ISSUE FIVE | 2018

hospital times

SPECIAL FEATURE:

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Welcome

I am delighted to take on the role of Editor of Hospital Times. This is a new experience that brings with it an array of new challenges. I hope to bring my own ideas to a publication which already provides comprehensive insight into acute services in the UK and around the world.

I wish to pay tribute to John Whelan, the magazine's former group editor who sadly passed away this year. I never knew John personally, but I know he was devoted to creating a single publication that brings together thought leadership, analysis, insight and best practice covering the ever-changing landscape of hospital services. It is thanks to John that I have a strong foundation with which to build upon and I look forward to continuing this legacy.

I want to use the features in this publication to place a renewed focus on discussions concerning integrating health and care services in the UK, working in conjunction with our sister publication, Accountable Care Journal (ACJ), which operates online.

In my brief spell at Hospital Times, I have already seen the potential that ACJ has in bringing together thought leaders from a multitude of sectors to engage in lively and thought-provoking discussions surrounding the future of health and social care. I recently attended an extensive ACJ conference (for which I have written a full review in this issue) where speakers such as Rob Whiteman (CIPFA) outlined the serious challenges facing the health sector and how a far greater sense of cohesion between health, care and local government is required to tackle them.

Where possible, Hospital Times will build upon the analysis and debate provided by ACJ and will work with this rapidly growing title to discuss the potential changes that integrated care models can bring to hospital services.

This is not to say, however, that we will lose the focus of our core aim; to provide hospital executives, managers, operatives and clinicians with the latest insight into the acute sector. I plan to take this even further, expanding our features list to include more high-profile interviews, analytical pieces and independent content from a range of contributors across the sector, while continuing to report on the products and services of interest to health and care professionals.

As the government progresses its' policies, we will ensure that Hospital Times is there to cover the resulting changes to hospital services. Digital reform within hospitals is a key policy area which I will look to cover, with the new Secretary of State for Health, Matt Hancock, naming technology as one of his three main priorities upon taking the position in July.

I hope that the aims I have outlined above will serve to enhance this established publication while bringing a new perspective to the debates and developments in acute healthcare.

hospital times

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Hancock promotes innovative digital health solutions in China visit

Secretary of State for Health and Social Care, Matt Hancock, recently went to China to highlight the importance of healthcare collaboration in developing innovative digital health solutions.

In Beijing, the Secretary of State co-hosted the UK-China Health Dialogue with China's Health Minister Ma Xiaowei, highlighting the need for collaboration in maintaining good population health and early identification of serious illness through the strengthening of primary care.

Discussions expanded to focus on the importance of having well-trained health professionals, ensuring patient access to medicine and clinically- effective therapies, and the need to work together to address global health issues such as pandemics and anti-microbial resistance (AMR).

In Tianjin, Hancock sought to demonstrate UK leadership in the use of technology and data innovation in healthcare to a global audience while he co-chairs the World Economic Forum Meeting of New Champions.

Commenting on the importance of the trip, Matt Hancock, said: "I want the UK to have the most advanced healthcare system in the world, and this continued dialogue and co-operation with China will bring us one step closer to achieving that aim.

"As global leaders, the UK and China must work closely together to tackle key emerging issues in healthcare like how we can harness the power of technology to help patients live longer, healthier and happier lives, the issues of an ageing population, and the increasing resistance to antibiotics - there is much we can learn from each other to improve care for patients."

The Secretary of State will also lead a UK business delegation to demonstrate UK expertise and innovations in life sciences, med-tech and digital health while in China.

Secretary of State

New nursing associates expected in 2019 to boost pathway to nursing

The Nursing and Midwifery Council (NMC) has announced the final proposals for the creation of nursing associates to bridge the gap between registered nurses and healthcare assistants.

The outline includes the skills and knowledge that students need in order to qualify for the role as well as providing a pathway for associates to become fully registered nurses and pursue their career in the profession. The proposals await approval from the NMC's governing council which will undertake it's review on 26 September.

Geraldine Walters, Director of Education and Standards at the NMC said: "It's clear from what we've seen and heard that trainee nursing associates are appreciated by those they're caring for, and that the nurses they are working alongside recognise the potential of the role now and in the future.

"We know just how important it is that students who are training 'on the job' have time away from their everyday duties to learn. We're confident that the plans we've outlined today will not only support students to learn and keep patients safe but also work for employers too.

"We look forward to seeing the first qualified nursing associates caring for people across England from January next year."

The main way for a nursing associate to train will be through work based learning - an apprenticeship. So the NMC has worked closely with employers and educators to develop a new approach to ensuring appropriate learning time for students. This will give education providers and their practice placement partners more flexibility to decide how students will get the protected learning time they need.

One option could be the traditional 'supernumerary' model – where students are additional to the minimum number of staff required for safety.

While under the new option, nursing associate students would be included in the numbers required for safety but their employers must show the NMC how they will protect a certain amount of time for them to learn. This might be by giving them time away from their usual duties or showing that they have supervision when developing new skills.

Under both options, students would be supervised and must receive the same amount of protected learning time.

As part of its plans, the NMC has also set out how the existing Code - with a new introduction and some minor changes - will apply to nursing associates as well as nurses and midwives, ensuring that the same high standards of professional behaviour and conduct will apply to everyone on its register.

While the proposed fees that nursing associates will be expected to pay have also been set out and will bring nursing associates broadly into line with nurses and midwives.

Discuss, debate and get on and deliver integrated care

Anyone who attended the most recent Accountable Care Journal seminar was left in no doubt that the priorities of health and social care professionals in England are aligned – but does the theory match what's actually happening?

The extensive line-up of speakers from the acute, primary care, social care, mental health, and local government sectors all presented the same objectives for how they would like to see reforms made while noting surprisingly similar challenges to delivering this.

Rob Whiteman, Chief Executive of CIPFA and Chair of the North East London STP, opened the seminar in his signature style, addressing the themes of leadership, managerial and systematic culture and the need to focus on the prevention agenda as opposed to simply channelling funds into treating ill health in the acute sector. Turning to the topic of breaking down silos in health and care, Whiteman commented: "In my STP I have banned the use of the word sovereignty… there is no sovereignty with regard to public money."

This was to become a theme of the seminar with Gerard Hanratty, Partner at law firm, Browne Jacobson, following up on the theme by addressing the legal practicalities and conditions for developing Integrated Care Systems (ICS's). While many in the room were clearly still sceptical of whether this model can be achieved at all, interest was certainly peaked by the confident reassurance that it can and is being done successfully across the country.

Dr Claire Fuller, Senior Responsible Officer at the Surrey Heartlands Health and Care Partnership, one of 10 ICS regions in England, testified to this, drawing from examples in the South East and the unique challenges faced in the region. Claire was joined on the panel by Andy Bell from the Centre for Mental Health and Cllr Richard Kemp, Deputy Chair of the Local Government Association Community Wellbeing Board, who both ardently advocated the importance of ensuring community health services are supported to deliver on new models of prevention, changing the debate to focus on health as opposed to healthcare.

Of course, social care was not absent from the agenda, nor were discussions of the mounting workforce pressures facing both health and care as Sharon Allen, Chief Executive of Skills for Care, brought the afternoon's debate round to critical underfunding and growing demands from an ageing population. The message couldn't be clearer, that health and care organisations need to work more closely and that the dominant culture across many providers needs to change. But where does this leadership come from? The Department of Health and Social Care? NHS England? STPs? Individual Trusts and practices? A mixture of all perhaps.

Closing proceedings, Dr Nav Chana, Chair of the National Association of Primary Care (NAPC), presented findings from the NAPC's Primary Care Home model, currently implemented in over 200 sites across the UK. There is crucially a role for all elements of the system to play but it is resolutely clear that these fragmented corners that look after the population's health and wellness need to get together once in a while, share ideas and most importantly, see them converted into systematic change and improved outcomes.

Care Minister

For those that made it through the afternoon and still had an appetite for insight from the top, the seminar was followed by a reception with Caroline Dinenage MP, Minister of State for Care, who, while saying little about the upcoming Social Care Green Paper, did offer some reassurance that the concerns and priorities of speakers and delegates were echoed in the Department of Health and Social Care. Alongside the ambitious digital agenda outlined by the Secretary of State, it is clear that integration is at the forefront of the government's plans, looking at the long-term as well as short and mid-term funding and workforce challenges being faced in the sector.

To continue fuelling this debate, ACJ is hosting it's next seminar in Manchester on 19 November with Jim Mackey, Chief Executive of Northumbria NHS Foundation Trust. To find out more, you can visit accountablecarejournal.com

New report calls for fire safety procedures to be addressed

Nearly half of all key decision makers do not strongly trust the fire safety measures they have in place, says a new report from Allegion UK. Following the tragic events at Grenfell and the ongoing inquiry, it has become increasingly clear that re-evaluating fire safety procedures, not only in high-rise buildings but in all government-owned buildings, is of great importance.

In light of the ongoing Grenfell inquiry and Dame Judith Hackitt's Independent Review, fire safety standards in high-rise buildings in the UK are being placed under the microscope. The report involves more than 500 decision makers in education and healthcare to establish a spectrum of perspective surrounding vital requirements to bolster fire safety procedures.

The data, collected in May 2018, shows that nearly half of all respondents did not strongly trust the fire safety measures they currently have in place, with more than one in five respondents believing their fire safety procedures to be compromised. In order to rectify the issues, fire safety standards must be addressed.

In healthcare, the respondents who say their fire safety measures may be compromised state that this is due to lack of fire safety product knowledge, under-training and budgetary constraints. Of all healthcare respondents, 65 per cent say they have also seen fire doors propped open, which is one of the most common breaches of fire safety regulations. Almost one fifth of respondents across both education and healthcare said they have experienced a fire safety incident in the last three years.

James Keith – Allegion

James Keith, end user solution strategy manager at Allegion UK, said: "Our research suggests that facility managers for education and healthcare premises may not be carrying out sufficient protocols, and there are legitimate concerns over the safety of both staff and visitors within these buildings.

"As an industry, we're failing on fire safety standards due to insufficient product knowledge and general complacency. We're urging facility managers to review their current fire safety measures, including their exits, doors and evacuation plans, to improve the safety of those who enter such premises."

For further information, James Keith is contactable at: james.keith@allegion.com

Community backs Kettering Trust's new dementia garden

Kettering General Hospital NHS Foundation Trust is making headway with its innovative new dementia garden, after raising £40,000 through the Forget-Me-Not Appeal in its first year.

The appeal was launched in March 2017 to transform a courtyard adjacent to the Lamport and Twywell wards, built in 1932, into a dementia-friendly garden where patients can safely be active. The campaign is seeking to raise £200,000 overall to complete the development which would be the first of its kind in Northamptonshire and one of only a few nationally.

In the UK there are currently 850,000 living with dementia, a number that is expected to increase to over 1 million by 2025. Locally, between 20-25 per cent of over 75's admitted to the Trust with an acute illness have dementia, some of roughly 8,000 individuals living with the condition in Northamptonshire.

Families and businesses from the surrounding area all contributed to the project which seeks to provide a space that is both safe and stimulating for dementia patients. The Trust believes strongly that keeping patients active is crucial to maintaining wellbeing. However, the dementia garden has the added benefit of ensuring that those recovering from ill health are able to maintain their independence and be social in a safe space.

Following the early success of the project, the second phase involves transforming the ward areas themselves into a more dementia friendly environment. The Trust is also looking to develop an office area for dementia nurse specialists, providing a space for conversations with patients and families.

Jayne Chambers, Capital Programmes Operational Delivery Manager and organiser of the appeal, said: "One of the ways that dementia presents in patients is that they can become restless and need to be actively engaged, walking around and investigating their environment.

"We want to create a new kind of dementia-friendly environment in the courtyard next to our older adult wards by turning the courtyard into a garden area with flowers, activity stations and a seaside theme so that it is a safe and stimulating place for dementia patients – and their families – to spend time while they are in hospital."

Leanne Hackshall, Director of Nursing and Quality, said: "This new initiative is another aspect of our AGE (Academy for Geratology Excellence) programme, launched in 2014, that is taking shape. This program is developing new approaches to the care of older people that are sensitive and exemplary."

With the challenge of Britain's ageing population and increasing numbers with the potential to develop and live with dementia, Trusts need to look at alternative methods of treatment for vulnerable individuals. Could Kettering be leading the way.

Power to the People – The future of healthcare

On the 70th year of the National Health Service, many people have taken time to reflect on what the NHS means to them and there have been numerous articles and news reports extolling its virtues, writes Glyn Barnes, Marketing Director, International Markets at AliveCor

I often wonder what Nye Bevan would think of his idea if he could see it as it is today. Something tells me he would be impressed and proud. On July 5th, 1948, Aneurin Bevan launched the concept at Park Hospital in Manchester, known today as Trafford General. He based his idea on three core principles:

- That it meets the needs of everyone
- that it will be free at the point of delivery
- that it will be based on clinical need, not ability to pay.

Since then, these principles have been extended to seven to match the changing times, yet essentially they remain the same. But spare a moment to consider some of the monumental changes that have occurred in treatments and diseases over the past seventy years.

If you were to undergo a surgical operation in 1948 you would more than likely be anaesthetised using ether delivered from a stainless-steel trolley that resembled something like Mrs Overall might have used to deliver the tea. Henry Boyle designed the first of these machines during the first World War and, whilst they were improved over the coming decades, I remember seeing these in use right up to the late 1980's.

Today, your anaesthetic will be controlled by a consultant using devices with sophisticated monitoring capabilities that can titrate the drug dosage very accurately and provide information on numerous physiological changes that can occur during the procedure. The data recorded can be fed automatically into patient data management systems to provide a complete record of the event.

On contracting an infection in 1948, you might have received one of the new wonder drugs – antibiotics. Whilst discovered in 1929 by Alexander Fleming, it was not until the early 1940s that the true potential was acknowledged, and fermentation processes were developed to produce antibiotics on a large scale. Today, of course, antibiotics are common place, but we face new challenges of microbial resistance.

Sir Richard Doll began research into lung cancer in the 1940s. His findings demonstrated the link between lung cancer and air pollution from coal fires and smoking. Research went on, of course, to further demonstrate the link between smoking and heart disease. Since then, the technological development of devices both for imaging and radiotherapy have been tremendous. CAT and MRI scanners introduced dramatic imaging improvements over recent decades and now 3D imaging software enables much greater visualisation and precision.

Amazing developments like these have delivered enhanced diagnoses and treatments that in turn improve outcomes and longevity. The rate of change of medical technology continues at pace exponentially along with the cost. This can be challenging for a public health service that was born out of a necessity to care of those who were poor or unemployed and could not afford payments.

With changing disease states facing the population today, there is a new focus on patients. An epidemic of obesity through bad diet and lack of exercise has lead to a dramatic increase in hypertension, heart failure and diabetes. We must therefore educate the population to take greater care of themselves. Unfortunately, the old adage that 'the NHS is always there for me' can sometimes mean it's an all too easy shoulder on which to rest. Queues in GP surgeries and Emergency Rooms demonstrate this when you consider some of the minor ailments that absorb resources.

So what's to be done? The NHS is well aware of the challenge and yes, part of this is about increased funding. However, there is a noticeable shift towards prevention where possible, rather than just cure.

The launch by the NHS of the Academic Health Science Network (AHSN) has made significant inroads in both searching for new health technologies and helping them achieve adoption by the service. One noticeable feature of many of these technologies is the involvement of the patient. Blood glucose monitoring can now be needle free and the patient can have an app on their phone providing graphic displays of their progress. There are numerous medical apps now available for public use. Broadly speaking, these fall into three categories: patient engagement, telemedicine and medication. All are intended to empower and engage patients to play a greater part in their healthcare by self-monitoring, self-treatment or by encouraging behavioural modifications.

Our devices at AliveCor allow patients to take a quick diagnostic quality ECG recording using their phone or tablet and results can be emailed instantly to the clinician. Time to diagnosis and therapy can therefore be drastically reduced, not to mention avoiding unnecessary trips to the doctor. One of the unexpected benefits of this type of technology was the positive engagement demonstrated by patients. Doctors frequently mention that their patients love it because they feel reassured to have a device in their pocket with a direct line to their clinic should they experience a cardiac event.

Ultimately, the goal of these devices and/or software is to make a difference to people's lives. But the very positive side effect can be a reduced burden on our NHS services both from workload and financial points of view. If people are better educated and provided with simple tools to encourage personal monitoring of conditions, it must be a win-win for all.

Glyn Barnes – Alivecor

In terms of healthcare, had Nye Bevan been able to look into the future and see what we see today, he would no doubt have been astounded. Had he witnessed healthcare passing into the hands of patients themselves, I suspect he would have gasped in disbelief.

Glyn Barnes
Marketing Director, International Markets
AliveCor

Is greater choice needed to speed up adoption of new technology for patients?

A much-needed 3.4 per cent funding increase for the NHS is a step in the right direction for our health service. However, greater choice is needed if patients are to benefit from robotic-assisted surgery in healthcare, writes Martin Frost, CEO of CMR Surgical.

By 2023, an extra £20.5bn will flow into our nation's health system every year – an extraordinary financial investment demanding similarly remarkable improvements in technology and services. If the NHS is to get its money's worth from this funding, we need to re-look at how we invest in tech; embracing choice and competition to increase the adoption of affordable technology.

In my field of surgical robotics, investment in technology would allow more hospitals to offer enhanced types of procedures, such as minimal access surgery (MAS). Robot-assisted MAS is currently perceived as expensive, but this thinking is relatively narrow; MAS is proven to reduce length of stay in hospitals, lower levels of pain, scarring and infection, and speed-up recovery times. We just need to find a way to make it more accessible to patients.

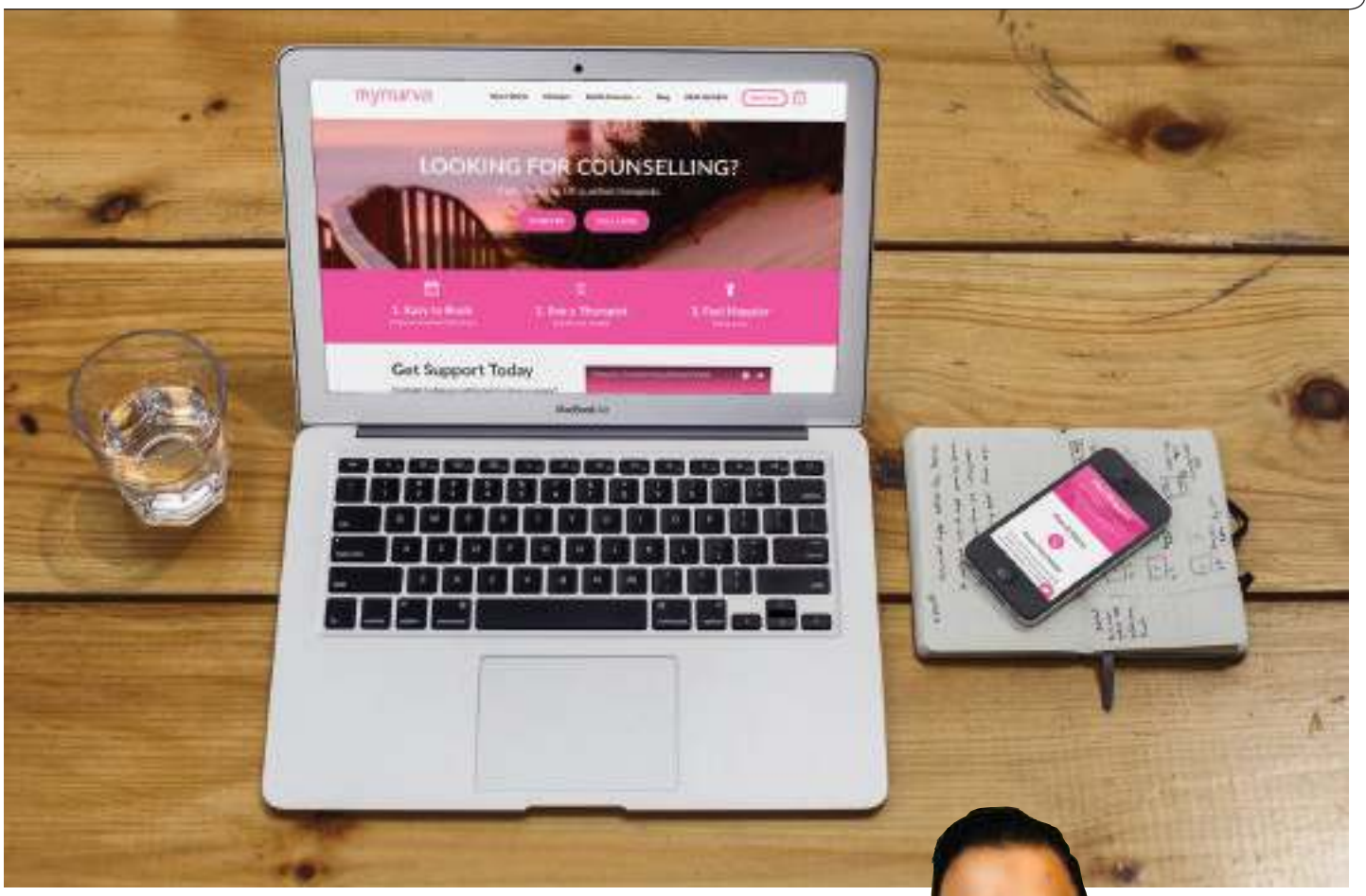
Currently, surgical robots carry high upfront capital costs, both financially and in terms of resourcing and training for surgeons to use them. A recent study found 96 per cent of surgeons believe upfront capital costs are a barrier to uptake. As a result, uptake has been limited and scores of UK patients continue to undergo open surgery, when they could receive the benefits of an operation conducted using MAS techniques.

In robot-assisted MAS, there are currently only limited options available on the market and consequently pricing conversations can be restricted. The lack of competition in the healthcare robotics space can stifle innovation and prevent robotics becoming more universally used in the NHS.

However, we are now starting to see several challengers arising to take on the current stalwarts; in the next year, we expect to launch the first British surgical robot – Versius. The ground-breaking design, coupled with genuine affordability, means that patients everywhere have the potential to benefit from the advantages of minimal access surgery. The NHS has a duty to continue evaluating whether they are getting the best service or price, which may require the introduction of new competitive tendering processes for areas where no competitor previously existed; helping to ensure managers and procurement teams are delivering the most cost-effective services and technology for patients.

The onus is also on technology companies to work alongside the NHS. No-one wants to see burdensome, lengthy adjudication processes that slow the delivery of the latest innovations for patients. Innovators must work in partnership with NHS management and procurement teams to establish clear processes for demonstrating clinical and cost effectiveness. This will help the NHS to continue providing cutting-edge healthcare services in a transparent and affordable way.

Martin Frost - CEO CMR Surgical



The real cost of poor mental health at work

Mental health has become an important topic of discussion recently – especially in light of the wave of celebrities and public figures speaking up about their struggles and encouraging open and honest conversations. It's now become common to read about mental health in the newspapers and magazines, and to hear about it on TV. Unfortunately, however, the topic still carries a 'taboo' in some sectors of society – and this particularly when it comes to the workplace, writes Dr Zain Sikafi.

Mental health at work

There's no denying it – mental health is a pressing national issue that requires urgent attention. The Prime Minister's 'Thriving for Work' report revealed just how extreme the problem is within the workplace; indeed, every year, 91 million working days are lost to poor mental wellbeing – costing the UK economy up to £99 billion annually. Sadly, this also means that 300,000 people lose their jobs each year due to mental health problems.

The stigma attached to mental health often means that people are reluctant to seek the help that they desperately need for fear of reprisal – worried that speaking out about their issues could have a negative impact on their job. In fact, most employees opt to keep quiet about their struggles, resulting in a poor uptake of conventional treatment offerings – merely 20 per cent of these support mechanisms are utilised.

This is despite the high prevalence of mental health issues within the professional environments; the 2017 Mental Health at Work Report revealed that almost a third (31 per cent) of professionals had been formally diagnosed with a mental health issue, with three out of every five employees having experienced mental health issues in the past year because of work. By contrast, a massive 67 per cent of employees feel scared, embarrassed or unable to talk about mental health concerns with their employer according to the Mental Health Foundation.

The role of technology

The need for absolute confidentiality is often cited as the main factor preventing employees from taking advantage of the treatment on offer to them. Luckily, technology and digital innovations can play an important role in treating mental health by offering much-needed solutions to problems of confidentiality and convenience.

Dr Zain Sikafi – Founder Mynurva

Alternative options for those seeking help now include solutions like video counselling, as offered by the Mynurva app. Mynurva allows clients to schedule and undertake counselling appointments online via live video technology completely confidentially, and even better – clients can access therapy from the comfort of their own homes, outside of traditional working hours. This means that even evenings and weekends are no longer out of reach for those seeking professional help, and employees struggling with mental health now have the ability to tackle their problems without having to disclose their personal issues to their managers or colleagues.

Although there have been noticeable improvements in the way we think about mental health treatment in the UK, much more needs to be done to ensure that the current stigma is removed, and that effective support mechanisms are in place to help those in need of treatment.

Proactive measures need to be taken especially within workplaces to foster an open discussion about mental wellbeing. The role of technology in supporting mental health should not be looked over, as it can provide necessary avenues of support for those who require confidentiality and flexibility – and particularly those in demanding professions who are faced with long, inflexible working hours.

Having worked as a GP for several years, Dr Zain Sikafi founded Mynurva to improve access to mental health support. Mynurva provides fast access to therapy or counselling, confidentially and securely, via its live video platform.

Innovators tackle crippling agency fees with new staff management app

This year has seen the NHS report a record number of patient operations either delayed or cancelled, many of which are due to shortages of qualified specialist doctors, with almost 10 per cent of all doctor posts remaining unfilled.

Frustrated at the way hospitals source and pay for locums to fill these empty shifts, ex-NHS hospital doctors Nicholas Andreou and Ahmed Shahrabani decided to develop an app to transform the efficiency with which hospital staff are recruited, removing the need to pay expensive commissions to private sector agencies. Some recruitment agencies charge 10 per cent for every individual they find, placing massive costs at the doorstep of Trusts despite existing funding shortages.

One solution, initially conceived three years ago, has now been launched as 'Locum's Nest'; an app that digitises Trust staff banks so HR have better data on, and direct access to, doctors on their payroll who might be free for a shift. The app also allows doctors who aren't employed by the Trust but are looking for extra shifts to register their availability.

Trusts typically pay about £80-100 in recruitment agency commissions per shift filled, whereas Locum's Nest only costs £15, whatever the shift and is licence-free to install. Moreover, the app allows Trusts to digitise and transform their hospital staff bank and payroll processes so HR departments can very easily track and plan their vacancies against their spending, thereby cutting out the agencies and avoiding all commissions or charges. A typical trust has 1,200 doctors, and needs a staff bank of about 40 per cent for good levels of shift filling.

Ahmed Shahrabani, one of the founders of Locum's Nest said: "In the last full financial year the NHS spent £2.4billion on agency staff to cover vacancies, which means at least £200 million was spent on recruitment agency commissions, a ludicrously high amount which could otherwise have been used to finance other areas of clinical improvements that would directly benefit patients.

He added: "We couldn't help but think that there are myriad different ways we should be spending that money, for example on better patient care or helping to futureproof the NHS. We know from data from Trusts using the app that the NHS could claw back up to £500m of this year's projected Trust overspend."

Locum's Nest has been in use across more than 15 hospitals and nearly 100 GP practices for two years now. Earlier this year, with four of its partner organisations, Locum's Nest launched the South England Collaborative Staff Bank - a collaboration between four Trusts working together to share over 2,000 doctors as part of a mega digital Staff Bank, a first for the NHS.

This initiative allows both Trusts and doctors to work flexibly and freely between the hospitals without being subject to multiple paper forms.

Co-founder, Nicholas Andreou, said: "The latest staff shortage figures released by NHS Improvement are incredibly concerning and they are likely to worsen with Brexit. The current recruitment agency model is costly, admin-heavy and outdated, but technology offers solutions.

"The new health secretary is a passionate advocate of how technology can drive performance improvement in Trusts and is a firm supporter of the role of apps in boosting productivity. We believe the NHS must harness these platforms now if we are to overcome delays in treatment and operations and release more funds for our doctors, nurses and for patients."

Locum's Nest has already matched more than 40,000 doctors to shifts. It has helped to cover 100,000 hours treating patients with emergency conditions and 50,000 surgical hours.

Locum's Nest has also demonstrated it can deliver savings for its partners. One NHS Trust saved £2.6m in locum agency fees in just 10 months with another saving £4.9m in two years. There is significant potential for this to be put to use elsewhere in Trusts to support care provision while balancing staff resources more efficiently.

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Race to the bottom: Changing the culture of infrastructure and service delivery

High profile distress and failure across the public sector contracting market has become all too common, culminating most recently in the collapse of Carillion. All are entangled in allegations of mismanagement and corporate profiteering. But is this the real story? Almost certainly not.

The real story is about a race to the bottom. However, it has to be asked whether the competitors are fully fit to race; the organisers and management sufficiently experienced for the task in hand; and the officials capable of ensuring the rules are upheld or indeed, whether the rules make sense at all.

Coming out of a period of prolonged recession, and associated austerity, there has been a tightening of the public sector purse and an increased focus on the commercial capacity and capability within government and the wider public sector. However, it has to be asked if the attempts to manage value have been masked by less positive behaviours that focus on transferring increasing levels of risk for the lowest possible cost, short term cost reduction or chasing penalties for non-compliant performance.

At the same time corporates need to maintain volumes of work to retain skilled and experienced workforces and to demonstrate their sustainability to shareholders. This has led to agreeing to risk profiles that previously wouldn't have been accepted and at prices that wouldn't have been contemplated.

These organisational imperatives have resulted in an unsustainable race to the bottom risking much collateral damage, degradation of value and delays to project completion. Where in these debates is mention of the levels of performance that are required to support patient care?

Affordability has to be taken into consideration. An elite well-funded athlete will consistently out-perform a club athlete, but at a higher cost. However, In many procurements the officials are seeking to provide day in day out record breaking performances but at the cost of a club runner.

This is not always by design. Often, stakeholders lack reference points against which to comment on performance standards, leading to the risk of over specifying. Meanwhile, external advisors use benchmarks and market norms from previous procurements when specifying requirements, which if flawed previously, remain flawed. The result is that suppliers are contracted

to perform to a standard that the procurer does not actually want or need at too much cost to the procurer, supplier or both.

In many situations where the public sector is self-delivering a service, the lack of measurement of performance means that there is no historic base from which to assess service performance with the cost of the service. Furthermore, in complex performance and contractual regimes, operatives often haven't the capacity to respond as quickly as standards require while also complying with the rules in place.

Is it realistic to expect an elite athlete to run every available race and win every time? Of course not, but there is an expectation that buildings are constructed with no snags or defects and support services are delivered 100 per cent right, first time. Contractual provisions and performance regimes need to be crafted to recognise the operational reality rather than a theoretical construction in which perfection can be consistently achieved.

To the officials managing the contract, practical realities can often be perceived as deliberately cutting corners rather than a consequence of a contractual construct that is operationally unrealistic. This phenomenon has become almost unavoidable when delivering contracts at unsustainable prices, now considered the market norm.

Faced with a need to reduce the price paid, some officials have engaged a new breed of advisors forensically seeking to identify non-compliance to pursue deductions and secure contract terminations. This may result in short term financial benefits but the medium to long term impact on value is more questionable. Having specified that a certain service standard is required to support patient care, it must be difficult for an executive to justify employing consultants merely to chase deductions, rather than also working to secure the specified level of service from the service provider.

Maintaining the status quo is an option. But an option with a high probability of increasing levels of disconnect between what service users expect to receive and what can operationally be delivered; a high probability of costly and time consuming disputes; an increasing risk of corporate failures with the consequential risk to service delivery, employment and the public purse.

A reset is long overdue

Specification of services needs to integrate scope, affordability and risk. All too often, these different workstreams appear to develop in near isolation from one another. When applied to tendering, this creates an opportunity for bidders to take the most favourable interpretations in order to secure contracts.

For existing long-term contracts, the reset needs to focus on changing behaviours and achieving common operational understandings that are consistent with performance standards, contractual provisions, and what is actually needed. Should this model be flawed, contractual provisions must be in place to allow the review and reset of parameters such as response times.

In commissioning new contracts, whether they be construction or services, all parties would benefit from a clearly defined scope and an affordability envelope, rather than having a definitive performance standard being provided with an upper and lower limit. Such a specification would allow for a

competition on scope and risk to fit within affordable price frameworks.

Given the current market and political environment, it is unsurprising that there is a trend towards in-sourcing contracts and continuing with self-delivery. Without a measurable performance regime, there is a risk that standards will be relaxed without the benefit of proper examination. This risk is engendered not only by the loss of transparency but also because the enabling technology that an out-sourced provider can defray across a portfolio is unaffordable to individual NHS organisations.

Can a new form of partnership be defined in which the private sector provides the enabling technology platform, operating models and innovation, while day to day service delivery is an in-house activity?

Ultimately, the focus must be turned to securing the level of service required to support patient care. And achieving this in a way that is sustainable for the stakeholders involved.


Mike Hobbs

Mike Hobbs is an independent consultant with over 25 years-experience in developing and delivering health infrastructure projects and support services both in the NHS and the private sector.

Infrastructure Specialist Barry Francis reflects on the possible impacts of the forthcoming budget on healthcare infrastructure in the UK

As reported in the Hospital Times in June, the prime minister has advised that the UK's budget for the NHS would increase by £20.5 billion by 2023.

Barry Francis

This will be paid for in part by the Brexit dividend and in part by further taxation. Since then, it has become clear that some of that money will be used to pay increased pension contributions and there is some doubt as to the amount of Brexit dividend. There are also many competing demands on funds: both to keep the show on the road and to invest in future needs, whether they be service reconfiguration, new technologies or the built environment. So how much will be available for our infrastructure and what will it be used for?

There is a really useful summary of the current position for the NHS's built environment, the 'NHS Estate,' in Sir Robert Naylor's report published in March 2017 . He identified that some £10 billion is needed to bring the NHS estate up to scratch, including £5 billion on backlog maintenance. He tells us that the NHS Estate covers 6,500 hectares (for the sports minded, that is about 6,500 international rugby pitches), 20% of the NHS Estate was built before 1954 and 36% since 1995.

This suggests there is a lot of old infrastructure which is unlikely to be fit for purpose. It also suggests that there is a fair amount which will have been built under the private finance initiative – much criticised, but there over 100 hospitals which should not be ignored. So, what should be done? Sir Robert made various suggestions which have partly been accepted by the Department of Health. He suggested that part of the estate could be sold to generate capital for investment as well as genuinely affordable homes. We have seen an example of this in the announcement by Guy's and St Thomas' charity of the sale of land for £200m to be developed as residential, commercial and medical space– more easily done in London than elsewhere.

Where else might the money, and the vehicles for delivery, come from? The major hospital building programme such as we saw in the decades at the turn of the century is not going to be repeated. We have, however, been told that one major hospital a year is likely to be launched over the next 5 years in a £3.5bn capital programme announced in March this year by the then Secretary of State for Health, Jeremy Hunt. Much needed changes and expansion to address less grandiose ambitions, but which are at least as important, may come to fruition in the Regional Health Infrastructure Companies (RHIC) programme which will complement the existing LIFT programme. If approved by HM Treasury, this will provide new serviced built environment for primary and community care. This 'off balance sheet' solution would be run by Community Health Partnerships and it will be interesting to see the mix of organisations bidding to become the private sector partners in delivering and maintaining this important part of our healthcare infrastructure.

These solutions envisage finance being provided by public money in the form of new taxation, proceeds of sale (in the specific instance of Guys' and St Thomas charity funds), Brexit dividend or, in the case of RHIC, private investment.

Private investment does, of course, present political as well as practical challenges. The political toxicity may in itself hinder some solutions – headline grabbing is a lot easier than hard work - but it is worthwhile considering some other possibilities. We are seeing the development of estates partnerships. The nature of these vary. The common feature is that they involve an NHS organisation partnering with a private sector organisation to manage and develop part of existing NHS Estate. This is an approach more closely aligned to gradual change than the PFI model which was designed for one off new build. Other possibilities include private sector organisations developing and managing facilities such as rehabilitation centres or 'step down' facilities. The capital would be provided by the private sector and the operators may be more attuned to deliver specific aspects of care than the NHS, particularly in the case of step down. There is appetite for projects of this type, but a stable political environment and changes in payment arrangements within the NHS would help.

We have more 100 hospitals built and serviced to meet the urgent 20th century need for new infrastructure. In some cases these are now locked in time as needs have changed and are rapidly changing. Much of the criticism of these arrangements has been directed at poor contract management (not enough resource) and the relative inflexibility of the financing structures. These both need to be addressed and positive action taken to rebalance healthcare requirements whilst protecting the legitimate interests of the pension funds and others who have invested in these long-term assets. That is not easy, but it is not wise to ignore this challenge amongst all the many other problems faced in sorting out NHS Infrastructure: 100 hospitals are a lot of hospital.

A budget this year or next is unlikely to make a great deal of difference and proposals for some 10 years plan in the context of our current political environment seem optimistic. There are many tensions. Do those responsible for delivery wait for a comprehensive strategy in a fast-changing environment, with technology and scarce resources both driving and driven by the need to alter what is done? Or do they just get on with it? Is it better to be nimble than perfect? And where do the skills come from? Big change management programmes are needed as well as analysis of what change is needed. The competition for scarce project management and related skills is intense: HS2, Cross Rail, new trade deals... This is an ever-lengthening list. The competition is not just within the health system, which itself has its internal competition for resource to meet multiple challenges.

Asking the questions is easy. Formulating the policy to address them is harder, but the really hard bit is doing it.

BARRY FRANCIS

Barry Francis has worked in the financial and commercial areas of healthcare as a partner in international law firms for many years. His current activities include advisory support for commercial and financial aspects of healthcare projects and programmes. He is also Infrastructure Specialist at Healthcare UK. All views expressed are his own and not of any organisation.

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The future of Integration: Lessons from the Jean Bishop ICC

When the £9.5 million Jean Bishop Integrated Care Centre (ICC) in Hull opened this summer, it represented a successful combination of strong partnership working, flexibility and total commitment to meeting the needs of frail older people.

In a new and unique approach to health and care, the ground-breaking services and new clinically led team will primarily treat 12,000 frail older people in Hull with long term conditions who have been assessed by their GP as being at risk of hospital admission.

Nationally, we have an aging population. In Hull, overall population growth is projected at 17.4 per cent by 2025 – from 38,000 in 2014 to 44,600 – and is expected to continue to increase to a total of 53,500 people in this age group by 2035. Hull also has a high prevalence of long-term conditions associated with respiratory and circulatory disease with men spending an average of 26 per cent of their lives in poor health and women around 31 per cent.

In 2016/17, there were 8,163 emergency admissions to acute care for over 65s. In addition to this, 12,814 patients in Hull are moderately or severely frail and at risk of hospital admission. However, a third of older patients admitted to hospital had no clinical need to be in a hospital bed and readmission rates for those over 65 are known to be high.

A clinical model was needed to improve the quality of life for patients, reduce NHS costs through earlier intervention, and safely manage people with a higher level of risk of admission in community settings. The model needed to be patient centred and aimed at keeping people well for longer.

The new ICC brings together a whole range of services allowing patients to be referred from their GP into the centre for assessment, and then a managed through a treatment programme for long-term conditions. Services include everything from outpatient hub services including COPD to geriatric and general medicine, physical therapy, rehabilitation and treatment services for individuals and groups, diagnostic services, X-ray, ultrasound and phlebotomy with a CT scanner planned for the future.

The centre also includes hot desk space and interview rooms for social services to integrate with the health services as well as a functioning fire station offering support and community fire safety advice for people over 55. This co-location of service providers further supports the One Public Estate agenda to ensure better use of public buildings.

Dr Dan Harman, Consultant Geriatrician, explained:

"It's a totally different way of caring for patients. A member of our team visits the patient in their own home to undertake an assessment and identify issues that the patient wishes to discuss with the team when they attend the ICC. These issues often range from concerns about their health, social interaction or anything they are struggling with. Not only does this help the patient and carer understand what to expect at the ICC but it also helps us identify which members of the team they need to see."

The building itself is predominantly single storey with all patient-facing spaces located on the ground floor to maximise accessibility. It has been designed for flexibility and sustainability with standardised room sizes and structural and mechanical strategies devised to allow easier reconfiguration or expansion into the future and its layout is designed to maximise integration and space utilisation between services. It was built using a 'fabric first' methodology, photovoltaic panel installation, LED lighting throughout and significant Sustainable Urban Drainage System supporting the achievement of a BREEAM Excellent rating.

Community Health Partnerships (CHP), which is wholly owned by the Department of Health and Social Care, were involved in supporting the financial investment partnership, as part of the wider estates strategy to ensure value for money at every stage.

The ICC was developed through CHP's LIFT (Local Improvement Finance Trust) programme, which is a public private partnership. The actual building is owned by a subsidiary of the local LIFT company, Citycare Ltd. of which CHP owns 40 per cent. The land it sits on was provided by Hull City Council and CHP have taken the 25-year head lease for the whole building and then let under leases for NHS service providers and the Fire Service.

CHP also provide the soft FM services, such as cleaning, with hard FM services (such as building maintenance) provided by Sewell Group. As a further innovation to support building utilisation, CHP have developed an occupation model allowing service providers to book space only for the times they need to deliver their care. This sessional occupation approach is administered by Citycare, who have developed an app to make booking as easy as possible.

"CHP is pleased and proud to have been part of the development of the Jean Bishop Centre," said CHP Chief Executive Dr Sue O'Connell. "It is an excellent example of how estate can be developed in partnership to support new models of integrated care to meet the needs of patients, particularly those increasing numbers who may be frail and elderly and who might otherwise risk a hospital admission."

As well as providing the land, Hull City Council are the social care provider and a key stakeholder in shaping the clinical model.

In addition to the development of the ICC, a local housing association, Pickering and Ferens, have brought forward a social housing scheme which will provide 82 homes for elderly people on an adjacent site, complementing the services provided in the ICC. Construction of the homes is already underway.

The business case for the centre was based on a conservatively estimated 10 per cent shift in projected activity from the acute hospital into the ICC, providing an anticipated minimum saving of £1.6 million per year. This is expected to increase as the service model matures.

Emma Latimer, NHS Hull CCG Chief Officer, says she is immensely proud of the service: "We know people don't want to be in hospital unless they absolutely need to be. We have listened to this and have developed a fantastic new facility that can support people to remain independent wherever possible."

The ICC demonstrates how partnership working between clinicians and property professionals can maximise the ability of property to support new models of care, demonstrating how integrated care between different public-sector providers can delivered effectively and cost efficiently.

Eugene Prinsloo - Senior Commercial Leader & Health Real Estate Programme Director delivering specialist property investment strategies for the public / private sectors, currently as Development Director at Community Health Partnerships ltd.

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TUESDAY 20TH NOVEMBER

TIME	THEATRE 1	THEATRE 2	THEATRE 3	THEATRE 4
09:00 - 09:35	**Acute oncology** **Dr Thomas Newson-Davis**, Consultant Medical Oncologist, Chelsea & Westminster Hospital, London	**Headaches: when to worry** **Dr Pooja Dassan**, Consultant Neurologist, London North West Healthcare NHS Trust and Imperial College Healthcare NHS Trust	**Pulmonary hypertension** **Dr S. John Wort**, Clinical Senior Lecturer, National Heart and Lung Institute, Imperial College London; Honorary Consultant, Royal Brompton Hospital	**Unusual cases in ED** **Dr Zal Mirza**, Consultant in Emergency Medicine, Chelsea and Westminster Hospital NHS Foundation Trust; Honorary Senior Clinical Lecturer, Imperial College School of Medicine
09:45 - 10:20	**Acute ophthalmology** **John Sharp**, Post-CCT Corneal Fellow, King's College Hospital NHS Foundation Trust	**Stroke: improving diagnosis and treatment** **Dr Anthony Pereira**, Consultant Neurologist, St George's Hospital	**An opportunity to standardise the management of deterioration and sepsis** **Dr Matthew Inada-Kim**, Consultant Acute Physician, National Clinical Advisor, Hampshire Hospitals	**Ambulatory care** **Dr Clarissa Murdoch**, Consultant in Care of Older People and Acute Medicine, Whittington Health NHS Trust
10:20 - 11:00 BREAK				
11:00 - 11:40	**Headaches: when to worry** **Dr Pooja Dassan**, Consultant Neurologist, London North West Healthcare NHS Trust and Imperial College Healthcare NHS Trust	**Endocrine emergencies** **Dr Francesca Saords**, Consultant in Endocrinology, Norfolk and Norwich University Hospitals Foundation Trust	**Session sponsored by BMS Pfizer**	**Session details coming soon**
11:40 - 12:00 BREAK				
12:00 - 12:40	**Renal patients and latest evidence** **Dr Raj Patel**, Consultant Haematologist, Clinical Thrombosis Centre, King's College Hospital, London, UK	**Acute heart failure** **Professor Andrew Clark**, Chair of Clinical Cardiology; Honorary Consultant Cardiologist, Castle Hill Hospital, University of Hull	**Acute oncology** **Dr Thomas Newson-Davis**, Consultant Medical Oncologist, Chelsea & Westminster Hospital, London	**Pulmonary hypertension** **Dr S. John Wort**, Clinical Senior Lecturer, National Heart and Lung Institute, Imperial College London; Honorary Consultant, Royal Brompton Hospital
12:40 - 13:30 BREAK				
13:30 - 14:05	**Guide to irrelevant tests on AMU - the director's cut** **Dr Kevin Jones**, Consultant in Acute Medicine, Bolton Hospitals NHS Foundation Trust	**Assessing and managing the main disorders of potassium and sodium balance** **Professor Sunil Bhandari**, Consultant in Nephrology, Hull and East Yorkshire Hospitals NHS Trust; Honorary Professor, Hull York Medical School	**Acute heart failure** **Professor Andrew Clark**, Chair of Clinical Cardiology; Honorary Consultant Cardiologist, Castle Hill Hospital, University of Hull	**Stroke: improving diagnosis and treatment** **Dr Anthony Pereira**, Consultant Neurologist, St George's Hospital
14:15 - 14:50	**Session sponsored by MPS**	**Session sponsored by Mylan**	**Session details coming soon**	**USS at the front door - interesting cases** **Dr Sarbjit Clare**, Clinical Lead Acute Medicine, Sandwell and West Birmingham Hospitals NHS Trust
14:50 - 15:15 BREAK				
15:15 - 15:50	**Ambulatory care** **Dr Clarissa Murdoch**, Consultant in Care of Older People and Acute Medicine, Whittington Health NHS Trust	**Ageing well: The national approach to frailty** **Professor Martin Vernon**, Consultant Geriatrician, National Clinical Director for Older People, NHS England	**Inpatient falls: reducing the numbers and harm** **Dr Wallace Tan**, Chair of Falls Group; Consultant Geriatrician, Croydon University Hospital NHS Trust	**Session details coming soon**
16:00 - 16:40	**Unusual cases in ED** **Dr Zal Mirza**, Consultant in Emergency Medicine, Chelsea and Westminster Hospital NHS Foundation Trust; Honorary Senior Clinical Lecturer, Imperial College School of Medicine	**Update on overdose management for post-take ward round** **Dr Stephen Waring**, Consultant in Acute Medicine and Toxicology, York Teaching Hospitals NHS Foundation Trust	**The acute abdomen on the medical take** **Dr Alex Di Mambro**, Consultant Gastroenterologist and Clinical Lead for Nutrition, Gloucestershire Hospitals NHS Foundation Trust	**Guide to irrelevant tests on AMU - the director's cut** **Dr Kevin Jones**, Consultant in Acute Medicine, Bolton Hospitals NHS Foundation Trust
16:40 - 17:05 BREAK				
17:05 - 17:40	**Inpatient falls: reducing the numbers and harm** **Dr Wallace Tan**, Chair of Falls Group; Consultant Geriatrician, Croydon University Hospital NHS Trust	**The acute abdomen on the medical take** **Dr Alex Di Mambro**, Consultant Gastroenterologist and Clinical Lead for Nutrition, Gloucestershire Hospitals NHS Foundation Trust	**Assessing and managing the main disorders of potassium and sodium balance** **Professor Sunil Bhandari**, Consultant in Nephrology, Hull and East Yorkshire Hospitals NHS Trust; Honorary Professor, Hull York Medical School	**The perils of polypharmacy** **Professor Emma Baker**, Professor of Clinical Pharmacology, St George's, University of London
17:50 - 18:30	**Exhibition & networking time**	**THE BIG DEBATE: Avoiding another Mid Staffs – how can we promote quality in difficult times** **Dr Neil Bacon**, CEO, iwantgreatcare.org; **Prof Stephen Powis**, Medical Director, NHS England; **Prof Ted Baker**, Chief Inspector of Hospitals, CQC; **Dr Taj Hassan**, President, Royal College of Emergency Medicine	**Update on overdose management for post-take ward round** **Dr Stephen Waring**, Consultant in Acute Medicine and Toxicology, York Teaching Hospitals NHS Foundation Trust	**Exhibition & networking time**

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WEDNESDAY 21ST NOVEMBER

TIME	THEATRE 1	THEATRE 2	THEATRE 3	THEATRE 4
09:00 - 09:35	**Managing IBD** **Dr Stuart Bloom**, Chair, UK IBD Registry; Consultant Gastroenterologist, UCL Hospitals NHS Foundation Trust	**Acute respiratory presentations** **Dr Omar Usmani**, Reader and Consultant Physician, National Heart and Lung Institute, Imperial College London & Royal Brompton Hospital	**Parkinson's: management on the take and on the wards** **Dr Christos Proukakis**, Senior Lecturer and Honorary Consultant Neurologist, University College London, Royal Free London NHS Foundation Trust	**HIV: the challenge of acute management** **Dr Emma Devitt**, Consultant Physician in Infectious Diseases, Chelsea and Westminster NHS Foundation Trust
09:45 - 10:20	**Dealing with delirium** **Dr Annabel Price**, Visiting Researcher, Department of Psychiatry, University of Cambridge; Consultant in Liaison Psychiatry for Older Adults, Addenbrooke's Hospital	**Sepsis - the silent killer** **Dr Manu Shankar-Hari**, Consultant in Intensive Care Medicine, Guy's and St Thomas' NHS Foundation Trust; NIHR Clinician Scientist, School of Immunology & Microbial Sciences, Kings College London	**COPD update for the generalist** **Dr Nicholas Hopkinson**, Reader in Respiratory Medicine, Imperial College; Honorary Consultant Chest Physician, The Royal Brompton Hospital	**Acute dermatological presentations** **Dr Rachael Morris-Jones**, Dermatology Consultant, Kings College Hospital, London
10:20 - 11:00 **BREAK**				
11:00 - 11:40	**HIV: the challenge of acute management** **Dr Emma Devitt**, Consultant Physician in Infectious Diseases, Chelsea and Westminster NHS Foundation Trust	**Acute dermatological presentations** **Dr Rachael Morris-Jones**, Dermatology Consultant, Kings College Hospital, London	**Acute respiratory presentations** **Dr Omar Usmani**, Reader and Consultant Physician, National Heart and Lung Institute, Imperial College London & Royal Brompton Hospital	**Session sponsored by The MDU** MDU
11:40 - 12:00 **BREAK**				
12:00 - 12:40	**Handovers: art and science** **Dr Adam Chesters**, Consultant in Emergency Medicine and Pre-Hospital Emergency Medicine, Cambridge University Hospitals	**Session sponsored by BMS Pfizer**	**COPD update for the generalist** **Dr Nicholas Hopkinson**, Reader in Respiratory Medicine, Imperial College; Honorary Consultant Chest Physician, The Royal Brompton Hospital	**Managing IBD** **Dr Stuart Bloom**, Chair, UK IBD Registry; Consultant Gastroenterologist, UCL Hospitals NHS Foundation Trust
12:40 - 13:30 **BREAK**				
13:30 - 14:05	**Update on NAFLD** **Dr Stuart McPherson**, Consultant Hepatologist, The Newcastle upon Tyne Hospitals NHS Foundation Trust	**Parkinson's: management on the take and on the wards** **Dr Christos Proukakis**, Senior Lecturer and Honorary Consultant Neurologist, University College London, Royal Free London NHS Foundation Trust	**Sepsis - the silent killer** **Dr Manu Shankar-Hari**, Consultant in Intensive Care Medicine, Guy's and St Thomas' NHS Foundation Trust; NIHR Clinician Scientist, School of Immunology & Microbial Sciences, Kings College London	**Rheumatology at the front door** **Dr Catherine Matheus**, Consultant Rheumatologist and Deputy Director of Medical Education, Lewisham and Greenwich NHS Trust
14:15 - 14:50	**Early diagnosis of acute coronary syndromes** **Professor Richard Body**, Consultant in Emergency Medicine and Honorary Lecturer in Cardiovascular Medicine, Central Manchester University Hospitals Foundation Trust	**Session details coming soon**	**Session details coming soon**	**Legacy after critical illness - from survival to living** **Amy Chen-Deming**, Cardiothoracic & Paediatric Intensivist, Royal Brompton Hospital, London
14:50 - 15:15 **BREAK**				
15:10 - 15:45	**Dealing with delirium** **Dr Annabel Price**, Visiting Researcher, Department of Psychiatry, University of Cambridge; Consultant in Liaison Psychiatry for Older Adults, Addenbrooke's Hospital	**ECG Masterclass** **Dr Simon Fynn**, Consultant Cardiologist and Clinical Director for Cardiology, Papworth Hospital, Cambridge	**Update on NAFLD** **Dr Stuart McPherson**, Consultant Hepatologist, The Newcastle upon Tyne Hospitals NHS Foundation Trust	**Handovers: art and science** **Dr Adam Chesters**, Consultant in Emergency Medicine and Pre-Hospital Emergency Medicine, Cambridge University Hospitals
15:55 - 16:30	**Rheumatology at the front door** **Dr Catherine Matheus**, Consultant Rheumatologist and Deputy Director of Medical Education, Lewisham and Greenwich NHS Trust	**Early diagnosis of acute coronary syndromes** **Professor Richard Body**, Consultant in Emergency Medicine and Honorary Lecturer in Cardiovascular Medicine, Central Manchester University Hospitals Foundation Trust	**Superbugs - what you need to know at the front door** **Dr Sarah Logan**, Consultant in Acute Medicine and Infectious Diseases, University College London Hospitals NHS Foundation Trust	**Exhibition & networking time**

Sepsis: More needs to be done to tackle this killer disease

Sepsis is a killer and the number being diagnosed with the condition is on the rise. Following the sad death of our Group Editor, John Whelan in August this year, Hospital Times is calling for more action to be taken to stop the deaths of tens of thousands of patients. Hospital Times is dedicating this special feature to his memory.

Sepsis is something all medical practitioners will face in their careers and the full horrors of the disease can be life changing. It is very difficult to treat, occurs at very short notice and causes patients and their families considerable distress. Thousands of patients a year are maimed by this killer disease and yet prevention is not as hard as many think.

There are around 250,000 cases of sepsis a year in the UK according to the UK Sepsis Trust and at least 46,000 people die every year because of the condition. To put this in some context, 42,000 people die prematurely from cardiovascular disease every year. With such high numbers of patients dying from sepsis, why is there so little attention?

The NHS lists four early signs of sepsis to watch out for:

- A high temperature (fever) or low body temperature
- Chills and shivering
- A fast heartbeat
- Fast breathing

It does not take a medically trained professional to realise that these symptoms could also apply to flu, which has led many to ask whether public awareness campaigns are enough. NHS England needs to be doing more to give better and more detailed guidance to the public.

Are policy makers preparing for the improvements required to tackle this killer disease? Are politicians aware of the impact this is having on families around the country? The former Health Secretary, Jeremy Hunt, made huge strides on the issue of patient safety, introducing practical measures to tackle sepsis in Trusts.

So why are we seeing an increase in sepsis cases?

Clearly more needs to be done to tackle both the causes of sepsis and the treatment of the disease. Safety expert, Sir Brian Jarman, the director of the Dr Foster research unit at Imperial College London, has suggested that an apparent increase in sepsis deaths by more than a third in two years has been fuelled in part by staff shortages and overcrowding on wards in hospitals.

The number of recorded deaths where the primary cause was sepsis was 11,328 in 2014-15. By 2016-17 there were 15,722 deaths in hospital, or within 30 days of discharge, where sepsis was the leading cause, an increase of 38.8 per cent. With all NHS trusts under financial pressure, more resources will need to be found.

In the last edition of Hospital Times, John showed his typically brilliant insight from his hospital bed. He could see what was failing under pretty difficult circumstances; hospital staff trying their best to keep on top of their ever-increasing workload. Keeping on top of hospital infection controls is challenging enough for clinical staff, despite growing levels of demand and persistent workforce pressures facing all corners of health and care in the Britain.

However, this is not a phenomenon unique to the UK. Reports can be seen around the world that highlight growing numbers of sepsis cases and a lack of resources being focussed on infection prevention. This must be viewed in the context of ever-increasing anti-microbial resistance that presents an even greater global challenge.

As the Chief Medical Officer for England, Professor Dame Sally Davies has said on numerous occasions, AMR poses a "catastrophic threat" that will cause patients who undergo minor surgery to die because of an ordinary infection that cannot be treated by antibiotics. Earlier this year, the Scottish government launched a campaign to raise the awareness of the "silent killer", highlighting the signs and symptoms of the condition which kills around 3,500 people in Scotland every year. Other examples of best practice can be seen across the NHS with new programmes being piloted in Trusts to combat the condition. However, while this is all laudable, the NHS needs more resource and an increased focus to stop unnecessary deaths.

Multisite hospital study demonstrates hand drying method can affect risk of bacterial dissemination in real world settings

Findings have important implications for minimising risk of cross infection in hospital washrooms

Brussels, Belgium – 13 September 2018; A new, real-life multisite study has found that washrooms have significantly less bacterial contamination when equipped with paper towels for hand drying instead of using jet air dryers.

The study, led by Professor Mark Wilcox of the University of Leeds and Leeds Teaching Hospitals, was carried out in France, Italy and UK and examined the extent of environmental contamination in hospital washrooms from potential bacterial pathogens according to hand drying method. Antibiotic-resistant bacteria - including MRSA and ESBL-resistant enterococci - were detected more frequently in the washrooms when jet air dryers were in use.

"The findings will have important implications for hand drying guidance in healthcare settings," commented Professor Wilcox, "and they should be of particular interest to infection prevention and control doctors and nurses, procurement managers and all responsible for minimising the spread of cross–infection."

The study design was conceived and carried out independently by research scientists at three different hospitals: Professor Wilcox at Leeds General Infirmary, (Leeds Teaching Hospitals), UK; Professor Frédéric Barbut of the Infection Control Unit at Hospital Saint-Antoine (AP-HP), Paris, France; and Professor Silvio Brusaferro, of the Department of Medicine, Udine University Hospital, Italy.

The study compared two washrooms per hospital – each had paper towel dispensers and jet air hand dryers, but only one drying method was available to use at any given time. Each was frequented by patients, visitors and staff. A crossover design compared contamination levels within each over a 12-week period. During the study, 120 sampling sessions in total in each of the three hospitals were carried out. The independent study was undertaken in 2017 and supported with a grant from ETS.

Presence of Antimicrobial resistant microorganisms (AMR)

Bacteria recovered included methicillin susceptible (MSSA) and resistant Staphylococcus aureus (MRSA), enterococci and enterobacteria, including ESBL (Extended-spectrum β-lactamase producers) producing bacteria.

Key findings

In general, bacterial contamination was lower in washrooms using paper towels (PT) than those using jet air dryers (JAD), and total bacterial recovery was significantly greater from the JAD outer surface versus the PT dispenser at all three sites (median 100-300—vs 0-10 colony-forming units (CFU) respectively all $p<0.0001$). While contamination in France and UK was similar, it was markedly lower in Italian washrooms, thought to be due to a combination of a lower footfall and different cleaning practices.

There were differences between the three locations, and significantly more bacteria were recovered from the floors of JAD washrooms in the UK and France (median 24 v 191 CFU, $p<0.00001$). In the UK overall recovery of MSSA was 3 times more common and 6-fold higher from JAD versus PT surfaces (both $p<0.0001$).

"MRSA was recovered 3 times more often in UK washrooms (21 vs 7 CFU) from the JAD outer surface or on the floor beneath compared with respective PT sites," explained Mark Wilcox of his part of the study at Leeds General Infirmary. "There were also significantly more ESBL-producing bacteria recovered from UK washroom floors during JAD versus PT use."

Commenting on the results from Hospital Saint-Antoine, AP-HP, and Professor Frédéric Barbut said, "In France we saw significant differences in bacterial contamination between the two types of hand drying method. Higher numbers of bacteria were recovered from the floors and drier surfaces in the JAD condition than when using PT. In particular ESBL-bacteria were recovered from dust twice as much during JAD versus PT use."

Silvio Brusaferro, Professor of Hygiene and Public Health, with regard to the experience at Udine hospital in Italy stressed the

importance of selecting a hand drying system that prevented the spread of microorganisms. "We found the dispersion of microorganisms to be more than 25 times greater with jet air dryers than single use paper towels," he explained. "Indeed, Italian infection control personnel traditionally avoid the use of jet air dryers in hospitals."

Complements previous research findings

While hand hygiene is a fundamental component of infection prevention, there are few studies on the contribution of hand drying method to the dissemination of potential pathogens. Previous studies, including those undertaken by Professor Wilcox and Keith Redway of the University of Westminster, also found that electric dryers can contaminate both the air and the surfaces with bacteria and viruses.

"We already had both laboratory and in situ evidence. Now with this study we also have real-world evidence that jet air dryers spread greater levels of bacteria," explained Professor Wilcox. "This latest research demonstrates that paper towels offer the most hygienic way to dry hands and minimize the spread of bacteria including MRSA, enterobacteria and enterococci following a visit to the washroom."

Is a lubricant a contaminant or a crucial necessity for maintaining the proper operation of a surgical instrument?

Most instrument manufacturers recommend the use of lubrication to ensure the correct functioning of their surgical instruments and to minimise wear and tear, thus extending the life of the instrument. Unfortunately, there is a trend away from the use of lubricants on surgical instruments due to the fact that a lubricant is considered a contaminant. This definition does not apply to a water-soluble lubricant; a residue would be a more precise definition.

You can use a water-soluble lubricant before sterilization; however, the use of oil-based lubricant is discouraged.

The ideal location for using the lubricant is the packing room before sterilization. However, if the lubricant dislodges dried contaminates, the instrument will require returning to the decontamination area for re-processing, which may include soaking in a lubricant bath until all traces of the soil lodged in the joint are removed.

By introducing the following safeguards into your lubricating routine, you will be able to reduce surgical instrument failures and extend their life span. By ensuring that only the minimum amount of lubricant required is used, the level of lubricant residue will be totally harmless. By not using a lubricant we are running a greater risk of the instruments failing in use, than the risk from lubricant residue on the instrument causing contamination of the operation site.

- Only use a water-soluble lubricant.
- Ensure the product has been tested to be totally steam sterilizable and steam penetrable.
- Check the lubricant's COSHH(SDS) sheet, section 3 -Hazard Identification Signs/ Symptoms of Exposure, to ensure that the product will not react with tissue.
- Restrict the use of the lubricant to the area of the instrument requiring lubrication.
- Test the action of the lubricated joint to ensure penetration.
- If the lubricant dislodges dried contaminants from the joint, return to the decontamination /wash area for reprocessing.
- When introducing a lubricant into the department, ensure that the manufacturer of the lubricant supplies a method of residue testing following steam sterilisation.
- Most importantly ensure the manufacturer backs up any claims with independent test results

Matthew Peskett
Peskett Solutions Ltd

LTE scientific partnership with KEN Hygiene offers the complete decontamination solution to sterile service departments

LEADING British autoclave manufacturer LTE Scientific has teamed-up with European washer-disinfector manufacturer KEN Hygiene to offer a complete decontamination solution for sterile services departments across the UK.

Key advantages include autoclaves offering very fast sterilising times with options of automatic or semi-automatic unloaders, and back-up technical support from a nation-wide team of qualified engineers.

All LTE Scientific sterilisers use minimal energy and water, whilst delivering fast cycle times - in many cases less than 45 minutes.

LTE's range of Touchclave porous load steam sterilisers come in sizes from 15cu.ft to 42cu.ft, with single-entry and pass-through variants. All can be configured to run on conventional or clean steam supplies, and LTE provides a wide range of steam generators and heat exchangers.

LTE can also supply a choice of manual, semi-automatic and fully automatic loading/unloading solutions, which can often be retro-fitted to LTE and other autoclave brands. Semi-automatic and automatic unloaders provide significant health-and-safety and efficiency advantages over manual handling.

LTE has worked with KEN Hygiene, based in Denmark, since 2016. A leading washer disinfector manufacturer, KEN has recently launched the new touchscreen IQ5 and IQ6 washer range, with loading capacities from 10-18DIN.

The IQ range boasts lower energy and water use, and faster cycle times than competitors. These savings and capital payback projections can be demonstrated on KEN's comparison tool.

Another key feature is the ability to install IQ5 and IQ6 washers side-by-side without the need for service voids in between machines. This dramatically reduces floorspace use, especially with multiple installations. A range of KEN trolley washing systems is also available.

All products are supported by LTE's service centre, with engineers available nation-wide and qualified to the relevant HTM guidelines.

Althea and Samsung Enhance X-ray Services in Leicester

The team from Leicester General Hospital pictured with Lloyd Stewart and Robert Mason from Althea and Tony Rogers (Far Right), Account Manager for MIS with their new Samsung GC85.

Through the Trust's vendor-independent managed service, Althea and Samsung Healthcare have worked with Leicester General Hospital (LGH) to replace their plain x-ray rooms. Supported by Althea's Implementation & Technology experts, LGH selected Samsung's GC85 from all available systems.

The GC85 is a fully-automated digital suite which reduces physical stress on users, increases patient throughput, and delivers superb image quality. The new equipment features Samsung's intuitive 3-step workflow which takes the user easily through worklist, acquisition and review. LGH is now able to share their lightweight detectors between Samsung x-ray rooms – adding greater flexibility and reducing costs. These state-of-the-art detectors offer a high DQE but still maintain the ability to deliver fantastic images. Andy Mear, Plain Film Superintendent, says "everyone has been blown away by the new equipment and we can't wait to get all of the new rooms installed."

First Intracranial Aneurysm Patients Treated with BRAVO Flow Diverter Following European Regulatory Approval

BRUSSELS, Belgium – September 19, 2018. CERENOVUS, part of the Johnson & Johnson Medical Devices Companies, announced today that the first patients have been treated with the BRAVO Flow Diverter, following recent CE mark approval for the device to be used in the treatment of intracranial aneurysms.

"The BRAVO Flow Diverter is a welcome addition to the existing treatment options for intracranial aneurysms" said Dr Patrick Brouwer Senior Consultant Neurointerventionalist at Karolinska University Hospital, and Evaluator for the BRAVO Flow Diverter. "I am impressed with the overall handling of the device, in particular the ease of use, opening functionality and stability of the device placement."

Flow diverters divert blood flow from the aneurysm and promote healing thereby reducing the risk of rupture, a main cause of hemorrhagic stroke. Accurate positioning of the flow diverter and effective delivery and deployment are important factors in the successful treatment of intracranial aneurysms. The design of the BRAVO Flow Diverter reflects these requirements and aims to provide surgeons with confidence when positioning and deploying the device, contributing to complete diversion effect.

"We are delighted with the clinician feedback and patient outcomes from the early evaluation cases" said Daniella Cramp, Worldwide President, CERENOVUS. "After an extensive research and development process we are proud to see that our latest innovation is enabling patients to live a life free from the burden of hemorrhagic stroke."

Stroke is a devastating disease that strikes 15 million people each year,1 with hemorrhagic strokes accounting for 13%2 of all strokes. Aneurysms are a main cause of hemorrhagic strokes and occur when a weakened region of a blood vessel balloons until it ruptures and bleeds into the brain.2

The device is currently not approved for use in the United States.

Novaerus Closes the Infection Control Loop with the Defend 1050: An All-in-One Air Disinfection and Purification Device

Novaerus had announced the launch of the Defend 1050 – a portable, easy to use device ideal for rapid disinfection and purification of the air in large spaces and high-risk situations such as operating theatres, ICUs, IVF labs, emergency and waiting rooms.

Hospital pathogens infect nearly 6 million patients each year, antibiotic resistance is on the rise, and compliance with hand hygiene and surface cleaning protocols well below standard . Now more than ever, healthcare facilities must deploy innovative technologies that address airborne pathogens and particulate to supplement hand hygiene and surface cleaning to reduce the risk of direct and indirect transmission of infection.

The Defend 1050 brings long-awaited innovation to the infection control market with ultra-low energy plasma technology – a highly powerful yet extremely gentle method of rapid pathogen destruction – combined with a high performance multi-stage filter system from Camfil®.

The all-in-one Defend 1050 can be operated continuously around patients and staff to kill airborne pathogens, adsorb odours, neutralise volatile organic compounds (VOCs), and trap particulate as small as 0.3µm.

Independent tests completed to date show that the Defend 1050 at max. speed reduces:

- Influenza A by 99.9% in 10-20 minutes (28.5m3 space)
- Staphylococcus epidermidis by 99.9% in 15 minutes (30m3 space)
- Aspergillus niger by 99.99% in 30 minutes (15.9m3 space)
- Nitrogen Dioxide (NO2) by 100% in 6 minutes (16m3 space)
- VOCs at a clean air delivery rate (CADR) of 596 m3/hr
- PM1.0 at a CADR of 860 m3/hr (19.7m3 space)
- PM2.5 at a CADR of 870 m3/hr (19.7m3 space)

The Defend 1050 combines six coils of Novaerus' patented, NASA-tested, ultra-low energy plasma technology with a M5 pre-filter, a genuine H13 HEPA filter certified in accordance with EN-1822, and carbon/molecular filter from Camfil, a world leader in high quality air filtration.

Since 2009, Novaerus has been researching and developing plasma technology that is unmatched in its ability to safely destroy airborne pathogens that lead to infection in populated indoor spaces. The patented technology uses short-exposure, ultra-low energy plasma that has been tested and shown by several respected laboratories – including Airmid, Aerosol, Microbac, ARE, and Ames – to deactivate pathogens on contact.

Many air cleaning methods in use by healthcare facilities today rely on filters to capture pathogens. But without deactivating those pathogens first, the filter can become a safe haven for viable pathogens to colonise. The Novaerus plasma technology solves that problem by killing airborne pathogens before they become trapped in the filter.

The Defend 1050 can be moved easily by staff and plugged into any power outlet. It has five fan speeds to accommodate different room sizes and noise level requirements.

Click here to download our free white paper about the limitations of hand hygiene and surface cleaning in the superbug era and how closing the loop by disinfecting the air is the future of infection control.

To learn more about the Defend 1050, visit: www.novaerus1050.com

www.novaerus.com

Highly effective cleaning offers up to 20 per cent saving on gigazyme

Schülke – specialists in infection prevention and control – have just announced a price reduction of up to 20 per cent on a 5-litre container of gigazyme® from 1 June.

gigazyme® is a highly effective cleaning agent based on a combination of enzymes and non-ionic surfactants. The formulation has been designed specifically for use in the manual and automatic cleaning of endoscopes and surgical instruments. gigazyme® is also suitable for use in an ultrasonic bath.

Based on an innovative combination of protease, amylase and lipase to help remove proteins, starch, and fats, gigazyme offers excellent cleaning power, is non-foaming and leaves no residue.

It is highly economical in use and a 0.5 per cent dilution makes 1,000 litres of in use solution from a - litre container of gigazyme®.

The optimum cleaning temperature is below 35°C, and to make it easy to recognise if this temperature has been exceeded, because the solution turns 'milky' at 32 degrees and above. This is easily remedied by adding cold water to the solution.

Leanne Anderson, Product Manager at schülke UK says: 'schulke has been committed for over 125 years to developing innovative solutions for infection prevention and control. We understand the need for trusts to maintain the highest standards of patient care, while also needing to deliver cost efficiencies. As a result, schülke has undertaken a comprehensive review of pricing structures, which has meant we are able to offer the highest standards of disinfection products at a lower price.'

schülke UK Ltd, Cygnet House, 1 Jenkin Road, Meadowhall, Sheffield S9 1AT

0114 254 3500 / mail.uk@schuelke.com

www.schuelke.com

More than a funding boost needed to improve cancer outcomes in England

In June this year the Prime Minister announced a major investment boost for the NHS in England, providing £20bn of funding over a five-year period. The detail of how this funding would be apportioned across health services was not part of the announcement and instead was set as a task for Sir Simon Stevens to develop as a ten-year plan, despite the funding covering only five years.

NHS England needs to produce its plan is before the budget in the Autumn, creating a particularly tight timeline for Sir Simon to work up a plan covering 19 different streams of work across a spectrum of policy areas. These include clinical priorities such as cancer, cardiovascular and respiratory, learning disability and autism, and mental health.

NHS England's Cancer Strategy notes survival rates in England have never been higher. However, the UK still lags behind many comparable European nations for five-year survival rates with numerous other challenges impacting access to diagnosis and treatment that need to be recognised as part of the new plan.

The strategy contains a commitment of £130m for technology and equipment to ensure access to the latest radiotherapy treatment and £200m to accelerate the rapid diagnosis and assessment of patients.

Recent performance figures for the NHS in England show key targets have been missed yet again. In addition to the missed targets for non-urgent operations for knee and hip replacements, the proportion of cancer patients who began treatment within the two-month target was the lowest since records began in 2009.

Earlier this month, cancer charities and the Royal College of Radiologists (RCR) issued warnings of shortages in clinical staff across the cancer workforce – leading to possible delays in the administration of chemotherapy treatment and radiology services on the brink of collapse.

According to the RCR, the vacancy rate for consultant posts has increased to more than 10 per cent over the last two years. This shortage of skilled staff has led to NHS hospitals having to outsource the analysis of scans to private companies and pay staff to work overtime at a cost of £116m in 2016/17. The RCR's Clinical Radiology: UK Workforce Census 2017 report points to the increasing gap between supply and demand from a shortfall of 1,000 consultants in 2017 to an estimated shortfall of 1,600 in five years' time.

More concerning still is the 44 per cent of radiology departments who disclosed that some images were auto-reported or unreported – with the potential for diagnoses to be missed or delayed.

In June, the RCR predicted that the NHS was also short of oncologists and that without investment, will be short of 247 full-time consultants by 2022. This amounts to roughly one fifth of the number required to treat the growing number of cancer patients.

In December 2017, Health Education England published its long-awaited plan to address staffing in NHS cancer services, acknowledging the need for more staff to administer cancer tests, including radiologists, radiographers, endoscopists and pathologists. The report also promised to deliver over 5000 extra staff by 2021, focusing on two key groups: those who diagnose cancer and those who treat it. Despite these increases, the plan did not include a commitment to more funding and the assumption that local budgets would shift as hospitals recruit or train people in these workforce groups is now beginning to demonstrate its limits.

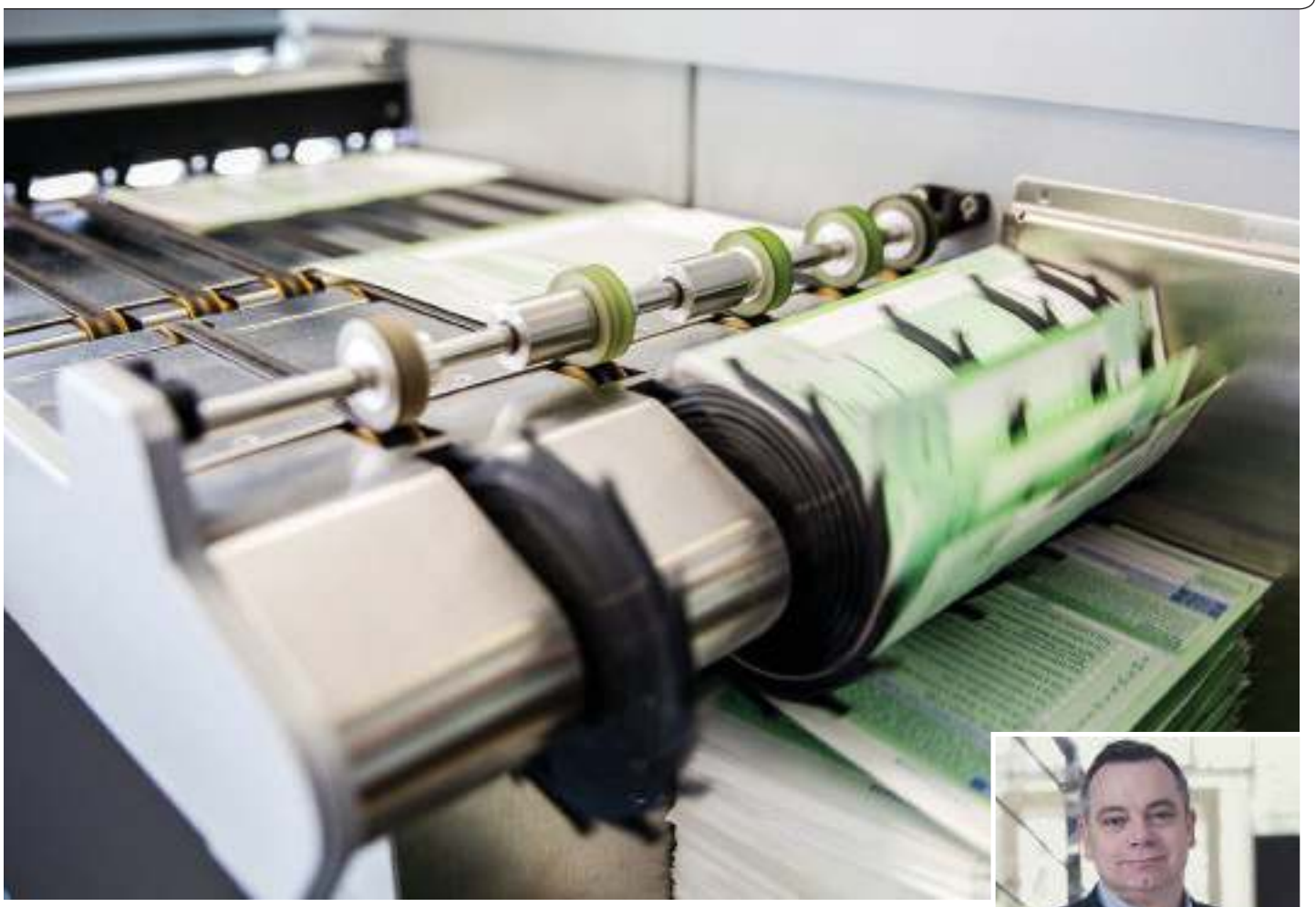
As NHS England puts together its plan for the next ten years, it will have to tussle with the ongoing tension between long-term prevention measures, the very real and current pressure on acute cancer care.

Public Health England is clear about the need for greater focus on and investment in prevention and Chief Executive, Duncan Selbie called for more decisive action in the new long-term plan at the recent NHS Expo conference.

While cancer is one of the leading causes of ill-health in the UK, it is also highly amenable to prevention, with 4 in 10 cases considered 'preventable'. As the BMA notes in its report, Prevention before cure: Securing the long-term sustainability of the NHS, prevention offers the most cost-effective long-term strategy for controlling cancer.

Anyone concerned with improving health outcomes would wish to invest in both prevention and treatment. However, with a funding boost that is still less than the 3.7 per cent average rise the NHS has had since 1948, and less than the 4 per cent a year needed to see even modest progress on priorities such as waiting times and mental health provision, there remains a lot to be desired.

With such dire warnings on staff shortages and the impact on accurate diagnosis and access to life saving treatment, NHS England's plan must prioritise investing in the cancer workforce or face falling further behind on cancer outcomes.



NHS BSA leads the way digitising records

Since 2006, the Business Service Authority (NHS BSA), a not for profit admin arm of NHS England, has been managing prescriptions, pensions, bursaries and dental claims. Employing roughly 2500 individuals and covering £35bn worth of transactions per year, it is reasonable to say the NHS BSA is a fairly sizable operation. Recently, however, it has turned its attention to the digitisation agenda, most notably through electronic prescriptions.

Martin Kelsall, Director of Primary Care Services at NHS BSA, speaks to Hospital Times about the changing role of the Business Services Authority in light of the digital agenda.

"As prescriptions become electronic, we now have the capacity to help other NHS organisations deal with their paper challenges," says Martin. Given that two thirds of prescriptions are now managed electronically, resources that were previously dedicated to scanning and managing paperwork can now be used elsewhere in the NHS.

Martin is turning his attention to medical records, keen to see the end of legacy 'Lloyd George' records in favour of cloud-based data management solutions. Currently, the NHS BSA is 14 months into the digitisation of 60 million documents for North Bristol NHS Trust.

Neil Darvill, director of Informatics, North Bristol NHS Trust, says, "We've been working alongside the NHS BSA for the last 2 years. Throughout this process, they have demonstrated an ability to fully understand our requirements, piloting the service initially and then helping us to develop a full service specification."

The service they offer covers collection, scanning, character recognition, quality assurance, analytics and secure management or destruction of paper files. Seeking to offer this service to Trusts, CCGs and other health and care providers across England, NHS BSA plans to move into new offices in Newcastle to make more efficient use of space.

As with any digitisation, security and data protection must be at the forefront of the agenda. NHS BSA holds data for 18 months while it is being processed before passing it back to individual providers. This is deemed as sufficient to ensure a comprehensive digitisation process can be completed while not keeping hold of personal patient data for longer than necessary, thus adding to the risk of data breaches.

Why the NHS BSA? Martin's answer, because it's already in the NHS. "NHS to NHS offers a far more pragmatic approach," he comments, "this makes it easy for procurement as the work is being done by a familiar body." NHS BSA is also no stranger to working at scale, processing over 44 million dental claims per year, alone. So what is the agenda?

Beginning with digitisation of records, it is clear that NHS BSA has much more to offer. "Medical records are an obvious starting point and given we are NHS servicing the NHS," says Martin, "the whole process of engagement is easier, faster and cheaper compared to using commercial third parties."

Further to the work in Bristol, NHS BSA has also started work in Newcastle Gateshead CCG, where it is digitising all primary care records for 293,602 patients. While Martin is confident in getting the work done, so far they are only 15 per cent of the way through the 25.25 million documents that need to be processed.

Looking to the future of integrated care in the NHS, Martin says: "This would eventually eradicate the need to transport paper files between practices, offer total interoperability, allow access across organisational boundaries and meet the needs of any future integrated care system. A flexible and simple solution on a national scale would be far more cost effective than 211 CCGs or thousands of practices working independently. Our solution also removes the reliance on third parties who charge to integrate scanned documents into their IT systems and therefore keeps ownership of all images within the NHS family."

How can this be achieved? NHS BSA has partnered with CCube solutions to develop its software to ensure efficiency and keep costs down. Delivering tailored solutions is essential to managing unique patient records and if the new Secretary of State's digital agenda is to be supported, this is something that will have to be achieved.

Martin Kelsall – NHS BSA

Gamma Knife Icon launches in London

The Wellington Hospital has announced the introduction of The Gamma Knife Icon to treat patients with brain tumours, vascular and functional disorders at the dedicated London Gamma Knife Centre, in partnership with Barts Health NHS Trust.

The Gamma Knife Icon uses radiation to treat tumours and lesions in the brain. It can treat both malignant and benign brain tumours, vascular disorders in the brain including cavernous malformations and arteriovenous malformations as well as a range of neurological disorders including Trigeminal Neuralgia, Parkinson's tremor, OCD and epilepsy.

The new technology will provide more streamlined treatment plans, meaning patients will not be required to stay in hospital overnight, will have shorter recovery times and have the option to use a custom face mask.

Using this new equipment, the multidisciplinary team of neurosurgeons, oncologists, radiologists and physicists can target and treat conditions with higher accuracy than any other system within 0.5mm, enabling consultants to deliver a high dose of radiation to the affected areas. The design of the gamma knife also means that there is much less radiation delivered to the rest of the body, reducing the risk to the patient from treatment.

The launch of The Gamma Knife Centre is part of a £20 million investment in The Wellington Hospital.

Mr Ian Sabin, Consultant Neurosurgeon, Skull Base Surgeon and Medical Director of the London Gamma Knife Centre, said: "The launch of The Gamma Knife in the 1980s meant many patients no longer had to undergo conventional brain surgery which can be traumatic to the body and incur lengthy recovery times.

"This new technology means we can offer patients the most accurate and precise radiosurgery completely tailored to them and their condition. Treatment times will be quicker, which means I will be able to treat more people within a day, and patients will be able to go back to their daily activities almost immediately after."

John Reay, Chief Executive Officer of The Wellington Hospital, said: "The new centre has been launched as part of our commitment to providing our patients from the UK and oversees with world-class and comprehensive care."

Innova Wins £205,000 Contract with NHS Wales

Wetherby-based healthcare equipment supplier Innova Care Concepts is today announcing that it has been awarded a contract to supply and install 47 overhead hoist systems to The Grange University Hospital.

This marks the third successful NHS contract bid for Innova in the past year after it secured deals to provide hoisting systems to Midland Metropolitan Hospital in Birmingham and Balfour Hospital in Orkney, Scotland.

The £350 million Grange University Hospital is currently being built in Cwmbran, Wales and will have 560 beds. This facility will provide specialist critical care to patients across the south-west of the country.

Innova will be supplying and installing a total of 47 X-Y overhead hoist systems inset to the ceiling to help maintain the hospital's level of infection control, which was an important factor for the new critical care centre.

Bob Oliver, senior contracts manager at Innova said:

"We worked closely with BDP Architects on this project to ensure that all the plans would tick all the boxes for an environment as demanding and important as the critical care centre.

"We also did a demonstration to the NHS Trust that showed how our systems would work in the hospital. They ended up awarding us the contract because of our innovative equipment and entrepreneurial spirit!"

The Grange University Hospital will also be treating plus-sized patients, and so they required hoist units with a larger weight limit. Innova was the only company who could supply a large number of single unit systems that had weight limits of 500kg.

Bob Oliver – Senior Contracts Manager, Innova Care Concepts

Innova's managing director, Tom Hulbert, said:

"It's great to win another NHS contract; I think it just shows how much of a trusted supplier we are to hospital and healthcare facilities all around the country."

Innova will begin work on The Grange University Hospital in 2019.

Blackpool Teaching Hospitals NHS Foundation Trust selects Medstrom for total bed replacement

Blackpool Teaching Hospitals NHS Foundation Trust is replacing around 800 beds and 600 mattresses in a move that will improve patient safety and experience, while helping it to operate with greater efficiency. The new equipment being rolled out at sites across the Trust and will be provided and maintained by the UK's only independent provider of bed management services to the NHS, Medstrom Healthcare.

The new beds and mattresses represent the latest advancements in medical equipment technology; offering benefits to patients and staff by helping to reduce instances of preventable harm, the spread of infection, and need for clinicians to physically mobilise patients.

The total bed and mattress replacement was a significant, multi-departmental project, but an essential step to future-proof the provision of high quality patient care, as the Trust's Assistant Director of Nursing and Quality, Tracy Crumbleholme, explains: "The selection process was a collaborative multi-disciplinary approach, involving both clinical and non-clinical staff. We wanted to review proposed equipment from a quality, safety and efficiency perspective to ensure we selected the best product for our specific needs now and in the future. We established a specification early on; defining what was essential and what was desirable. Crucially, we examined vendor propositions against the key criteria of quality, safety, patient experience, and value for money.

"With the patient population ageing, we needed beds to support patients at high risk of falls and tissue damage to support our organisation's strategic aim of reducing patient harm. The MMO 5000+ caters for this need with its ultra-low height setting and split side rails. Equally, the increase of patients experiencing respiratory complications made the 30° and 45° pre-set backrest angles a very attractive function. The bed's ability to eliminate heel travel and promote safe, early, and independent mobilisation also ticked many of our boxes. Finally, the pressure redistribution qualities of the AeroSpacer mattress supported our goal of minimising preventable patient harm due to tissue damage.

"Selecting Medstrom was a unanimous decision. Not only do I have confidence in the equipment's ability to enhance patient care, but I believe that clinician efficiency will also greatly improve because of access to a better class of hospital bed that can tailor support to the individual needs of patients."

Infection Prevention

Infection Prevention Society

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SUNDAY 30th SEPTEMBER – TUESDAY 2nd OCTOBER

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Join the Infection Prevention Society for our annual conference, **Infection Prevention 2018**, the premier event for all those involved in infection prevention and control.

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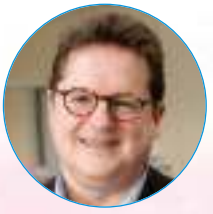
Professor Andreas Voss

Highlights to include:

- Innovative programme including dedicated one-day conferences on **Infection Prevention in Care and at Home** and **Infection Prevention and Antimicrobial Resistance**
- E.M. Cottrell Lecture to be presented by **Professor Jennie Wilson** and the Ayliffe Lecture by **Professor Shaheen Mehtar**
- The largest UK infection prevention exhibition
- Infection Prevention Show – *New for 2018*
- Networking opportunities with like-minded colleagues
- Invitation to submit your research at conference as an oral presentation or poster
- Full social programme including: A Sunday Fun-Night, Annual Awards Ceremony and A Gala Dinner

If you are a healthcare professional with an interest in any aspect of infection control then you will benefit from attending this conference.

Online registration is available at
www.ips.uk.net/conference

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Infection Prevention Society

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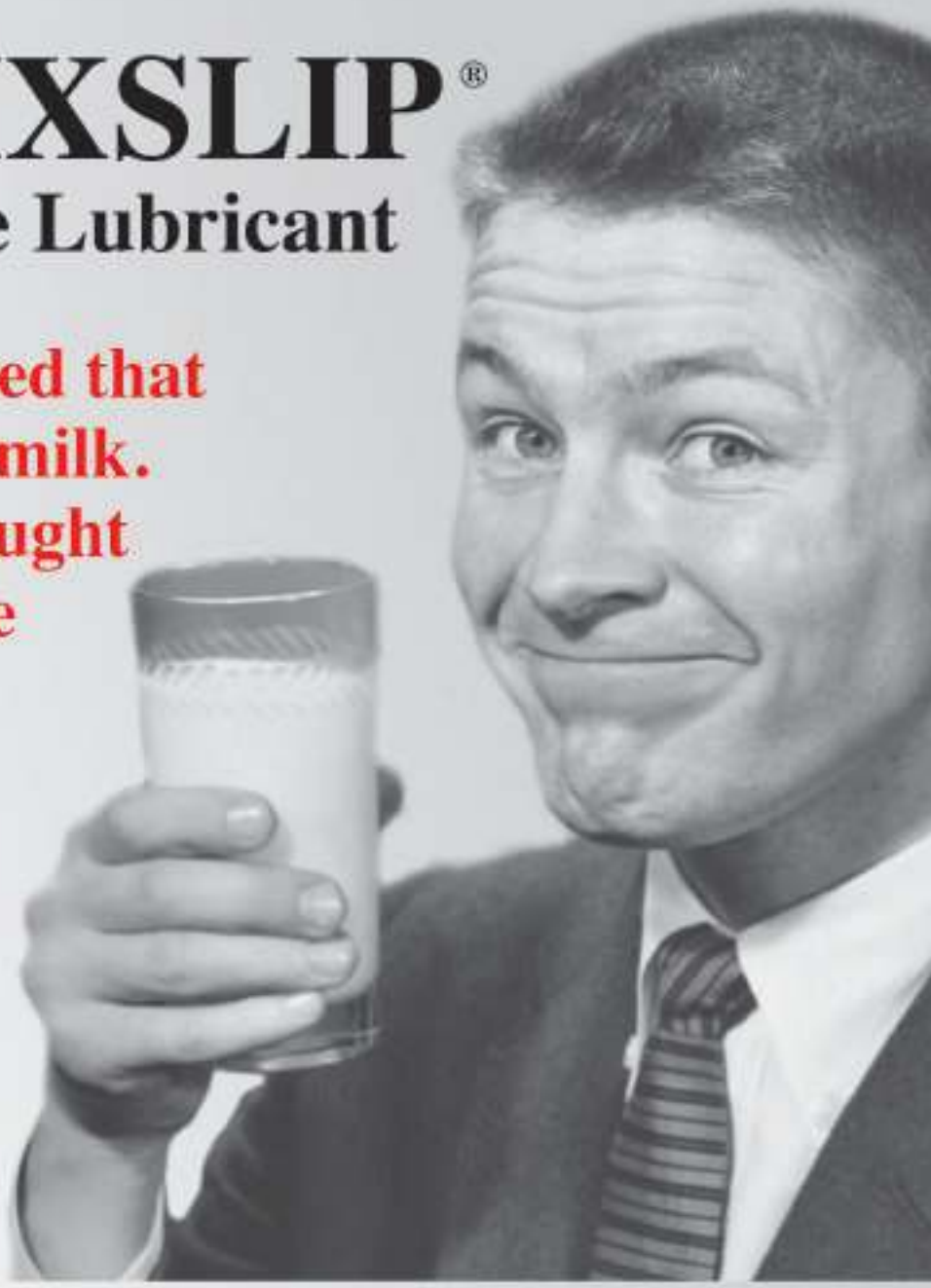

Bob was reassured that it was as safe as milk. Although he thought it might not taste as good.

A premixed instrument lubricant and rust inhibitor clinically tested to be thoroughly steam penetrable and steam sterilizable.

Biocompatibility has been tested according to EN ISO 10993. Tests for cytotoxicity, irritation or intracutaneous reactivity, and sensitivity showed no biocompatibility risk associated with Premixslip.

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