."

Mr Lawson says that the trend is towards long-term managed equipment service (MES) contracts, in which the life cycle for

CASE STUDIES OVERLEAF ▶



'You are transferring the risk to a third party to make sure that they provide the equipment and it is maintained'

the equipment is specified and the service provider upgrades it.

He adds that having the right equipment is associated with "better productivity outcomes, which may improve the operational efficiency of the hospital".

Mario Varela is managing director of the London Procurement Programme, which procures for trusts across the capital. Until two years ago Mr Varela was director of procurement at the Bart's and the London Trust, which entered into an MES contract for 35 years covering its diagnostic medical equipment. He says MES contracts have many advantages, including the flexibility to respond to changes in demand for services following reconfigurations and changes in technology. This is a benefit that service providers such as Asteral feel they offer trusts. Mr Langley adds: "It is important that MES contracts can accommodate changes in patient demand, which means understanding the clinical requirements today and in the future. Aligning clinical strategy with equipment procurement helps to ensure that decisions are focussed on improving patient care."

Mr Varela agrees that clinicians want to influence what equipment they are using not just initially but for the life of the agreement. He says: "Being a large teaching hospital we wanted to ensure we didn't end up with equipment that was second rate but was leading technology. To actually build all that into a contract is extremely complex and difficult to achieve because who knows what technology exists in 20 years' time and what sort of services you will be providing?"

The need to adapt to technological innovation and evolving patient demographics is a key consideration for all trusts. Mr Langley identifies better planning and evaluation of equipment performance as vital in ensuring that the right portfolio is in place to meet patient needs both now and in the future.

He says: "By understanding equipment capacity, utilisation and demand, trusts can reconfigure services to deliver measurable efficiency savings without impacting service delivery, while also informing procurement decisions and optimising future investment. This is what MES solutions can help to deliver."

Mr Lawson says that his trust primarily entered into contracts with outside companies to bring in the latest equipment, update their facilities and improve and diversify their services. Guy's and St Thomas' has contracted out its entire pathology service and has put the provision of satellite units in the community for endoscopy, respiratory medicine and radiotherapy out to tender.

As well as outsourcing in the medical area for diagnostics and treatment, trusts are also beginning to enter into similar service contracts with companies to improve their facilities.

Mr Lawson says: "There is a driver around how hospitals modernise and update their equipment, how do they look at expanding their facilities, looking at opportunities to commercialise their services and effectively win more new business when we haven't got the money to invest."

This commercial approach being adopted by a number of trusts is, says Mr Langley, important to enable trusts to operate in an increasingly competitive environment.

He says: "The procurement, management and maintenance of equipment can have a hugely beneficial impact on a trust's ability to meet cost reduction targets. It can also provide a competitive edge by enabling the hospital to offer new and improved services and treatments. It is therefore of critical importance that the issue is taken on at board level to enable trusts to meet the challenges currently being faced." ●

ASTERAL

PROCUREMENT: CASE STUDIES

DON'T LET US DOWN

Minimising downtime is seen as a vital advantage of managed equipment service contracts

UNIVERSITY HOSPITALS OF LEICESTER TRUST

University Hospitals Leicester Trust entered a managed equipment service (MES) contract with Asteral in 2003 which covers more than 200 pieces of diagnostic equipment.

The trust has an equipment strategy stating that there must be clinical choice, vendor independence and "equivalency" (ie ensuring equipment is replaced by something equivalent). Equipment and contracts manager Ernie Thompson says that, although equipment selection is a joint process, the trust has ultimate sign off based on these three criteria.

Several equipment manufacturers tendered for the contract but Mr Thompson said the conditions were too limiting, with penalties if the trust did not choose their equipment. The trust opted for a vendor-independent service provider that not only offered knowledge of equipment across manufacturer's product ranges but could also improve the service for patients. Under the contract, Asteral guarantees 98 per cent uptime for each individual asset under management, including strict criteria for dealing with maintenance issues.

As part of its service, the company keeps robust records of equipment performance. Mr Thompson says that this is useful for Care Quality Commission and NHS litigation audits and assessments because it shows that the correct processes are in place, equipment is maintained and serviced, and that staff members are appropriately trained.

"Our staff have been freed up to do what they do best and that is treating patients," says Mr Thompson. "If we have a problem we make one phone call to Asteral. Dependent upon ... whether it is routine or urgent or major, we have a response time of two hours to five working days."

The MES contract has enabled the trust to move from analogue to digital for most of its equipment. The last of its x-ray equipment is going digital this year. Mr Thompson says this has created savings because the new equipment works faster, smarter and quicker.

Flexible contract: Leicester can increase or decrease the assets managed if there are reconfigurations

Waiting lists for diagnostics have been reduced as has length of stay, because patients do not have to wait so long for assessments or results. Chemicals and film no longer need to be processed, which requires fewer staff, and the CDs that have replaced them are much cheaper.

For UHL an important part of the contract is its flexibility. This allows the trust to put in or remove up to £5m in assets over a rolling period of three years, allowing for reconfiguration or changes in technology. It also enables the trust to increase or decrease assets under management by £0.5m per year, to include any extra capital or charity funded equipment it may have acquired.

Over the past year, Asteral has helped the trust to reconfigure its services and rationalise its equipment estate, ensuring it has the equipment in place to maximise clinical benefit, while further reducing cost.

WHITTINGTON HEALTH TRUST

Whittington Health Trust, which provides acute and community services to patients in north London, entered into a 15-year MES contract with Asteral in 2006. The hospital was extending and wanted to find a service provider of state-of-the-art technology meeting both the clinical and financial brief.

Recep Suleyman, imaging services general manager at the trust, says of the result: "This is the first time ever that I have worked in a department that didn't have any machines older than some members of the team."

The biggest mistake managers of

Latest technology: the Whittington trust – staff like the fact that equipment is upgraded regularly

'This is the first time I have worked in a department that didn't have any machines older than some members of the team'

diagnostic units make when moving to new facilities is to simply duplicate the technology in the old unit. He explains: "I thought I would rather leave rooms empty than actually buy something that will be dormant for most of its life. Six years down the road ... we are not running out of rooms. We have expanded into some of the rooms that were empty but those contain new modalities, new techniques, new income for the trust or new services for the local people. This contract has given us flexibility to extend and enhance our service to patients."

One previously empty room now houses a DEXA machine to measure bone density and another digital mammography equipment for the local screening project.

At the outset Mr Suleyman would have preferred to have bought the equipment outright, but lack of capital meant that this was not an option. However, he soon realised the benefits of MES when a year into the contract the hospital was given some ultrasound machines, through a cancer screening initiative, that were identical to the ones under the MES contract.

"The quality of the maintenance or after sales service was very different," he reveals. "Asteral's MES ... means that if equipment is down for more than an agreed number of hours, Asteral incurs a penalty." As a result the trust has now rolled more equipment into the MES contract.

All the equipment is digital and since the MES contract the trust has improved its productivity by 90 per cent. Prior to the MES there were 86,000 examinations per year, the first year of the contract it was 96,000 and now it is over 156,000, yet the staff headcount has remained the same.

The agreement has enabled the trust to increase radiology reading time to account for extra patients owing to digital equipment, which removes the need for processing, and to a better department layout. Diagnostics for chest patients, the most common type of patients, are in the room nearest the entrance. "They don't spend 10 minutes walking in and 10 minutes walking out, knocking on the wrong doors and stopping activity in the room," says Mr Suleyman.

A major advantage of the contract is that equipment is upgraded regularly, so it is not necessary to compete for capital to install the latest kit. While payments are heavier than for maintenance alone, Mr Suleyman adds: "You are actually saving at the same time. You are not purchasing the equipment in the first place and then you also have a replacement programme so at the end of 10 years you don't have to look for capital to replace. This helps you budget more effectively."

KINGSTON HOSPITAL TRUST

Kingston Hospital embarked on its first ever MES contract with Asteral to upgrade its CT services following an increase in patient demand. In a typical day, the department would see more than 40 patients for various types of CT scan and levels looked set to increase. Over the past decade, national demand for scans has increased by 10 per cent year-on-year.

Head of radiology Jim Weir says: "The previous technology, an eight-slice CT scanner, provided a good service but the high level of use caused occasional downtime, which led to patient rescheduling. The consistently high volume of patients also meant that many scans were delayed, increasing the pressure on staff to maintain acceptable waiting times."

The radiology team had a compelling business case, but the funds required to replace and upgrade equipment and remodel the building represented a significant investment, which called for a new approach.

Asteral provided a flexible service that enabled the hospital to make monthly payments over a seven-year contract. These cover the technology and maintenance plus the build, project management, training, response desk and other services.

Mr Weir says: "Since both scanners became operational in late January, Asteral has provided detailed monthly reports of the performance and availability of each scanner complete with key performance indicators, something I have never experienced from any other supplier.

"I am really proud of our new department. We provide an excellent quality of care due to new imaging techniques enabled by state-of-the-art technology. We also provide outpatients with a much improved experience, thanks to a more efficient imaging facility and remodelled patient flows. This is our first experience of an MES but it has been a very good one and certainly something that we will look to repeat."

The project has considerably increased the capacity of Kingston's radiology department. This not only improves services but enables the hospital to increase urgent or inpatient access and will support a planned "walk-in" direct access service. ●

ALAMY

PETE SHERGILL ON INNOVATION

As debate around the Health and Social Care Bill continues, we cannot afford to take our eye off the ball of the unprecedented efficiency challenge faced by the NHS. And within these much tighter budgets there is a real imperative to deliver better care, truly integrated across the patient pathway.

This is not, however, a time to be pessimistic about the future of healthcare. Instead it is a context in which we can innovate by developing new, more efficient services for patients.

Medicines optimisation is a perfect example of where we could make a significant impact. In the last year alone, the total spend on medicines in the UK was over £12bn, roughly 10 per cent of the total health spend.

With medicines accounting for the single biggest cost in the NHS outside of labour, this is an area with huge scope for innovation. In the prison sector, medicines cost savings already total 10-20 per cent due to a roll-out of more robust internal processes and guidance on prescribing policies where Lloydspharmacy provides these services.

At Lloydspharmacy Healthcare Services we're working in partnership with trusts across the UK to develop and implement innovative ways to deliver efficiency in services and the medicine supply chain. Our outpatient dispensing service, for example, allows hospitals to couple their clinical expertise with

'In the prison sector, cost savings already total 10-20 per cent'

the operational expertise that pharmacy can offer. Hospital staff can focus on core clinical activities while using specialist partners to deliver non-clinical activities. The scheme has already been rolled out across 14 trusts and an equal number are in the pipeline. We are also talking to trusts that are looking to work with partners to support fuller pharmaceutical services across the hospital setting.

But it's not all about reaping the financial benefits and bowing to the business bottom line. Efficiency comes from creating strong partnerships which allow each organisation to play to their strengths, resulting in the delivery of a higher quality service across the board. Successful partnerships are the ones that have been created with a strategic view to deliver QIPP benefits.

Whatever the result of the debates around the Health and Social Care Bill and its impact on the structure of healthcare across the UK, progress has to be made to make our health and care services more efficient. This is a goal that can only be met by finding different ways of working and innovative solutions.

Pete Shergill is head of strategic services at Lloydspharmacy
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OUTSOURCING

TIME FOR A DOSE OF REALITY

Underperforming hospital pharmacies are being urged to take a look at outsourcing. By Ingrid Torjesen

Around one tenth of the NHS budget is spent on medicines, so optimising their use and delivery has real potential to make a significant contribution to the £20bn efficiency savings required by the Nicholson challenge. Making the best use of pharmacy expertise both within the hospital and the community is essential to achieving this.

Numerous studies have demonstrated that greater involvement of pharmacists in delivering direct care to patients reduces adverse drug events and treatment costs and improves patient outcomes. In hospital, increased input by clinical pharmacists at each stage of the patient's journey has been shown to cut the length of stay and readmission rates.

In 2008 the pharmacy white paper, *Building on Strengths – Delivering the Future*, recognised this, saying that innovative new ways of working are needed to deliver on pharmacy's clinical agenda, and suggesting that outsourcing service elements, such as outpatient dispensing, could be part of that.

The white paper also emphasised the need to ensure integrated care supports patients between hospital and the community. "When patients have ongoing needs for complex therapies, there is a clear opportunity for hospital and community pharmacy to work together, to ensure that medicines and advice are provided conveniently and consistently," the document says.

It also acknowledges a role for care at home in hospital dispensing. "In some circumstances, the delivery of medicines directly to a patient's home by a home care company may offer advantages from the patient's perspective and also address capacity issues," it says.

The Hackett report, *Towards a vision for the Future*, published by the DH in December 2011, went further, saying the NHS needs to develop stable contractual frameworks for home care organisations and encourage home care to improve services.

Mike Cross, managing director of medicines management consultancy Hambleton Medical, which advises trusts on pharmacy services, says a trust with a hospital pharmacy service delivering on the savings and safety agenda that offers a pleasant outpatient experience for patients probably should not consider contracting out pharmacy services. But in his experience few trusts are in that lucky position.

"If you have got a hospital that cannot manage its stock safely and can't maximise and optimise its use of drugs, then you really need to divert the focus of the medicines management service away from just the routine supply function towards doing those things that are critical to the business of the trust and actually generate more money. Getting someone else to do a good job with your outpatient pharmacy is a way of improving that focus and making much greater savings on those things that are actually key to the business," he says.

Contracting out

Mr Cross, who spent 18 years as a director of pharmacy in NHS hospitals and whose MBA is on contracting out pharmacy services, says there are financial savings to be made by contracting pharmacy outpatients to a private sector company, because that company can reclaim VAT on drugs at 20 per cent but that these savings cannot be the main reason for contracting out. For it to be acceptable to HM Revenue and Customs there has to be a clinical reason.

He says trusts decide to go down this route for several reasons: to reduce headcount, to

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refocus pharmacy staff, or because the outpatient dispensary is tired and there isn't the capital to build a new one.

Pharmacy is often the last experience of a hospital that patients have, Mr Cross points out. "If that's a memorable pleasant experience they might forget some of the things that happened to them during their stay if it wasn't as they would have wanted. A smiley face and a lot of support, a lot of positive information in a clean environment, could be their last memory, and I think organisations tend to miss that opportunity."

Hambleton Medical has reviewed 60 pharmacies and found that the average savings for trusts outsourcing outpatient dispensing to be around 10-15 per cent of the drug budget, plus the reduction in staff costs from the loss of the work outsourced. For one organisation the savings were over a quarter of the drug budget and for another over £8m a year.

Royal Derby Hospital contracted out its outpatient pharmacy services in 2010, when the hospital moved into a new PFI building, to a private sector community partner for 12 years. Tom Gray, chief pharmacist at the hospital says that this was a cost neutral decision to improve the patient experience.

'Pharmacy is often the last experience of a hospital that patients have'

"With two busy dispensaries coming into one, it was going to be a struggle to maintain appropriate waiting times for patients and also to ensure that we could give them the extra support," he says.

"We thought the best people to do it are the people who make a habit of it, make a livelihood of it – our community pharmacy colleagues."

Mr Gray says the trust was working with primary care colleagues to ensure that the savings that had been generated were reinvested in the health community.

Mr Gray, who is pharmacy lead for NHS East Midlands, says the move has resulted in shorter waiting times for patients and fewer complaints and problems. It has also released a lot of experienced hospital staff to support inpatients, deal with more complex prescriptions, support patients at discharge and to try to develop the interface between hospital and community.

Delivering drugs for care at home is another option that trusts can consider – one which can prove to be a cheaper option and more convenient for patients.

East of England SHA set up a framework contract for home care to standardise its use across the region and make it more cost-effective, as previously prices charged by home care companies had been very variable.

Home care savings

Many of the drugs delivered through home care are expensive drugs, such as anti-TNFs for rheumatoid arthritis patients, beta-interferons for MS patients and HIV drugs – and East of England SHA is also considering it for oral chemotherapy. There are VAT savings delivering through a private home care company, which are large for expensive drugs, and this is also time saving and much more convenient for patients, particularly those with mobility issues who find it hard to get to the hospital.

Carol Roberts, pharmacy and prescribing lead at East of England SHA, says: "The home care companies have to ensure that there is adequate education and training for the patient [on storage of the drug] and that the patients know what to do if something goes wrong like the fridge breaks down." Clinical staff have to ensure that patients are suitable for home care and know how to take the medicine.

The SHA is trying to move more patients to home care. "What we are trying to do is work with the hospital trusts and put in resource to help them with the extra workload that is required to manage these patients to ensure there is good clinical governance and financial governance," Ms Roberts says. ●

OUTSOURCING: CASE STUDIES

How Royal Liverpool and Broadgreen Hospitals Trust managed its successful and pioneering project to outsource pharmacy services

'IT COSTS LESS AND

OUTSOURCING OUTPATIENT PHARMACY SERVICES IN LIVERPOOL

Royal Liverpool and Broadgreen University Hospitals Trust has been one of the pioneers for outsourcing pharmacy outpatient services to the private sector.

In the early 2000s the trust decided that its pharmacy was not working as efficiently as it could be, so it decided to find a community partner to handle outpatient dispensing. After an abortive attempt to pilot this in 2005-6 with a small chain of pharmacies – which was shelved after the chain was bought out by a multiple that did not want to go ahead with the project – the trust began a 12-month pilot with Lloydspharmacy in September 2008.

Alison Ewing, the trust's clinical director of pharmacy and therapies, says: "Quite by chance Lloyds opened a branch of their pharmacy right opposite the hospital and what we felt was that it gave us a chance to pilot a scheme with one directorate to see if it would work."

Haematology was the specialty chosen because it was challenging: drugs for leukaemia and non-cancerous blood disorder would not normally be dispensed by a community pharmacy. It involves low volume dispensing but of high cost drugs, so any financial savings would be seen quickly. Patients come back regularly and know the hospital well so would be able to give informed feedback.

One of the biggest barriers was negotiating with drug companies to ensure that they sold the drugs prescribed by the hospital to Lloyds at the same preferential pricing as to the in-house pharmacy.

Ms Ewing says: "Lloyds had specific staff in a particular part of the community pharmacy dedicated to supplying the outpatients and even with this the drug companies were very wary that preferential prices might get mixed up and go to NHS prescriptions.

"The barriers have broken down a lot now but, as we were the first ones to do it, we had to make sure that the drug companies and wholesalers were quite satisfied that they were only going to be using these medicines for our outpatients."

She said that, to reassure them, a separate Lloyds hospital pharmacy account was set up with most of the companies to demonstrate that Lloyds were not buying stock more cheaply and using it elsewhere. In addition, auditing was used to show that dispensed stock tallied with prescriptions written.

All the Lloyds staff carrying out outpatient dispensing were trained by the trust's in-house pharmacy team. "We stipulated that it could only be people who are trained with us who could work in there," Ms Ewing says. "And I asked for dedicated staff. I didn't want locums coming in and out because they wouldn't understand the issues."

Another hurdle that had to be overcome was the speed of data processing to ensure that the PCT was sent information on PBR (payment by results) excluded drugs promptly. Outsourcing the service meant that this information could not be easily pulled off the trust's dispensary computer system, so needed to be provided by Lloyds quickly.

High cost drug savings

PBR-excluded drugs tend to be higher cost drugs with very specialist indications, such as anti-TNFs, and drugs for leukaemia and chemotherapy. These have to be billed back to the PCT separately at cost price. Doing this promptly is vital because PBR-excluded drugs make up around 70 per cent of the cost of drugs dispensed in outpatients. As the drugs are now dispensed by a private company, no VAT has to be paid, but the savings go to the PCT so any savings for the hospital trust have to be negotiated.

The trust's pharmacy team built a database for Lloyds which highlighted all the drugs that are PBR-excluded and the trust's finance team worked with finance at Lloyds to set up an acceptable system for turnaround times, processing invoices, invoice reconciliation and data transfer. Ms Ewing says the ideal would be to have an integrated computer system because this would make invoice reconciliation much easier.

The evaluation of the pilot looked at the quality of patient care, whether dispensing

was done quickly and accurately, whether the necessary medicines were in stock, how patients and clinicians liked it, and how it was working for the trust and for Lloyds.

It found that patients were only having to wait 10-12 minutes for their outpatient scrips to be filled in the Lloydspharmacy, whereas previously, when the trust team was dispensing, patients were having to wait around 40 minutes. Ms Ewing explains: "In the dispensary we have only got one pharmacist and that pharmacist is clinically checking inpatients and outpatients, overseeing problems with prescriptions and overseeing discharges. With electronic prescribing if there's a problem, everything gets held up. Lloyds were really only doing outpatient prescriptions and outpatient prescriptions were the focus of their attention. In essence they were much more dedicated to providing the service that the

FREES UP TIME'

'Patients were only waiting 10-12 minutes for scrips to be filled, rather than 40 minutes'

patient needed." The dispensing error rate was also excellent and well within the limits the trust had set.

Stock control was a problem initially because of the difference in dispensing patterns between a hospital outpatient clinic and a GP practice. Ms Ewing explains that outpatient pharmacies need to hold quite a large stock of very expensive medicines for chronic conditions a hospital manages because dispensing patterns are very different. Whereas GP surgeries usually prescribe one or two months' medicine, prescriptions written by the hospital outpatients for conditions such as HIV are often for five months.

"If you have 10 patients all coming back on one day for five months' supply you need to keep a very big stock. In the community they tend to say can you come back for it in the afternoon, but if they've come from the Isle of Man you can't do that.

"Very expensive drugs sitting on your shelf might not be a great business proposal when you're running a community pharmacy but is an absolutely essential element of running a good outpatients service." So performance management clauses were put in the contract to ensure that the pharmacy keeps sufficient supplies of drug in stock and does not run out.

The pilot was such a success that the trust decided to roll it out across other departments. A formal tendering exercise took place in early 2009 and Lloyds was awarded the contract for five years with the option of a two year extension, which will run until the current hospital relocates to new premises.

Lloyds managed to secure a shop unit within the trust so the outpatient dispensary service was relocated to these premises. The unit is registered as a pharmacy but does not have an NHS dispensing contract, which ensures there can be no mix-up between stock for outpatient dispensing and NHS prescriptions. The pharmacy has a smallish shop front, run by non-dispensing counter staff, which sells small items such as toothbrushes and deodorant that patients may require while in hospital.

The roll-out took 12 months and the consequent decrease in the number of items going through the trust dispensary made it more efficient. In outsourcing outpatient dispensing, Lloyds took over responsibility for dealing with between 4,500 and 5,000 items per month, removing 20 per cent of the workload at the dispensary which had been processing just under 30,000 items a month – creating opportunities for workforce remodelling.

Restructuring the workforce

The dispensary had previously had two receptionists but, with less work to do, only one was needed. When one receptionist left, the post was not replaced with a receptionist but with a dispenser in the dispensary instead.

Some of the pharmacy staff were realigned to enable two more band five technicians to be appointed. These technicians go on the ward to provide patient care, giving patients advice about their medicines and enabling more of the patients' own medicines to be utilised while in hospital. They also work with the clinical pharmacist to improve the quality of patient care and the way the pharmacy is integrated into the ward networks.

The purchasing department also had less to buy so when someone retired they were not replaced

Ms Ewing says the exercise had to be cost neutral and it has turned out to be cost saving. "We have a more efficient system, it costs less money and it frees up time within the pharmacy."

Since Liverpool outsourced outpatients pharmacy there has also been a tremendous focus on reducing length of stay which has increased patient throughput and the amount of work going through the inpatient pharmacy.

Ms Ewing says: "We are seeing a big rise in the number of items that we are dispensing but, because we have remodelled our staff and because we have been able to have much more near patient care, we haven't needed to increase our staffing to cope with the increased workload." ●

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