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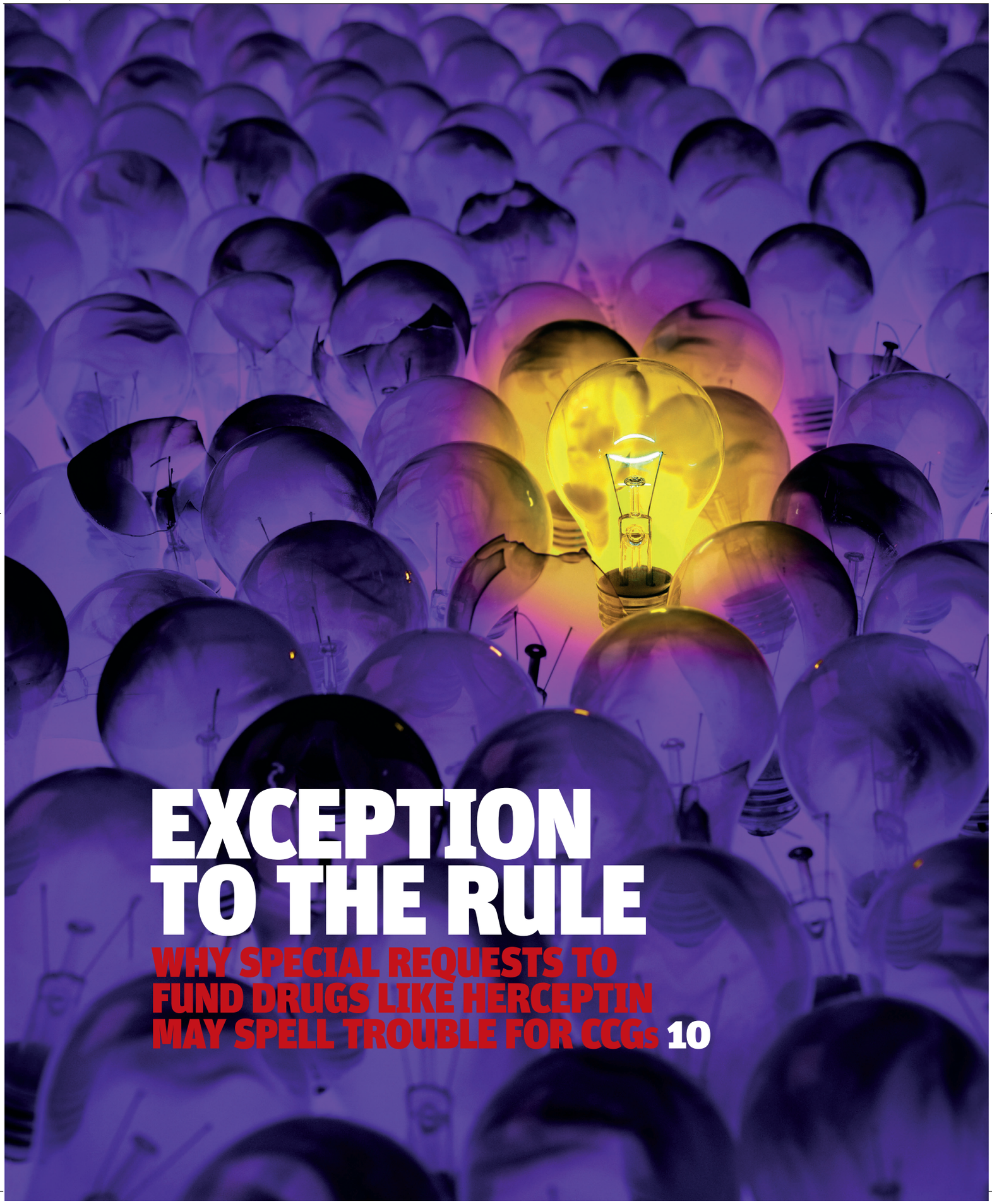

EXCEPTION TO THE RULE

WHY SPECIAL REQUESTS TO FUND DRUGS LIKE HERCEPTIN MAY SPELL TROUBLE FOR CCGs 10

CONTENTS

INSIDE

Supplement editor
Daloni Carlisle

ANDREW TURNER ON GETTING RID OF PAPER

It seems timely to be holding a debate about how we can make end-to-end automation in pathology a reality. With the Department of Health calling for a paperless NHS and the announcement of the successful tender for pathology reconfiguration in the East of England, we're likely to see dramatic changes in laboratory services over the coming years.

The necessity for much of the restructuring is probably financial. But the underlying direction will start to take us towards the reforms recommended by Lord Carter of Coles in his seminal 2006 report highlighting cost savings aligned with significant improvements in service provision.

As a logistics company specialising in transport across a number of sectors, we've been able to look at the challenges facing NHS pathology from a different perspective. We've always understood that healthcare is different. But we've been able to look at reconfiguration from a practical quality and efficiency point of view.

The starting point for much of our work with the NHS is mapping routes and workflow. This means being a little dispassionate about the bricks and mortar that have traditionally housed parts of the NHS. We understand and respect the deep-felt feelings people have for their local services. But we have to look at what will create the safest and most efficient pathology logistics to support patient quality and service needs now, and into the future.

Once the workflow is understood, technology can be applied in the appropriate way to transform pathology services. Laboratories that are able to prioritise deliveries and specific testing requirements can process more samples. GPs can offer patients greater flexibility in phlebotomy services. Samples can be tracked en route and everybody in the system – from the phlebotomist to the laboratory – has the reassurance provided by an electronic audit trail that bleed-to-test times are being met.

Delivery performance for the first time can be auditable, ensuring sample testing is valid across campuses.

This is an example of where automation, and removing the paper systems such as those highlighted by the secretary of state for health, can make genuine improvements to delivery and the services patients receive.

We understand that logistics are only one piece of the pathology jigsaw. But we also know that we can offer more than trained, accredited drivers and specialised vehicles. By applying proven technology, with our PathTrak Solution, and approaches from other sectors where we transport important goods, we can help the NHS move forward in this critical part of the service.

And perhaps we can play our small part in helping to deliver the vision of modern pathology as outlined by Lord Carter of Coles.

Andrew Turner is director of CitySprint Healthcare

www.citysprinthealthcare.co.uk

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ROUNDTABLE: PATHOLOGY

AUTOMATIC FOR THE PEOPLE

'End-to-end automation' of pathology could lead to huge savings for the NHS. But what does it really mean? Daloni Carlisle reports from an expert discussion

Pathology is not known as a cutting edge service. But with major reconfigurations underway at last, this backroom specialty is now in the spotlight. Where pathology leads in the attempts to create the "end-to-end" pathway, others may follow.

The idea of reconfiguring pathology to drive up productivity and create a more efficient service has been around for the best part of a decade. Lord Carter's first report recommending that services develop into hubs carrying out the "cold" non-urgent work and spokes carrying out "hot" or urgent work appeared in 2006. His follow up, concentrating on the dependence of the hub and spoke model on connected IT, came out in 2009.

Four years later and it is only now that plans to reconfigure services are truly moving forward with tenders, the naming of preferred bidders and contracts being put in place.

So in January, *HSJ* and CitySprint Healthcare – which provides logistics support to pathology as well as advice on reconfiguration transport strategies – put pathology under the spotlight, convening a roundtable to discuss how to move to new service models and to explore the technologies and processes that need to be in place if reconfiguration is to release the expected efficiencies.

Les Martin: 'Lab staff should not fear reconfiguration'

While this debate is interesting in itself – pathology accounts for 4 per cent of NHS spending and is involved in 80 per cent of decisions affecting diagnosis – it is also of wider interest to an NHS undergoing transformation.

As Alastair McLellan, *HSJ* editor pointed out: "It's my view that pathology is the vanguard for change that will come in a number of areas. Some of the opportunities, problems and issues raised by pathology will be used as a guide to how other changes can be introduced."

Automation was a continuous theme of the debate. From a logistical viewpoint, efficiencies can only be delivered in highly automated systems, whether that is within labs testing samples using modern analysers or in the processes that deliver the samples to the labs in the first place.

From a clinical point of view, best care can only be delivered in a system where results are shared automatically and electronically between clinicians caring for patients at different sites.

Richard Dolby, commercial manager for Community Pathology Procurements, who is involved in tendering for pathology providers for general practice work in the East Midlands, made the case for automating processes.

He compared the task of managing a pathology service carrying out millions of tests a week to that of managing a large company such as Amazon with millions of

Alastair McLellan: 'Pathology is the vanguard for change in a number of areas'

'In England there are more than two million tests carried out a day – and still GPs have to order on paper'

transactions. You'd be mad to try to do it without technology and automated processes, he suggested.

"In England there are more than two million tests carried out a day – and still GPs have to order on paper," he said. Not only is this slow and inefficient but it is also prone to error and carries an unnecessary clinical risk.

For example, a blood test taken in a practice and accompanied by a paper order form cannot be tracked from the time the blood was taken to the time it is delivered at the laboratory – and therefore it cannot be determined whether it arrives within the four hour window required for many tests.

It cannot be tracked en route or traced if it gets lost. The paper and sample risk being separated and there are risks of data being entered into the lab system from the paper incorrectly. From a management perspective it is impossible to audit what percentage of samples reach the lab for testing within four hours or to examine where any bottlenecks might exist in the system. From an efficiency point of view, paper orders require more data inputting and more couriers as there is less ability to plan.

Phil Koczan: 'Where does the process start and end?'

Andrew Turner, director for CitySprint Healthcare, said: "The use of tracking and GPS technology is standard within other sectors such as retail logistics; we have ourselves developed an industry leading sample tracking solution which provides full electronics audit detail, which the CCGs [clinical commissioning groups] will find invaluable. The lack of electronic automation within the NHS pathology sector often makes the task of providing an efficient integrated solution difficult to achieve."

"We do not want to see handwriting. We do not need people with pens making mistakes," added Mr Dolby. "We want to see bar coding of samples in the general practice so that samples can be tracked and data entered into lab systems automatically. I am keen for our specification to be automated end to end."

Sharing results

Phil Koczan, a GP in Chingford and chief clinical information officer of UCL Partners, made the case for automating results sharing.

He asked: "We talk about an end-to-end

Geoff Searle: 'Phlebotomy is the biggest opportunity to improve services'

process but where does that start and where does it end? As a GP, it starts with deciding whether I need a test, sometimes based on other results and it is often difficult to get access to these."

The lack of data sharing worked both ways, he added. His practice, for example, carried out patient testing for people on anti-coagulant therapy. "Within the practice our results are easily available but they are not available if the patient pitches up in hospital."

Not only did this lack of sharing compromise clinical care but it also led to waste, with patients being retested or general practice spending hours chasing paper. The lack of integrated pathology results made it nigh on impossible to measure quality of care and investigate variations in practice, he added.

Geoff Searle, chief executive of the private laboratory company iPP, brought the clinical and the logistics aspects together. End-to-end connectivity was required to support the order communications and the automated processing of samples as well as provide the decision support software and other tools to support clinical and managerial needs.

"I continue to be astounded by the number of NHS trusts who have decided not to invest in order comms," he said. "I would propose that true automation cannot be delivered without it."

He suggested that clinicians had not made the case for such systems strongly enough to trust boards.

Neville Desouza, phlebotomy manager at South London and the Maudsley Foundation Trust, countered that clinicians had too often been excluded from retendering and service specification in pathology.

Service redesign needed to include not just senior pathologists but also the clinicians who used the service and those who worked in it – including phlebotomists, he said. They were able to articulate the need for processes that led to patients undergoing tests before they needed a medication review, for example, or the need for an integrated view of an individual patient's test results. "The trust I work in is quite dispersed and clinicians want an integrated system to look at results from different sites," he said. "They ask if we can have all the results for patient X in one place. At the moment, we can't."

'Clinicians have too often been excluded from retendering and service specification in pathology'

Mr Turner agreed: "I do not understand why phlebotomy is not more involved in the discussions."

While everyone agreed that simply putting technology in place would not solve all the problems – pointing out that automating a poor process still gives a poor process – there was also a cultural issue.

Rachael Liebmann, registrar of the Royal College of Pathologists and clinical director of the Kent and Medway Pathology Network, recounted a pilot project using choose and book in phlebotomy. Patients who needed blood tests were invited to use the C&B system to make their own choice about where and when to give blood.

It was "extraordinarily popular" with patients, she said, but foundered on the GPs' resistance. "They felt they had to be with the patient when they chose and it added to the length of time they spent with patients and therefore it was never rolled out and implemented." She agreed that sitting with patients using C&B was not a good use of GP time – but argued that there could have been other solutions such as asking receptionists to support patients.

Changing the workforce

Reconfiguration will mean profound changes for the workforce too. Mr Dolby argued that automation would create winners and losers. "With big machines you do not need so many lower grade staff and you may create options for some people to do more clever things," he said. "But some may end up facing redundancy or may have to travel to a different place of work." Anyone involved in retendering a service must face up to inevitable and difficult workforce challenges, he added.

Geoff Searle agreed. "Anybody can build a new lab and fill it with technology," he said. "But without a doubt the single hardest part of any reconfiguration is the workforce aspect."

His company is now building a new lab in Somerset that will be highly automated. "We have to do a skill mix review to get the right people into the right job. We have to do it from the bottom up and genuinely engage and that takes a lot of time. The temptation is to make short cuts but our view is that the time it takes to do this upstream will deliver benefits downstream."

Les Martin, head of Cumbria and Lancashire Collaborative Pathology Commissioning team and a biomedical scientist by profession, argued for a thorough look at skill mix and the way that laboratory equipment is utilised in order to make best use of both. Point of care testing, for example, may provide opportunities for skilled laboratory scientists to provide support to GPs in interpreting results of tests carried out at their surgeries, he suggested.

He argued that laboratory staff have nothing to fear from reconfiguration. "It is about providing the right service at the right time," he said. Pathology needed to find ways to add value to its service.

Up to a point, said Dr Liebmann. In her view, staff would be protected and new roles created through contracting. "There is a great onus on the commissioners," she said. "If services are commissioned correctly and with the right level of quality built into the contract, then staff are protected and the added value of scientists is valued in that contract. But if pathology is commissioned badly and the contract is written from a

Joining the debate (from left): Phil Koczan, Andy Turner and Les Martin

Neville Desouza: 'Clinicians want all the results for patient X in one place'

minimalist point of view, then both staff and patients will suffer."

Who owns the sample?

One bone of contention was who should "own" samples at what point on the journey. Mr Martin argued early on that quality (including formal, legally mandated quality assurance processes) and clinical governance dictated that ownership should fall to the pathology service from the moment that the blood is taken from the vein. Members of the panel, however, suggested that GPs needed to "own" samples from vein to the lab and then to hand over. This would create a sense of responsibility for ensuring a smooth flow of samples to labs.

'We need to redesign services and consider access to phlebotomy. Why can I not go to Tesco's to have it done?'

There was no clear answer – perhaps reflecting the lack of clarity around the mechanical pathway of the tube.

Mr Turner said: "Ownership and turnaround times are the biggest issue we have. We need to understand the mechanical pathway of the tube." He suggested using "lean" principles in redesigning it.

Patient experience

Often, said Dr Koczan, patients had a frustrating experience of pathology. They had little or no choice about where to go to get their blood taken and the process often involved queuing. Patients with long term conditions often had to repeat tests carried out in hospital in primary care – and vice versa – because organisations did not share data. They had to wait for appointments to get results.

He said: "Every morning on my way to work I go past the phlebotomy service and there is usually a queue outside waiting to get in when the doors open. Patients know if they are there first they will be seen quickly but, if not, they can wait for two hours. We need to improve things from a patient perspective."

Mr Martin agreed. "We need to redesign services and consider access to phlebotomy," he said. "Why can I not go to Tesco's to have it done? Do I really need to go to the hospital and pay for parking and take time off work or go to my GP? We have to look at critical points in the system and design what is required."

Mr Searle agreed and raised a specific point about the East Midlands GP work being led by Mr Dolby. Why, he wanted to know, had phlebotomy been excluded from the specification? "It is very disappointing that phlebotomy has been excluded," he said. "It is the single biggest opportunity to improve services from a patient perspective."

Mr Dolby agreed that ideally an end-to-end service would include phlebotomy; it had been excluded because there was too much variation in the existing service. "It was just too hard to articulate what was wanted so it has been excluded for now," he said. "It is a hot potato."

Appetite for technology

Commissioning high quality, automated services requires an appetite for investment. Mr McLellan pointed out that there was a new appetite at secretary of state level for improved technology in the NHS; was this also apparent in conversations with CCGs?

Yes, said Mr Dolby. He envisaged a contract in the East Midlands in which technology would push providers to share information and in which demand management would push GPs to ask for the right tests at the right time. "GPs are looking to the acute trusts for guidance on smarter ordering," he said.

Mr Searle argued for a dose of realism, however. While some CCGs understood how pathology impacted services, many were still feeling their way. "They are still trying to get their heads around what it means to be a CCG and we have to be realistic. If you are looking for efficiencies you are probably not going to start with pathology."

Of course all eyes presently are on the East of England, set to be the first region to reconfigure pathology at scale. Preferred bidders have been identified in a service change designed to save £40m by centralising cold pathology on two sites, leading five other hospitals to lose a large part of their pathology service.

So, asked Mr McLellan: "Is this a brave new dawn – or will it be seen as an interesting experiment that had some impact locally but did not infect the whole system?"

The former, said Dr Liebmann: "Certainly it will be the catalyst for other large scale reconfigurations. I am doubtful that the CCGs of their own volition would do this kind of work."

Mr Turner and others argued that success would hinge on automation and integrated technology coupled with visionary leadership. Mr Searle added: "I think there is no doubt that the challenges are there for everybody to see. Will it be a catalyst? If it is perceived to be a success then yes but it is too early to tell." Mr Dolby added: "It will depend whether it does what it says on the tin." He pointed out, though, that the reconfiguration plans in the East of England had been driven by the chief executives of a handful of PCTs. "In the East Midlands we have spent nine months talking to 42 commissioning groups."

Ultimately the experience in the East of England may decide whether pathology remains a core NHS service or is provided under any qualified provider. Such discussions are some way down the line, the panel agreed, but eventually the spoils will go to whoever can deliver the service commissioners want. That means a highly automated, efficient service with integrated IT and shared results. ●

SHIRAZ AUSTIN ON GOOD PARTNERSHIPS

Efficiency, accuracy, and reliability are, of course, hugely important in the effective delivery of clinical documentation in the NHS. But I'd add another element to the mix: partnership.

At ScribeTECH, we firmly believe that the secret of our success over the past nine years is strong partnerships, and we never forget that we are providing a service. In fact, I'd go further by saying that it's the former which enables the latter.

In contrast to the mid-2000s when it was largely the preserve of a few pioneering early adopters, outsourced clinical transcription is rapidly becoming, if not the norm, then certainly part of the NHS mainstream.

I believe there are several reasons for this. Firstly, as we all know, health services are facing perhaps unprecedented challenge, in terms of improving both quality and efficiency. Resources are tight, and there's an ever-increasing emphasis on squeezing the most out of every penny.

Outsourcing clinical transcription will save money – for example, by reducing reliance on expensive agency staff, and on in-house typing pools – but that's only part of the story.

Where I believe the trusts really score is in using ScribeTECH to facilitate internal efficiencies and to drive up consistency and quality of services. This can be anything from taking the pressure off medical secretaries, allowing them to give more focused support to consultants – and to patients – to ensuring that the patient journey is not stalled because the right documentation is still sitting in a pile somewhere, waiting to be typed.

So why choose ScribeTECH? We are the UK's premier offshore medical transcription company. Last year we were also ranked top supplier in both national frameworks for outsourcing. We provide our own software called ScribeNET – free of charge – but also, crucially, we will integrate directly with whichever digital dictation system you decide to use, for the ultimate flexibility. Our integrations with BigHand and Winscribe, plus others at a number of sites, have enabled those trusts to see real efficiency gains. We use external accreditation systems to make sure that our work meets the highest standards, particularly in accuracy and security.

We've been doing this for a long time, and we're a trusted and progressive company. Working in partnership, we bring the right expertise and experience so our customers achieve the ultimate goal of delivering better patient care in a proficient, cost-effective way.

As the health service continues to rise to the twin challenges of improving both quality and efficiency, it's never been a more appropriate time for managers to take a good hard look at how they can do things better. Working with ScribeTECH can make that a reality.

Shiraz Austin is managing director of ScribeTECH

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OUTSOURCING

LETTERS FROM INDIA

Jennifer Trueland reports on the case for offshore outsourcing of typing of patient letters

The NHS is seeing and treating more patients than ever before – meaning that the number of patient letters is also increasing. As the population ages, and demand continues to rise, the typing pile will only grow higher.

So what do you do? Employ more medical secretaries? Set up an internal typing pool? Take on expensive agency staff to help tide you over at times of particularly high pressure? Or do you outsource the work – and the worry – offshore?

Sending patient letters abroad to be typed has, in the past, been seen as controversial, leading to outcry in certain parts of the media, and even from some politicians. But as the sector has matured, more and more trusts are now seeing it as a solution to the clinical correspondence conundrum. As ever, say managers who have tested it out, it's a matter of thoughtful procurement, choosing the right provider, and making sure that the quality, data security – and the price – is right (see case studies, overleaf).

"Offshore outsourcing is now a way of life," says Shiraz Austin, managing director of clinical transcription company ScribeTECH. "This wasn't always the case – a few years ago, people tended to be a bit worried about it – they worried about losing jobs to India. But India's image in the world has changed: we buy many products and services from India, there's a greater recognition generally that we're operating in a global market."

For Don Sturgeon – a procurement consultant with many years of NHS experience – provided they get the basics right, trusts can benefit hugely from outsourcing clinical transcription.

Until recently he was interim head of procurement at Croydon Health Services Trust, which brought in ScribeTECH to support its in-house staff, following an extensive tender process.

"Look at the number of letters generated every day in hospital," he says. "It's not surprising that backlogs build up. But sending letters to India means they are typed up – usually overnight – and sent out in good time. Of course it's something that needs very close governance, but when you look at the risks of not doing it, and of allowing a backlog to build up, then it suddenly looks a lot less of a risk."

It's important to patients that they get their letters in a timely fashion, he says, whether to allay anxiety about a test which turns out to be negative, or to ensure prompt treatment for something more serious. When it comes to the bottom line, there are "substantial gains" to be made in efficiency.

According to Andy Rennison, UK operations manager at ScribeTECH, the benefits of outsourcing clinical transcription include making a tangible difference for secretarial staff.

"I go into trusts [where managers are considering outsourcing] and the medical secretaries are frazzled. I feel very sorry for them, because not only are they incredibly stretched, but they see this guy with a suit coming in and think – wrongly – that he's threatening their jobs.

"Two or three months later and it's a completely different story. They're still working hard but they're relaxed; there's a bit of laughter and joking in the office, and the consultants – and patients – are getting more of their time."

Taking away much of the burden of typing has considerable knock-on effects, he says. "Maybe I shouldn't call it a burden because some people really like doing it," he says. "But when they're typing and having to stop to answer a phone, or deal with an enquiry, then of course it takes much longer, and it piles up. That's how backlogs develop.

"Then the secretaries are getting phone calls from GPs asking where the patient

CASE STUDIES OVERLEAF ▶

letters are, and that just adds to the workload – it's a double whammy."

Each trust tends to be starting from a different point, he says, but some have backlogs which run into months. "The aim [of outsourced transcription] is to get letters out very quickly so that trusts can meet their targets," he says. "And from the clinicians' point of view, they're doing the dictation like they always did, and making corrections in the way they always did. It shouldn't make a difference to the way they work."

'Clinicians are doing the dictation like they always did, and making corrections in the way they always did'

ScribeTECH takes data security very seriously indeed, says Mr Rennison. Letters are sent to India with codes, rather than names, all data is transferred securely (using 256-bit encryption, which is double the standard 128-bit encryption) and anti-virus, firewalls and IDS (intrusion detection systems) – effectively burglar alarms for computers – are in place.

In addition, the company's Bengaluru (formerly known as Bangalore) headquarters, being situated in the same building as a bank, has extensive physical security.

The company also prides itself on the quality of its staff, and training. "We have a number of graduates in life sciences working for us, and also clinicians," says Mr Rennison. "Some of them prefer the regular hours, and also the higher pay which, in some cases, they get with us. We also have our own training academy."

Supervision is also important for guaranteeing quality, he says. A full-time quality assurance team is assigned to each account and daily audits are used to ensure quality compliance. The company's six-point quality check and multi-tier quality assurance system means they have over 98.5 per cent accuracy, he adds.

ScribeTECH uses external measures for validation, so that its quality systems are certified to UKAS accredited ISO 9001 and the transcription centres in India are certified by the British Standards Institute to ISO 27001.

Although ScribeTECH prefers to build long lasting partnerships with clients, many of the relationships begin when they are brought in to deal with a backlog. Indeed, flexibility to adapt capacity and resources is one of its big selling points. "We're not the only solution in a trust's toolbox," says Mr Rennison. "But we like to think we're an important part of the mix."

That "mix" could well involve internal typing, speech recognition, and other technologies as yet on the drawing board, but outsourced clinical transcription is an integral part of it, he adds.

Good communication is also important, says Mr Austin, who believes that time, care and perseverance taken to set up the service can help trusts reap long term benefits. "Our approach involves a lot of support and guidance," he says. "It's a very gentle process, not rushed, and our experience is that helping managers and staff through the change is very important."

There's one final point Mr Austin makes. "Efficiency shouldn't cost the earth," he says. "Which is why we are pleased to be an ISO14001 certified company (for environmental management) – assuring the NHS that our services help reduce carbon waste and protect the environment." ●

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OUTSOURCING: CASE STUDIES

WORLD CLASS POST

Two pioneering hospital trusts' experience of global outsourcing of transcription. By Jennifer Trueland

UNIVERSITY HOSPITALS BIRMINGHAM

Around seven years ago, University Hospitals Birmingham Foundation Trust embarked on a trust-wide project to modernise patient administration.

As well as considering issues such as bookings, the trust began to look at ways of producing its massive output of dictation more efficiently.

That was when digital dictation – and subsequently outsourced clinical transcription – came into the picture.

"We were looking at the whole of our administration processes to see how we could improve them – and, of course, improve the service to our patients; digital dictation was part of that," says service improvement manager Linda Mennell.

"The administration review was a really inclusive process – we had clinicians involved from the start, we worked collaboratively with staff side and, importantly, we weren't taking just one issue in isolation: it was part of a much bigger project. We also had executive support, which was really important."

The trust decided to pilot outsourced transcription services and that was when they started working with ScribeTECH – and could see what high quality clinical transcription services could do for them. By the time the trust procured their full digital dictation system (through a formal tender process) ScribeTECH had started to work in partnership with other digital dictation companies to ensure their transcription services could still work effectively through their dictation systems.

"A big thing for us to start with was managing peaks and troughs in demand and supply," says Ms Mennell. "Outsourcing clinical transcription meant that we didn't have to hire agency staff who were unfamiliar with our processes and approach to quality as well as being more expensive than our own staff."

Another important element, she says, was making it an opt-in service for departments and units across the trust to take up. "There was no 'you must do this'. We simply said we were offering this to our operating divisions to help them meet their targets."

The aim was not to cut medical secretary numbers, she says. Rather it was to free up the time of these valuable members of the team so that they could allocate more resources to patient-facing activities, such as dealing with patients' queries or concerns and reducing letter turnaround times. "A big thing for us was releasing medical secretary time to improve the patient experience," says Ms Mennell.

Involving secretarial staff, as well as clinicians, in development of appropriate templates and style of documents was also important in gaining buy-in.

Having worked with ScribeTECH during the pilot, the trust had no qualms about the quality and accuracy of the transcription work and was reassured by the company's information governance measures.

Outsourcing has reduced the turnaround times for dictation across the board wherever it has been introduced in the trust. More than half of the trust's clinical transcription is currently outsourced, with the remainder being done in-house – a mix which gives flexibility.

Also important for flexibility was ScribeTECH's ability to link with different digital dictation systems, says Ms Mennell.

The trust conducted a lengthy procurement exercise before making its final choice and "piggybacked" on to the East Midlands Procurement Hub's arrangements.

But Ms Mennell says there is really no substitute for doing your own research. "I'd advise looking at where it's happening in practice," she says. "That's how you really get an idea of how it works on the ground."

She also advises making sure that the company you choose has a good reputation, excellent performance, quality and accuracy, preferably externally assured. Looking at the training and qualifications of the staff of the transcription company is essential.

The main gain in terms of efficiency for UHB has, as predicted, included more effective use of staff time, contributing ultimately to a better service for patients while reducing the overall cost to the trust.

Although the trust is keeping a close eye on developments such as voice recognition, Ms Mennell believes that outsourced clinical transcription will be part of the mix for the foreseeable future.

"I don't think that the staff would like it if I said I was going to take it away tomorrow," she says. "But on a more serious note there is a downside in that outsourcing can lead to some dilution of medical secretarial skills, particularly around medical terminology and a detailed understanding of patients' conditions and treatments, gained when typing letters themselves. Having the flexibility to type new and urgent patient

Staff refocused: outsourcing has not led to staff cuts at Chelsea and Westminster

correspondence in-house and outsource follow-up correspondence can help reduce this risk.

"I do think that the way we introduced it – collaboratively and not in isolation – was important. It was gradual, rather than a big bang."

CHELSEA AND WESTMINSTER HOSPITAL

Improving the quality of patient care and making efficiency savings are the rationale behind Chelsea and Westminster Hospital Foundation Trust's transformation programme. Digital dictation – and outsourced clinical transcription – are very much part of that.

For the past 18 months, ScribeTECH has been working with BigHand, the Trust's digital dictation software platform, to help Chelsea and Westminster improve performance and meet targets, particularly around ensuring that GPs receive clinical letters within five working days of their patient's outpatient appointment.

Jen Allan, project lead and head of performance, says there were several drivers that encouraged the trust to look at outsourcing clinical transcription.

"Typing workload is increasing as trusts become ever more productive, carrying out more procedures and offering more outpatient appointments than before," she says. "This will only increase due to pressures from an ageing population and advances in medical technology which means that new and more efficient ways have to be found to meet demand."

'Secretarial staff were snowed under one week, but too quiet the next'

Managing the workload of secretarial staff was another important issue. "Fluctuating demand for services could mean that secretarial staff were snowed under one week, but too quiet the next. Outsourcing means that we transfer that risk," says Ms Allan.

Implementation at Chelsea and Westminster has not led to any drop in medical secretarial numbers – nor was it intended to. "We wanted to meet increased demand, not cut staff.

"Eventually we hope that by outsourcing clinical transcription we will free up our secretarial staff to do other things. They'll be case managing to help patients through the care pathway, rather than spending their time typing."

It has, however, helped clinicians to meet their clinical correspondence targets and improved document management.

She suggests that there are three main areas of concern to address when looking at outsourcing clinical transcription, and also when choosing a supplier.

First, you have to be sure of data security. Second, the quality must be as high, or even better, than an equivalent service in-house. Third, you should consider whether outsourcing provides the best value solution. If clinicians and managers are not convinced on any of these three points, the project won't have the buy-in needed for success.

On the first point, Ms Allan has been reassured that ScribeTECH fully meets all required information security measures, and says the clinicians and managers at the trust have also been very happy with the quality of work undertaken.

As she says: "There's no point in outsourcing at all if the quality isn't right, because you end up doing work twice over if there are too many mistakes."

She acknowledges that some of the trust's clinicians were concerned about sending typing work abroad in the context of the straitened economic climate. But she adds: "In the NHS we have to consider whether we are making the best use of public money. The efficiency and pricing of the ScribeTECH service means that what we're doing is getting value for money for the NHS."

Ask her for tips for a successful implementation and she is quick to reply. "It's important that it is project managed from the business, or operational side, not from information technology," she says. "This is not an IT project."

She also says that its vital to take time at the beginning to design how the system will work with clinicians and administrative staff, and to ensure that there are excellent lines of communication between the trust and the supplier.

For Mr Shiraz, ScribeTECH's director, this model of proactive project management and clinical buy-in from the trust side has been crucial to the success achieved at Chelsea and Westminster.

"This strategy from the outset has proved very effective in enabling the trust to achieve maximum efficiencies in cost and productivity through outsourcing, in particular with departments being able to meet turnaround targets for GP letters following patient visits " he says. "The nature of the environment we work in provides endless challenges, so the achievements are something to be proud of." ●

ALAMY

DAVID HILL ON TRICKY REQUESTS

We are weeks away from clinical commissioning groups formally assuming commissioning responsibilities for their local populations. Clinical leadership promises real benefits. GPs know their patients, both individually and collectively, and will be in a position to develop health services and care pathways that are more patient focused.

However, how will CCGs handle those cases where individual patients feel that the services which are commissioned for the local population as a whole are not right for them?

Individual Funding Requests (IFRs) have always been a tricky area for the NHS. They concern treatments that are often of critical importance to patients – holding out the prospect that they might be able to start a family or achieve a better quality of life while living with a terminal illness.

Until now, it has been the job of primary care trusts to decide upon such requests. While some PCTs have involved GPs in IFR processes, as organisations they have been perceived as remote from patients. The situation with CCGs will be quite different. Each person who makes an IFR to a CCG will be a patient of one of its member practices.

If CCGs' IFR policies are to gain legitimacy in the eyes of patients, they will have to engage with the local population to explain what can and cannot be done within the resources

'It should not be that those patients who shout loudest have the greatest chance'

available to the local NHS. CCGs will want to ensure that patients are familiar with the processes that are in place for making IFRs and that these are accessible to all.

It should not be the case that those patients who shout loudest have the greatest chance of having a request approved. Decision makers on IFR panels will need to be well versed in how to make clear, carefully reasoned decisions. Every GP will have to become used to explaining these tough decisions to their patients.

Taking steps like those above should help to strengthen relationships with the community and reduce the chances that decisions will be successfully challenged. The fact that a challenge is made should not necessarily be viewed as a sign of failure – patients will bring challenges simply because of what they feel is at stake. Learning to deal with challenges in a sensitive but robust way is a skill in itself.

Clinical commissioners will want to draw on the body of expertise that PCT staff and their lawyers have developed in this difficult area which can give rise to significant reputational and financial risks for CCGs if they get it wrong.

David Hill is an associate, healthcare, Hill Dickinson LLP
www.hilldickinson.com

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FUNDING

IT'S THE DRUG THAT I WANT

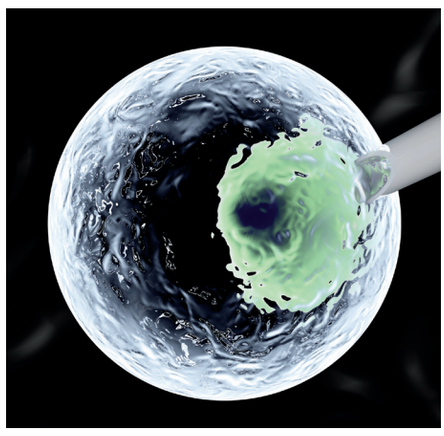
Individual requests to fund particular treatments have caused PCTs some thorny problems. Do CCGs have the expertise to cope with them? By Claire Read

When, in April 2006, the Court of Appeal ruled that Ann Marie Rogers was entitled to receive breast cancer drug Herceptin on the NHS, it was the conclusion of a process which had lasted close to a year. The legal costs to Swindon PCT, which had initially refused to fund the treatment on the grounds that Ms Rogers' was not an exceptional case? Some £300,000.

It is of course an extreme example of what can happen when an individual challenges a decision about whether a planned treatment is eligible for NHS funding. According to David Hill, associate in healthcare at law firm Hill Dickinson LLP, just two or three such cases tend to reach court each year and while the cost of the Rogers case was exceptionally high, the bill can run to six figures.

But the Herceptin controversy does provide a powerful illustration of the importance of clear and robust policies for dealing with individual funding requests (IFRs).

IFRs are used when a clinician believes an individual patient will exceptionally benefit from a treatment not normally provided by a commissioner. They are often sensitive and complicated. That means that dealing with them can be time consuming, costly, and necessitate legal support – scenarios which are all made much more likely when an organisation has not set out clear procedures to handle them.



Lawyers at Hill Dickinson have offered support to multiple PCTs which have felt the need to seek legal advice on IFRs, but Mr Hill says there is no such thing as a standardised cost in these instances. "That's because it could go the whole way to judicial review where you're talking tens of thousands of pounds in legal support, or it could sometimes just be a telephone call to us – or anything in between," he explains.

Nor do IFRs have a standard number or nature. "It does tend to ebb and flow a bit," reports Mr Hill. "You will get requests that actually perhaps don't go very far but will have to be dealt with. These can be triggered by an article in the newspaper talking about a new wonder drug. One of the big areas is cancer drugs, obviously, and any treatment which is potentially life sustaining.

"Another very difficult area is that of fertility treatment. But you also get things like minimally invasive hip replacements – obviously still very significant to the patient but not what you immediately think of in terms of an individual funding request."

One aspect of IFRs is consistent, however. "If there is an issue raised which has reputational issues for the PCT, generally senior management are quite hands on with it," Mr Hill explains. "They tend to consume quite a lot of time on the part of senior management within PCTs."

The complexities, sensitivities and risks of IFRs – particularly when a decision is

CASE STUDIES OVERLEAF ▶

Legal minefield: Ann Marie Rogers famously refused to accept she was not entitled to Herceptin

ALAMY

challenged – is such that organisations such as the NHS Confederation and the National Prescribing Centre (now part of the National Institute for Health and Clinical Excellence) have offered detailed guidance on how to approach the area.

It is generally accepted that there are key aspects to having an efficient, fair, robust policy and process: standard forms for making requests, someone capable of accurately assessing whether a request needs consideration by an expert panel, ensuring that any such panel has a clear framework for making decisions, and communicating that framework to the general public.

Mr Hill reports that most PCTs now fully understand the value of having a clear and robust IFR policy. "There's been a move towards uniformity in terms of the processes and a general trend of improvement," he reports.

The big question, of course, is whether that lesson will be carried over as the responsibility for IFRs moves from PCTs to CCGs. Mr Hill worries that the change could mean the loss of a significant body of knowledge. "Most PCTs have someone engaged more or less full time on the management of the process and the individuals dealing with IFR cases have developed a body of expertise," he explains. "They keep our advice on file, they go to

'Unlike my PCT managers, who were based about 40 miles away, we GPs are very much in the public face'

meetings with others at other PCTs who are dealing with the same issues, they go to training sessions. Generally we've now reached quite a good position – you don't get too many schoolboy error cases at the moment.

"But if it's an administrative person who has been dealing with IFRs, someone with predominantly management experience, are they going to sit in the CCG, or are they going to sit in the CSU [commissioning support unit]– and will they be around at all?" It is a question which is also worrying Dr Amit Bhargava, clinical accountable officer for Crawley Commissioning Consortium. "IFRs are complex and need to be handled very sensitively," he says.

"We have been considering whether they should be dealt with by our commissioning support unit but the unit has been a slow starter and we are troubled that we may be handing it over to people who may not have had experience of these requests. We need to ensure the experience that has been built up is not lost to the system."

GPs do however actually already have some expertise in IFRs. "PCTs will have had clinicians fairly heavily involved in IFR processes," says Julie Wood, commissioning development director at NHS Clinical Commissioners, a coalition of the NHS Alliance and the National Association of Primary Care. Operating in partnership with the NHS Confederation, it aims to be the independent collective voice of CCGs.

"I think [CCGs taking on these decisions]

is actually quite similar to what has happened before."

Where there may be a real difference, argues Mr Hill, is in the matter of public perception. "I think in some areas, where perhaps GPs haven't been as actively involved in the individual funding request process, PCTs have played a useful role because they have taken that decision out of the hands of the GP.

"CCGs will be viewed as a collective [of GPs] by the patients, and therefore when a decision is taken which is adverse to a patient and they know it's been a group of clinicians which has done that – or a group which has been led by clinicians – it does risk alienation and the doctor/patient relationship in a way that there wasn't really [a chance of] before. I think the reputational risks are real and bigger for CCGs than they were for PCTs."

Dr Bhargava is in complete agreement. "Unlike my West Sussex PCT managers, who were based about 40 miles away and so never seen in Crawley, we are very much in the public face," he points out. "They were literally faceless bureaucrats but we're a small CCG and so the clinicians on the board are always in the face of the patients. So we are in the firing line and if we make decisions which would harm the patient, rightly we will be taken to task."

Ms Wood acknowledges this change, and argues that GPs will need support in this regard. "It's quite difficult for GPs, because it's not something they've been used to taking responsibility for," she comments. "In old times, some of my clinicians would say: 'Oh, the PCT is turning it down and we need to go to an IFR.' Now if the CCG is working efficiently as a member organisation, they cannot or should not say that – they should actually be saying we have decided as a collective that it's not something we will do. The ownership of the problem sits with the member practices. So that's a fundamental difference."

It is a change for which Mr Hill is not confident CCGs are prepared. "The ones we've spoken to have understandably been very focused on authorisation. We've heard some talk of engaging around the issue of IFRs, but not a great deal. I have to say that I have spoken to others who deal with this issue in other areas of the country and they do perceive it to be a bit of a blind spot."

He argues that to address that blind spot, organisations will need to develop robust policies on IFRs in the way PCTs had done previously – and to do it quickly. He also suggests that early engagement with local populations about commissioning priorities will be crucial. "Obviously that's about commissioning in the aggregate, really, but it will also inform patients that if there is an IFR for them for a very specialised, expensive treatment where the cost/benefit analysis doesn't stack up, it will not be possible to fund the treatment."

Dr Shane Gordon, chief officer designate at North East Essex CCG, shares a belief that a public conversation is needed if IFRs are to be dealt with efficiently by CCGs. But he queries at which level that conversation needs to take place. "There is some question in my mind about how that sort of debate is had more publicly nationally," he says. "I think there is still a sense of having your cake and eating it – the NHS will provide everything for everyone.

"Whilst we do strive to provide all effective treatments to people at the point of need, I think there is always a tension between what we're capable of offering and what we're able to afford to offer. I'm not sure that CCGs on their own can have that debate."

He suggests that organisations such as NHS Clinical Commissioners will have a key role to play here, not least because of the NHS Commissioning Board's dual role as CCG supporter and body accountable to government.

Dr Bhargava agrees that national support and decisions would be helpful. "Eighty per cent of what we do in IFRs will be similar across the country," he argues. "We need to nationally define what that 80 per cent is."

However IFRs are ultimately handled in the new commissioning landscape, there is an awareness that this is a topic which needs to be resolved sooner rather than later.

"We need to say early in the CCG cycle what the NHS can and cannot do," argues Dr Bhargava. "Because if we start making yes and no decisions, reacting to national headlines or problems, then it would be like the Herceptin situation, which became a problem because individual patients challenged a PCT and then national policy was made.

"We need to lay some foundations out because once the patient gets ill and it is not written down, it is very difficult to say no."

It is a lesson that has been learnt the hard way by many PCTs. CCGs' challenge is to avoid making the same mistakes. ●

Counting the cost: legal fees for a dispute over funding a particular drug can be huge

NOW IT GETS COMPLICATED

How one trust has negotiated its way through what one senior manager describes as 'the most complicated bit of commissioning'

TRAFFORD PCT

Gina Lawrence, director of commissioning at Trafford PCT (and currently preparing to take up the same role at the CCG), has a stark way of summing up the issue of individual funding requests.

"I think it's the most complicated bit of commissioning," she says. "They're made by individual people, and they come in, and they tell you their stories. So it's very, very hard."

When Ms Lawrence joined the PCT five years ago, those difficulties were being compounded by a lack of clear policies and procedures on IFRs.

"I found all these people requesting things and no real process about how we would consider those requests," she remembers. "I couldn't quite understand how we made the decisions we made. It all seemed to be quite random."

That meant challenges to decisions were relatively common. "When I first arrived, I spent a fair proportion of my time either in court or sitting around a table with families to the point where we knew we were going to court with them," explains Ms Lawrence.

It was clear that this was a situation that needed to change, and so the trust joined with law firm Hill Dickinson to develop standard operating procedures for dealing with IFRs. The publicly available policies now mean there are clear timeframes for making requests, that a panel – which would include a non-executive director and others such as public health clinicians and commissioning representatives – is in place to consider them, that there is a transparent right of appeal, and that patients receive clear and carefully reasoned communication throughout the process. That includes being kept up to date on the stage their request has reached, and being given clear explanations should the request be turned down.

The procedures also ensure that the trust performs checks when a request first comes in – is there any research supporting the procedure or treatment, is there any provider offering it, and is there appropriate follow up care available?

"It has helped us make the right decisions," comments Ms Lawrence. "When you audit it backwards, you can no longer see any stark areas where you think: why did we do that?"

So can developing robust and clear procedures on individual funding requests increase efficiencies and save an organisation money? Definitely, says Ms Lawrence, but not necessarily in the way you might think.

"I think there are some commissioners out there who think 'If I put enough process in and I get enough legal framework, I can say no to everything'," she says. "But at Trafford we never really set out to save money in that way when we designed our IFR standard operating procedures. It was about giving the right treatment to the right patient at the right time, as opposed to asking 'how can we stop people?'"

The result, she argues, is that money is being managed much more effectively – used for those individual funding requests that can be justified and that will have the most impact on people's lives.

"What we're not doing is saying to one individual who comes in one day, 'yes, you can have that treatment' and then to the person who comes in the next day, 'no you can't have it because we've run out of money and we probably shouldn't have given it to the first person in the first place'."

Having a clear policy also means she and her colleagues now spend significantly less time considering and defending decisions on IFRs.

"I can now sit very confidently in an appeal panel knowing that I can absolutely justify what I've said and why I've said it, because it's gone through a really tight procedure," comments Ms Lawrence.

"That saves time and I also think it saves a lot of anxiety both for patients and staff. My teams are not out there being hounded by families saying they've made a bad decision. Of course, nobody ever likes it if you say no. But if you're really clear why you've said no, it's much easier to manage."

"We need to lay some foundations out," she concludes, "because once the patient gets ill and it is not written down, it is very difficult to say no." ●

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