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Now is the time, innovate.

If you pay much attention to the news you would perhaps be forgiven for forgetting about the innovation that takes place in the UK. In healthcare the government could and should be showcasing more examples of this, and highlighting some of the innovations covered in this magazine would be a good start.

In fairness to Health Secretary Matt Hancock, digital innovation in the NHS has been at the forefront of his agenda so far, and we have some fantastic examples of NHS Trusts and health organisations utilising digital power to evolve and often revolutionise health and care services. Infamous taglines, such as the NHS still being one of the biggest global purchasers of fax machines, could finally become a thing of the past if NHS trusts are able to replicate the success of the University Hospitals of Morecambe Bay NHS Foundation Trust in implementing an extensive electronic patient record system. I spoke to the Trust's Chief Medical Information Officer Colin Brown and Chief Information Officer Andy Wicks about the progress made there.

While some Trusts are innovating to evolve their services, others are trying to revolutionise modern medicine itself. I was able to visit St James's University Hospital in Leeds to see the UK's first 100 per cent digital pathology lab, where simply being able to view histology slides on digital screens eliminates the need to use microscopes and saves hours of strenuous manual tasks for pathologists.

Innovative projects will always receive coverage from Hospital Times and will be an ongoing theme in 2019. That is not to say, however, that we will simply be showcasing clever digital tech. We want to explore the wider significance of these innovations and the impact they have upon culture within the health service. Understanding this will aid us in sharing these ideas between Trusts across the country.

In addition to exploring these themes with our sister publication, Accountable Care Journal (http://accountablecarejournal.com), Hospital Times will also work in unison with Dorson West's new publication, World Healthcare Journal, which will be launched at Arab Health in January (www.worldhealthcarejournal.com). The title will provide opinion, news and intelligence for governments, healthcare providers and senior private sector organisations across the globe and you can read more about the specific vision for World Healthcare Journal on page 34.

We hope that this trio of publications, Hospital Times, Accountable Care Journal and now World Healthcare Journal, will provide comprehensive insight and analysis on the innovation that is taking place in the UK and across the globe.

For more information on Dorson West's privacy policy, please visit www.hospital-times.co.uk/privacy-policy/

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Increased diabetes prescriptions pile pressure on stretched health care services

New figures from NHS Digital reveal an increase in the number of prescriptions being given for diabetes. The total number of items prescribed for diabetes in England totalled 53.4m items in 2017/18. The total cost on the health service amounts to over £1bn a year.

In its recent report: 'Prescribing for Diabetes: England 2007/08 – 2017/18,' NHS Digital examined prescribing trends in primary care in England for treating and managing diabetes.

There were 53.4m items prescribed for diabetes in the financial year 2017/18, at a total net ingredient cost of £1bn. This is an increase from 22.6m prescription items at a cost of £421.7m since 2007/08.

Drugs used in diabetes now make up 11.4 per cent of total primary care net ingredient costs (NIC) and 4.9 per cent of prescription items.

All corners of the health service face an increasing burden from diabetes suffers, many of whom have the condition as a result of lifestyle factors that are entirely preventable. While the burden on GPs and other parts of the system increases, there is much that can be done to combat excess weight and inactivity, two of the main contributors to Type 2 diabetes.

Professor Helen Stokes-Lampard, Chair of the Royal College of GPs, responded to the report by highlighting the importance of medication in helping patients manage their diabetes and allowing them to live a good quality of life. However, it is not all about medication, as lifestyle changes can also have a positive impact.

GP services remain stretched with unrelenting workforce and resource pressures still prevalent. This is exacerbated by increasing numbers with the condition in England.

While GPs have the ability to offer detailed advice on lifestyle changes that can be made, the trade-off for longer appointments is that fewer patients can be seen and wait times increase.

Professor Stokes-Lampard added: "Ultimately, we need to see the delivery of NHS England's GP Forward View, which promises an extra £2.4bn for general practice and 5,000 more GPs, as well as our additional ask of £2.5bn extra a year as part of the forthcoming NHS long-term plan, to ensure we can give more time to all of our patients, including those with diabetes."

https://digital.nhs.uk/data-and-information/publications/statistical/prescribing-for-diabetes/2007-08---2017-18

NHS at risk of 51,000 nursing vacancies by end of Brexit transition

A new report commissioned by 36 health and social care organisations reveals that the NHS could be short of 51,000 nurses by the end of the Brexit transition period.

Brexit and the Health and Social Care Workforce in the UK, from the National Institute of Economic and Social Research (NIESR), forecasts a potential shortfall of 5,000 to 10,000 nurses in the NHS in England by 2021.

Between 2011 and 2016, the number of EEA nationals employed in social care grew by 68 per cent, or 30,600 people. There were 42,000 registered nurses working in adult social care in England in 2017, with almost a third of registered nurses (32.4 per cent) estimated to have left their role within the past 12 months.

Danny Mortimer, co-convenor of the coalition and Chief Executive of NHS Employers, says: "The health and social care sector is deeply reliant on talented colleagues from across Europe and the rest of the world."

Dr Heather Rolfe, Associate Research Director at NIESR adds: "Measures designed to increase recruitment from within the UK, like 'return to work' schemes, have potential to help fill gaps left by falling migration to the UK. However, they will take some time to take effect and are very unlikely to produce sufficient numbers to make up for a shrinking EU workforce."

https://www.nhsemployers.org/-/media/Employers/Documents/Cavendish%20Coalition/NIESR%20Report%20Brexit%20Health%20and%20Social%20Care%20Workforce%20Executive%20Summary.pdf

Report Recommendations:

- Any future immigration system should be transparent, cost effective for applicants, and responsive to the changing health needs of the population.
- National and devolved governments must review their workforce planning approach for the future.
- The Home Office should guarantee that its settled status programme for EU nationals will be honoured in the event of a no-deal Brexit.
- All levels of government should work together to review career routes within social care.
- Professional regulators should regularly review their processes for registering international professionals.
- The UK and devolved government should introduce measures to monitor and address the decline in the number of applications to medical schools.

BMA calls on NHS England to take cervical cancer screening back 'in-house' after communications error

The British Medical Association (BMA) has written to Simon Stevens, Chief Executive of NHS England, expressing grave concerns that up to 48,500 women have not received information regarding cervical cancer screening following a system error earlier this year.

The errors made between January and June 2018, resulting in thousands of women not receiving information relating to their screening, have been labelled by Dr Richard Vautrey, the BMA GP Committee Chair as "appalling."

In the letter, the BMA urged NHS England to strip Capita of the contract and take Primary Care Support England (PCSE) services back 'in-house'.

NHS England has given assurances that it has written to those affected and informed relevant GP practices. However, the BMA has begun informing its members in general practice of the situation so they are better equipped to deal with any patient concerns.

Dr Vautrey said: "Because of the nature of this procedure, many patients are already reluctant to attend these appointments, and therefore reminder letters are crucial to provide encouragement and reinforce the importance of having a cervical smear test done."

He added: "Since it took responsibility for GP backroom functions three years ago, Capita's running of these services has been nothing short of shambolic and after repeated warnings from the BMA and government, this is now clear evidence that its failings have put patient safety – and possibly lives – at risk."

Around 4.5m invitations are sent every year for women between the age of 25 and 64 to take the test. Those aged between 25 and 49 are offered a screening every three years with older women being invited every five.

Up to 270 women are speculated to have died as a result of the error, leading Dr Vautrey to call for Capita to be stripped of their contract.

A Capital spokesperson said: "The risk to women of this incident is low and there is no current evidence of harm, but Capita nevertheless apologises to both the NHS and to the women whose correspondence was delayed."

NHS England has set off reviewing each individual case, ensuring that each woman in questions is contacted to avoid further damage arising as a result of this blunder.

Tackling health inequalities to provide £13.2bn boost for economy, says new report

Poor health has been linked with the north's low productivity for the first time in a major new report by six northern universities.

The report, entitled *'Health for Wealth: Building a Healthier Northern Powerhouse for UK Productivity,'* was commissioned by the Northern Health Science Alliance (NHSA), an alliance of universities, hospitals and AHSNs across the north of England, to look at the relationship between the north's poor health and its poorer productivity.

Tackling health inequalities between the north and south would put an extra £13.2bn into the economy, says the report. Improving health in the north is speculated to lead to substantial economic gains, reducing the £4 gap in productivity per-person per-hour between the north and the rest of England by 30 per cent, or £1.20 per-person per-hour.

Calling for more funding for prevention strategies, Professor Clare Bambra, lead author of the report, says: "For the Northern Powerhouse to reach its full potential there needs to be increased investment in place-based public health in local authorities." She added; "Work needs to be done to improve labour market participation and job retention among people with a health condition in the region."

Focusing on the importance of employment, the report also reveals that people in the north experiencing a spell of ill health are 39 per cent more likely to lose their job compared to their counterparts in the rest of England.

This is likely to have a detrimental impact on both physical and mental health. The report also suggests that a 3.5 per cent increase in the proportion of people in good health in the north may result in a 10 per cent reduction in the employment gap between the north and the rest of England.

Considering the wider impact, Dr Hakim Yadi, CEO of the NHSA, said: "Post-Brexit we need to build a stronger, healthier UK economy and the north of England is a key part of this. By improving health we can also make a direct impact on productivity and that is something no government should ignore."

Among the recommendations made in the report were calls for central government to increase investment in 'place-based' public health strategies. This could be achieved by supporting local authorities which in turn would boost labour market participation and job retention.

Further recommendations were made for stakeholders in the region to implement 'health first' programmes. These would include local integrated care systems and health and wellbeing boards to commission more health management and prevention strategies.

The report was launched on November 20 in Newcastle with Dame Jackie Daniel CEO of Newcastle Hospitals NHS Foundation Trust, Ben Houchen Metro Mayor of Tees Valley, Nick Forbes Leader of Newcastle Council, Dr Hakim Yadi CEO of the NHSA and Clare Bambra, Professor of Public Health at Newcastle University.

http://www.thenhsa.co.uk/2018/11/major-new-report-connects-norths-poor-health-with-poor-productivity/

1 in 4 hospital sites exceed WHO pollution limit

A new study from Public Health England has revealed that 1 in 4 hospitals and 1 in 3 GP practices in the UK are in areas that exceed safe levels of air pollution, according to World Health Organisation (WHO) guidance.

The study, commissioned by The British Lung Foundation and conducted by Cambridge Environmental Research, used existing data on PM2.5 levels to measure how many UK based health centres were in unsafe areas.

The research covered a total of 9,988 health centres across England, Scotlandand Wales (1457 hospitals and 8,532 GP practices), revealing that 248 hospitals and 2220 GP practices are currently in areas exposed to 'above recommended' levels of PM2.5.

Inhalation of these particles can have extremely adverse effects on human health. There is, in fact, no safe threshold below which no adverse effects can be expected.

Studies have consistently linked PM2.5 levels to multiple health outcomes, such as deterioration of the respiratory tract leading to irritation, coughing and impaired cardiovascular function. Ultimately, consistent exposure to dangerous levels of PM2.5 can lead to serious cardiovascular disease or lung cancer.

There is at least one large NHS trust in an area with unsafe levels of pollution in Birmingham, Cardiff, Leeds, Leicester, London, Nottingham Hull, Chelmsford and Southampton.

However, the study revealed that the problem is not exclusive to larger urban areas, with Ipswich, Westcliff-on sea, Gillingham, Worthing, Kettering, Basingstoke and Colchester being some of the smaller towns that are currently subject to unsafe pollution levels.

Currently, the UK complies with EU regulatory limits for PM2.5. However, the legal limit for PM2.5 is currently twice as high as the WHO recommendation (10μg/m3) and as such, this is still a concern for public health. Additionally, the report only highlighted the national average for PM2.5 levels and did not capture peaks caused by concentrated roadside traffic.

This report reinforces the need for action to be taken at a national and local level to incentivise clean air policies and improve air quality for public health.

https://www.gov.uk/government/case-studies/blf-new-data-on-pollution-levels-around-hospitals-and-surgeries
https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution#summary

Digital innovation to create social care of the future

Nine councils in England have been awarded extra funding for digitisation projects from NHS Digital and the Local Government Association (LGA).

Up to £700,000 of funding has been made available to support projects including anxiety triggers for people with autism, exoskeleton devices for carers, an online financial self-assessment and benefits checker and an app for social care providers to help them collate important employment information to improve the care recruitment process.

"These important projects will improve people's experience of care and support as part of efforts to support people's well-being," commented Kate Allsop, digital lead on the LGA's Community and Wellbeing Board.

In June 2018, twelve councils were awarded £20,000 in the 'discovery' phase to investigate local challenges that can be addressed using digital innovation. The extra funding has been awarded to nine projects to design and implement their solutions.

Councils who will receive the funding are:

- Bracknell Forest Council – Interactive information kiosks with information on community support and activities to combat loneliness.
- London Borough of Havering – App for social care workers to share employment information securely.
- Isle of Wight Council – Pilot for exoskeleton device for informal carers to help with manual tasks.
- Lincolnshire County Council – Online financial self-assessment and benefit checker tool for people on social care packages.
- Nottingham City Council – Portal for care providers and social workers to match outcomes with care packages and monitor progress.
- Shropshire Council – Data visualisation tool to improve commissioning for care home and home care markets by identifying areas of need.
- Stockport Metropolitan Borough Council – Fast-track installation of tailored assistive technology devices to reduce telecare false alarms.
- Sunderland City Council – Devices to monitor medication management, mood, nutrition and hydration around the home.
- Wirral Metropolitan Borough Council – Biometric wearable devices for people with autism and complex learning disabilities to identify periods of anxiety.

"The successful projects all showed great promise during their discovery phase, looking at a wide range of areas," said James Palmer, Programme Lead for the Social Care Programme at NHS Digital.

Mr Palmer added: "We will be sharing learning from the projects, with a view to these blueprints supporting other social care providers looking to innovate in the same area. "

Full details of the report can be found at http://accountablecarejournal.com

A disruptive tech vision for health and care

Rt Hon Matt Hancock MP, Secretary for Health and Social Care, presents his vision for a digital future for the NHS.

At an evening reception in partnership with Siemens Healthineers, Matt Hancock joined Public Policy Projects, Accountable Care Journal and Hospital Times to discuss his 'techvision' for the NHS. *'The Future of Healthcare'*, the Department of Health and Social Care's policy paper, outlined a digital future for the NHS based on open standards, innovation and interoperability. Mr Hancock was given the opportunity to reaffirm this agenda to a host of senior clinical leaders at the reception, which took place at the Institute of Engineering and Technology in London.

"The whole system is biting my hand off to have better technology"

With Mr Hancock's predecessor occupying the post for almost five years, many in the health and care sector have been looking to the Department of Health for fresh, innovative ideas. Mr Hancock began by acknowledging the timing of his appointment, commenting: "I am lucky to arrive at a moment when the whole system is biting my hand off to have better technology, all the way through from the basic IT to the most advanced cutting-edge use of machine learning on genomics to treat cancers far better than we ever have before."

With much of the health and care sector looking to the Secretary of State to stimulate the spread of innovation, Mr Hancock is under no illusions of the scale of the task ahead. He said: "Confidence must be established throughout the health sector to be able to make the first step into digital logistics before you even get into the linking of patient records. Then the linking of patient records between bodies, then onto the clinical and operational benefits you get from that, then through into the research that you can get from managing all that data in a way that is consistent with current privacy settings and within the sphere of good cyber security."

"People need to be allowed to try new things"

But despite the enormity of the task, "it is no less than that full spectrum that I am interested in," he said. That the health service has been unable to achieve this, Mr Hancock argues, is due to an inability to change our 'overly cautious culture.'

"More permission to fail and a lower fear of failure is one of the important changes that we need to drive through the health system," he added. "People need to be allowed to try new things." At the same time, the new strategy from the Department of Health is not based on the assumption that innovation is inevitable.

"If you are trying to change the culture of any organisation – it is not enough to presume that people have an innate capability or it is naturally going to change – it changes through rigorously applied tracing and training people in the new way of working," he considered.

"I can insist from the top but granting permission is far better"

As Secretary for Health and Social Care, Mr Hancock sees himself as a facilitator rather than a delegator and is trying to move away from the 'top-down' heavy style that has doomed previous attempts at digitisation. "I can insist from the top but granting permission is better. There are thousands of people in the NHS that are desperate to get going on this; it's about empowering those who want to make it work and highlight where it does work," he said.

Mr Hancock will be hoping that the digital 'disruptors' needed to drive this change will be encouraged by the 'open standards' set out in the aforementioned policy document. "We have learned a huge amount over the last 15 years about how to do this right and it involves setting standards and mandating them rigorously from the centre. Standards for interoperability, cyber-security, privacy and then allowing people to innovate on those grounds. That's what we are going to do."

The business case for investing in health

Tim Elwell-Sutton, Assistant Director of Strategic Partnerships at the Health Foundation, offers his insight on the impact of the social determinants of health, the cost of health inequalities and why, most crucially, it makes sense to invest in boosting health outcomes.

I got a letter recently from a new pension scheme I joined. It told me that I could start drawing my pension in 2044 – the year when I will turn 65. This raised two questions in my mind. First, what are the chances that I will be able to retire at age 65? (Answer: not good!) Second, what are the chances that I will be well enough to continue working beyond 65? Here, the odds are much better.

For someone of my socioeconomic profile, healthy life expectancy is well over 65. However, as Figure 1 shows, if you live in one of the most deprived parts of the country, the answer to that second question is quite different: healthy life expectancy for women in that group is just 51.8 (Figure1). That means they can expect, on average, to have 27 years of poor health at the end of life.

Is there a cogent business case for investing in health?

At a societal level, the case seems overwhelming if we invest in keeping people healthy, not just fixing them when they are already sick. This is vital because we know that the biggest influences on our health are not health services but the conditions in which we live, grow, work and age: the social determinants of health (Marmot 2010).

Investing in health does not just mean investing in the healthcare system. It means creating living conditions in which people can thrive physically, mentally and socially.

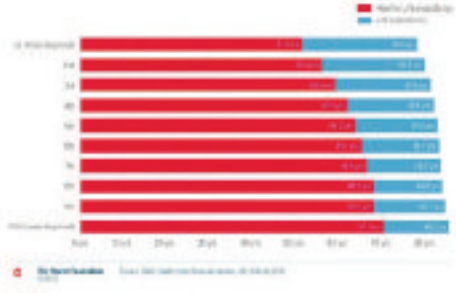


Figure 1. Life expectancy and healthy life expectancy by decile of deprivation

By contrast, public policy that is short-sighted and fails to take account of the wider determinants of health, has the potential to erode our quality of life and damage our productive potential. There are already worrying signs that the constant health improvements we have come to expect can no longer be taken for granted.

Life expectancy rises have stalled in recent years and life expectancy has actually started to decline in Scotland, Wales and Northern Ireland (see Figure 2), although these figures do not take account of possible health improvements in future cohorts. More worrying still, healthy life expectancy has failed to keep pace with life expectancy, particularly in more deprived areas.

So, what kinds of investments keep people healthy and reduce costs to society? These range from traditional public health programmes such as tobacco control to complex interventions such as Sure Start children's centres which support children and families at a crucial point in their lives.

However, in spite of evidence that these schemes have a positive impact, cuts to local authority budgets over the past 5 years have meant that investment in these services has declined substantially in recent years with spending on local tobacco control falling by 45 per cent between 2014-15 and 2018-19 (Finch 2018), and Sure Start spending falling by 59 per cent between 2009-10 and 2016-17 (Kelly 2018).

While there are clear social and economic incentives to keep people healthy, making the business case for specific interventions can be challenging. The causal pathways involved in population-level health interventions are often complex, making it more difficult to demonstrate clear links between intervention and outcome, or investment and return.

While this is difficult, it is not impossible. The Health Foundation is currently working with academic partners to develop and disseminate new methods for designing and evaluating the impact of interventions in complex systems.

Looking beyond individual services and interventions, there is also an important case to be made for investing in population health as an important contributor to economic and social outcomes.

Good health, in and of itself, enables people to have better enjoyment of their lives, of the goods and services they consume, and of the activities they undertake. Health can be a key determinant of the social and economic outcomes of individuals and of the places in which they live. Ongoing research funded by the Health Foundation is estimating the impact health has on such outcomes to better inform policy.

Figure 2. Change in life expectancy at birth in weeks: UK and UK countries, between 2014 to 2016 and 2015 to 2017

The case for investing in healthcare has been made very effectively in recent years with spending on the NHS set to rise from 20 per cent of total government spending in 2000 to 38 per cent by 2023-2024 (Zaranko 2018). Making the case for investing in keeping people healthy is, in many ways, more challenging but the prize – a healthier, more productive society which allows people to flourish – is one worth fighting for.

By Tim Elwell-Sutton, Assistant Director of Strategic Partnerships, The Health Foundation
https://www.health.org.uk/about-the-health-foundation/our-people/healthy-lives-team/tim-elwell-sutton"

Professor Russell Viner

Royal College calls for ban on energy drinks for under 16s

Professor Russell Viner, President of the Royal College of Paediatrics for Child Health (RCPHC), has responded to the government's consultation on energy drinks, urging them to ban the sale of sugary drinks for under 16's.

The RCPHC spoke to around 200 children and young people before responding to the consultation. Many children drink energy drinks because "they wake them up, give them energy and they are cheap," said Professor Viner. However, he claims this is untrue.

In addition, the college raised concerns about the limited body of evidence surrounding the impact of caffeine and sugar on the body and minds of young people.

In addition, the RCPHC also recommended that:

- School-based Personal, Social and Health Education (PSHE) programmes be delivered by experts covering healthy diets,
- a minimum price be applied to all energy drinks,
- there be clear sponsorship rules for events and sport athletes,
- clear labelling be applied to caffeinated products with warnings if caffeine content is particularly high,
- And there be a ban on energy drinks in vending machines.

Is there a wider question to be asked about public health education?

Children and young people get energy from food, sleep, exercise and positive interactions with others, all factors that need to be encouraged if issues are to be addressed.

There is clearly a need to educate young people on the damage caused by readily available consumable products, similar to the efforts made to curb smoking. However, this will need cooperation from retailers, schools and even families if public health benefits are to be seen.

This response comes amidst the RCPHC's support of Action on Sugar Awareness Week which runs from 12 to 18 November. Dr Max Davie, Officer for Health Promotion at the college, raised concerns over the close links between excess sugar consumption among young people and the 'ongoing childhood obesity crisis.'

"With the introduction of the soft drinks industry levy, and the ongoing consultation on energy drinks, the government's Childhood Obesity Plan is making steps towards reducing children's excess sugar consumption and is helping to educate the public on the impact that added sugar can have on their health," said Dr Davie.

Is enough being done?

It is clear that further steps could be taken to address these issues with the right political will. However, where does the duty of the state end and families begin? Should this go as far as making health education a compulsory subject at school? Perhaps not, but there are clear advantages in ensuring young people are aware of the harmful effects of excessive sugar in their diet.

Steps have already been taken with the introduction of the soft drinks industry levy. However, the impact on health outcomes for young people is still unclear.

In a letter from the Health and Social Care Committee to the Secretary of State on 3 October, Committee Chair Dr Sarah Wollaston MP outlined their support for action to ban the sale of energy drinks to children. Citing the conclusions of the report 'Childhood Obesity: Time for Action,' Dr Wollaston called for further action from the government to continue with its sugar reduction and wider reformulation strategy. She urged the government to "maintain the pressure on industry to reformulate through concrete further action if there is not faster progress on reformulation, and this action must come regardless of any legislation on energy drinks."

The Science and Technology Committee is conducting an inquiry into the consumption of energy drinks with a report to be published later this year.

We await the outcome of the government's consultation, which closed on the 21 of November, to gain further certainty over future policies in this area.

Secretary of State Matt Hancock leaving Downing Street

New focus on prevention to provide five extra healthy years by 2035

The Department of Health and Social Care (DHSC) has released a new policy green paper outlining the Government's renewed focus on prevention.

In the paper entitled *'Prevention is better than cure'*, the Secretary of State for Health and Social Care, Matt Hancock, outlines his own vision for prevention. The mission, he says, is to ensure that people enjoy at least five extra healthy, independent years of life by 2035, while at the same time narrowing the difference in life expectancy between the richest and the poorest in the UK.

The plans also outline the Government's intentions to reduce loneliness, reduce childhood obesity by half by 2030 and diagnose three quarters of cancers at stage 1 and 2 by 2028.

While the Government has not announced any additional measures to support this focus on prevention, Mr Hancock suggested in a speech on Monday that more of the additional £20.5bn the Chancellor Phillip Hammond found for the NHS this year will be used to improve prevention. "In the UK, we are spending £97bn of public money on treating disease and only £8bn preventing it," said Mr Hancock. "You don't have to be an economist to see those numbers don't stack up."

Responding to the plan, Niall Dickson, Chief Executive of the NHS Confederation which represents 85% of NHS providers and commissioners, said: "This is great leadership from the Secretary of State. If backed by action and resources this could be a seminal moment."

Encouraging personal responsibility

As part of the plan outlined in the green paper, Mr Hancock is encouraging people to take more personal responsibility for preventing illness before slipping into ill health. "Prevention cannot be solved purely by the health and social care system alone," said Mr Hancock. "Everyone has a part to play and we must work together across society."

This repeated theme within the green paper - the 'everyday decisions' that people have personal responsibility for - aims to reduce levels of obesity and smoking in the UK, while also encouraging heathier lifestyles overall.

Although the green paper does identify the "role for government to create the environment that makes healthy choices as easy as possible", the focus on personal responsibility over health has caused some controversy among clinicians who suggest that the plans shift too much blame towards citizens themselves.

Limited resources at a local level

The primary obstacle facing Mr Hancock's prevention plan is one of local funding. While it may be true that part of the additional £20.5bn found for the NHS this year will go towards this, the plan still relies heavily of the cooperation of local and civic authorities to put prevention "at the heart of everything they do."

Welcoming the intent of the plan, Helen Donovan from the Royal College of Nursing said that Mr Hancock "must realise his plans will start at a disadvantage as local authorities struggle with planned cuts to public health budgets of almost 4 per cent per year until 2021."

Meanwhile Shadow Health Secretary, John Ashworth, dismissed the plan, labelling its aims as 'laudable'. He said that in local communities, years of cuts and "failed privatisation have resulted in health visitor and school nurse numbers falling, while children are losing out on the key early years health interventions they need." He went on to say that unless future planned cuts to public services were reversed, the plans would be "be dismissed as a litany of hollow promises."

A small country with a big punch in medicine – The Czech Republic

For a country with a population of around ten million, it's surprising to hear that the Czech Republic is a global leader in specialist, cutting edge healthcare. But despite its size, the Czechs can boast some major achievements in medical innovation.

The first heart transplant to be performed in Eastern Europe was undertaken in the Czech Republic. Similarly the Czech Republic has world-renowned cancer care and makes use of high class, home produced, medical devices and facilities across the cardio and gastrointestinal, medical technology and general medical sectors.

"Both the standards of medicine and of the medical devices produced are regarded as some of the best in Europe," said Czech Ambassador to the UK, Mr Libor Secka, at the Medical Devices Day at the Czech Embassy in London in October. "It is well known at home but our reputation is growing abroad every week."

But Czechs experts are not standing still and relying on past achievements, but moving forward and keeping abreast of global scientific progress. Currently, the Czech Republic spends more resources on research and development than many competing countries.

"It's no exaggeration to say that Czech producers are world class and offer top quality"

The keynote speaker at the event was Deputy Minister for Health, Radek Policar, who echoed the Ambassador's comments: "We have long tradition of high quality medical device production that is competitive on the global market. It's no exaggeration to say that Czech producers are world class and offer top quality, cutting edge technology."

Czech Ambassador to the UK, HE Mr Libor Secka entertains embassy guests

Speaking to Hospital Times about the way in which the Czech Republic has been able to innovate in medicine to such a level, Mr Policar said : "It is down to our tradition of solid relationships between clinicians, suppliers and the government. It has always been this way so we have found it easier to innovate than other countries of a similar size." Epitomising this level of clinical cooperation is Mediatrade, which has more than 20 years of tradition in working with doctors to produce high quality, globally used, pacemakers.

Understandably, there is a high amount of pride in the level of innovation occurring in Czech medicine. Karel Volenec, Chairman the Association of Manufacturers and Suppliers of Medical Devices, noted that it is the Czech Republic, not the United States, that is currently supplying UCL in London with first ever self-expandable, biodegradable prosthesis. "We can offer devices that are not only commercially competitive but truly globally unique," said Mr Volenec.

Czech Deputy Minister for Health Radek Policar addresses guests

Exporting innovation

The Czech Republic medical sector currently exports to a high extent. Ella-CS, a purely Czech-owned company which specialises in stents for the gastrointestinal tract, already distributes to more than 60 countries worldwide. Additionally, MZ Liberec distributes high quality medical gas distribution systems to 45 countries worldwide, including China.

Clinical Programme Lead for NHS England, Dr Nikki Patel, spoke at the embassy of the need for innovative manufacturers such as those offered by the Czech Republic. "The ever-increasing needs of our patients will require ever-increasing technology to address them and suppliers who have innovative products and services to help the NHS deliver the services we need," said Dr Patel.

She added she hoped that in the future the UK will be able to make use of the innovative medical devices currently being produced in the Czech Republic and that the UK health care market will be able to facilitate this. "We are trying to develop a market of innovation to help our suppliers survive," she said.

Most of the firms present at the event are already suppliers to a large international market and are now seeking partners in the UK. With such innovative and new medical products, the Czech medical sector is sure to find new markets both here and abroad.

The changing face of health and care regulation

Andrea Sutcliffe, Chief Inspector of Adult Social Care at the Care Quality Commission, on turning the organisation around and her plans for the Nursing and Midwifery Council.

As Andrea Sutcliffe prepares to leave her role at the Care Quality Commission, she can look back at five years of success in revitalising a once-flagging institution. Named by the Health Service Journal as the 3rd most influential woman in the NHS and the 25th most influential person, she has brought her evident skills to bear on the somewhat previously nebulous world of health and social care regulation.

Andrea fully believes that the CQC exists to ensure people receive health and social care services that are safe, high quality, compassionate and effective. "But people were not clear on what we were doing; we were not delivering an effective regulatory regime in the way that people needed us to," she said. "Now nobody can dispute what we are here for."

The Care Quality Commission (CQC) was established on April 1st 2009 and saw the merger of three UK health watchdogs: the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. In combining the three, the CQC was designed to be the UK's principle health and social care regulator, an authoritative and respected voice to maintain standards across all aspects of health and social care.

CQC starts under pressure

Mounting criticism against the standard and the frequency of evaluation marred the early days of the CQC. Care homes were becoming increasingly neglected from inspection, while misconduct and malpractice was consistently going unnoticed across the acute sector. This culminated in an unprecedented performance and capability review from the department of health. The report found that the CQC had an 'out of touch leadership' with 'no clear strategy', ultimately leading to Chief Executive Cynthia Bower's resignation in 2012.

In 2013 Andrea Sutcliffe became Chief Inspector of Adult Social Care at the CQC, a newly-created position designed to address the increasingly gaping hole in social care service evaluation across the UK. The context surrounding her appointment was never lost on Andrea, and she was under no illusions as to why people doubted the ability of the CQC to regulate care services.

With her team she has had to navigate a fragmented, diverse and complex picture in Adult Social Care, currently responsible for regulating 25,000 locations, run by more than 12,000 providers, with 152 local authorities commissioning those services and 10 different trade associations representing those providers.

The challenges presented by operating in such a fragmented landscape were daunting. In her view, "regulation alone cannot secure the improvement and the sustaining of good quality care that people want." An approach that includes providers, national partners, with government and its various agencies listening to the voices of people using these services is more preferable and conducive to success.

Wider challenges

Wider challenges facing the social care sector are equally as obvious. Issues of staffing and recruiting continue to be a problem with high levels of vacancies and turnover in critical roles in registered managers. The funding restraints that have exacerbated these problems are no means a recent problem, but clearly it has put a tremendous amount of pressure on commissioners of services as well as providers.

Despite financial restraints on care providers, it has never been Andrea's role to compromise on CQC principles of standards. "If a provider tells me they cannot improve services because the local contract with commissioners doesn't allow for it, then they should use the evidence the CQC has provided to argue for more funding."

Particularly frustrating for Andrea is the lack of understanding people have of social care. "It drives me to distraction when people say that it is low skilled work. It doesn't receive the recognition that the NHS and other hospital services have. As a result, one of her greatest challenges has been to make sure that there is a consistent profile for adult social care and ensure that people never lose sight of this.

Supporting the elderly

Andrea has used her position to work with the NHS and other local authorities to provide a framework for the assessment of integrated health systems and place-based models of care. Last year, the then Secretary of State for Health asked the CQC to look at 20 local authorities to see how the system assisted elderly people and helped them move through different aspects of their care.

"We looked at how those systems supported people to maintain their health and being in their normal place of residence," she says. "We also looked at what happened in a crisis, and the aftermath of the crisis – in effect the whole process."

As Andrea's team didn't have a framework in place for this work, it was undertaken in conjunction with local authorities and the health service, using the framework in

place for individual inspections. "We asked the same questions - was it safe? Caring? Effective? And was it responsive to people's needs?" This exercise has given Andrea's team an excellent basis with which to work in the future, looking at local authorities and systems where they are integrated. This work was ultimately published in July of this year in a report entitled *Beyond the Barriers.*

The obstacle facing Andrea and her team in evaluating integrated care is one of commissioning. The CQC currently needs to have explicit permission from the Secretary of State in order to conduct work of this nature.

"Ultimately we are looking to obtain extra authority to enable us to review these integrated systems as there are going to be an increasing amount of them. People who move between these systems do not live in health and social care silos – they want person centered, coordinated care."

Ahead of the upcoming Social Green Paper Andrea wants to see additional money guaranteed for care services, but believes that if the focus is purely on funding then an opportunity will be missed. "It's not just long term sustainable funding – we can do this better by focusing on person-centred, coordinated care. That is my number one ambition for the Green Paper."

She also wants to see a Green Paper that recognises adult social care in and of itself, not just to bail out the health service, but one that has its own purpose in terms of supporting people in the most vulnerable circumstances of their life and to help them maintain independence. "This must be applied holistically across all age groups," she insists.

The Nursing and Midwifery Council

As of January 2019, Andrea will become Chief Executive of the Nursing and Midwifery Council (NMC), the largest regulator in Europe, accounting for more than 690,000 nurses, midwives and other associates. "There are some real challenges in terms of the scope and breadth of the role," says Andrea. "The NMC has done much good work over the last few years, but it's quite clear based on feedback from the Professional Services Authority, both in their performance review of the NMC and the lessons learnt around Morecambe Bay (published this year) that there is still a way to go."

"We need to be clear about our standards and expectations of people on those roles, that they have the education and support to deliver – where there are problems, we look to see what we can do to help and, if necessary, remove them from the register."

Andrea will look to apply a personal touch to her new role at the NMC and the level humanity that defined her time at the CQC where she is known for coining 'the mum test' in evaluating care services. "The mum test was not originally my idea, but what was original was to apply it to a regulatory regime - is this a service you would want your mum to use? If yes, then we need to celebrate that, if not we need to do something about it. And I think absolutely the same applies to the NMC."

In taking up the role as Chief Executive of the NMC, Andrea will have the unique perspective of having had senior positions at two major regulatory bodies. Reflecting on how UK health and care regulation compares with equivalent bodies abroad, Andrea says: "I think the Care Quality Commission is leading the way. We have a regime which is clear and understandable to the public and providers; we provide excellent information to providers and the public as well and I think that we speak with an authoritative voice about the issues of the day that is listened to and responded to by our other partners and government. I can't think of another regulatory body which spans health and social care across the world that has achieved such a feat.

"The challenge we all have, and I don't think any of us have cracked this yet, is how to use the intelligence and information we get from services to inform our collective understanding of risk, so that we can go back out and inspect services in a much more targeted and proportionate way."

Kings Fund Review into CQC

The Care Quality Commission (CQC)'s 'Ofsted-style' inspection and rating regime is a significant improvement on the system it replaced but could be made more effective, according to a King's Fund report.

The report, funded by the National Institute for Health Research, found that the impact of the inspection regime came about through the interactions between providers, CQC and other stakeholders, not just from an individual inspection visit and report. It suggests that relationships are critical, with mutual credibility, respect and trust being very important. The report calls on providers to encourage and support their staff to engage openly with inspection teams.

The report highlights a number of areas for improvement in CQC's approach. It cautions that the focus on inspection and rating may have crowded out other activity which might have more impact. It recommends that CQC focus more on regular, less formal contact with providers.

The evaluation found significant differences in how CQC's inspection and ratings work across the four sectors it regulates. Acute and mental health providers were more likely to have the capacity to improve and had better access to external improvement support than general practice and social care providers. The report recommends that CQC think about developing the inspection model in different ways for different sectors, taking into account these differences in capability and support.

Ruth Robertson, report author and Senior Fellow at The King's Fund said: "Although we have heard general support for their new approach, we also uncovered frustrations with the process, some unintended consequences and clear room for improvement."

According to Kieran Walshe, report author and professor of health policy and management at Alliance Manchester Business School, the University of Manchester: "CQC has already taken some of our findings into account in developing their approach to regulating health and social care. Fundamentally, the purpose of regulation is to drive improvement – not just in poorly performing providers but across the board.

"But CQC cannot do this alone. It is just as much up to health and social care providers, and other stakeholders like NHS England and NHS Improvement, to make regulation work in improving services for patients."

Giving healthcare professionals control over their working lives

What did you do when you first woke up this morning? A lot of us will reach for our phones – whether it's to check the time, get the weather forecast or have that first scan of emails.

Whether we like it or not, our phones are an integral part of our lives, but when it comes to working in the NHS the digital experience is often very different for the new generation of healthcare professionals.

For those who have worked in the NHS for some time, although the relationship with digital is improving, it's still a complex one. 101 logins for different websites, systems and apps, many of which can only be accessed when you're on site and on a computer terminal. Communication comes from printed newsletters, email, text and increasingly via social networks such as Whats App.

All of this can play a role in how connected staff feel to their organisation and how much control they have over their working life. We all know the importance of staff satisfaction and good engagement. In March 2018 the King's Fund published research which brought the impact of engagement to the forefront:

"There is clear evidence that Trusts with higher engagement levels have lower levels of sickness absence among staff, and also have lower spend on agency and bank staff….An average upward shift of only 0.12 on scores on a five-point scale (NHS staff survey) is associated with a saving on agency/bank staff spend of 1.7m."

Ryalto gives healthcare professionals a simple way to manage their work life, from their phone. With experience across critical NHS functions we have an acute understanding of the challenges faced by staff on the ground and the leadership teams looking to drive positive change, backed up by talking to Trusts and their staff to find out where the issues lie.

Designed in partnership with NHS staff, our mobile app provides a comprehensive set of tools and content, from the latest Trust news and policies to bank shift booking, feedback and secure messaging,

Live in 14 hospitals (and soon more), as well as the Wessex Deanery (where we're supporting junior doctors), the impact has been incredibly positive.

The app has thousands of active users, 66 per cent of them reading Trust news every week. Hundreds of thousands of messages are sent via our secure platform. For a medium-sized Trust we save an average of £107k in three months via reduced agency commission alone.

Now staff can manage every aspect of their working day from the palm of their hand.

If you'd like to know more about Ryalto, then get in touch – email hello@ryaltoapp.com. We'd love to chat with you.

Leading think tanks predict major NHS workforce shortfall by 2030

An alarming 250,000 shortage raises vital questions for the ambitions of the forthcoming NHS Long Term Plan

The briefing, entitled *'The health care workforce in England: make or break?'*, draws on a new forecast of staffing gaps in the 1.2 million-strong NHS workforce to stipulate that the yet-to-be-announced plan may be unachievable from the outset. From 100,000 staff vacancies at present, it is thought that by the end of the next decade one in six health service posts could be empty.

Experts from leading health think tanks The Health Foundation, The Nuffield Trust and The King's Fund warn that shortages could reach more than 350,000 if the NHS continues to lose staff from abroad without being able to attract others to fill the posts. According to Candace Imison, Director of Policy at the Nuffield Trust, the situation has "reached a critical juncture," adding that "unless the NHS Long Term Plan puts in place urgent and credible measures to shore up the workforce both in the short term and in the longer term, it risks being a major failure."

The NHS Long Term Plan will set out how the health service will change over the next ten years in response to funding boosts announced this year. However, even before the extra funding, the briefing suggests the NHS was not able to recruit effectively due to an incoherent approach to workforce policy, poor planning and restrictive immigration rules.

In response to the briefing, Danny Mortimer, Chief Executive of NHS Employers, suggested what is needed is "more

1 **Address the immediate workforce shortages.** Urgent measures are needed to address shortages in certain jobs and locations, such as radically boosting international recruitment in the aftermath of Brexit and improving staff retention.

2 **Deliver a sustainable workforce over the next 10 years.** This will involve expanding training places and apprenticeships and will require the government to look into financial incentives to attract more nurses.

3 **Support new ways of working across the health and social care workforce.** Including making better use of the skills of some existing staff– such as a far greater role for nurses, pharmacists and physiotherapists in family doctors' surgeries.

4 **Address inequalities in recruitment, pay and career progression.** Tackling gender, race and other inequalities must be a key feature of national and local workforce strategies.

5 **Strengthen workforce and health service planning.** This should involve a much more coherent and transparent approach to planning and strategy development.

flexibility with the use of the apprenticeship levy as well as reinstating funds to support CPD and workforce development."

According to the report, funding for education and training dropped from 5 per cent of health spending in 2006/7 to 3 per cent in 2018/19, the equivalent of a £2bn drop. Further challenges come from concerningly high levels of health staff leaving service before the age of retirement.

The briefing sets out five tests for the NHS Long Term Plan. These tests would require a 'funded and credible strategy' to:

In response to the report, Emma Broadbent, Director of Revalidation and Registration at NMC, said: "It's encouraging to see that the number of nurses and midwives on our register from the UK and countries outside of the EU is increasing, and we look forward to welcoming the first qualified nursing associates in January."

However, she also called for more to be done to "retain the highly skilled workforce we have" by investing in training and career development. This goes beyond acute trusts and applies to all corners of increasingly integrated health and care systems in England.

"We are currently short of at least 6,000 GPs in England, and if this isn't addressed, it is our patients who will ultimately bear the brunt by not being able to see their GP when they need to," said Professor Helen Stokes-Lampard, Chair of the Royal College of GPs.

Equally serious are the pressures and strains on the social care workforce where there is a 'critical interdependence,' with health, the three organisations argue. This sector is even more reliant on 'low-skilled' migration, currently experiencing exacerbated levels of uncertainty due to Britain's exit from the European Union.

What about funding?

The NHS received a crucial funding increase from the Chancellor of £20.5bn in the Autumn Budget. However, for these funds to be used effectively, a reasonable portion must be spent on workforce training and development.

Richard Murray, Director of Policy at The King's Fund, said: "Unless the NHS long-term plan is linked to a credible strategy for recruiting and retaining staff, there is a real risk that some of the extra funding pledged by the government will go unspent and waiting lists for treatment will continue to grow."

This is a real concern as we await further details of the NHS Long Term Plan due to be published before the end of the year.

More than just recruitment

Of course, workforce needs are not just related to numbers. It is also about ensuring staff are trained and adequately skilled to deal with patients that have increasingly complex health and care needs and an ageing population.

The briefing comes amidst drives to boost the adoption of new technologies in health and social care which take advantage of new digital capacity and innovation. However, politicians must remain aware that these advances are no substitute for a strong and capable workforce.

Recruitment, training, career development and retention of staff must all be looked at to avoid a potential crisis in the NHS and wider health system. This requires long-term planning as, unlike emergency funding, a functioning workforce cannot be delivered overnight.

"It takes 10 years to train a family doctor," commented Professor Stokes-Lampard, reinforcing the need to take a long-term view. While trainee numbers are at the highest rate ever, this does not alleviate pressures on the system now and may still lead to pressures in the future as demands on all aspects of health are set to increase.

It is clear that these issues must be addressed in conjunction with systematic change to integrate health and social care, the delivery of prevention strategies and existing pressures in the primary and acute sectors. "The NHS is overstretched and services are being compromised by serious staff shortages," commented Anita Charlesworth, Director of Economics at the Health Foundation.

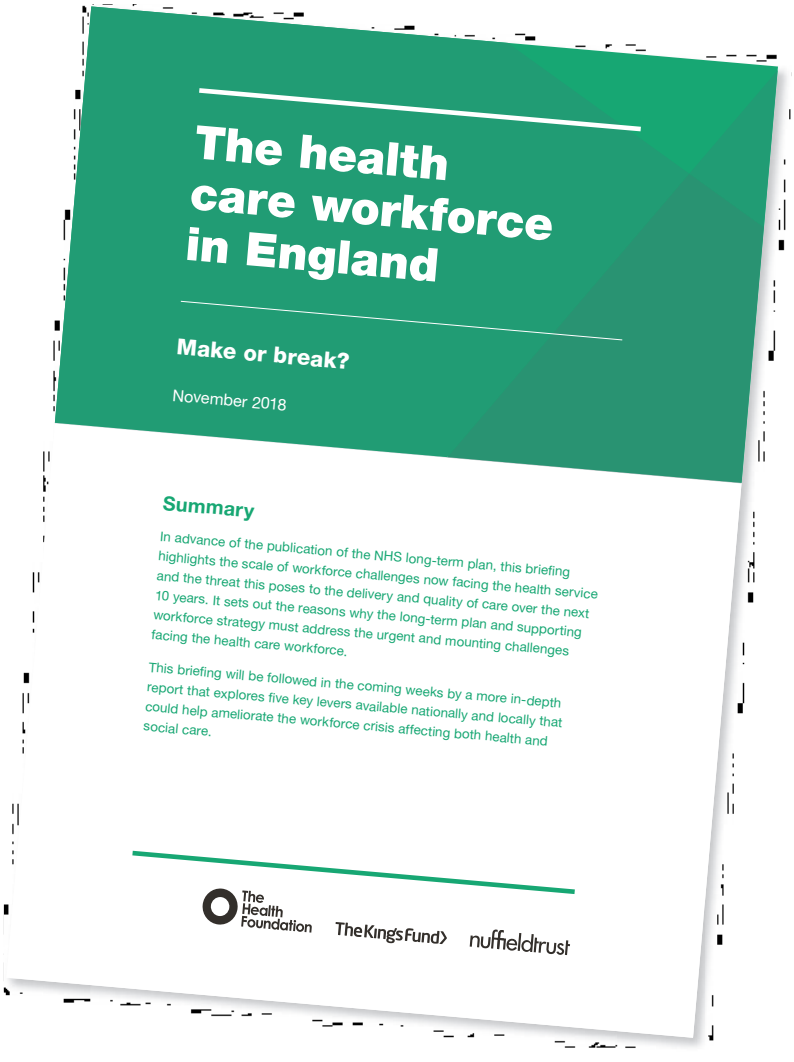
On the current trajectory, things are set to get worse. "The NHS can't sustain current services, let alone improve, with such a large and growing gap between the staff it needs and the people available to provide care," she added.

What are the impacts of staff shortages?

Firstly, the quality of care delivered in all aspects of the health system will decrease. Without adequate staff to manage demands, wait times will likely increase, meaning patients will be in a worse condition by the time they are able to receive treatment and, in some cases, may not be treated in time at all. It may also mean that certain elective procedures are withdrawn to the detriment of patients.

However, the impacts are not just limited to patients. Existing staff will be placed under greater levels of pressure as they struggle to meet the needs of patients across the breadth of the system, increasing the likelihood of mistakes, burnout and decreasing standards of patient care.

Now is the time to address workforce concerns, or at the very least develop a credible strategy to do so, if the NHS Long Term Plan is to have a chance at being successful.



Download the full report at:
http://accountablecarejournal.com

NHS managers must take back seat approach for innovations to spread

An extensive study has suggested managers need to be 'back seat drivers' and share leadership if much-needed innovations are going to spread across the NHS.

Billions of pounds are spent annually on Research and Development in the NHS – the National Institute for Health Research has an annual budget of £1bn alone – and yet spreading innovations across hospital trusts is notoriously problematic.

Graeme Currie and Dimitrios Spyridonidis of Warwick Business School followed the progress of 12 innovation projects for three years as attempts were made to spread them across NHS trusts.

The report encompassed 210 interviews and 56 hours of observation. One innovation dealing with chronic obstructive pulmonary disorder (COPD) was found to be the stand out performer as it successfully spread to 15 other healthcare providers, while others were less effective. The cost savings from this particular intervention were in the region of £124,000 across each of the 15 trusts.

"It was a workforce innovation where a team combining nurses, community nurses, and doctors was assembled and through a programme of care, education around lifestyle and monitoring they were able to keep long-term sufferers of respiratory conditions under control and out of A&E, so saving the trusts thousands of pounds while improving patients' health," said Professor Currie.

Graeme Currie

Dimitrios Spyridonidis

"There were other great innovations we looked at involving HIV care, diabetes and more, but they did not spread as successfully as this COPD innovation. This was because they did not have the same shared leadership model as the COPD innovation - either managers put too much pressure on doctors with performance or financial targets or those innovations initiated by doctors simply ran out of money.

"But this COPD innovation saw managers, nurses and doctors working in concert. Managers gave the mandate to innovate and provide the resource, but then took a back seat. They understood that doctors have the power and expert knowledge while nurses deliver the care, so they understand the operational context."

At the hospital in North West London where the study took place, managers outlined the problem with COPD and called for funding bids to work on solutions. The winning bid from a group of doctors was then given a trial and evaluation period. Managers took a back seat as doctors worked with nurses in the hospital and community in putting together a package of care. To enable the trial to spread to other hospitals in the region, managers created structures and organised meetings between doctors, commissioners and peers to reveal evidence of the successful innovation.

Nurses in each hospital would then take over leadership of the innovation by adapting it to their context and environment. As one manager said: "We cede responsibility for innovation to medical leaders but provide support for their projects, specifically through supporting leadership development for innovation. The result is sharing of leadership with junior doctors now emerging as champions for innovation."

Managers were reliant upon doctors to influence commissioners to release extra resource to help spread the innovation. As one doctor commented: "This could be the template for lots of other innovation attempts."

Working in the NHS is getting harder for doctors – according to new report

The majority of UK doctors are happy to be doctors and find their jobs rewarding, but most say working in the NHS is becoming harder, with staffing levels and workloads being cited as the biggest challenges.

More than 800 UK doctors responded to questions about their salaries, levels of debt and net worth, and whether they were satisfied with their job and career choice. They were also questioned on the impact of Brexit, with three in ten saying it was affecting their plans and more than a third saying they were considering moving to work abroad.

Additionally, the Medscape reports found that:

Read the full report at www.hospital-times.co.uk

- The average annual income is £114,600, and 3 out of 5 doctors say they aren't paid enough. Male doctors are more likely than female doctors to say they should be earning more. Pay dissatisfaction is also more common in younger doctors.
- The salary survey found a gender gap in pay, with male doctors in the UK earning an average 56% more than their female counterparts. Full-time female physicians earn an average £80,000 p.a. versus £126,400 for men. In contrast, the NHS figures published earlier this year reported a gender pay gap of 21.2%
- More than half of all doctors say being good at what they do and the gratitude from their patients makes the job rewarding, but 87% of doctors say increased workloads, lack of funding, waiting lists and resources have made their job more challenging in the past year.
- The majority of doctors – 83% — are happy with their career choice, but less than half would want their children to be doctors.
- Mortgages, car loans and childrens' private school/university tuition represent the largest debts for physicians over age 45; for those younger, it is mortgages and their student loans.

Medscape is a leading source of clinical news, health information, and point-of-care tools for health care professionals, offering specialists, primary care physicians, and other health professionals the most robust and integrated medical information and educational tools.

Royal Liverpool Hospital to be delivered after Carillion collapse

The Royal Liverpool and Broadgreen University Hospitals NHS Trust, The Hospital Company (Liverpool) Ltd (THC) and the lenders (the European Investment Bank and Legal and General), have finally signed a legal agreement that will terminate the 2013 project agreement with Carillion and will enable construction work on the new hospital to be restarted.

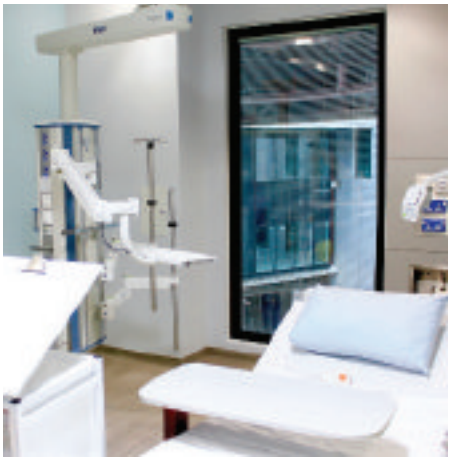
Construction work on the new hospital began on 3 February 2014 and was originally scheduled to be completed by March 2017 but moved to February 2018 due to asbestos removal and structural issues. However, at the end of November 2018 Carillion informed the Trust that they would be unable to meet this date but were not able to provide a revised date before going into liquidation in January 2018.

Since then other problems have hampered progress further as a post-Grenfell fire inspection in September revealed that Carillion had used non-compliant cladding throughout the hospital.

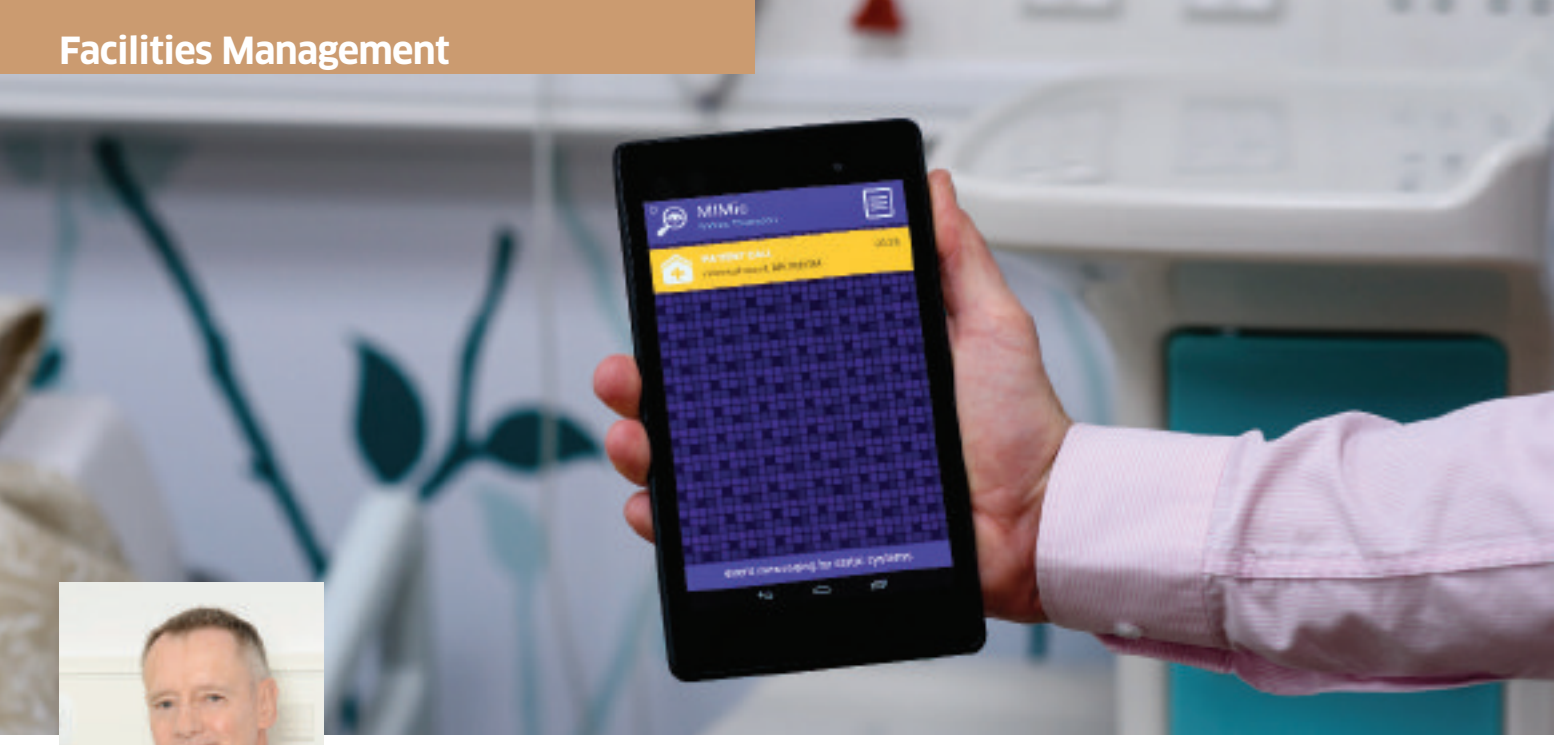
Construction work on the new hospital is expected to be completed in 2020. The Government will also be finalising details of the funding package that will enable the Trust to complete the project.

Aidan Kehoe, Chief Executive of the Royal Liverpool and Broadgreen University Hospitals NHS Trust said: "We are delighted to announce that we, The Hospital Company, lenders and the Government have all signed up to this agreement and the new Royal will now be publicly funded."

The new facility will provide single room en-suite accommodation for inpatients, with 646 bedrooms across 23 wards. It will have 18 state of the art operating theatres and one of the biggest Emergency Departments in the North West, with dedicated ambulance-only access. It will also have a large MHRA Phase 1 accredited clinical research facility to support human clinical trials.



Once the new Royal has opened, the current hospital will be demolished and landscaped to provide underground car parking and space for the creation of the Liverpool Health Campus. The hope is that the campus will transform the gateway to the city of Liverpool, alongside the regeneration of this area of Liverpool into a bustling, cosmopolitan Knowledge Quarter.



Enhancing the patient experience

Phil Wade, Director of Marketing at Static Systems Group, explores how the latest developments in nurse call technology are revolutionising patient care.

Across the healthcare industry there is an increasing focus on task management – in particular using technology and data collection in a meaningful way to assist nursing staff and support teams in their daily tasks. The role that nurse call systems can play in task management cannot be underestimated and, thanks to more widespread adoption of IP, VoIP and RFID technologies in healthcare settings enabling integration, nurse call is fast becoming the hub of the patient ward.

A nurse call system, in essence, provides interconnectivity between the patient's bedside and nursing and medical teams on the ward, as well as to central points throughout the hospital, such as bed management, catering, estates and porters. Alarms, patient services, voice communication, diagnostic information and other important data can all be integrated into nurse call systems. These notifications and data can then be shared to a range of devices such as VoiP telephones, as well as messaging platforms for tablets, smartphones and other mobile devices.

At Static Systems we have developed an information portal as part of our nurse call system that enables patient information and a range of 'tasks' associated with an individual patient to be captured and displayed at the patient bedside.

The information portal can be easily integrated as part of a screen into the bedhead unit and effectively replaces the traditional whiteboard used for patient basic patient information. In addition to these details, routine information about diet requirements, pain management and time until the next required observations and medications are all captured and displayed on the portal for sharing and alerting, as relevant, on mobile or tablet devices of the staff members.

Specific tasks can be initiated from the bedside and sent to tablets or vice versa and, once a task is complete, it can be closed down, with all timings recorded. If, for example, a patient requires their blood pressure to be checked every four hours, this can be set as a 'rounding' task with an alert sent to the relevant staff at the due time and a reminder continuing until this task has been actioned.

The portal can also be used to request, for example, catering, porters or housekeeping – all at the touch of pre-defined icons. When used for bed management it means that once a patient has been discharged, the bed can quickly be cleaned and turned around ready for the next patient.

The benefits of managing tasks in this way are manifold: nurses, clinicians and support staff are able to raise tasks or collaborate with their colleagues without having to go and find them on the ward, saving time and maximising efficiencies. Calls and tasks can be routed to a specific nursing or support team to be dealt with without the need to return to the staff base. As all tasks are 'time stamped' on the nurse call database, response times and performance objectives can be easily reviewed. Fundamentally though, the portal ensures that the right person for each particular task can be easily and promptly notified of the requirement.

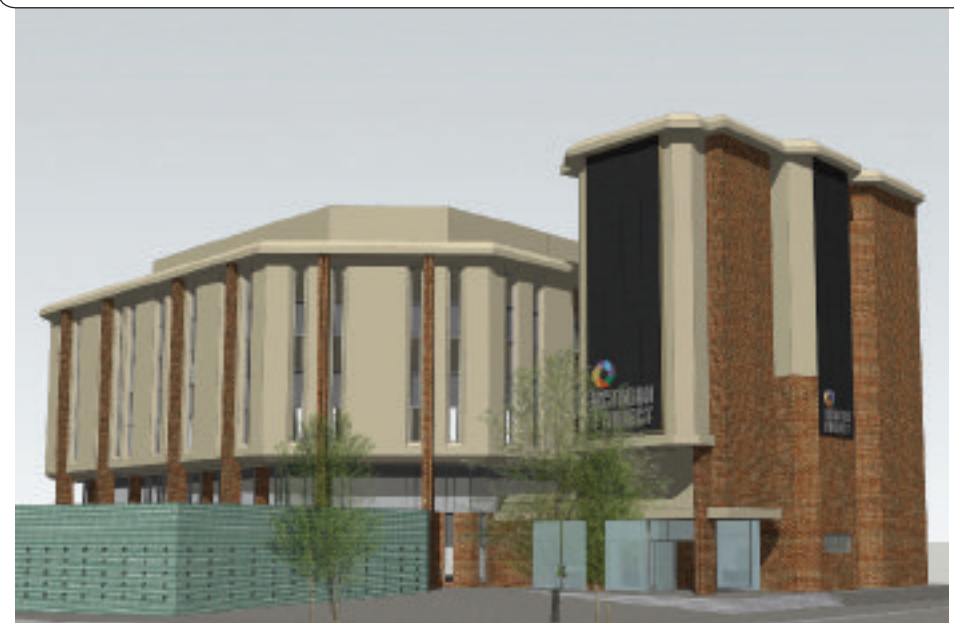
Enhancing patient safety

Patient safety and enhancing the patient experience will remain key themes over the coming years and this is another area where nurse call, when combined with the latest technologies, can play a vital role. For example, nursing staff can be alerted if a patient exits their bed or room, enters the bathroom, or spends an excessive amount of time in the bathroom and therefore may need assistance. All of these measures support patient safety during a hospital stay.

Furthermore, in terms of enhancing the patient experience, we can build up a picture of clinical activity at the bedside during a patient's stay. Data such as when the patient was admitted, length of their stay, which wards they spent time in, which calls or tasks were raised, which nurses responded to them, average response times and even how the patient rated their care in a satisfaction survey can all be captured.

Data collection and analysis of this type of information not only helps nursing management understand peaks and troughs of demand, but can also help should any quality issues or patient complaints arise. Hospitals can then use this information to help focus on specific issues to improve the overall patient experience.

For further information please contact Jennifer Terry on 01902 895551 or email her at jennie.terry@staticsystems.co.uk



New lease of life for Octagon House

New central Manchester NHS renal dialysis satellite unit takes up residence on Hathersage Road.

Occupying much of the ground floor, the dedicated unit, which consists of 35 state-of-the-art dialysis stations together with 6 isolation rooms, has been totally purpose-designed to provide a spacious and modern environment for dialysis patients, with easy access, dedicated car parking and ambulance drop-off. The unit is capable of treating up to 40 dialysis patients each day and has a separate 15-station area for training patients on home dialysis or to be self-caring in a more independent environment.

The facility is co-managed by Fresenius Medical Care, the country's largest specialist dialysis service provider. Its proximity to Manchester Royal Infirmary makes it an ideal location for the specialist NHS renal medical and nursing team to provide the clinical care to patients who attend three times a week for treatment.

Dr Leonard Ebah, Consultant Nephrologist and Clinical Head of Specialist Medicine at Manchester University NHS Foundation Trust, said: "This community dialysis unit is an exciting new development and part of a wider project to provide care closer to home and in a non-hospital environment for our dialysis patients. We believe that it's a major step in driving forward and transforming the high quality dialysis service we provide to patients."

Once providing employment for over 600 people, the Octagon building and site became vacant in 2013 when it was purchased by property developer Richard Everton. "We acquired the site with a vision that its future would be associated with medical research and technological innovation in the burgeoning life sciences sector of the city, all directly linked with or related to existing local healthcare institutions, such as the MRI. The fact that the NHS chose the location endorses that belief to be well founded."

The rest of building, which is undergoing substantial remodelling and refurbishment, will be available for letting, in suites ranging from 2,500 sq.ft. to full open-plan floors, later this year.

"We are confident that this unique location will attract many more businesses in the healthcare sector, creating substantial employment opportunities and contributing to the economic upsurge of this area of the city".

NEWS FROM OUR PARTNERS

PayByPhone implementation success at Northampton General Hospital

Since February 2018, mobile parking payment provider PayByPhone has been available to visitors at Northampton General Hospital NHS Trust. The hospital receives around 1,600 daily visits across seven on-site car parks and approximately half that number on the weekend. Traditional pay-and-display parking was in use in each of the car parks, but over time the hospital identified a growing need for cashless parking.

Brian Willett, Hotel Services Manager for the NHS Trust, explains: "Visitors started enquiring about alternative payment methods at the hospital and we felt that we could make better use of available technologies to improve their parking experience."

In the first month after PayByPhone was launched at the hospital, the company processed 1,800 transactions, the rate of which has consistently grown month by month with 3,800 in August, 4,700 in September and 6,000 in October 2018. Moreover, 86 per cent of those who use the PayByPhone service rely on the app rather than the phone or text functions to pay for their parking.

PayByPhone, a wholly owned subsidiary of Volkswagen Financial Services AG, is one of the fastest growing mobile payments companies in the world, processing more than £242m in payments annually. In the UK, the company processes more than 60,000 transactions per month across more than 30 hospitals.

Anthony Cashel, Marketing Manager for PayByPhone UK, says: "Removing the need for hospital visitors to remember change for parking payments takes away one small layer of worry from what is often an already stressful time. Coupled with the ability to allow users to extend their parking session from their smart phone or Apple Watch without having to return to the vehicle, visitors have one less thing on their mind should an appointment or visit take longer than expected."

PayByPhone solutions are used successfully at hospitals of all sizes. In addition to an improved visitor experience, hospitals also benefit from a reduction in the time spent maintaining pay-and-display machines, reduced cash collection and lower risk of theft.

Cashel concludes: "Our implementation at Northampton General Hospital, where more than 13,400 unique users have been registered and 33,000 transactions processed so far, shows that there is substantial demand for this type of solution. We are delighted with the success and keen to help more hospitals across the country improve their service."

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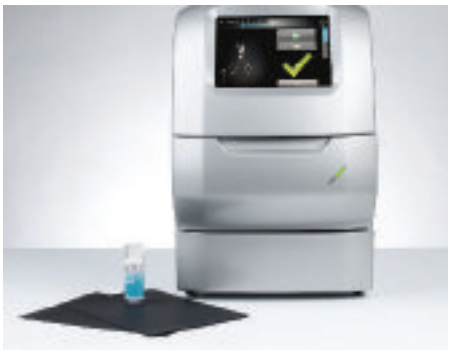
NEWS FROM OUR PARTNERS

Largest hospital in Wales uses ProReveal in-situ protein testing

Synoptics Health, a manufacturer of innovative digital imaging systems for healthcare applications, is delighted to announce that ProReveal, its sensitive test to detect proteins on surgical instruments, is now in use at the University Hospital of Wales (UHW) in Cardiff. ProReveal is being used at UHW for routine monitoring and process improvement of surgical instrument decontamination protocols to help prevent inadvertent exposure to prion infections associated with conditions such as Creutzfeldt Jakob Disease.

The HSDU Department at UHW is using ProReveal in-situ fluorescence detection daily to precisely quantify how much protein remains on reprocessed surgical instruments. This is the first Trust in Wales to adopt the technology. Additionally, ProReveal is being used as part of continuous process improvement research where staff are assessing a range of decontamination parameters such as manual pre-washing and ultrasonic cleaning, as well as different types of washer/disinfectors and detergents to develop the optimum process for removing residual protein on neurosurgical instruments.

Mark Campbell, Decontamination Service Manager at UHW said: "The HTM 01-01 is quite clear that instruments used in neurosurgery should be tested for proteins using in-situ methods rather than swabs, because potentially they aren't sensitive enough to detect low levels of proteins or indeed prion proteins. We have been trialling ProReveal since 2016 and decided that, as this is currently the only in-situ test, we purchased a system in 2017 to ensure compliance to the updated WHTM and bring further safety factors for managing high risk sets."



Mark added: "By reviewing and making changes to our decontamination process, in just six months, we have been able to reduce our residual proteins from 3µg to 400ng and have set our ProReveal to detect nanogram rather than microgram levels as we were getting results of 0µg. The ProReveal is now key to assuring us that we have done everything practically possible to reduce patients' risk of exposure to prion-related diseases."

Guy Fiddian, of Synoptics Health's commented: "We're pleased that the largest hospital in Wales is also the first to be routinely using ProReveal for in-situ detection of proteins on reprocessed surgical instruments. Their rigorous approach to continuous quality improvement has shown some very impressive results in reducing residual proteins on neurosurgical instruments and demonstrates that minimising patients' exposure to prions is viewed very seriously by this hospital."

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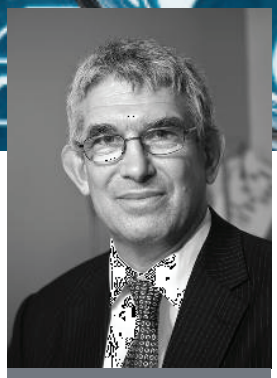

Mike Hobbs

Non-clinical service efficiency – digital is part of the answer, but only part

A digitally-enabled NHS with patients owning their own healthcare information and clinical practice supported by artificial intelligence, machine learning and data analytics is a vision that few would disagree with. And it's not only these headline-grabbing aspects of the NHS that get name-checked in this digital vision. More humble activities including logistics are rightly recognised as being opportunities that can be unlocked through digital innovation. And at its core much of healthcare is about getting the right patient, at the right time, to meet with the right clinician, with the necessary information and the right equipment to undertake the clinical activity – a long way of saying logistics.

Yet healthcare providers don't think of themselves as major logistics operations. And over the years many end-to-end logistics processes have developed to manage failure. Thus there is significant opportunity for improvement in the patient and staff experience and in delivering improved efficiency. And digital certainly has a part to play.

But digital is not the answer. It is an enabler. Almost by the day there are new digital options all proclaiming to enable improved quality and reduce cost. Before being able to assess this, it is necessary to understand the fundamental question that is being answered. There is little point in improving the efficiency of one part of a process only to create larger bottlenecks or disruption elsewhere. The starting point should be to understand the workflow, which may benefit from targeted data analytics and subsequently identification of appropriate technology and digital enablement.

The digital revolution needs to be fuelled by in-service data. Data that initially will almost certainly be able to be challenged. However, it will be the exception to get a perfect data set that no one can challenge. A mindset change is needed that recognises when data is sufficient to make informed decisions to improve processes that people know are inherently wrong or ineffective.

The role of data analytics

Healthcare processes are often operationally reactive, correcting processes that are failing, without recognising that the same failures are repeating themselves. Data analytics has a part to play in transiting from reactive to a proactive performance culture focused on continuous improvement and celebrating doing more with less. In this context, innovation can be defined as a new idea utilising a more efficient device or process.

There are many opportunities to invest in technology and digital. For instance, the Internet of Things attracts much press. But the IoT relates to devices that capture more data. There is already a world of data produced by existing systems, much of which isn't used because any shortcomings in a data set are used to discredit the whole data set. The opportunity must be taken to identify robust data elements within existing datasets and to use digital analytical tools to maximise the impact of existing data on process improvement and ongoing monitoring to drive continuous improvement.

The IoT becomes relevant when specific business cases are identified where acquiring timely data to support a business process has the demonstrable potential to reduce or avoid costs. As an example there are many applications of the IoT in building maintenance. However, the level of engineering staffing is often close to the minimum to achieve statutory compliance. Hence, is it likely that investment in IOT devices will have the desired impact of reducing costs? It will almost certainly have a disproportionate cost benefit in terms of improved service but this does not meet the primary objective of reducing cost.

The need for cultural change

Embracing and reaping the rewards from digital enablement requires a cultural change. A change that will include the development of new capability and capacity in the workforce. It is an major change programme that needs adopter organisations to recognise it is a longer term change programme and to seek out the quick wins on this journey to digitally-enabled healthcare.

It is difficult to find any fault with the Secretary of State for Health's statement that: "The time is ripe now to bring about this tech revolution in healthcare". The test of success will be measured against another statement from the Secretary of State: "The critical part is that it will save money in the medium term and it's abiding by the standards that will allow a system to run better."

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.

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Putting patients back in control of their health records

John Rayner, Regional Director, HIMSS Analytics for Europe and Latin America, discusses the digital future for patient records with Hospital Times.

Building on a 35-year career in the NHS as a registered nurse, clinical services manager and as the Chief Information Officer, John Rayner is an authoritative voice on the digital agenda for health.

John is well-placed to have strong views on patient data and he is determined to encourage the adoption of patient-owned health data. It's an uncertain area but one that is vital for the increased efficiency of both the NHS and private providers today.

"By giving patients access to their own care records so they can contribute to them, we can create a more holistic picture of what's happening with that particular individual," he says. "As a result, patients can be more informed either prior to, or following, an encounter with a healthcare professional."

The idea is that individuals should be more aware of their own health than anyone else and are therefore best placed to manage their records. However, while this may increase efficiency, it puts the reliability of the health record at risk. As the patient becomes more accountable for managing their own record, there is an increased risk that the consistency and quality of the record is put in jeopardy.

Implementing patient-centred records

John has been at HIMSS for four years now, initially heading up the professional development by raising the profile of CIOs as strategic leaders, before moving on to refocus on analytics, specifically in relation to clinical health. As HIMMS sits between providers of healthcare and industry, it is well positioned as a platform to influence and support both providers and developers of systems.

So how do we start? Any steps towards giving patients access and control over their data begins with digitisation. John distinguishes between two types of digital medical record, the standard electronic patient record which 'takes a snapshot' view of the patient, seen within hospital trusts, and the personal health record which is something the patient can contribute to themselves.

One of the issues with the adoption of the personal health record is the hosting of data. Regardless of the debates surrounding ownership which is a legal matter, there is the practicality of how the data is recorded and where it is physically stored. "We often see in other European countries that governments or health ministries provide the hosting opportunity," says John. So what does this mean for health outcomes?

While the theory of giving patients more accountability for their own medical and health records is empowering for individuals and has the potential to support integrated systems of care, there is limited proof available to suggest patient health outcomes are improved. "I think there is some evidence to suggest that it improves knowledge and education, and it potentially removes and reduces the impact the patient has on medical practitioners," says John. However, the impact on outcomes is still open to speculation.

What are the risks?

The primary concern when introducing new electronic systems in health is the security risk which is especially prevalent when it comes to managing patient data. In the aftermath to the WannaCry cyberattack on the NHS, this is not surprising. However, "the risks are relatively low in comparison to the gains," says John. If the system is "managed securely and properly then there's everything to gain and very little risk."

If anything, an overemphasis on data security is a hindrance to progress in John's eyes. "If we were a little more open-minded then things would move much quicker. It's very easy for certain clinical groups and professional groups to scaremonger where you know generally the risks are very low."

With advances in consumer technology, there has been vast leaps in the quantity and quality of health data which can be gathered at the individual level. The most cutting-edge wearable devices can now even take an ECG and companies in the industry are gathering momentum. However, John warns that while this is great as a supplement, some aspects of the personal health record must remain for clinicians. Despite regulation, it is clear that there is still too much scope for erroneous data to be gathered and mistakes to be made.

Systematic Change

Often seen as disruptive, digital innovations can have positive impacts on systems if they are implemented and managed effectively. All new services are have an impact on existing services when they are introduced. But what does this mean for regulation? And how do these new services interface with existing systems of care?

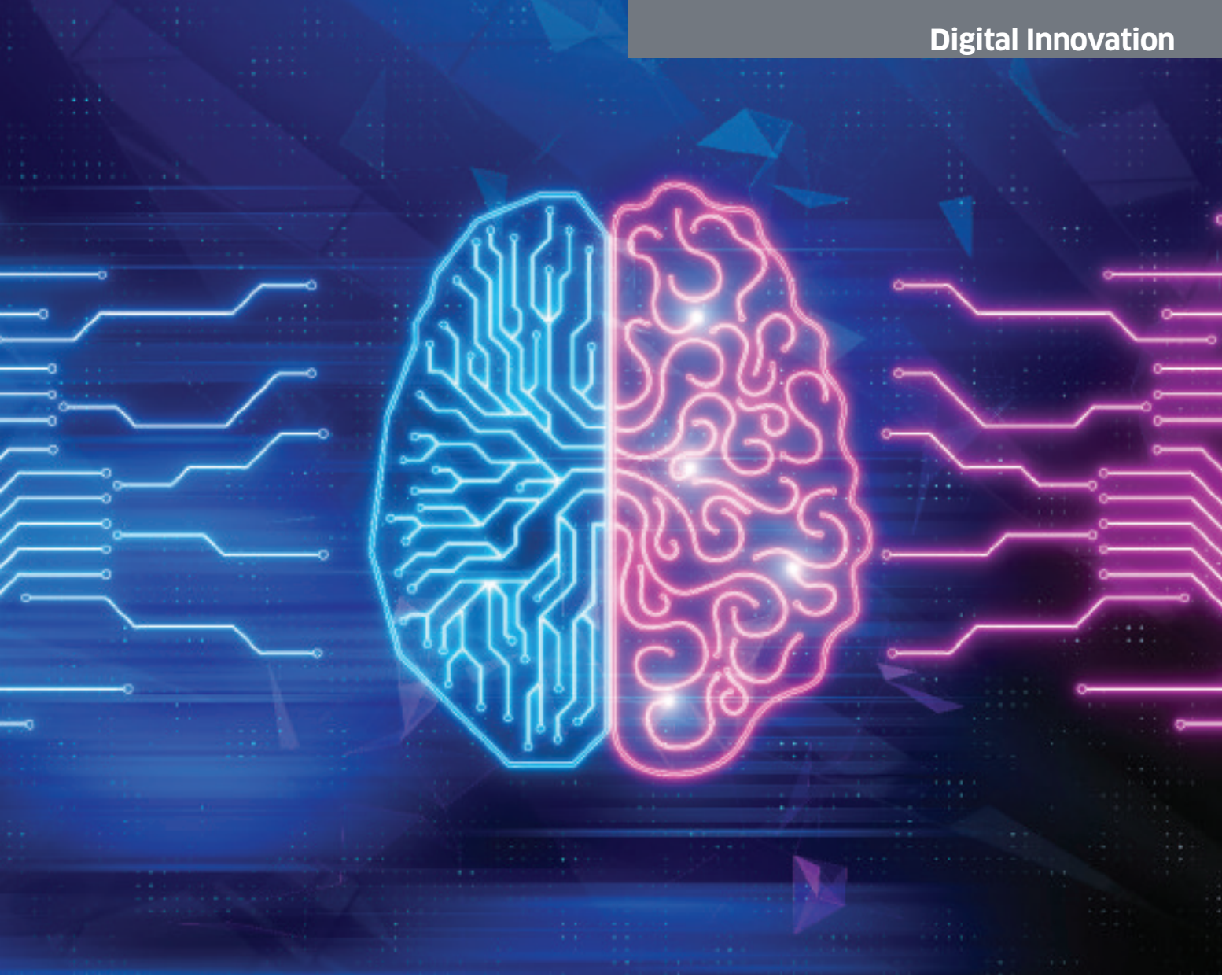
Addressing both of these issues requires transparency, open API's and a solid legal framework, suggests John. But these are not the only requirements. Patients and healthcare professionals need to be educated to ensure new technologies are used correctly and records are not corrupted.

"The biggest problem in the NHS is trying to start from where we are now and if you were to start again, you wouldn't design it quite like this."

So where now?

"Everybody recognises that integrated healthcare is the is the gold standard," reflects John. "If we can acknowledge that evidence, we've got to ask ourselves why in the U.K. do we regulate individual providers and not whole systems? Why do we fund individual providers and not whole systems? And why do we commission individual providers and not whole systems? If we were to change those three things then we would force integration of care to be a much more prominent feature."

It is clear that integration, digitisation and technology all form corners of the new direction of patient-centred care. But whether this means patients control their own records is not so clear. What is obvious, however, is that John is keen to see patients seated at the centre of their own health universe and that adopting new technologies to boost accountability is the way to do it.



Five new UK AI centres to be opened in 2019

Business Secretary Rt Hon Greg Clark MP has announced £50m of funding for five new 'Digital Centres for Excellence' across the UK. Each centre make use of artificial intelligence (AI) to improve detection for abnormalities, increasing opportunity for early diagnosis.

The centres, located at universities and hospitals in Leeds, Oxford, Coventry, Glasgow and London will use scanning technology to make digital biopsy images, potentially freeing up substantial amounts of NHS staff from time-consuming manual tasks. Each of the centres will be funded through the Industrial Challenge Fund, the government's flagship investment programme, which is managed by UK Research and Innovation. The centres will be spearheaded by some of the UK's leading medical companies including GE Healthcare, Siemens, Philips, Leica, Canon and Roche Diagnostics.

The Department for Business, Energy and Industrial Strategy is trying to implement a modern Industrial Strategy that puts pioneering technologies at the heart of its plans. Mr Clark said that the use of AI has the potential to revolutionise healthcare and improve lives for the better.

Health and Care Secretary Rt Hon Matt Hancock MP said: "Artificial intelligence will play a crucial role in the future of the NHS – and we need to embrace it by introducing systems which can speed up diagnoses." Mr Hancock also said that part of the government's long-term plan is to turn the NHS into an 'ecosystem of enterprise and innovation' that allows technology to flourish and evolve.

In Leeds, more than 200,000 histology slides have already been digitally scanned as part of their fully digital pathology laboratory, eliminating the need for pathologists to use microscopes. The added funding focus will further boost the city's reputation for innovation in this field.

The London Medical Imaging and Artificial Intelligence Centre for Value-Based Healthcare will use artificial intelligence in medical imaging and related clinical data for faster and earlier diagnosis, as well as automating expensive and time-consuming manual reporting.

The use of AI is more and more widespread and increasing its use has become one of the government's Grand Challenge Missions. The government will be looking to bring doctors, businessmen and academics together to harness the power of AI and other data technologies to save time and money across the health service. The ultimate aim is to develop an entirely new industry of diagnostic tech companies that will drive UK economic growth.

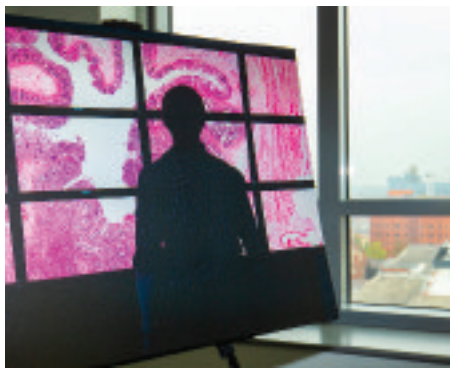
Digital Pathology Fellow Dr Bethany Williams demonstrating the 'Powerwall'

How Leeds is driving pathology into the 21st century

Pathology plays a critical role in cancer care. It is the only way to definitively diagnose a cancer, grade how aggressive it is and measure how far it has spread, and yet it has long been a background thought in modern medicine. It is associated with jobs of a repetitious nature within dull settings, often practised by those who perhaps want to take a break from more stressful clinical roles. In fact, it would be fair to say that many people do not actually know the role of a pathologist. But they certainly do in Leeds.

Leeds Teaching Hospitals NHS Trust already boasts one of the largest pathology labs in the UK. Located in St James Hospital, it produces more than 1000 histology slides per day. As of 11 October, every single slide produced can be viewed digitally. Digital pathology, otherwise known as whole slide imaging (WSI), allows for the viewing of glass histology slides to be conducted on a computer as opposed to underneath a microscope. This could result in a seismic shift within pathology and potentially modern medicine.

To appreciate this, it is essential to understand just how desperately pathology needs rejuvenating and the obstacles traditional pathologists face. The innovation occurring in Leeds has the potential to revolutionise the workflow of a pathologist and ultimately, their ability to effectively and efficiently diagnose disease. One must also understand this progression in the context of other technological advancements, potentially further revolutionising the workflow of pathology.



The process

But what exactly is it about the process of pathology that is now different? And how are these spectacular images created? Despite digitisation, there is still the need for highly skilled and often painstaking manual work that has always been associated with pathology. Each specimen is carefully trimmed to fit into cassettes before each being embedded in formalin wax. Once the wax has set, the sectioning process begins where each specimen is trimmed into microscopic sections before transfer to a glass slide. As most tissue cells are transparent, histochemical stains (typically haematoxylin and eosin) are therefore used to provide contrast to tissue sections, making tissue structures more visible and easier to evaluate. It is the staining process which give these slides a spectacular array of colours.

It is the next step where things start to change. Instead of sending the slides to a pathologist to view underneath a microscope, they are placed within highly sophisticated, dedicated scanners to capture images used for primary diagnosis. To date, more than 200,000 slides have been digitally scanned from Leeds and the surrounding area.

The scanners are provided by Leica Biosystems, which works in partnership with Leeds Teaching Hospitals. A Leica Biosystems Aperio AT2 scanner usually takes around 2-4 minutes (depending on the amount of tissue on each slide) to create a complete digitisation for each slide at up to 200,000 dpi. To put this in some perspective – if one digital slide was printed at 300 DPI (used for most standard photos) it would produce an image the size of a tennis court. Each digital slide takes up on average 1 GB of memory, meaning that the daily rate of 1000 digital slides that the hospital is producing is in turn creating 1 TB of images to store every single day. The scale of this project is quite simply, as one doctor put it, 'immense'.

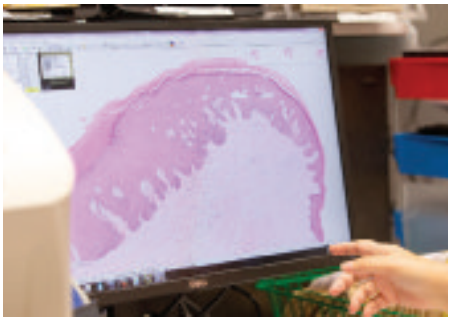
Once each slide has been digitally captured, it can be sent instantly for examination in ultra-high resolution using the 'Powerwall', a huge LED screen allowing for demonstrations to students and the wider public, operated via a video game controller.

Overcoming traditional challenges

Some of the obstacles facing traditional pathologists are quite alarming. Pathologists who face long commutes and are required to work remotely have had to physically carry specimens to and from work. This increases the chance of losing slides, a problem that several doctors iterated is common within the field of pathology. The loss of a single specimen could delay diagnosis of a patient's disease and ultimately surgery by days, potentially being catastrophic for patients.

Thankfully the innovation at St James' University Hospital can render these problems a thing of the past. By viewing digital slides on a computer screen, staff cycle instantly between any numbers of slides through ultra-high resolution.

With the correct software installed these slides can be viewed remotely from anywhere in the world. This allows for streamlined case preparation from multidisciplinary (MDT) meetings and encourages far easier



collaboration with other pathologists in complex cases of diagnosis without compromising patient safety.

Currently there is an increasing demand for pathology with an ever-dwindling pool of resource. Due to other advances in medicine doctors are now able to detect more complex cases of cancer and are able to do so much earlier in a patient's life.

According to Cancer Research UK, the year on year volume of cellular pathology requests increases by an average rate of 4.5 per cent and yet the number of trained pathologists has only increased by 1.2 per cent. To make matters worse, 32 per cent of cellular pathologists in the UK are over the age of 55 and are expected to retire in the next five years. Thus digital pathology has the potential to improve workflow and pool resources across hospitals.

What next?

St James's fully digitised lab now opens the door for the future use of Artificial Intelligence (AI) algorithms to further speed up and improve diagnosis. Computer programmes could potentially help pathologists detect smaller areas of cancer and better quantify and measure tumours. As Chair of the Leeds Hospital Trust Linda Pollard said in her opening speech, the innovation does not stop here, so "watch this space".

Just one of many PCs where staff can access the Lorenzo EPR

Electronic evolution at Morecambe Bay

Over the past decade, University Hospitals of Morecambe Bay NHS Foundation Trust have seen a range of improvements thanks to its increasingly developed Lorenzo Electronic Patient Record system (EPR). Two instrumental figures in this progress, Chief Clinical Information Officer Colin Brown and Chief Information Officer Andy Wicks, spoke to Hospital Times about the work involved in this digital journey.

The EPR is now a 'golden thread' through the Trust's hospitals and is being used by staff as soon as a patient enters a hospital via the Emergency Department or Outpatient clinic until they are discharged. The way in which staff work has been revolutionised - they can access up-to-date patient information instantly - from anywhere in any of the Trust's three main hospitals.

By reducing the amount of forms and paper needed over the past few years, the EPR has saved the Trust £196,000. "We were a heavily paper-dependent organisation," says Colin, reflecting on working life before implementing the EPR. "It was a very 20th century way of working."

First steps

The initial step for the Trust was to digitise the paper records they already had, a process that began in 2010. Over the next few years the Trust began deploying different parts of the EPR, such as an early bed management system that allowed nurses to instantly allocate beds, an admissions assessment system in 2011 and changes to the emergency department which went fully digital in 2012. Furthermore, a £1.3m government-funded project to expand the use of EPR whiteboards has provided an alternative interface for all nurses to monitor patient progress instantaneously.

The implementation of the EPS was one of the first major change projects for the Trust. With the service now fully implemented, 4,000 different drugs are prescribed electronically every day and 14,000 drugs are prescribed electronically across all of the Trust's 59 inpatient areas. The impact of the EPR is not exclusive to the acute sector –it is also having an effect for GPs. More than 250 GP records are accessed electronically every day and 100,000 letters and documents were sent electronically to GPs in 2017.

"An evolution, not revolution"

While each system deployment represented a breakthrough in patient care for the Trust, both Colin and Andy are keen to emphasise that the work happened incrementally and slowly. "It was an electronic evolution, not a revolution," says Andy. "The strategy to have a single point EPR system was decided in the 1990s."

The point at which the Trust truly began making strides was in 2004, when Andy joined the Trust as Head of IT and began merging the team with Morecambe Bay CCG's IT team. A process of procurement lead to Lorenzo being chosen as the main EPR supplier in 2016. This was followed by an 18-month EPR optimisation progress that built on the foundations put in place over the previous decade. "We delivered everything we said we would and within budget," says Colin, reflecting on this success.

Collaboration and engagement

Actively-engaged clinical staff was key at Morecambe Bay. "All of this was clinically led," says Andy. "Clinical design authorities were formed and allowed clinical leadership to become engaged with the design of each device interface and they were able to oversee the EPR project from start to finish from a medical perspective."

According to Colin, the fact that clinical staff wanted to take part and recognised the need for change was the most crucial ingredient to success. "Without the workforce being ready to change, you simply can't do it," he says.

The combination of clinical involvement and cooperation from executive leadership ensured that every decision was fully informed and made with utmost attention to patient safety. The e-prescribing programme was delayed by four weeks as the workloads for hospital staff meant there was not enough free time to train the clinicians properly.

With involvement from nurses, clinical staff, executive leadership and primary care, the project began to take a pace of its own. "It morphed from being IT-led into a clinical lead informatics position," Colin says. Andy added "At some point we passed the tipping point and after the nurses came on board, we were the ones struggling to keep pace with the change."

But can this type of success be replicated in other Trusts? "You couldn't just take our model and drop it into other Trusts without our leadership structures and expect it to work," says Andy. "There will always be those that have sophisticated understandings of digital technology and know the functionality of that tech inside out. But if we have learnt anything from the past few decades, it's that you can't just throw technology at an NHS Trust and expect it to stick. You need top-to-bottom leadership structures ready to embrace the potential of digitisation."

Chief Information Officer Andy Wicks and Chief Clinical Information Officer Colin Brown

NHS Blood Scandal: "The time for secrecy is over"

A government inquiry into what has been labelled the worst treatment scandal to hit the NHS has heard from representatives of nearly 250 victims ahead of a full hearing which is set to open next spring. The inquiry was told that there has been a 'systematic attempt' to destroy evidence, and that this must be investigated.

David Locke, representing 240 victims and their relatives, spoke on the second day of the inquiry, revealing that "incriminating" documents had been destroyed by civil servants in order to draw a line under the scandal. Locke went as far as to suggest that these documents "may have included the private papers of (the former Health Secretary) Lord David Owen."

If there was any chance that these documents existed in an alternative government location Locke said they must be found. "Whatever the financial cost, the time for secrecy is over," he said.

The inquiry also heard from Adrian O'Neill QC, who urged the chair to investigate any evidence of a cover up by government officials. Mr O'Neill, who represents 140 Scottish victims of the scandal, suggested that not only had records disappeared but that "false information" had been added to undercut the scandal, such as adding conditions like alcoholism to patient records in order to explain liver damage that actually resulted from blood infection.

Mr O'Neill said: "In many cases it appears that medical records have been redacted by persons unknown and important information has gone - but also false information has been added, in so many cases. As part of this culture of blaming the infected and affected, the suggestions have sometimes come in those medical records which have been recovered that this person must be an intravenous drug user or a secret alcoholic… they're just not owning up to these issues."

The NHS blood scandal, routinely described as the single worst treatment crisis to hit the NHS since its inception, saw thousands of patients over the 1970s and 1980s given infected blood products to treat bleeding disorders, such as haemophilia.

Paul Desmond told the public inquiry on that as many as 300,000 patients had been infected with HIV and hepatitis conditions by the early 1990s; however estimates on the number of victims vary substantially. It is believed that, over a period of around 20 years, more than 5000 haemophiliacs were infected with HIV and hepatitis viruses. Almost 3000 have died since. A further 30,000 patients are believed to have been infected as a result of having blood transfusion from infected blood product.

History

Blood transfusions were a new treatment in the 1970s, and were used far more frequently than they are today, in some cases even for minor injuries. Due to its extensive use in hospitals, the Department of Health required ways to cope with demand for blood products. This resulted in blood being imported, often from US prison inmates who sold their blood, which was then pooled and concentrated to create blood plasma originating from more than 40,000 people.

Eventually, a combination of heat treatment to the plasma and the introduction of synthetic treatments for conditions such as haemophilia removed the risk of infection. But the scandal still affects thousands today, many of whom may still be unaware of their condition.

The Chief Executive of the Haemophilia society, Liz Carroll, has asked the inquiry to deliver justice. "This scandal devastated generations of people with haemophilia and other bleeding disorders and our members have waited decades for this to be properly investigated."

The head of the inquiry is retired judge Sir Brian Langstaff who stated that, due to the number of pieces of evidence and documents that they have received so far, the inquiry could take as long as two years before presenting its findings.

Looking forward

It has now been more than 40 years since the crisis first took hold of the NHS and it looks set to be a continuing major controversy for the foreseeable future. The fact that this scandal has been allowed to engulf the NHS for so long appears to be a result of the organisation's apparent reluctance to hold relevant figures accountable.

Despite the severity and extent of the crisis, this is the first time the blood scandal has been investigated on a UK-wide basis and public anger against government inaction has reached a pressure point. It seems that it would be difficult for the NHS to truly move on from this scandal unless the inability of previous inquiries to hold any and all responsible persons to account is corrected.

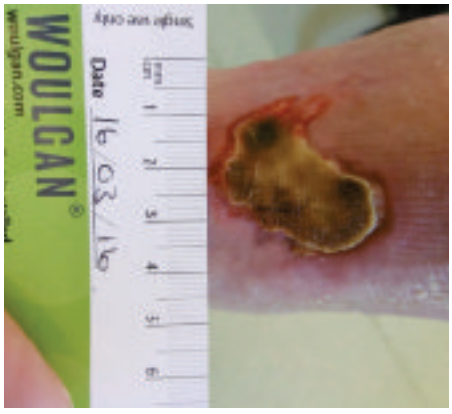
NEWS FROM OUR PARTNERS

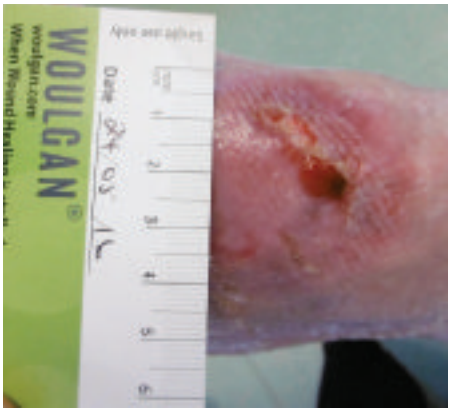
Beta-Glucan Gel demonstrates healing rates double that of standard care in slow to heal wounds

Newly published research comparing healing rates of long term, slow-to-heal wounds in a community care setting has demonstrated the use of bioactive beta-glucan gel (Woulgan) doubles the healing rate over a 12-week period.

The study, published in the Journal of Wound Care, compared wound healing times in 300 patients, 150 of whom had a beta-glucan gel applied twice a week alongside a normal dressing change. Results showed significant improvements in healing across various wound types with Woulgan, showing more than double (107 per cent) the rate of healing over 12 weeks for ulcer-type wounds. With double healing rates measurable from week 8, the study demonstrated a 92 per cent complete healing at 24 weeks. The accelerated healing time delivered a cost saving benefit of 24 per cent on average per patient.

In the UK, approximately 2.2m wounds are classified as being insufficiently responsive to standard care protocols within 3 months. The active component, soluble beta-glucan, can restart healing in the wound, including stalled wounds, through macrophage activation. Woulgan promotes a moist healing environment and helps rehydrate necrotic tissue, supporting cell proliferation and stimulation of the wound bed itself, kick-starting the healing process. Woulgan should be applied to wounds as early as 4 weeks when healing is seen to be slow with standard care, thus limiting both the financial and psychological impacts of a slow to heal wound.





Sharon Hunt, advanced nurse practitioner and lead author of the clinical evaluation, said; "By using Woulgan on slow healing wounds, not only have we improved the rate of healing significantly, but we have seen cost savings of £211 per patient."

The combined cost for the treatment of chronic wounds in the UK is estimated at £4.5-5.1bn per annum. Innovative healing treatments like Woulgan have the potential to significantly reduce the overall financial burden that chronic wound care currently represents.

The full study was published in the Journal of Wound Care, September 2018.

For more information about Woulgan, refer to their website www.woulgan.com

NEWS FROM OUR PARTNERS

New thermosept® X-tra – outstanding cleaning performance with cost savings

Schülke – experts in infection prevention and control - have just introduced new thermosept® X-tra, an innovative detergent for the safe and gentle cleaning of instruments used in minimally invasive surgery.

A recent study has demonstrated that thermosept X-tra offers economic and environmental savings as 25 per cent less product can be used compared to other similar enzymatic detergents, without any compromise on efficacy. At a 25 per cent lower dosage thermosept X-tra achieved a comparably good cleaning result in terms of protein removal and various other cleaning indicators. It also demonstrated overall improved material compatibility for various test materials, including sensitive materials such as anodised aluminium and non-ferrous metal.

Specially formulated for use with automated instrument reprocessing units, thermosept® X-tra offers exceptional cleaning properties, through the use of high performance enzymes in an innovative detergent system, which includes surfactants.

Even at low doses thermosept® X-tra removes organic contaminants such as blood, proteins, tissue residues as well as mucus and fatty impurities.

Leanne Anderson, Product Manager, schülke UK commented: 'The launch of thermosept x-tra represents a new generation of enzymatic detergent systems, for the universal cleaning of medical instruments and accessories. With efficacy at a low dose and low temperatures, thermosept x-tra sets new standards in instrument cleaning, whilst also offering cost savings."

Thermosept x-tra is available in a five litre container.

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Antimicrobial resistance: time is ticking

Warnings over increasing antibiotic usage, and the resulting resistance to its healing effects that comes as a result, are increasing in frequency.

It would be fair to say that discussions about antimicrobial resistance do not maintain traction in the public eye to the same extent as issues like climate change or global terrorism, but they certainly should.

The effects of antibiotic resistance are no less serious and pose an equally substantive threat to human life. Figures from the World Health Organisation state that around 700,000 people globally die every year from drug-resistant infections and, if this trend goes unchecked, it is estimated that the annual death toll will be 50m.

In the UK, England's Chief Medical Officer, Dame Sally Davies, has been banging the drum to raise awareness of antibiotic resistance. Repeatedly, she has warned of a "post-antibiotic apocalypse" and in 2016 she suggested that antibiotic resistance should be considered as big a threat as global terrorism. When you look at the current data, few could blame her.

Public Health England (PHE) published a report in September revealing that 3m surgical procedures, such as hip replacements and caesarean sections, could become resistant to antibiotics. Standard surgical practices would become extremely risky to perform and Dame Sally said in September that "we face a return to the dark ages of life-threatening surgery."

UK implications

Worrying trends in data suggest that we are already seeing the effects of antibiotic resistance in UK hospitals. Recent figures from NHS Digital have revealed that the annual rate of in-hospital infections have more than quadrupled in eight years, from 5,872 in 2008 to 24,800 in 2013 and 48,000 in 2017.

While some progress has been made in reducing the overall rate of antibiotic prescriptions (a fifth of which are considered to be 'unnecessary' by PHE), reducing overall usage is not in itself a solution to the problem, as performing some sorts of surgery without the use of antibiotics could potentially be lethal for patients.

Furthermore, focusing on inappropriate usage can often lead to blame being directed towards GPs. Professor Helen Stokes, chair of the Royal Society of GPs, recently said, "GPs will only recommend antibiotics if we genuinely believe they will help the patient sitting in front of us… antimicrobial resistance is a society-wide issue and GPs cannot be held responsible for tackling it on their own.

An array of challenges

The obvious solution to the problem is to create new drugs; however, there have only been a handful of new products created in the past few years and no new classes of antibiotics have been invented for decades. Alexander Fleming himself recognised that bacteria could eventually become resistant to drugs, so why in this age of medical innovation are we not able to produce new and revolutionary forms of antibiotic?

Basically, inventing antibiotics is extremely complicated and takes serious time. Discovering chemicals that kill bacteria is easy; what is not easy is developing substances from those chemicals that is not toxic to humans. After potential chemicals are discovered, a long period of medical testing follows - on average it takes around 10-20 years from discovery to produce a new antibiotic, not exactly an attractive investment opportunity for pharmaceutical companies.

Despite the fact that we are now seeing 48,000 in-hospital infections a year, the issue of drug-resistant infections simply hasn't occupied a consistent space in public debate. It does not have the same 'face' as a disease like cancer and those affected may think of their condition as a typical uncontrolled hospital infection rather than something more significant. Dame Sally Davies raised the idea of adding drug-resistant infections to death certificates in order to raise awareness amongst the families affected. In this context it could only serve to help and we need more ideas like this to maintain awareness of the issue.

A sustained global effort from governments is required, firstly in investing in promising new treatments and doing their utmost to bring them to market whilst promoting awareness of the issue amongst the general public. Additionally, improving hygiene in our hospitals and exploring the potential for pre-emptive vaccines will help stop drug-resistant infections spreading in the first place.

NEWS FROM OUR PARTNERS

Reduce your costs for biological sample transport

How do you package your send-away pathology samples? Are you spending too much time and money on packaging your samples correctly? If you are currently wrapping tubes and using boxes to transport samples by courier or Royal Mail, this could be costing you a lot more and taking much longer than necessary.

The Transport of Dangerous Goods Regulations require patient specimens and other biological samples to be transported according to UN3373 Biological Substance Category B, P650 Packaging Instruction. However, compliant packaging requires multiple elements that can result in a bulky package which is expensive to transport. One pathology laboratory, sending away 1000 samples per month, has recently switched to the SpeciSafe® complete secondary sample packaging system which will save them over £21,000 per year.

SpeciSafe® fulfils multiple requirements of the packaging regulations. The compact, clam-shell design holds primary 95kPa containers in rigid, cushioned, pre-moulded compartments, so they are protected and multiple vials are separated from each other. The bonded ultra-absorbent lining will soak up the entire liquid volume in the event of a primary container breach. The SpeciSafe is leak-proof when closed and its rigidity means only a flexible outer envelope is required for road transport.

SpeciSafe also delivers further benefits. It is very quick and easy to use and the transparent front means any leakages from the primary container are easily visible. Patient information is easily seen and can be read by barcode readers without unpacking. Samples can be posted by Royal Mail at large letter rates which could save over £2 per package, provided the primary container is less than 25mm in diameter and the sample volume does not exceed 50ml.

Please visit www.un3373.co.uk for further information or contact Alpha Laboratories on 0800 38 77 32 or email marketing@alphalabs.co.uk

NEWS FROM OUR PARTNERS

Vital importance of high quality surgical gloves highlighted by survey

A survey of practicing UK surgeons has highlighted the importance of investing in high quality surgical gloves to improve surgical safety and create long term value for the NHS.

The survey, carried out by Creative Medical Research and commissioned by Mölnlycke, found that UK surgeons agree that using high quality surgical gloves provides greater long term value for the NHS, improves patient outcomes and plays an essential role in improving both clinician and patient safety.

Improved patient and clinician safety

Infection prevention and control in the operating theatre is of critical importance to surgeons. 100,000 needlestick injuries occur in the NHS each year, at an estimated cost to each NHS Trust of £500,000 each year. Qualitative data from the survey highlighted serious concerns for surgeons and their team over exposure to blood borne viruses such as HIV. 92 per cent of surgeons agreed that using high quality surgical gloves would reduce the chance of being exposed to blood borne viruses.

Efficiencies and long term value

As the NHS prepares its spending priorities for the next five years, the survey revealed that 70 per cent of surgeons think high quality gloves provide more long term value to the NHS by ensuring the safety and efficient working of surgeons and their teams. Three quarters of surgeons responded that higher quality surgical gloves save time during operations, leading to greater efficiencies whilst the majority of surgeons agreed that investing in high quality gloves leads to long term cost savings and better outcomes for the NHS.

Surgical gloves are one of the key factors that work together to prevent infections in the operating room and should not be viewed as a commodity. A surgical site infection can increase a patient's hospital stay by an average of 16.8 days at a considerable cost to the taxpayer. As one surgeon with over 10 years' experience said, 'Surgical site infections have enormous implications for cost, morbidity, and lengthened hospitalisation.'

The survey also demonstrated the clear preference amongst surgeons for Mölnlycke's Biogel® Surgical Gloves, with more than three quarters of surgeons stating that Biogel was their preferred choice. The survey also found that 90 per cent of surgeons recognise Biogel as a high quality glove.

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Leicester introduces cutting-edge decontamination unit

The University Hospitals of Leicester NHS Trust have contracted a ground-breaking new mobile decontamination unit to the hospital estate, anticipated to create significant time and cost efficiencies across its endoscopy departments.

The University Hospitals of Leicester NHS Trust have contracted a ground-breaking new mobile decontamination unit to the hospital estate, anticipated to create significant time and cost efficiencies across its endoscopy departments.

Collaborating with leading mobile medical unit provider, EMS Healthcare, the Quest+ Decontamination unit will be stationed at Leicester General Hospital for 12 months.

The introduction of the single trailer solution will allow the trust to continue endoscope reprocessing services with minimal disruption to its departments or patients, removing the need to use external decontamination services. Features of the unit include four RapidAER™ Endoscope Reprocessors, a double endoscopy grade height adjustable sink, integral RO plant, a track and trace system and clean and dirty areas enabling a one-way flow for scopes.

"Crucially, EMS Healthcare's support has allowed us to take a proactive approach to tackling capacity challenges – a real benefit to the overall efficiency of our trust."

Jo Quarterman, Account Manager at EMS Healthcare, added, "When developing the Quest+ Decontamination unit, we worked closely with leading healthcare providers and market experts to create a solution that could address capacity challenges just like this, so it is especially encouraging now to see the unit having an impact on the ground."

EMS Healthcare has officially partnered with reprocessing equipment provider, Cantel (UK) Ltd, and RO plant provider, Veolia Water Technologies, on the Quest+ Decontamination unit. Collaborating in this way has enabled EMS Healthcare to provide trusts with a one-stop solution for all decontamination needs.

"When we put this partnership with EMS Healthcare and Veolia in place, we aimed to be able to support hospitals in the delivery of uncompromised care," said Nic Barnes, Sales Director at Cantel.

EMS Healthcare has launched a fleet of Quest+ Decontamination units in response to market demand. News of the unit's imminent arrival at Leicester General follows its successful deployment at Pinderfields Hospital, Wakefield. The unit continues to support services at the Mid Yorkshire Hospitals NHS Trust whilst the hospital undergoes vital refurbishment.

Together we have a healthy future

World Healthcare Journal is a new title, providing strategic insight to the development of policy and practice in international healthcare and life sciences. The publication offers truly independent insight on the big issues facing the world today.

Available as an app, online and in print, the title will provide opinion, news and intelligence for governments, healthcare providers and private sector organisations at a senior level covering all global markets, topics and sectors. World Healthcare Journal (WHJ) crosses borders – because that is what delivering healthcare internationally requires.

Group Editor, Sarah Cartledge and Publishing Director, Steve Gardner set out their vision for this new publication.

'In healthcare more than in any other sector, true international collaboration is the key. Healthcare is the world's one true intergenerational and unstoppable growth market. Populations will continue to increase; we will all live longer, and both these factors expand demand exponentially.

This increased pace of demand inevitably leads to a greater impetus to augment the pace of innovation, along with the requirement for faster delivery. To achieve this, partnerships between providers and suppliers that take the best care around the world, amalgamates and delivers where it is most required, are vital.

Sarah Cartledge
Group Editor

Steve Gardner
Publishing Director

The provision of healthcare, particularly in newer markets, needs to internationalise. This means both public and private sector providers and suppliers have to come together with their equivalents in other countries to provide the best results.

With WHJ we are creating a microcosm of the global marketplace, truly independent and unbiased towards any individual nation, market or system of healthcare policy or delivery.

WHJ's agenda is to showcase the best models, ideas and systems of care for a global market. It aims to present the most effective ways to deliver them to do business in international healthcare. It should not matter where that care is provided or where it originates, because we believe the most important aspect of our development as a human race is that healthcare should be affordable and available to every global citizen.

Some countries may be delivering great healthcare to their own citizens, but that doesn't mean these systems and models are ideal or would work in other cultures and societies. Care systems cannot simply be 'transplanted' from one nation to another. Partnership is vital, not just with a cohort of international colleagues for the delivery and supply of healthcare but also with customers. All clinicians know their patients and have much to teach about dealing with different conditions, challenging environments and the development of new solutions that can be brought home and encompassed into existing markets.

One of the exciting aspects of healthcare, as opposed to any other commercial marketplace, is that it exists in an environment where everyone shares the same goals of fighting disease, preserving life and keeping the workforce fit and healthy.

Improving the health of the world is a high priority for all nations. Whether the development of an international forum and portal for bringing together global partnerships to develop health projects can have an impact on that objective or not, only time will tell.

For all these reasons, we would like to see WHJ unpick the debate, add value and ultimately deliver change."

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