hospital times

ISSUE TWO | 2021

The road to recovery

CLINICAL SERVICES SPECIAL

Can elective care be brought back from the brink?

Will cancer services recover from the pandemic?

How can flexible infrastructure be harnessed to increase capacity?

INSIDE: INTERVIEWS WITH PROFESSOR NEIL MORTENSEN AND DR KATHERINE HENDERSON

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- **Enhance interconnectivity**
  - make data available across an ICS, scale up GP collaboration and work more effectively with PCNs.

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Welcome

I am keen to dispel the notion the challenges facing the health and care sector have manifested purely because of the Covid-19 pandemic. Buying into this narrative excuses decades of underfunding and misguided health policy. Waiting lists have been rising rapidly for many years, and meeting targets for procedure waiting times have become increasingly unachievable goals. Increasing demand, combined with acute workforce shortages and inflexible infrastructure have compounded issues and created bottlenecks in care delivery. Throw a global pandemic into the mix and you have a healthcare crisis the likes of which have not been seen since the inception of the NHS.

I appreciate I am likely preaching to the choir here; I assure you that this magazine does far more than simply cite complaints about government mismanagement of the NHS – that is a well-trodden path. With this issue of *Hospital Times*, we blend our usual combination of news, insight and analysis to provide high level thought leadership into the task facing the health service as it looks to recover and renew as well as providing practical advice for key decision makers. Why has the backlog manifested? Where are the pressure points? And what innovative solutions are there to health providers? These are just some of the questions we address in this magazine, and we hope that decision makers find it useful as they navigate through this multifaceted healthcare crisis.

In terms of practical advice, this is exactly what David Cole; Chief Executive of Vanguard Healthcare Solutions has provided on pages 30 to 33. David calls upon NHS leaders to start prioritising infrastructure differently to boost capacity and alleviate demand on service providers – who are often hampered by an inflexible estate. David does this while providing a step-by-step guide on how flexible infrastructure can be implemented to alleviate capacity concerns for overstretched hospitals.

Increased flexibility within health infrastructure facilitates new models of care, which ties nicely into one of our highlight features in this issue. The Royal College of Surgeons have put forward a new proposition for UK elective care, central to their recommendations is the establishment of 'surgical hubs' to create newfound surgical capacity across the NHS. I spoke with Professor Neil Mortensen in what was a fascinating interview, read his thoughts on the matter on page 43.

Covid has exposed an undeniable truth, that it is unacceptable and dangerous to constantly run a health service at near total capacity. Systemic failures are increasing pressure in other parts of the system to the cost of patients. This is also true for A&E departments across the country – as Dr Katherine Henderson, President of the Royal College of Emergency Medicine, bluntly puts it on page 50: "It wasn't like we went into Covid singing and dancing".

David Duffy

Editor, Hospital Times

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NEWS & VIEWS

Amanda Pritchard takes over as NHS Chief Executive

Amanda Pritchard has been appointed Chief Executive of NHS England, taking over from Lord Simon Stevens and becoming the first female NHS Chief Executive in the health service's 73 year history.

Pritchard began her new role on 1 August, she was previously Chief Operating Officer of NHS England, and Chief Executive and Chief Operating officer of NHS Improvement, essentially working as deputy to Lord Simon Stevens. She has been working for the NHS for more than 20 years, beginning on the NHS Management Training Scheme in 1997 and previously serving as Chief Executive of Guy's and St Thomas' NHS Foundation Trust in London.

Pritchard was seen as a "continuity" candidate having spent multiple decades in senior leadership positions within the NHS. Dr Jennifer Dixon, Chief Executive of the Health Foundation said: "Amanda's proven credentials as a senior NHS leader and manager are vitally important to address record waiting lists and support an exhausted and understaffed NHS workforce.

"Amanda has a huge opportunity to build on the work of her predecessor Sir Simon Stevens whose leadership led to significant investment and a clear long-term vision for the NHS. Amanda's experienced leadership will need strong government support and funding as the public clearly expect. We wish her every success and look forward to working with her."

Chief Executive of NHS Providers, Chris Hopson, said: "The challenges ahead are formidable, but the NHS has shown, in its response to the pandemic, an extraordinary capacity to innovate and adapt at pace whilst maintaining the collective, compassionate and caring ethos that places the NHS at the heart of our national life. These are firm foundations from which to meet the coming challenges.

"Over the last two years, trust leaders have welcomed Amanda's calm, team oriented, and effective national operational leadership of the NHS through one of the most challenging periods in its history. She has a deep and strong connection with NHS frontline leaders and staff which will be much needed given the scale of the challenge ahead. It is also particularly pleasing to see a female NHS Chief Executive appointed for the first time in the service's 73-year history."

Matthew Taylor, Chief Executive of the NHS Confederation, said: "Amanda is the continuity candidate, and her appointment ensures she will hit the ground running when Lord Stevens leaves. This role is arguably the most significant across the entire public sector and with a new Secretary of State getting up to speed, this continuity at the top of the NHS will be vital."

Doctors report high degree of pandemic burnout

Doctors have found their work "emotionally exhausting" during the Covid-19 pandemic, according to a new General Medical Council (GMC) report.

More than 63,000 UK doctors, all either trainees or trainers, completed the GMC's annual national training survey. The responses showed an increase in burnout among doctors, the worst since the relevant questions were introduced in 2018.

Trainees responded to seven questions regarding wellbeing, across all medical specialties. A third of trainees said they felt burnout to a high or very high degree due to their work, while in previous years a quarter of trainees responded this way.

Three in five trainees said they always or often felt worn out at the end of a working day and 44 per cent felt their work was "emotionally exhausting" to a high or very high degree.

Charlie Massey, Chief Executive of the GMC, said: "It is not surprising that burnout has worsened during the pandemic, but we cannot expect doctors to continue to operate at this level of intensity. As health services emerge from Covid pressures will remain, but we must not risk reversing the gains that have been made in recent years.

"The danger is that, unless action is taken, workloads and wellbeing will continue to suffer, and future burnout rates could get even worse. As we move on from the pandemic, it is vital that doctors' training and wellbeing needs are central to service recovery plans. This year's results should be a blip caused by Covid, not part of a new normal."

Despite the effects of the pandemic, the survey found that the quality of training remained high, and similar to pre-pandemic levels. About three quarters of trainees rated the quality of teaching as good or very good, and almost nine in 10 reported that their clinical supervision was good or very good.

Eight in 10 trainees felt they were on course to meet their curriculum outcomes for the year. However, one in 10 – a significant number in real terms – was worried about progressing through their training.

Mr Massey added: "The pandemic has caused inevitable disruption, and some training opportunities have been lost. But, thanks to the efforts and hard work of trainers and trainees, where training has been possible the quality has been sustained.

"We know many trainees remain concerned about their training progression, so we are working hard to ensure training is flexible, fair, and helps prepare doctors to meet current and future patient needs."

Patient-facing technology may help relieve pressure over surgery backlog

Chelsea and Westminster Hospital NHS Foundation Trust has adopted new technology to tackle the elective surgery backlog that has resulted in West Middlesex University Hospital reducing time spent gathering pre-operative information by 63 per cent.

The NHS trust, home to two of London's busiest acute hospitals, has implemented a digital-first pathway from healthcare technology specialists DrDoctor for its endoscopy diagnostic service.

The current endoscopy backlog is about half a million appointments, according to research from University College London (UCL), contributing to pressure on the NHS to reduce surgery backlog.

Using patient-facing technologies, the Trust has been able to streamline the pre-operative process. The technology cuts out time spent on phone calls and trying to contact staff by allowing the trust to send reminder messages, digital letters and assessments to patients ahead of their operations.

To reduce waiting lists and cancellations, DrDoctor's Quick Question functionality is being used to send email and text notifications to patients. This enables staff to check that patients still wish to be seen and means staff do not need to spend time phoning the patient.

Tom Whicher, Chief Executive of DrDoctor, said: "One of our main ambitions is to provide a patient engagement platform with components that are critical to the sustainability of NHS trusts and work efficiently for both service users and staff. The work we are doing with Chelsea and Westminster NHS Trust is helping to lay the groundwork for clinical change and speedier adoption of a digital first healthcare system, while putting the needs of the patient at its heart."

By enabling patients to complete assessments ahead of endoscopy operations, the Trust has seen the average time taken fall from 26 minutes to just under 19 minutes, a 29 per cent decrease.

Staff reactions to the digital pathway have been positive, with 80 per cent of staff finding the pre-operation assessment questionnaire useful and three quarters of staff satisfied with the revised pathway.

Bruno Botelho, Director of Digital Operations at the Chelsea and Westminster NHS Foundation Trust, said: "Thanks to DrDoctor, we have established an infrastructure to address the evolving needs of our patients and staff. By digitally engaging with patients, we're helping to release the capacity pressures our staff face. I'm really pleased that we can now provide a more efficient service to patients and provide more personalised care."

Lengthy waits for lifesaving cardiac treatment lead to "untold heartbreak"

Pandemic disruption has meant waiting lists for lifesaving heart diagnosis and treatment could more than double within two years to over 550,000 in England, a new report from the British Heart Foundation (BHF) has warned.

In the report, entitled *The untold heartbreak*, the BHF estimates that without sufficient government investment the number of people waiting for heart care and diagnosis could rise to 550,385 by January 2024, particularly with increased strain on the NHS from Covid-19 or a harsh winter.

The number of people waiting for heart surgery could peak at 15,384 people by February 2022, almost double pre-pandemic levels. Prior to the pandemic around 225,000 people in England were on a waiting list for heart diagnosis or treatment and 8,400 were waiting for heart surgery.

The BHF estimates that without decisive action, it will take between three and five years for the heart care backlog to return to pre-pandemic levels. The charity has called for a clear plan for cardiovascular services and rapid investment to build more capacity in the NHS and relieve pressure on health workers, as well as better support for heart patients waiting for treatment.

Professor Sir Nilesh Samani, BHF Medical Director, said: "Delay in diagnosis and treatment of cardiovascular diseases is not just about improving symptoms, however important that is – it is about saving lives. Tragically, we have already seen thousands of extra deaths from heart and circulatory diseases during the pandemic, and delays to care have likely contributed to this terrible toll."

Responding to the BHF report, Chris Hopson, Chief Executive of NHS Providers, said: "The NHS is going at full pelt to recover the care backlogs as a result of Covid-19, including those patients waiting for cardiac care. However, despite the great efforts of NHS staff, the extraordinary pressures posed by the pandemic have resulted in some patients waiting longer for treatment and care.

"This latest report highlights once again the scale of the challenges faced by the health service, and the importance of ensuring it has the resources to be able to provide the quality of care that patients rightly expect, and that trusts want to deliver."

Innovative project supports pandemic recovery across Greater Manchester

A project to provide additional capacity for endoscopy procedures is reducing waiting lists and helping patients receive essential care in Greater Manchester.

Vanguard Healthcare Solutions, the Greater Manchester Elective Recovery and Reform Programme and clinical services provider 18 Week Support developed the project to create a dual-procedure endoscopy suite at Fairfield General Hospital in Bury, part of the Northern Care Alliance NHS Group.

Asia Bibi, Programme Manager at the Greater Manchester Elective Recovery and Reform Programme, who has been overseeing the project, said: "A number of NHS partners have been working together to support the recovery of services as a region and this is one of the first projects to provide access for all regional patients. I am pleased at the pace we have been able to set this up in order to restore services for our patients."

The unit has been specifically commissioned by the Greater Manchester Provider Federation Board to support the delivery of endoscopy services across Greater Manchester following the Covid-19 pandemic disruption.

To fit the specific needs of the Northern Care Alliance, the unit has been designed with a Vanguard mobile laminar flow theatre, two procedure rooms, a six-bed recovery bay, two consultation rooms, and full staff and patient facilities.

Vanguard has also provided a unit facilitator, while 18 Week Support has provided eight specialist endoscopy nurses and two clinical consultants to deliver all patient endoscopy procedures and keep the unit fully operational seven days a week.

Simon Conroy, National Endoscopy Sales Manager at Vanguard, said: "Feedback from patients and staff at the unit has been incredibly positive.

"Many of the patients the unit is seeing are having surveillance procedures and are, of course, very relieved and grateful to have their appointments. Staff tell us it's a light, bright, spacious and well-equipped environment to work in and even that the unit provides more spacious than standard endoscopy procedure rooms and recovery areas."

Matt Marshall, Chief Commercial Officer at 18 Week Support, said: "This is an innovative project which is helping the trust significantly increase the number of their patients that are seen by specialist clinicians, delivering significant reductions in waiting lists and improving health outcomes. The patient feedback we have had has been excellent, with patients telling us the treatment and care they have received has been overwhelmingly 'very good'."

HEALTH POLICY

DR TONY DYSART

Improving imaging to strengthen NHS recovery

Services need a learning culture and support for staff from the top to tackle repeated failings in the imaging pathway that can have serious consequences for patients.

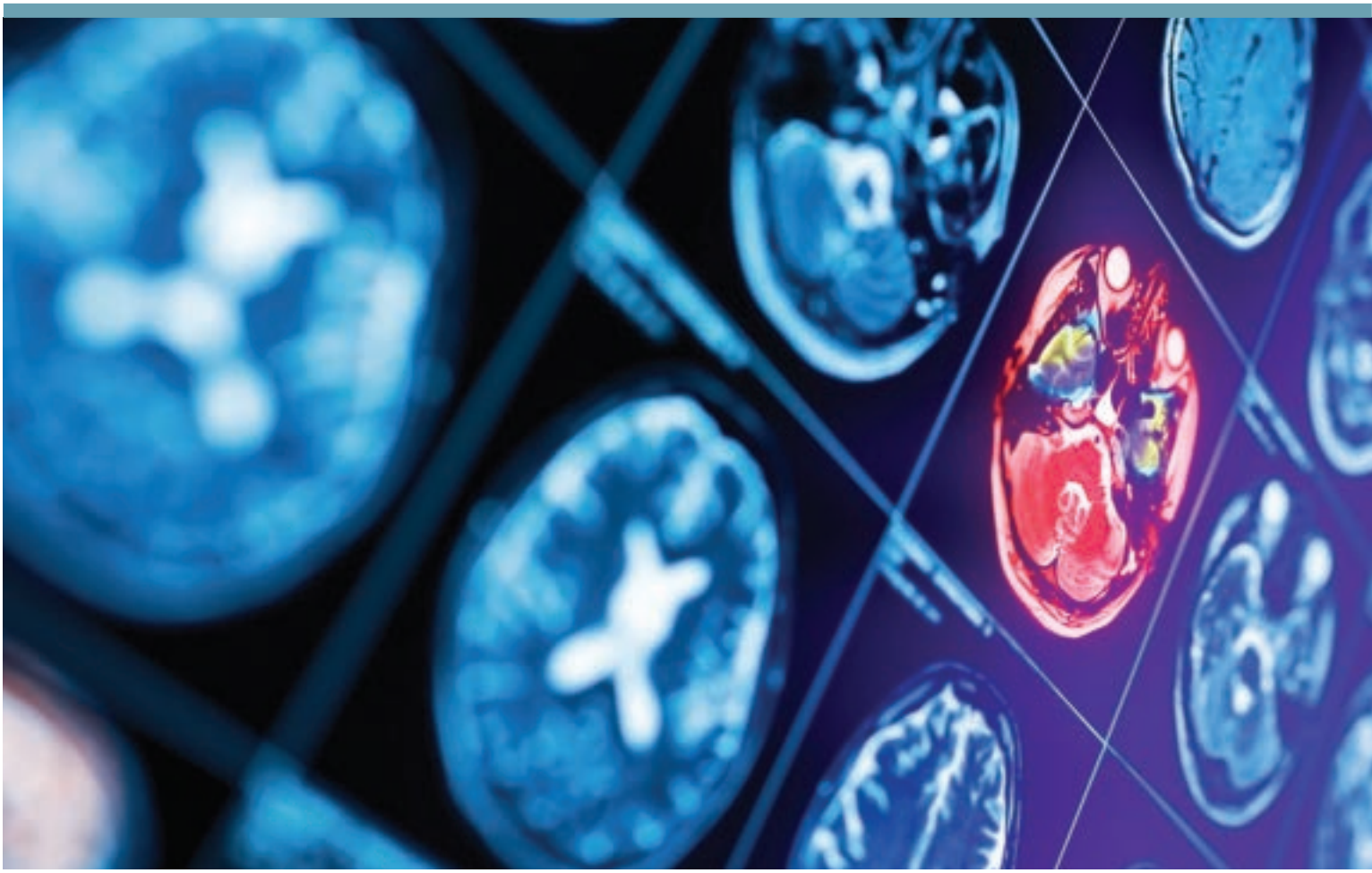
There is no doubt the NHS has huge challenges ahead as it recovers from the impact of Covid-19. But the recovery process also offers a real opportunity to embed improvements to services that will strengthen the quality and safety of NHS care.

In the Parliamentary and Health Service Ombudsman (PHSO) July 2021 report about complaints related to NHS imaging, we present recommendations to improve how clinical staff request, carry out and report on imaging.

Given that many of the five million patients currently waiting for elective care will rely on diagnostic services such as imaging as part of their treatment, it is vital that these recommendations are implemented with urgency. This is why Ombudsman Rob Behrens has written to the Government, asking it to prioritise improvements to NHS imaging.

The report findings

In an analysis of 25 complaints, we found four repeated failings along the imaging pathway:



1. Failure to follow national guidelines on reporting unexpected imaging findings
2. Failure to act on important unexpected findings
3. Delay in reporting imaging findings
4. Failure to learn from past mistakes.

These failings with the way imaging is requested, carried out and reported, and related wider issues highlighted in the report, are well acknowledged within the NHS. Not only does our casework evidence this point but extensive engagement with the Royal College of Radiologists (RCR), Society of Radiographers (SoR) and other NHS clinicians, confirms that the problems are systemic in nature. Evidence also tells us that the issues exist across clinical specialisms, in both primary and secondary care, and are not isolated to imaging departments.

Imaging is an essential diagnostic tool, so errors or inadequate practices have the potential to affect huge numbers of patients. If something goes wrong along the imaging pathway, the impact on patients can be severe, as documented in the PHSO report. For example, our casework analysis highlights multiple instances when delays in reporting imaging results have prevented or delayed patients from receiving treatment, sometimes with tragic consequences.

As a practising GP, I know at first hand the pressures under which NHS staff are expected to work and the high level of service expected from us. What is clear is that staff desperately want services to improve but have struggled to gain the necessary traction from senior leaders and government to support positive change. Without this support, problems will continue to arise, and staff will continue to feel the impact of providing a compromised level of care that they have little power to improve. At a time when staff morale has been challenged like never before, it is crucial that they are supported to do their job to the standards that they expect of themselves.

"Leaders of NHS services must recognise systems and processes as critical factors in patient safety, rather than seeing them as peripheral administrative issues"

Dr Tony Dysart
Senior Lead Clinician, Parliamentary and Health Service Ombudsman

What should be done?

Work to improve the imaging pathway is underway but there is still much more to do. Our report highlights the need to implement the recommendations of existing reviews by the Care Quality Commission (CQC), Healthcare Safety Investigation Branch (HSIB) and Independent Review of Diagnostic Services by Professor Sir Mike Richards. Effective local policies and processes and integrated digital capabilities must form part of the overall improvement programme to enable timely, accurate requesting and reporting.

For this reason, the report presents four recommendations for the system as a whole and three for imaging services.

To improve the system as a whole:

1. Recommendations from previous work related to imaging must be implemented as a priority. This should have central coordination and oversight from NHS England and NHS Improvement (NHSEI)

and include recommendations made by HSIB, CQC and the Independent Review of Diagnostic Services.

2. Digital infrastructure must be treated as a patient safety issue. The Department of Health and Social Care (DHSC) and NHSEI, working with NHSX and NHS Digital, should prioritise improvements to digital reporting capabilities across the system of requesting and reporting imaging.

3. DHSC and NHSEI should ensure there is national guidance on the roles and responsibilities of clinicians, and expected time frames, at each stage of the imaging journey. This guidance should apply to referring clinicians of all specialties and should involve the Academy of Medical Royal Colleges (AoMRC) and other relevant professional bodies.

4. DHSC and NHSEI should write to the House of Commons Health and Social Care Select Committee and Public Administration and Constitutional Affairs Committee by the end of March 2022, updating on progress in implementing these recommendations.

To improve imaging services:

1. All NHS-funded providers that have a radiology service should provide staff working in those services with sufficient allocated time in their job plans for meaningful learning and reflection. This should include identifying and sharing the learning from discrepancies and peer review of radiological reports.

2. Clinical directors and senior managers of NHS-funded radiology services should triangulate the learning from across their departments on a regular basis.

3. The RCR should review existing guidance on reporting unexpected findings and peer review of radiological reports to learn from the findings of PHSO's casework.

The way forward

The key to unlocking these solutions is achieving buy-in from clinical and managerial leadership, both nationally and locally. The report findings have significant implications for all clinical professionals who work with imaging so effective collaboration is vital.

Leaders of NHS services must recognise systems and processes as critical factors in patient safety, rather than seeing them as peripheral administrative issues. In the complaints we see, we have found poor ICT and poor assurance processes can have very serious real-world consequences for patients. The NHS faces continued pressure and the task of working through the backlog of patients that has built up over the past year. This makes it is more important than ever to put effective and efficient working practices in place.

It is also crucial that a just and learning culture is embedded throughout the NHS. Learning from mistakes is fundamental to the improvement process and must be prioritised, with senior leaders championing the benefits to patients and staff. Removing a culture of blame will enable this process and improve staff wellbeing. The principles of the NHS Complaint Standards should be implemented to facilitate this.

The impact of Covid continues to pile pressure on staff and services and, undoubtedly, additional challenges lie ahead. There is an urgent need for government and the NHS to address the failings we have identified, so the challenges created by the pandemic are not compounded by problems with care.

If no meaningful progress is made on these recommendations, patients and their families and NHS staff will continue to be negatively affected. We owe it to the dedicated NHS workforce who want to deliver safe, high-quality care to make sure the right guidance, systems and processes are in place to enable them to do exactly that.

LLOYD TINGLEY

Restarting and rebuilding the NHS

Public Policy Projects has created a new coalition of experts and stakeholders from across the health and care spectrum, designed to create a health service that boasts truly world-leading patient outcomes.

To be honest, the UK was not world-leading for patient outcomes prior to the Covid-19 pandemic. But the country has suffered immensely since March 2020, and citizens will continue to face hardship in years to come unless we act now.

In 2022, Public Policy Projects (PPP) will bring together policy leaders, experts in healthcare, social care and life sciences for a once-in-a-generation project to create a compelling vision for the delivery of universal healthcare in the 21st century. Using international examples of best practice, case studies of success from around the UK and innovative thought leadership, PPP intends to set out a blueprint to build a healthcare system that can respond to the challenges of today and the future.

As the UK looks ahead, there is an opportunity to evaluate the NHS Long Term Plan, assess the most impactful policies and reimagine what could be included within a new vision for the NHS. This coalition will reimagine opportunities for the future by creating world-leading, actionable policies that will urgently restart clinical pathways, tackle the backlog and outline a recovery roadmap.

Legislative change on the horizon

The NHS has been undergoing a slow and steady move to better integrate services, breaking down long-established institutional silos. This has been aided by the creation of primary care networks and the merging of many clinical commissioning groups as well as NHS England and NHS Improvement joining together. However, the biggest changes will come as a result of the government's new health and care bill.

The bill, *Working together to improve health and social care for all*, was introduced to Parliament earlier this year. It focuses on repealing many elements of the 2012 Health and Social Care Act. Of particular focus is a shift of power held by NHS leaders to enhanced powers for government, in particular the Secretary of State for Health and Social Care. These enhanced powers will mean that government will play a much larger role in the day-to-day running of the NHS, with responsibility over workforce and service reconfigurations.

The bill also includes a move to formalise the role of integrated care systems in the NHS by putting them on a legal footing that has been expected, and called for, over many years.

This shift provides us with an opportunity to rethink and reshape the way in which government can support rapid change in the NHS, particularly in a post-Covid-19 world in which the NHS will need to bounce back quickly to meet the needs of the population.

Restarting the NHS

The NHS restart programme that commenced in autumn 2020 has seen variable degrees of success, with numbers accessing primary care and outpatient services drastically reduced, and subsequent waves of the pandemic setting the recovery back. Due to this variation, it is clear that the impact of the pandemic on other previously unseen health areas, or those deemed to be non-urgent, might have been neglected.

The NHS is still overburdened in its response to the pandemic, with record numbers of people admitted to hospital because they have contracted Covid. However, with the mass vaccination effort well underway, the new, post-pandemic NHS is in sight.

That is why this is the right time to visualise and make the case for how the NHS should be rebuilt to best support the UK's population and to:

- restart services to tackle the backlog of diagnoses that have been missed due to the pandemic
- share best practice that has been established throughout the pandemic and make the case for the long-term adoption of new models of care.

"We cannot unlock the opportunities that lie ahead by merely recreating the failures of the past"

Lloyd Tingley
Policy and Partnerships Director, Public Policy Projects

In a July 2020 letter to NHS trusts and others on the third phase of the NHS response to Covid, outgoing NHS boss Sir Simon Stevens and incoming Chief Executive Amanda Pritchard outlined the need to "lock in beneficial changes" that the pandemic had brought to the NHS. This should include the rapid scale-up of the use of data and digital, new ways of care delivery via telemedicine and an emphasis on health inequalities and prevention.

Rebuilding the NHS

The need for a complete reboot and reset comes over two years after the NHS Long Term Plan was released, containing headline-grabbing ambitions for people living with long-term conditions, such as preventing 150,000 strokes, heart attacks and dementia cases in the 10 years following the plan's publication.

Restarting the NHS and the way we manage the health of the UK's population does not just mean a return to the pre-pandemic status quo. In its August 2021 report, the Commonwealth Fund found that the UK ranked 10th out of 11 countries analysed in terms of patient outcomes. There is much work to be done to improve patient outcomes, which continue to lag across the UK.

Therefore, following work done to clear the initial Covid backlog it is essential we create our vision for a truly universal health system. This work will allow us to concentrate on what matters most to people living in the UK.

We cannot unlock the opportunities that lie ahead by merely recreating the failures of the past. The UK must embrace the latest technologies and innovative medicines. By building a coalition, focused on the restart and rebuild of the NHS, we will be able to provide health system leaders with clear direction and examples on how to lock in beneficial changes.

As we look to the future, there is a unique opportunity to reimagine the opportunities for our national system of healthcare provision. Our cross-party objective is to encourage political leaders to rethink their agendas and create a truly world-beating universal healthcare system. We hope you will join PPP as we seek to unlock the opportunities of the future, by embracing the best examples from around the world and applying them here in the UK.

MORE INFORMATION

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PROFESSOR TERRY YOUNG

A new Secretary of State for Health and Care: three tensions he can recast

There is of course unprecedented challenge, but also unique opportunity for the still new Secretary of State for Health and Care to push forward significant sector reform.

The new Secretary of State for Health and Care arrives at a remarkably interesting time. Problems that had ground to an intractable halt may yield to different approaches. A more commercial background may apply fresh thinking to old problems. As we hover between the end of lockdown and the successful introduction of integrated care systems (ICS), the government has a chance to rethink the past and reshape the future.

Here are three tensions that our new Secretary of State for Health and Care faces and is unusually well-positioned to address.

Health versus wealth

The struggle between the Department of Health and the Treasury has been a major feature of the crisis and for a while it appeared that we were doing worse that the rest of the world of both fronts. Surely someone who has been at the helm at the Treasury and Health will have a more balanced view of the challenge.

Whatever the final analysis shows and it may take a year or two to come out, colossal damage has been done to swathes of our commercial infrastructure and educational systems, not to mention the pupils and students going through.

As the 'war on the virus' gives way to a more measured rhetoric on retrieving a better normality with or without (but probably with) the virus, it is becoming clear that we have survived under a false dichotomy: we have to make health and wealth work together.

Exactly how he makes this happen, will depend upon how our new Secretary of State for Health

and Care muscles his flexibility, but he comes to the fore at an opportune moment.

Funding versus investment

Coming from a banking background, the new Secretary of State for Health and Care brings an investment perspective to the table. The conventional thinking around NHS finances is of a fair distribution of funding, rather than the potential for investment.

The NHS is not an engagement ring offered to a grateful public by a governmental suitor, nor is it worth more if it costs more. The NHS is a service we pay for, and some have paid particularly dearly over the past 18 months.

The perspective of an investor can be more generous and harsher than that of a fund-distributor, since investors look at money very differently. Whatever happens, the new ICS's are going to cost a lot to make them work well. We know that payment systems need to shift in favour of outcomes and away from rewarding activity or mere size, so fresh thinking is needed. However, ICS's also have enormous potential for benefit at scale, and the right designs will be worth the investment.

Over the past two decades, NICE has promoted value-for-money at the heart of investment decisions. I am a great admirer of NICE and the methods by which it assesses value, and I hope that value-for-money thinking embeds itself ever more deeply in the NHS. However, there is still a problem in that economists can spread calculations over many years, while businesses must make decisions here and now. The way is open for someone with strong investment credentials to build better decision-making onto NICE's foundation.

Health for all versus personalised care

The language around this tension keeps changing, but at heart it involves programmes of broad benefit that reach everyone and services that meet the needs of individuals. Mass customisation in manufacturing persuaded many in health that they can have the benefits of large-scale provision and individual attention at the same time.

The pandemic provided a wonderful opportunity to showcase and refine personalised delivery but pushed the NHS into large-scale delivery of vaccinations instead (an undoubted success to date). However, we are recognising ever more groups whose personal health has been a casualty of the crisis.

The NHS has learned about industrial process through the pandemic (e.g. queue-free delivery environments) and has both successes and failures to inform future reform. There is now an opportunity to extend this quasi-industrial experience into care closer to the patient. Someone new may enjoy more freedom to recognise the setbacks of the pandemic alongside the successes and mediate a better balance for the future.

One clear message of the pandemic is that better decisions need better data, so someone needs to drive demand for better real-time data.

A new opportunity

The pandemic has created an unusual perspective from which to view healthcare. As we sit on the threshold of an era of greater freedom and the prospect of integrated care, the new Secretary of State for Health and Care has the opportunity to recast some fundamental tensions around health in a much more positive way. We wish him well.

"It is becoming clear that we have survived under a false dichotomy: we have to make health and wealth work together"

Professor Terry Young
Director, Datchett Consulting

About the author

Professor Terry Young worked in industrial R&D before becoming an academic and is now Director of Datchet Consulting. With over 30 years' experience in technology development and strategy, health systems, and methods to ensure value for money. His current focus lies in designing services using computer models and he set up the Cumberland Initiative to support healthcare organisations wishing to develop their services more systematically.

JEROEN VAN OS

Procurement's part in shaping the NHS journey ahead

Planned changes to how NHS and related health and care services are procured are intended to reduce bureaucratic processes and encourage joined-up care. How will this work and reassure commissioners they can procure with confidence to deliver a better service?

In February this year, an NHS white paper outlined changes to procurement as part of proposals to "improve health and social care for all". The paper references the NHS Provider Selection Regime intended to give commissioners greater flexibility in how health services are arranged.

On 6 July, the Department of Health and Social Care introduced a health and care bill to the House of Commons. The bill will enable a separate procurement regime when arranging clinical healthcare services, whether hospital or community services.

While the NHS Provider Selection Regime will only apply to the procurement of clinical healthcare services, the bill will enable allowances to be made for mixed procurements in the regime and in the interests of joined-up care, for instance, when a health service is being commissioned along with social care.

The procurement of non-clinical services, such as professional services or clinical consumables, will remain subject to the Public Contract Regulations 2015 rules until these are replaced by Cabinet Office procurement reforms.

Explanatory notes published alongside the bill say that this new procurement regime for NHS and public health services, the Provider Selection Regime, will reduce the need for competitive tendering where it adds limited or no value.

The bill will create a separate procurement regime for arranging clinical services, which will include removing the procurement of health care services for the purposes of the health service from scope of the Public Contracts Regulations 2015. It will also enable the development of a new procurement regime for the NHS and public health procurement (informed by public consultation) aimed at reducing bureaucracy for commissioners and providers alike.

New rules under discussion

Consultation on the Provider Selection Regime took place in February this year and the new regime would be established via a combination of primary and secondary legislation and set out in detail in statutory guidance. The consultation document proposes that

certain rules be applied when healthcare services are procured in the future and that current procurement requirements be removed. When read along with the published information on the establishment of statutory integrated care system (ICS) boards, including *Legislation for Integrated Care Systems: five recommendations to Government and Parliament*, the Provider Selection Regime document aims to make it more straightforward for our system to continue with existing service provision, particularly where existing arrangements are working well and there is no value in seeking an alternative provider. Currently, there is an expectation that nearly all contracts procured for NHS services should be advertised and awarded following a competitive tendering exercise, which leads to continuous upheaval and disruption among providers.

This legacy procurement pattern would be replaced by the new regime specifically created for the NHS – reinforced in the ethos that services procured are in the best interests of patients, taxpayers and the population.

Applying the proposed regime

Although it would depend on the type of service being procured, there are three decision circumstances in the scope of the Provider Selection Regime. Here is our take on each of them.

1. Continuing existing arrangements

If current arrangements are going well and are financially balanced, continuing with existing services has an immediate benefit to patients, commissioners and providers. However, if commissioning authorities must come out of the current procurement arrangement, which may only offer a marginal economical advantage, the question to ask is, is it worth potentially causing disruption to existing stakeholder relationships?

"Securing best value goes beyond price and must include a clear route to innovation and contribution to social value"

Jeroen van Os
Finance Director, ERS Medical

Continuing an existing arrangement offers contract security and encourages high-quality performance as all parties are invested in the contract for the longer term. It also promotes a partnership approach, with or without added investment in new technologies, infrastructure development and innovation, such as investing in electric vehicles for a long-term contract.

However, longer-term contracts, or continuing with existing arrangements, will still need to be clearly defined by certain parameters. Will it be a rolling contract with a short notice period? If so, this will once again lead to uncertainty and lack of commitment from all parties involved, not to mention a disrupted service to patients. For instance, a rolling contract with a six-month break clause could encourage an impassionate service that simply ticks the boxes to meet contractual key performance indicators (KPIs).

There has to be a sense of balance in continuing existing arrangements. Competition drives innovation, best practice and best value; continuing existing arrangements can lead to stagnation and a lack of development across the sector. There is no real drive for providers to continue to be industry leaders without a level of healthy competition. The plan for procuring authorities to continue with existing arrangements should be made with a clear service improvement and innovation agenda.

A lack of competition could shrink the overall supply chain, making it more difficult for the sector to collectively flex to changes in demand. This issue was spotlighted throughout the pandemic, when patient transport and frontline ambulance services collaboratively worked together to ensure patients were being transported to keep things flowing during an incredibly busy time.

Provider continuity must coincide with periodic quality and price evaluation, otherwise true value is difficult to establish. It is important to distinguish between best value and best price for the service as well, because a service should not just be procured on price. Regular service reviews must go beyond basic KPI. Contract reviews are important to ensure that procurement authorities are receiving the best value and a consistently effective and innovative service.

2. Identifying the most suitable provider for new/substantially changed agreements

The second decision circumstance in the Provider Selection Regime is identifying the most suitable provider for new or substantially changed agreements. This sounds very much like a tender process, but the consultation document states that a full tendering process does not need to be conducted. If so, what timescales will this new procurement take and is there a financial cap? Moreover, if the existing arrangement has substantially changed, can the existing provider deliver it with current relationships and local knowledge, such as providing vertical services in the same space if their service portfolio allows it?

Identifying the most suitable provider needs to be done against the proposed criteria in the Provider Selection Regime. These are quality, value, integration and collaboration, access, inequalities and choice, service sustainability and social value. The Provider Selection Regime consultation notes that value is not about securing the cheapest option, but about selecting the most suitable option that offers a combination of benefits.

Another point to consider for this scope is that the process for identifying the most suitable provider must have a robust (qualitative and quantitative) analysis behind it. Taxpayers and patients want to know they are getting a good and reliable service. Commissioning organisations want to know they are getting best value for their budget with evidence of a provider's experience. As it is public money, perhaps this information should be available in the public domain?

For instance, as mentioned in the August 2021 non-emergency patient transport services (NEPTS) review, *Improving non-emergency patient transport services, Report of the non-emergency patient transport review,* it is impractical to apply a holistic blueprint for all non-emergency patient transport as there are far too many variances in geographies, patient cohorts, local settings and technologies. However, local and regional planning of such services should be based on a national approach that raises the standards of service for patients as well as providing an incentive for investment and innovation in the overall sector.

3. Competitive procurement

The third decision circumstance in the Provider Selection Regime is competitive procurement. We would assume this will follow a clear legal process, therefore allowing the decision-making authority a detailed insight into each provider, with specific scoring against requirements. This approach encourages healthy and fair competition in the economy.

Done properly, competitive procurement is the best way for decision-makers to evenly compare providers to ensure that they choose the most economically advantageous provider for the service they are procuring. This can result in the best value. However, there is a tendency to attribute the highest percentage of scores to price, which is not the true test of a well-rounded or value-added service. This method of procurement can also become time-consuming and lengthy – the very pitfalls the new regime aims to avoid.

Competitive procurement will also need to address whether the service is being obtained for the short term or as a long-term solution. While there is no "one size fits all" solution, longer-term procurement generally results in a service bedding in properly with healthcare staff and patients. It gives the provider time to adapt and make improvements where necessary and, perhaps more importantly, it allows strong working relationships to form for better collaboration across health and social care.

Short-term procurement is often the route to cost savings but, while it has a place in the healthcare economy, it can sometimes lead to poor service, procedures not being followed and compromises on any additional due diligence checks.

Competitive procurement also needs to consider benchmarking. What is the standard for a particular service? Are we directly comparing two service providers across the same geography or different geographies? Maybe the answer is to have a standard set of questions to establish a provider's experience, their staff training, diligence checks and compliance standards, and to supplement this with a bespoke set of questions for patient cohorts, KPIs, local geography and service delivery compliance. Furthermore, how will the scoring be defined and what will it be based on? Setting a narrow range of scores between responses can stymie innovation.

It is accepted knowledge that securing best value goes beyond price and must include a clear route to innovation and contribution to social value. True value is also derived from the reduction of environmental impact with investment in new technologies, and long-term sustainability should be a central priority. When services are being provided to patients, their opinion, patient opinion and feedback to shape the service are essential.

For instance, the August 2021 NEPTS review states that there will be a new national framework for patient transport comprising five components. One of these components is "better procurement and contract management, to improve service responsiveness and enable investment and innovation".

The review gives initial advice and outlines further best practice principles and proposals on improving non-emergency patient transport services where "contracts for core specialist provision are agreed for a minimum of five years, comprise of a combination of fixed and variable payments, and that tender processes run for a minimum of 60 days; and that non-specialist provision draws on wider transport markets".

Historically, procurement has sought responses in a written format, but there would be merit in exploring other ways of establishing a provider's credibility and experience. For instance, procuring authorities could visit the provider's premises to get a first-hand and close view of their experience, staffing levels, vehicles and premises. This could be an innovative way to supplement the presentation stage of procurement. The written format of a tender response could remain in place as a strong fact-finding exercise to determine the basics of a provider's capability. However, an on-site visit could be hugely beneficial because, while Care Quality Commission (CQC) ratings are valuable, they do not reflect a provider's service experience and value for a particular bid specification.

The NHS is continuing its recovery from the pandemic and at the same time undergoing transformative changes such as the formation of integrated care systems (ICSs) to provide more joined-up health and care to all. As providers, we have a collective responsibility to contribute experience, opinion and feedback to shape the NHS procurement journey ahead.

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JONATHAN PEARSON-STUTTARD

We need targeted investment to tackle deep-rooted health inequalities

Disparities in the growth of waiting lists due to the pandemic highlight the importance of addressing unmet needs among certain populations.

The total NHS waiting list, one of three priority areas for the Secretary of State for Health and Social Care, has increased by 25 per cent since the pandemic began and is still rising. Larger waiting lists are an indirect impact of the pandemic and indicate a deterioration in the population's health due to acute direct pressures from Covid-19 negatively affecting other acute and chronic disease pathways.

In May 2021, the number of open pathways was 5.3 million, up more than 180,000 on the previous month, but this is only part of the story. When we add the several million who are likely to have avoided seeking treatment during the pandemic due to both health system pressure and behaviour change, it is clear that any recovery will require novel approaches to prevent millions of people from living in pain and poor health for many years.

The 25 per cent increase in the total waiting list since the pandemic began is dwarfed by the vast increase in those waiting 52 weeks or longer for treatment. Before the pandemic, the number waiting more than 52 weeks for treatment was (relatively) low at around 1,600. That number had increased to more than 435,000 by March 2021. Fortunately, the total has now fallen by around 12 per cent for two consecutive months, suggesting early signs of a recovery, but it still stands at 336,733 individuals, representing one in 14 on the waiting list.

In contrast to the data suggesting that the one-year waiting list may have peaked, the number of

patients waiting 18 months or two years continues to grow, increasing by 22 per cent and 44 per cent from April to May 2021, and now standing at 79,048 and 3,927 respectively.

Inequalities across regions and specialties

Beneath the (very) large total number on the waiting list, we find vast inequalities across clinical commissioning groups (CCGs), regions and specialties. For instance, there are 64 times more patients waiting one year or longer in Birmingham and Solihull CCG (17,060) than in South Tyneside CCG (266). There is more than a 100-fold difference in those waiting 18 months for treatment in Norfolk and Waveney CCG (3,735) compared with Bassetlaw CCG (35); and in North Central London CCG, 290 patients are waiting two years or longer, yet at least 15 CCGs have two or fewer patients waiting as long.

Similar inequalities exist in specialty pathways such as orthopaedics, which continues to have the largest waiting list at 647,450, with 20-fold differences in waiting list numbers, increasing to 80-fold differences in those waiting a year or more for treatment.

Specialties have been impacted unequally too. Gynaecology has seen the largest relative increase in waiting list size, up 35 per cent from February 2020 to April 2021 and 60 per cent higher than three years ago, compared with a 27 per cent increase across all specialties combined. In contrast, dermatology and rheumatology waiting lists have increased by just two to four per cent since the pandemic began.

Factors behind deepening disparities

There are a number of potential explanations for the inequalities in waiting list numbers across England.

"Each statistic represents a patient living in poor health that causes at the least discomfort and affects their day-to-day lives"

Jonathan Pearson-Stuttard
Partner and Head of Health Analytics, Lane Clark & Peacock

Age is the biggest risk factor for many conditions, so it might not be surprising if CCGs with older populations have, for example, a higher orthopaedic waiting list.

Many conditions across the life course are socially patterned, with higher rates in more deprived communities, and there are likely to be strong correlations between areas that were hardest hit by Covid, increased infection rates and hospitalisations, and those with the largest waiting lists.

Explaining the causes of disparities across CCGs, however, does not excuse them – each statistic represents a patient living in poor health that causes at the least discomfort and affects their day-to-day lives.

For all the data that we do have on waiting lists, there is much that we do not know. How many people have not come forward for referral over the past 18 months who would have done ordinarily? For most conditions, but particularly those such as cancer where early diagnosis has such an impact on trajectory, this risks worse health in the medium and longer term for individuals, and even threatens reversals in population survival rates across common diseases. The available data is at CCG level, so we are unable to estimate inequalities at patient level, such as how waiting lists vary by gender, age group, ethnicity or levels of deprivation.

Establishing a path forward

There are two key principles the recovery plan should be built around, not just to address the waiting lists, but also for the NHS and health systems more generally. Firstly, resources should be prioritised towards patients with the most unmet needs, using the data revealing regional inequalities to enable more granular, patient-level estimates across and within populations.

Secondly, we need to shift how we value health. Services have been running "hot" for years, so there is little resilience, and the inevitable result is that illness services are maintained while "non-acute" health services deteriorate. Unless we value and invest in health and the resilience of the NHS, rather than solely the treatment of illness, waiting lists and health inequalities more broadly, will continue to grow.

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Estates & Facilities

NIAMH MACDONALD

The new hospitals building the future of health infrastructure

The government intends to transform England's health estate through the construction of 40 new hospitals. At a recent Public Policy Projects webinar, several key figures in this ambitious programme discussed the benefits it should bring both locally and nationally.

In autumn 2020, the government made a commitment to build 40 hospitals in England by 2030, with a budget of £3.7 billion. In July this year, the government announced the selection process for a further eight new hospitals. The new sites are intended to transform NHS services, for patients, staff and the wider community.

With this quantity of builds taking place over a 10-year period, work must be carried out in a different way than previous new hospitals. The Department of Health and Social Care and the NHS allied improvement team have joined together in a collaborative approach to the design and development of these "hospitals of the future".

Speaking at a Public Policy Projects (PPP) webinar in July, part of PPP's Health and Care Estates Series, Natalie Forrest, Senior Responsible Officer for the New Hospital Programme at the Department of Health and Social Care, said: "Our vision is that we build healthcare infrastructure that allows for world-leading experiences for patients and staff. We know that, despite the fact that the medical care, nursing care and care that GPs provide for patients across England is outstanding, the facilities within which we expect them to work are not. That impacts on their day-to-day life and the experience of the patients."

Building trust

Collaboration across the different levels of hospital construction requires a great deal of trust between government, hospital executives and the local community.

Emphasising the importance of building trust with this programme, Natalie commented: "There is always a degree of scepticism when a new hospital comes into play because it has so many complexities and moving parts. We need to be working hand in hand with NHS trusts in order to build positive relationships, based on continual partnership and learning."

This positive relationship extends not only to those involved in the construction process but to those who will be using the hospital. One hospital that will be rebuilt as part of this manifesto commitment is the Princess Alexandra Hospital NHS Trust in Harlow, Essex. Lance McCarthy, the Trust's Chief

Executive, also spoke at the webinar and stressed the responsibility it has to the local population to get this right.

"We're doing a huge amount of engagement with the local population around how they may be able to utilise some hospital facilities, such as our training and education facility, outside of traditional hours, so that it starts to be an asset to the local community rather than just a hospital where you go when you're not feeling too well," explained Lance.

Building a system

The NHS is going through a period of structural change, as integrated care systems (ICSs) will increasingly affect how health and care services are organised and delivered. A new hospital is a catalyst to change healthcare delivery, not only within the hospital itself but across local systems. Services managed by a hospital must also be effectively integrated within its region and primary community services.

Craig McWilliam, Programme Director of the New Hospital Programme, said: "We need to make sure that the hospitals we build in partnership with trusts take the greatest advantage of system working. Hospitals are an incredibly important part of the healthcare system, so we need to make sure our buildings recognise that but also try and ensure that the most significant amount of care that's possible is delivered outside of the hospital environment."

Every area of England is now covered by one of 42 ICSs; these will be crucial to measuring the effectiveness of a hospital. The new hospital programme is an opportunity to highlight the many commonalities across hospitals and introduce more standardisation. Hospital buildings typically require many of the same "kit of parts" (a method used in pre-fabrication and assembly) and digital design allows more possibility for this uniform approach than ever before.

"Our vision is that we build healthcare infrastructure that allows for world-leading experiences for patients and staff"

Natalie Forrest
Senior Responsible Officer, New Hospital Programme

Craig explained: "By standardising design, we can encourage new entrants into the healthcare building market, new suppliers of kits of parts, which should become cheaper as supply increases. It also means that teams that are delivering hospitals become more familiar with the design and the pieces that they're building. We can design for manufacture processes from the outset, with all the benefits that they bring in terms of construction, improved sustainability, reduced waste and improved safety."

Building beyond tradition

The new hospitals will set a precedent for sustainable infrastructure at a time when reducing climate impact is of ever-increasing importance. The goal is for the NHS to become a truly sustainable operation, reaching net zero carbon emissions by 2040.

Craig laid out some of the incremental steps necessary to make such significant change. "We need to think about the materials we use, the supply chain and how we build the hospitals and support a low-carbon operation within them, as well as how the building facilitates trusts that build new hospitals to achieve a more sustainable operation.

"Significant technology is available now to be used within hospitals; the last couple of years have shown the kind of change that can be achieved. Transformation can take place when a new building is provided."

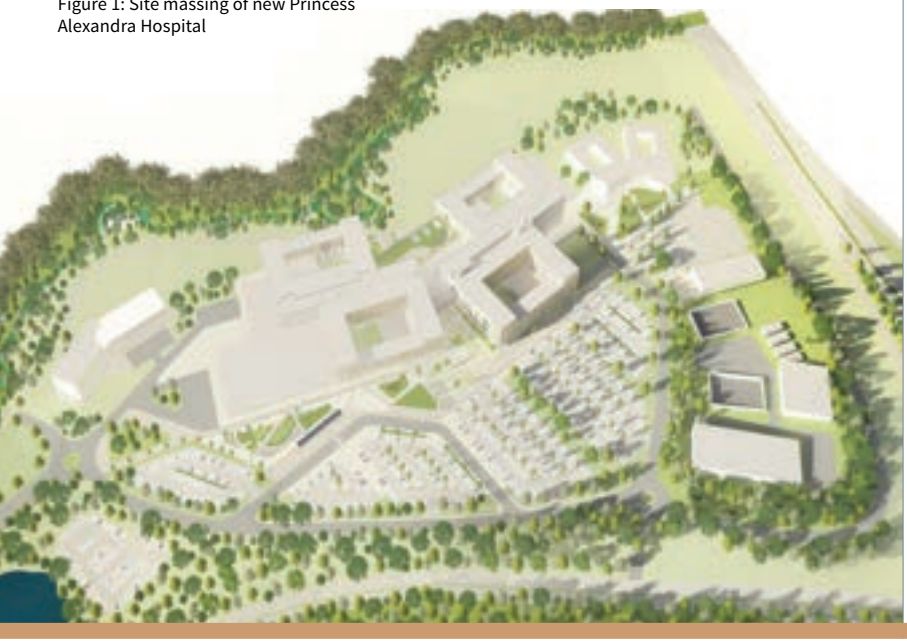
Digital transformation is a vital element of the programme, ensuring that the new hospital buildings incorporate and support advanced technology. This includes considering the operational healthcare technology that trusts will employ and how the buildings will support trusts to be digitally enabled.

Lance explained: "We've got to think about how the design of hospitals should change to reflect the impact and efficiencies that come from technology. It is crucial that we don't build yesterday's hospital for tomorrow's technology."

The experience of clinicians and patients during the Covid-19 pandemic could help to inform the implementation of digitally focused infrastructure. The pandemic revealed a need for hospitals to allow for flexibility and to adapt to healthcare changes over time. This also includes construction, meaning that additional buildings can be added in a less sporadic and more planned fashion.

"Flexibility is fundamental in terms of the immediate management of the Covid pandemic

Figure 1: Site massing of new Princess Alexandra Hospital



and post-Covid, but also in actually being flexible enough that we can manage any future pandemics," said Lance.

"Accessibility is also really fundamentally important, and we are using the local community and our patient groups to help us design the flow around the hospital, looking at how we can maximise virtual services with digital and technology being really key."

Laying the foundations

The new hospital build programme is a continual learning and improvement journey, bearing the responsibility of shaping modern health infrastructure across England. Several hospitals in the programme are already under construction, including Midland Metropolitan University Hospital in Birmingham and Royal Liverpool University Hospital.

Natalie emphasised the significant lessons that can be learned from the current construction of the hospitals in the programme. "We are working to develop best practice guidance and standards that we will be able to use across the board, but we're going to be learning. Those best practice guides will be dynamic and we'll be continuing to feed them in order to support all the organisation with the latest intelligence on how to build a new hospital."

The pandemic has prompted a nationwide reflection on the shortcomings of the NHS, with hospitals struggling to cope within the confines of their often-dated infrastructure. The new hospital programme comes at a time when we require a modern approach that sustainably provides for the needs of a growing population. The development of the new hospitals is an opportunity to build for the future and put modern healthcare at the centre of the hospital infrastructure ecosystem.

"Stand alone four operating theatre surgical hub and all associated services delivered and receiving patients in just three months using Modern Methods of Construction"

DAVID COLE

Time to think differently about boosting capacity

Flexible healthcare infrastructure offers a range of options for managing the healthcare estate effectively and increases the ability to adapt to sudden changes in demand or disruptions to service delivery, without lengthy lead-times and significant capital expenditure.

The pandemic has revealed serious limitations in UK health provision in key areas. This is particularly true of the NHS built environment, the dated nature of which has hindered responses to Covid-19 in several ways. Trusts have found it difficult to divert oxygen flows to new parts of their facilities, wards have been ill-equipped to repurpose in rapid time and spare capacity has been in short supply throughout the estate.

Central to recovery and renewal from Covid will be a thorough examination of the NHS built environment and a reprioritising of health and care infrastructure within wider health policy. It is safe to say that much of the healthcare infrastructure in this country is pretty inflexible.

Vanguard's mobile and modular healthcare facilities have practically been in total demand since the pandemic hit as NHS trusts rapidly looked to expand capacity and separate patient flow to protect patients from Covid. Trusts have come to us for a host of reasons; but underlying the specific nature of each of these requests has been the recurring theme of an inflexible estate that offers no spare capacity.

What sets Vanguard apart from other providers is that our offering is not restricted to infrastructure, we are specialists in healthcare and our team is made up of healthcare professionals and experts who have multiple years' experience of how-to best design and implement a solution and maximise the utilisation of assets. All supported by our clinical team of ODPs and Registered Nurses who are available to provide additional staffing to facilities

Capacity issues plaguing the NHS are nothing new, but it is often more than just a build-up of demand. We have found that many trusts we work with do in fact have the additional capacity within their estate, but it is in the wrong place. Put simply, the lack of ability to repurpose and redesign space means that potential capacity is going to waste when the NHS needs it most.

Many buildings in the NHS estate are over-specified for a particular use, making them inflexible and difficult to repurpose when demand changes. This has proven to be disruptive throughout repetitive waves of coronavirus and is creating additional barriers to tackling what are already daunting backlogs in elective care across the sector. During the first wave of the pandemic, Vanguard was able to repurpose a number of existing mobile operating theatresin to fully functional HDUs in a matter of days.

It is not just about the quantity of capacity that you may have; more fundamentally it is about the quality of that capacity. What can you do with this space? How quickly can it be repurposed? These are the sorts of questions trusts should be asking and thanks to our multifaceted approach to enhancing capacity, we have been able to build physical solutions as well as supplying the staff needed to utilise it.

Decisions relating to infrastructure are often left to NHS trusts on an individual basis, and this more fragmented approach restricts the profile of healthcare infrastructure than it has in some other health systems. Without a more coordinated, strategic approach to health infrastructure in the UK, I think there is a huge risk of repeating past mistakes.

This is particularly pertinent in the context of the UK government's plan to build 40 new hospitals. Hospital builds take time, and it is more than likely that, before completion, clinical practice and technological capability and requirement will have advanced to a significant degree. Ensuring that a hospital doesn't become immediately obsolete is important when you are building 40 of them in a relatively short space of time.

Reconfiguration, flexibility and re-optimisation – these have got to be principles that permeate throughout the government's build programme – and I think that many in the sector would like to see a much greater emphasis generally on modern methods of construction (MMC) running through the UK healthcare infrastructure.

Recovery of the healthcare sector absolutely requires MMC, and that is why you have seen two new modular procurement frameworks (that I am aware of) come out this year with the LHC and the NHSCS frameworks. They would not have done that had they not anticipated hugely increased demand for MMC.

Facilitating new models of care

Flexible infrastructure is likely to play an increasingly important role in healthcare estate considerations over the coming years, and so it should.

Our solutions-based approach has facilitated a rapid response to new challenges. For example, we have designed solutions that involve using a crane to place an operating theatre on the roof of an existing building, or onto a specifically designed steel frame for first-floor adjacency. Our experts are on hand throughout the development process to answer questions and provide support and advice.

Modular solutions, like those we offer, can do more than boost capacity; they can help develop entirely new models of care. Community diagnostic hubs are a particularly relevant example, especially those on sites that are easily accessible and with room for patients to sit while waiting. Patients also feel safer because the hub is not inside the hospital.

Many of these modular solutions do not necessarily have to be "temporary". If properly maintained they can augment health estates for years and, given the limitations in mobility exposed by the pandemic, it could be just the quick fix the NHS needs to boost capacity long term.

Creating capacity to tackle waiting lists

Flexible healthcare infrastructure can help hospitals respond to clinical capacity challenges and prevent waiting lists rising further in areas of particular concern such as elective care. According to the government's own models, the number of people waiting for NHS hospital treatment could more than double to reach 13 million by the end of the year.

There are other benefits to implementing a mobile or modular elective care facility. You might need extra capacity to cope with temporary spikes in demand, to test the case for a new service development, or for continued service provision during a refurbishment project or an unplanned event.

The new facility can be up and running very quickly, patients can remain in the existing clinical pathway and within the boundaries of the hospital's estate, and existing staff can be utilised. It provides a more flexible option for managing the healthcare estate and reducing the backlog without a need to increase the capital budget or outsource patient care.

Surgical Hub to deliver additional elective capacity

Ultimately, the secret to implementing such a project successfully is to choose the right delivery partner. Using a specialist healthcare provider with an understanding of the specific requirements for operating theatres ensures compliant and effective clinical environments. A flexible healthcare project must be a two-way process from beginning to end, and the provider needs to be prepared to listen and adapt to each individual hospital's needs.

How to get started

The process to mobilise a fully compliant mobile or modular operating theatre or care facility is surprisingly straightforward. It is essentially a six-stage process, which starts with assessing each hospital's unique requirements and then exploring suitable options within that context to ensure fastest and most effective outcome.

As a first step, a thorough scoping exercise should be undertaken. This will involve a visit to the site, during which a team of clinical, technical and logistics experts link up with hospital staff to gain a detailed understanding of the site requirements, as well as existing clinical practices and workflows.

A comprehensive scoping survey should include a review of access to the site, the site's topography, service connections and supply, telecoms/IT, and drainage system, as well as a review of any clinical adjacency needs and specific compliance requirements. An understanding of the type of procedures that will take place in the facility and the equipment needed will also be necessary.

Once the review is complete, a detailed design proposal focused on the unique needs of the hospital can be produced. This will include the identification of potential locations and recommendations about any additional infrastructure or enabling works that may be needed. For best results, the proposals should optimise the utilisation and activity levels of the proposed facility.

Laminar flow operating theatre

It is important to work together, and to engage clinical, technical and management teams in the design from the outset. A good way to do this is to arrange a visit to a hospital site already hosting a mobile or modular operating facility to see real-world examples of how flexible solutions can integrate with existing infrastructure.

Touring a similar facility to the one that is being considered and speaking to staff using it to find out about their experience of the delivery, installation and commissioning process, will provide a better understanding of what the optimal solution would be and how it would work in practice.

Essential requirements

As a starting point, a relatively flat concrete pad, car park or other area of hard standing with sufficient space for the planned solution is needed, but as long as a stable and broadly level base can be achieved, and there is suitable access to the site, a flexible solution can be installed.

In some cases, an interface between the facility and the existing site, such as a link corridor, steps or a ramp, can be constructed.

The requirements will differ depending on the solution chosen, but connections to utilities such as water, drainage and electrics are essential, along with telecoms and IT connections, although a generator can be used if the electrical supply on site is difficult. Mobile and modular facilities are fitted with fire, smoke, gas, nurse call and security alarms, which can be standalone or integrated with the hospital's own systems.

Tailoring the solution

Following the site survey, a comprehensive report is produced in partnership with the hospital, to include computer-aided design (CAD) drawings, a step-by-step delivery guide for the chosen solution and recommendations for link corridors, storage and utilities connections.

While mobile facilities have a standard footprint, layout and equipment, the final solution is almost always tailored to the individual needs of the hospital. Modular facilities are built completely bespoke, but we will carry out a similar consultation process with a site assessment and individual recommendations.

We will provide an account manager focused to understand the challenges the hospital is facing to support with business case preparation, procurement routes and project planning, while a clinical manager is available to advise on patient flow and to assess

the impact the project will have on patients and staff. A technical expert also assesses the site and infrastructure provision and works with the hospital to find a suitable location.

Often the optimal solution is created using a blend of mobile, modular and fixed infrastructure, in a variety of configurations. For example, a mobile operating theatre may be combined with a modular building containing a reception area and waiting room, a separate ward or staff welfare area. A full turnkey project, including groundworks and the supply of additional infrastructure such as link corridors, storage and staff welfare facilities provided by the flexible healthcare supplier, is often the choice of estates departments.

Installation and commissioning

Before delivery, an operational delivery meeting is held with key members of the hospital's various teams, so that work practices and responsibilities for the entire project can be agreed in detail. These include specifics around clinical practice, induction and training, governance, air-sampling and water-testing protocols, fire procedures, facility management, delivery method and timescales.

Delivery and installation must take place at a time convenient to the hospital to minimise the impact on staff and patients, and the schedule should allow sufficient time for any alterations to traffic flows or street furniture, trimming of trees or any other alterations that may be necessary to support efficient delivery. The installation of a mobile facility takes approximately three to four hours, while modular facilities are assembled on site and require a longer period to be assembled.

Once the facility is installed, a thorough commissioning process will be undertaken to test all systems, utilities and services. Typically, the commissioning process takes two weeks. The first week involves testing the facility and its systems, including water and air, while the second week focuses on clinical practices and the induction and training of staff who will be working in the new facility.

Using the facility

Support may be needed in the initial stages of using the new facility, and to this end we assign a clinical contracts manager to each facility for the duration of the contract. They will be on site during the commissioning period and provide support at the initial stages of the contract, as well as conducting a monthly audit to ensure compliance with policies and procedures.

Regular meetings and open channels for feedback are important. Requirements can change quickly – as they have during Covid-19 – and adjustments may be needed during the contract, or unforeseen events may occur. Both clinical and technical support is available 24 hours a day, seven days a week.

Performance monitoring is also crucial, and facilities are monitored against an agreed set of key performance indicators (KPIs) for the duration of the project. We also work closely with the host hospital to analyse metrics such as procedure numbers, case mix, patient satisfaction, incidents, infection rates and staff satisfaction, and suggest improvements. An online portal allows clinicians, estates teams and hospital management teams to quickly review key documentation, including facility drawings and dimensions, processes, instructions and emergency contact details.

"The lack of ability to repurpose and redesign space means that potential capacity is going to waste when the NHS needs it most"

David Cole
CEO of Vanguard Healthcare Solutions

Easing the pressure on three Essex hospitals

Vanguard's mobile solutions are helping the Mid and South Essex NHS Foundation Trust to address patient waiting times in the aftermath of the pandemic. The Trust was formed in April 2020 through a merger of three existing trusts and provides clinical services and care for a population of over 1.2 million people in central and south Essex.

Prior to March 2020, the trusts had collectively managed to reduce the number of people waiting over a year for an elective procedure to fewer than 200, but as a result of Covid and the cancellation of elective procedures across all hospital Trusts during the first period of lockdown, waiting lists rose again, and by March 2021 the Trust had a backlog of more than 8,500 "long waiters".

To substantially increase capacity to be able to tackle patient waiting times, the Trust decided to deploy mobile facilities at three separate hospitals, each supporting a different discipline. A team of 16 staff was also provided to support recovery.

A "visiting hospital" provides additional capacity at Broomfield Hospital for ophthalmology procedures, including complex cases. At Basildon University Hospital, a mobile laminar flow theatre supports orthopaedics. Southend University Hospital now has a mobile operating theatre for general surgery.

MORE INFORMATION

Vanguard

vanguardhealthcare.co.uk

STEPHEN HAMMOND

We must rejuvenate the health and care estate

Stephen Hammond MP, Deputy Chair of PPP's Infrastructure Policy Board, announces the *Health and Care Estates Series*.

In the UK, we have long known that the NHS estate needs rejuvenating. Much of the current property predates the creation of the health service itself. There are facilities across the country, both in acute, primary and community care that are in dire need of updating. The situation has been worsened with previously unseen rates of backlog maintenance, which inevitably increases risk to patient safety and effective healthcare delivery. The myriad and complexity of ownership and differing responsible NHS bodies has compounded the problem.

Shortfalls in our estate design have been further exposed by the pandemic. The dated infrastructure of the NHS has not always provided the flexibility to tackle the fluidity of healthcare challenges presented by Covid-19. The evidence for this is visible in the narrow corridors, restricted hospital space and old style Nightingale wards still seen across the NHS estate. Historically, the NHS has seriously underestimated the importance of reconfigurable space.

The new hospital building programme is essential and must be innovative. As Outline Business Cases demand that modern design and building techniques

About Stephen Hammond

Stephen Hammond MP is the Conservative MP for Wimbledon, and has been since 2005. He was Minister of State in the UK Department of Health and Social Care from November 2018 to July 2019. He was previously Parliamentary Under Secretary of State for Transport from September 2012 to July 2014. He was a member of the Treasury Select Committee from 2015 to 2018.

be used, that technology is embedded as is energy efficiency so that these new buildings are Net Zero. It is essential that several of the first proposals be built as "Sherpas" and exemplars for those that follow.

These issues are in no way exclusive to the UK and to the NHS. Across the globe, the requirements for an estate fit for the 21st century have changed in line with the rapidly adjusting needs of modern healthcare. While hospitals will likely remain a focal point for healthcare delivery for the foreseeable future, the increasing importance of prevention means health providers and governments globally should be looking to reduce overreliance on the acute sector.

Future considerations for a modern healthcare estate should be made with integration of health, care and community services as a core principle. For the UK particularly, this should include a thorough re-examination of the UK's primary care estate which has all the deficiencies of the acute sector estate.

Of course, this issue goes beyond bricks and mortar – as we must ensure that tech enablement is built into the heart of all future hospital design. Historically the NHS has been far too building focused and, while this crisis has highlighted the importance of an integrated IT and data approach to design, we are still a long way from achieving this. With calls increasing throughout the sector to harness sophisticated MedTech and intuitive digital technology, now more than ever we need a healthcare infrastructure that can deliver the befits of these advances and an environment for future innovation to flourish.

Addressing these concerns requires a close examination of how we make estate considerations, how we utilise space, how we construct it and what are the drivers behind procurement decisions that create it.

"Future considerations for a modern healthcare estate should be made with integration of health, care and community services as a core principle"

Stephen Hammond MP
Deputy Chair, Infrastructure Policy Board, Public Policy Projects

In seeking to answer the call for a modern, purpose build estate that facilitates the core needs of 21st century UK healthcare, the government has announced an ambitious hospital build program with over 40 projects currently in the pipeline, many of which have already started. In my own constituency, an unprecedented £500 million investment to rebuild Epsom and St Helier NHS Trust could have a revolutionary impact upon the community.

At PPP we are committed to ensuring the government makes good on these pledges and places built environments front and centre of its health and care strategy. It is for this reason that we are announcing a new policy series to dissect the core issues relating to the healthcare estate and of the future of capital funding in healthcare.

The Health and Care Estates Series will bring issues of estate management and capital funding to the forefront of policy discourse, providing a critical forum for key stakeholders from health and care to discuss how we improve the built environment of health and care service delivery.

MORE INFORMATION

Health & Care Estates Series

publicpolicyprojects.com/series/health-and-care-estates-series

KATY ROGERS

Innovative water delivery solutions can help hospitals control infection

The pandemic has put pressure on services but also pushed forward innovation to tackle the significant challenges of frontline infection control and prevention that the NHS should build on.

The NHS response to the Covid-19 pandemic was driven at speed by the rapid adoption of innovation, from diagnostics to vaccines and data. It is crucial that these welcome advancements in the use of technology are now turned into meaningful change across the whole NHS, to protect patients and healthcare professionals, while driving greater efficiencies. To achieve this, new hospitals must be fit for the future and embrace innovation in every form it takes, including in the critical area of water delivery solutions.

Every year, 50 billion cubic litres of water are used in hospitals around the country. Although water is a vital resource for achieving infection control and prevention, mismanagement of water can also lead to outbreaks of dangerous water-borne diseases, which have a high-mortality rate, and put patient safety and health at risk.

As we reflect on the pandemic, we need to make forward-thinking decisions about infection prevention, embracing digital innovation and promoting compliance with infection control measures.

Impact of Covid on infection prevention

Water delivery solutions are at the frontline of infection prevention in healthcare settings across the UK. Hand hygiene is widely understood as being the main driver for reducing the transfer of infections in the healthcare environment and Covid has reignited important conversations about how best to achieve compliance with handwashing measures.

Government advice during the pandemic stated that, where possible, contactless technology should be used to prevent cross-contamination and improve infection control as it removes the fomite transmission pathway. A January 2021 study found that hospitals with automated hand-hygiene monitoring systems had an advantage during the pandemic, in part due to their ability to quickly gather robust hand-hygiene data on compliance, with minimal investment of personnel time.

This drive to use innovative technology to promote infection control has also been seen in other parts of the hospital estate. The National Standards of Cleanliness 2021 – published in response to the pandemic – stipulate that "consideration should also be given to audit technologies that use objective evidence-based methodology to support the subjective measurement and efficacy of the cleaning process".

Data shows that six per cent of patients in NHS hospitals acquire a healthcare-associated infection, and three per cent of these patients will die. Most patients in hospital settings are typically vulnerable to infections like legionella and pseudomonas due to their age, existing comorbidities and the presence of

invasive devices. Applying the same innovative spirit seen across patient care to water delivery can solve real-world problems and drive operational efficiencies through a focus on both preventative and monitoring measures.

Tackling water-borne viruses

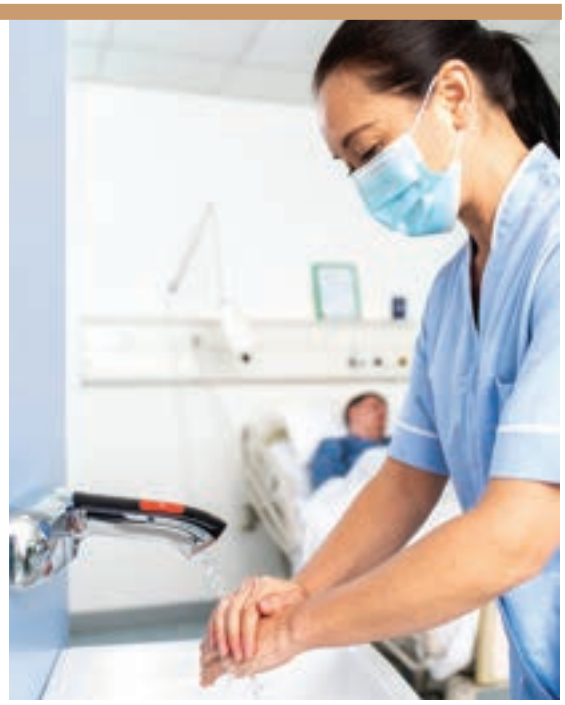
Rada's Intelligent Care range supports the NHS to deliver safe, efficient and sustainable water in healthcare settings. These solutions reduce the risk of microbial growth as the plastic materials and rubber diaphragms that are a high risk for growth have been removed, reducing the opportunity for outbreaks of water-borne viruses.

To further minimise the risk of dangerous bacteria build-up, all taps used in hospital estates should be regularly flushed. This is an important but hugely time and resource intensive process that is open to human error. Rada's Intelligent Care solutions are programmed to "duty flush" automatically, saving significant staff time and driving operational efficiencies by minimising opportunities for error and water wastage. This ability to consistently monitor the performance of every tap in the network also means that abnormalities can be identified immediately and any remedial action can be taken quickly.

Cross-contamination is also a leading cause of healthcare-associated infections. In response to this, Rada has removed touchpoints from the handwashing process, meaning the spread of viruses and faecal matter between each use is reduced. This intuitive no-touch control of water flow and temperature also encourages users to comply with hand-hygiene

"Covid has reignited important conversations about how best to achieve compliance with handwashing measures"

Katy Rogers
Commercial Business Director, Rada



procedures, supporting the health and wellbeing of patients through smart design.

The new hospital building programme, which commits the government to building 40 new hospitals by 2030, should ensure that buildings are designed using innovative technology that minimises the risk of infection. The government has a critical opportunity here to play an active role in ensuring the safety of patients, healthcare professionals and staff, while preparing the NHS estate for future pandemics.

Edward Argar MP, Minister of State for Health, is right to say that "investment in our NHS buildings will transform health services for millions of people for decades to come, by putting world-class patient care, staff wellbeing and sustainability first". This is true of all hospitals, whose leaders must now embrace innovation in water delivery to drive operational efficiencies, reduce water wastage and play their full role in building a more efficient and sustainable NHS.

Senior NHS executives have emphasised that "technology will play a central role in realising the Long Term Plan, by helping clinicians use the full range of their skills, reducing bureaucracy, stimulating research and enabling service transformation".

As part of the drive to embed digital solutions across the NHS, Rada's Intelligent Care range can improve environmental and financial efficiency across facilities and estates and enhance the health and wellbeing of patients and staff by optimising their safety in the fight against infections. A partnership with Rada is an investment in the future of healthcare design, delivering long-term sustainability for hospitals, the health service and the overall health of the country.

MORE INFORMATION

rada

radacontrols.com
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FRANCESCO TAMILIA

Achieving net-zero in health service delivery

Reducing carbon emissions in health service delvery not only help countries meet net-zero goals but also brings substantial public health benefits.

According to a study published in the *Environmental Research Letters*, CO2 emissions from healthcare services in the world's largest economies account for about five per cent of their national carbon footprints.

The 2019 study found that in OECD countries China and India, the combined emissions from hospitals, health services and the medical supply chain accounts for five per cent of the national CO2 footprint, a larger share than either aviation or shipping industries.

Net-zero targets for healthcare systems are not only important in helping countries to meet their commitments to zero greenhouse gas emissions, but the results of reaching such targets are also extremely beneficial to patients' health outcomes.

Net-zero in the NHS

In England, the health and care system is responsible for an estimated four to five per cent of the country's carbon footprint, emissions about the size of the entire countries of Croatia or Denmark.

In October 2020, the NHS published a report, Delivering a 'Net Zero' National Health Service, which examined a number of the areas critical to carbon reduction across the NHS including estate and facilities, medicines, supply chain, travel and transport, food, catering and nutrition, research, innovation and offsetting.

Through the Greener NHS programme, the NHS adopted a multi-year plan to become the world's first carbon net-zero national health system.

The person leading the NHS's transition to net-zero is Dr Nick Watts, Chief Sustainability Officer at NHS England. Speaking at Public Policy Projects (PPP) Environment and Health Series in April 2021, he reiterated the NHS's commitment to tackle the current emissions of the NHS' supply chain, which represents a large proportion of the overall emission of the health service. He promised that

"the NHS will no longer purchase from anyone that does not meet or exceed our commitments on net-zero".

While it is admirable that the NHS has already reduced its emissions in the past 10 years, Nick said: "The climate crisis is a health crisis, and this is a very good reason why the NHS should care about reaching net-zero."

For that same reason, in June 2019 Newcastle Hospitals became the first healthcare organisation in the world to declare a climate emergency, a commitment to becoming a net-zero carbon organisation by 2040. Dame Jackie Daniel, CEO of the Trust, also speaking at the PPP webinar, explained how its decision was fully supported by the staff, who are now playing an important part in reducing the emissions where they can.

Dr Marina Romanello, Data Scientist at the *Lancet Countdown*, explained how Europe does fairly well in terms of the carbon efficiency of its health care system. However, there are other countries with private health care that have enormous footprints.

A key component is changing the way health professionals treat and prescribe. "Starting to enhance prevention rather than treatment of diseases at late stages is not only good for health, but it's also carbon-efficient," she told *World Healthcare Journal*.

"The climate crisis is a health crisis, and this is a very good reason why the NHS should care about reaching net-zero"

Dr Nick Watts
Chief Sustainability Officer at NHS England

"It takes much less carbon and much less intervention to stop diseases and to prevent diseases rather than to treat them down the line. And our health systems are very obsessed with treating rather than with preventing. So that's key."

"Starting to enhance prevention rather than treatment of diseases at late stages is not only good for health, but it's also carbon-efficient"

According to Marina, green prescribing is another important element in decarbonising health services, which has now also become mainstream and formally acknowledged by the NHS.

"Green prescribing is a thing and can help people and their wellbeing, particularly exposure to green space, time spent outdoors, social prescribing as well," she said: "There's a lot of measures that can be done to improve health, improve health provision and also decarbonise our health systems."

Ensuring greater collaboration at an international level

One country or health service alone can't solve the problem. This was the message highlighted by Nick. The possibility of success is far greater if international collaboration between health services is enhanced.

Reducing the impact of climate change on health outcomes requires effective and socially equitable policy, technological innovation, and appropriate interventions to develop population resilience, increase adaptive capacity, and mitigate greenhouse gases and pollution. This process of change can, and must, begin with the health services across the world. While there are risks, there are numerous opportunities within this process. For instance, low-carbon hospitals can benefit from the advancements made in the energy sector in developing cleaner and renewable resources.

Figure 2: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus

CAMERON HAWKINS

Striving towards the NHS net zero vision

Changes to the healthcare estate by NHS Property Services are already resulting in both cuts in carbon emissions and cost savings. Future plans put sustainability at the forefront of new healthcare provision without negatively affecting patient care.

Decarbonising healthcare is a major focus for the NHS. This was made clear through last year's announcement that it would become a "net zero" national health system, a commitment recently reaffirmed by NHS Chief Sustainability Officer, Dr Nick Watts. The NHS is responsible for approximately four per cent of the UK's carbon emissions every year, so it is vital that it achieves its 2040 net zero goal.

To do this, every part of the health system must focus its efforts on becoming more sustainable and reducing its carbon footprint. The NHS estate is no exception. As owners of approximately 10 per cent of the NHS estate, NHS Property Services (NHSPS) is in a prime position to lead the way in reducing the environmental impact of the NHS.

We launched our energy and environment strategy in 2019/20 as we recognised the importance of ensuring our organisation was making a significant effort to reduce its carbon footprint. This three-year plan consists of around 200 actions across several main themes, including transport/travel efficiencies, increasing recycling as well as reducing waste and single-use plastic, improving water efficiency and, of course, reducing carbon emissions. In April 2021 we undertook our Greener NHS 2020/21 Review, when we looked at year two of our three-year plan. I am delighted to say that we have seen substantial improvements across our estate.

Switch to renewable electricity

In April 2020, NHSPS highlighted the importance of taking carbon reduction seriously by moving its entire building portfolio to 100 per cent renewable electricity. This is a major step for any company in reducing its carbon footprint, especially for the NHS estate. In addition to finding an environmentally friendly solution that is suitable for the health system, these energy sources must also be reliable, as hospitals understandably need to keep up and running 24 hours a day, 365 days a year.

The move to a flexible trading strategy and the negotiation of these new energy supply contracts has meant this has been achieved at no additional cost

to property tenants. These changes have helped to offset over 37,000 tonnes of carbon dioxide per year. I am also proud to say that it has created a significant cost saving of 12 per cent, equating to around £8.9 million over the first two years. What makes this saving even more important is that the money saved can be reinvested back into the NHS at a time of great need.

In addition to switching to 100 per cent renewable electricity, over 69 of our sites so far have been upgraded with LED lighting. In two years, we have invested over £6 million in standalone LED projects, excluding any works undertaken as part of backlog maintenance, with savings of £2 million and 2,500 tonnes of carbon expected per year. Not only do these types of initiative reduce the NHS estate's carbon footprint, but as noted above, they will provide financial benefits, as well as help us to enable better patient care in the long term.

Collaboration with healthcare providers

An extension of this is reducing the overall energy consumption of the NHS estate. This is complex, requiring communication and collaboration with the building occupiers. Most tenants are healthcare providers, whose primary focus will, rightfully, be on patient care. While patient care should absolutely be the primary concern of our healthcare providers, ensuring we reduce our carbon footprint will also affect the lives of future patients.

To make real changes, organisations need to identify ways to encourage engagement with their occupiers and discuss the benefits of energy efficiency. At NHSPS, we have introduced an engagement programme that involves upskilling engineers and providing them with energy packs they can use to work with tenants and advise on the steps to take to be more energy efficient in how they occupy our buildings. These steps include regular reporting, marking big consumers and poor performers against our benchmarks, and identifying sites with large gaps between their Energy Performance Certificate (EPC) and Display Energy Certificate (DEC) ratings for commercial and public buildings. The first two years of this programme resulted in a significant saving of 11,800 tonnes of carbon. We are passionate about ensuring that this momentum continues for the final year of our strategy and beyond.

"Organisations need to identify ways to encourage engagement with their occupiers and discuss the benefits of energy efficiency"

Cameron Hawkins
Head of Energy and Environment, NHS Property Services

Devizes Health Centre

Sustainability a priority in new development

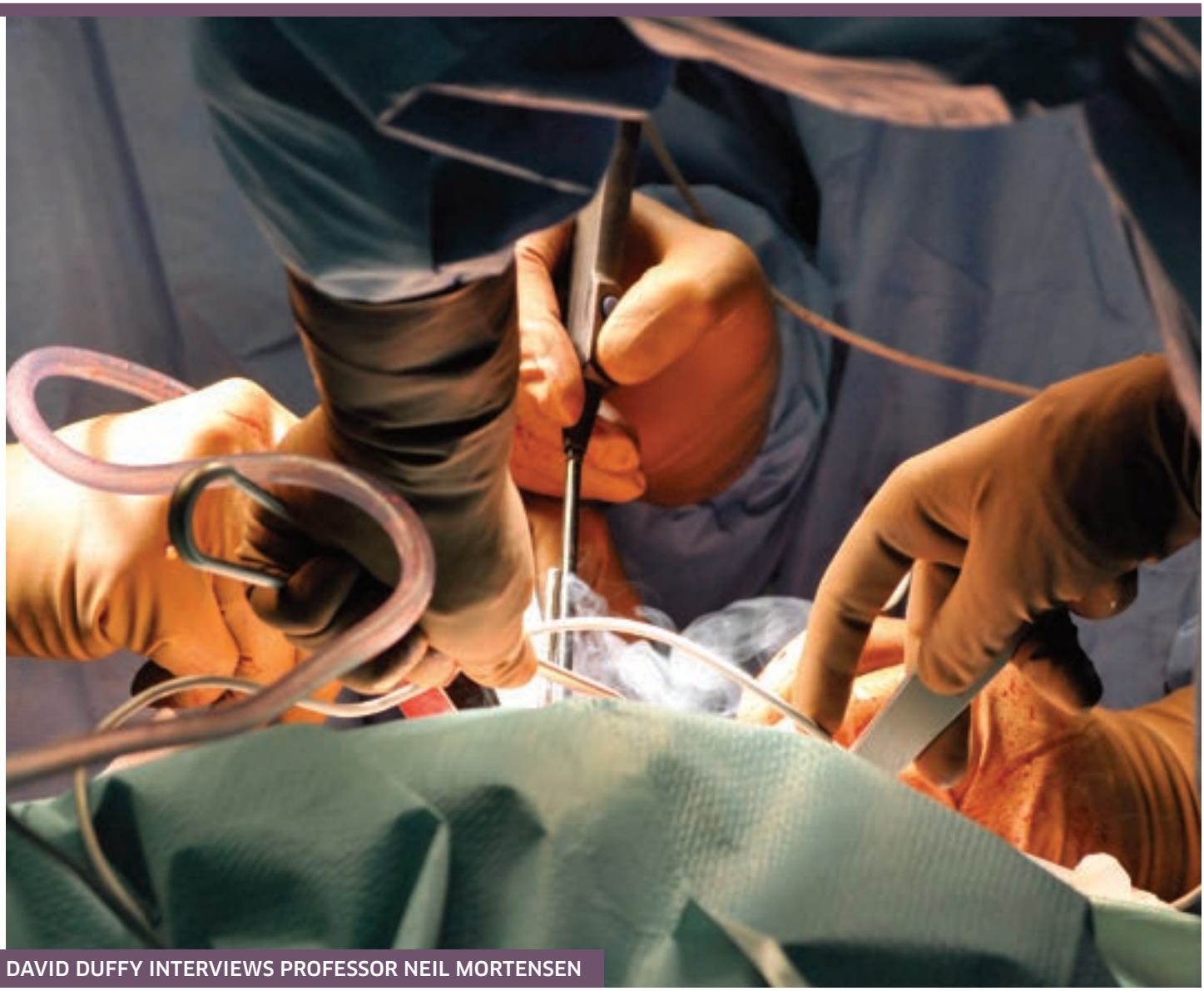
The ever-growing population and increasing pressure on the NHS due to the pandemic means that capacity across the NHS estate must increase. This must be done with sustainability at the fore to achieve the NHS environmental goal.

The government has committed to building 40 new hospitals, all of which must be net zero carbon buildings. This means that carbon reduction must be considered from the outset. We have accepted this challenge and are reviewing how we can bring our new health centres and GP surgeries into line. We are confident that this is achievable and are proud of the progress we are making.

Devizes Health Centre (pictured left), an integrated care centre, is the first net zero health centre we have constructed, providing space for Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group to offer primary care to the local community. It is currently awaiting final stage design sign-off, which seeks an EPC rating of A+, going beyond the "excellent" rating for new buildings (decided by the sustainability assessment method BREEAM) to be net zero in operation. This is a huge step towards our goals, and I am excited to see more buildings being made to this incredible standard in the coming years as we continue to improve our estate.

We understand there are challenges facing us in reaching the NHS target of net zero by 2040. However, we are working hard and are motivated to achieve this goal. While we have the technologies to make net zero happen, sourcing adequate finances and ensuring that our technologies remain cost effective will be paramount to remain on the current path towards achieving net zero. On behalf of myself and the whole NHSPS team, we are honoured to be able to play a significant role in achieving this goal and educating our customers on how to reach net zero.

Clinical Services



DAVID DUFFY INTERVIEWS PROFESSOR NEIL MORTENSEN

A "New Deal" for surgery

The Royal College of Surgeons of England has put forward a new proposition for elective care in the UK. Its suggested reforms could help chart a course out of the ominous backlogs currently facing the NHS.

No guesses where the Royal College of Surgeons (RCS) took inspiration from for its latest report. In the same way Franklin Delano Roosevelt transformed America following an economic blackhole, RCS President Professor Neil Mortensen is seeking to transform the surgical profession during a similarly bleak period for healthcare.

There are 5.3 million people on NHS waiting lists, and over half a million of those people have been waiting for over two years for treatment. It is estimated that nothing short of 120 per cent of pre-pandemic activity would need to be sustained over three to four years for the sector to have a hope of bringing these numbers down. Without a monumental effort, it is expected that this already daunting total waiting list could grow to 9.7 million by 2023/24.

A New Deal for Surgery, published by the RCS in March 2021, sets out 12 recommendations to create a sustainable proposition for UK surgery and to bring elective care in the country back from the brink. The report's recommendations outline reforms to the workforce, surgical training and access to technology, as well as outlining entirely new models of surgical care provision.

Problems long in the making

The problems highlighted by *A New Deal* have been long in the making. Even before Covid-19, waiting lists have been on an upward trajectory. In 2019, the Health Foundation found that parts of the NHS in England were already experiencing the worst ever performance against waiting times targets. The Foundation's research found that the number of people waiting more than four hours in A&E was at its highest since 2004, and more people were waiting over 18 weeks for non-urgent hospital treatment than since 2008.

In January 2018 elective care in the NHS was paused for almost a month to combat a serious outbreak of flu. "We got away with it in 2018," says Professor

Mortensen, "but we never learned our lesson, the issue did not truly become part of the public consciousness and the politicians did not take notice. The pandemic has made it abundantly clear how dangerous it is to run a health system with virtually no spare capacity."

The pandemic has placed a spotlight on this dangerously low level of spare capacity in the NHS. Like many other arm's length bodies, the RCS is looking to take advantage of this increased attention and enhanced public understanding of health service pressure to finally create tangible improvements.

"If the emergency rooms are full, the patients must go somewhere," explains Professor Mortensen, "and where they normally end up is in elective surgical beds – this constantly results in cancelled procedures and disrupts the entire patient pathway.

"We can't just go on accepting that surgical facilities can be used as a reservoir every time there is a crisis; we need a substantial increase in built-in capacity and we need it quickly."

The impact on patients waiting for procedures cannot be understated, both in terms of the continued pain of delayed treatment and the mental health implications of mentally preparing for a surgical procedure only to have it cancelled at the last second.

Long-term impact of disrupted training

The backlog itself is not a novel issue, but the widespread disruption to surgical training has created yet another challenge for the NHS to contend with. Staff from all corners of healthcare provision were redeployed to different parts of the sector as elective procedures ground to a halt, a factor Professor Mortensen is eager to stress. "Surgical training essentially stopped as a result of the pandemic; this is badly compromising the future of the profession." Logbooks from the RCS show a 50 per cent reduction in operations with trainees as the primary operating surgeon from 2019 to 2020.

Professor Mortensen likens surgical training to that of an athlete; if training and practice are disrupted this will have longer-term implications for performance and confidence. Put simply, "if there is no surgical training today, then there are no surgical staff for tomorrow.

"We need an environment in which surgical provision and training can go on unaffected despite what else is happening in the health and care space." Crucial to this will be changing the dynamics of surgical delivery across the country.

"A surgical team is an ecosystem of staff," says Professor Mortensen. "If any part of that ecosystem goes down due to 'pinging' or self-isolation, the entire process can fall apart, resulting in cancelled procedures and ultimately adding to the waiting list."

The health sector cannot guarantee that there will not be another pandemic or spikes in demand that cause major disruption to healthcare provision. Therefore, the RCS has proposed a shake-up of the structure and infrastructure that surrounds care provision, and these reforms go far deeper than simply calling for increased funding. A new way of delivering care is required.

"We can't just go on accepting that surgical facilities can be used as a reservoir every time there is a crisis, we need a substantial increase in built-in capacity and we need it quickly"

Professor Neil Mortensen
President, Royal College of Surgeons

Surgical hubs can relieve pressure

Central to recommendations made in *A New Deal* is the establishment of surgical hubs. These are designated areas for planned and elective surgery outside of central hospitals that enable "high volume, low complexity" standard surgery to continue when medical demand increases elsewhere. This would crucially include orthopaedics trauma surgery, which represents the single largest backlog in elective care. "If you can accurately predict when patients can get their surgery and get out, surgical teams can begin to build momentum and develop a rhythm of surgery, protecting the patient pathway and staff morale," explains Professor Mortensen.

The principle has already been demonstrated throughout the pandemic, with the independent sector being used as a pressure valve, allowing over three million people to receive treatment while NHS elective care was halted. In essence, the independent sector acted as surgical hubs.

"This allowed us to provide surgery in ways that we would not have been able to," says Professor Mortensen, "but it is unrealistic to think that this outlet can be there for the medium to long term. We need a long-term investment in beds and doctor numbers, as well as a committed approach to surgical hubs, within the NHS to reduce reliance on the independent sector."

The RCS's own research shows that 73 per cent of patients would be happy to move away from their locality to secure safe and timely treatment, and that surgical staff would be prepared to travel to prevent procedure disruption. "But civic pride of some trusts has often prevented this movement," claims Professor Mortensen. "Trusts feel obliged to be able do everything, to offer every procedure – as a result the issue has become political."

The development of integrated care systems (ICSs) presents a unique opportunity to shift this mindset. As providers strive to connect currently disparate parts of health and care services under a banner of integration, surgical hubs could play a crucial role in streamlining surgery and maximising output from health providers. The RCS is calling for the establishment of at least one surgical hub within each ICS. This hub would be connected to hospitals and centres in the region, allowing hospital resources to be concentrated where they are needed most.

"ICSs will have a crucial role in addressing inequity of care provision in a region, ensuring timely access to care and that no part of the population is unfairly disadvantaged.

"Some hospitals have already been working within their own estate to create surgical hubs," says Professor Mortensen. "If we could reassure trusts that there is going to be consistent money for this over the next five years, this would allow them to look ahead. If they can't, then they should be able to work with the local ICS to see if alternative solutions are available."

Urgent action needed to reduce backlog

Franklin D Roosevelt's New Deal was born out of the principle of Keynesian economics and of sustained public investment and rooted in a belief that this investment would pay dividends. Naturally, much of the RCS's proposition is underpinned by a call for sustained government investment. The "elective recovery fund" was set up by the government to reward trusts for achieving a certain level of elective activity, and the RCS is calling for an additional £1 billion every year for the next five years, specifically designed to bring the backlog down.

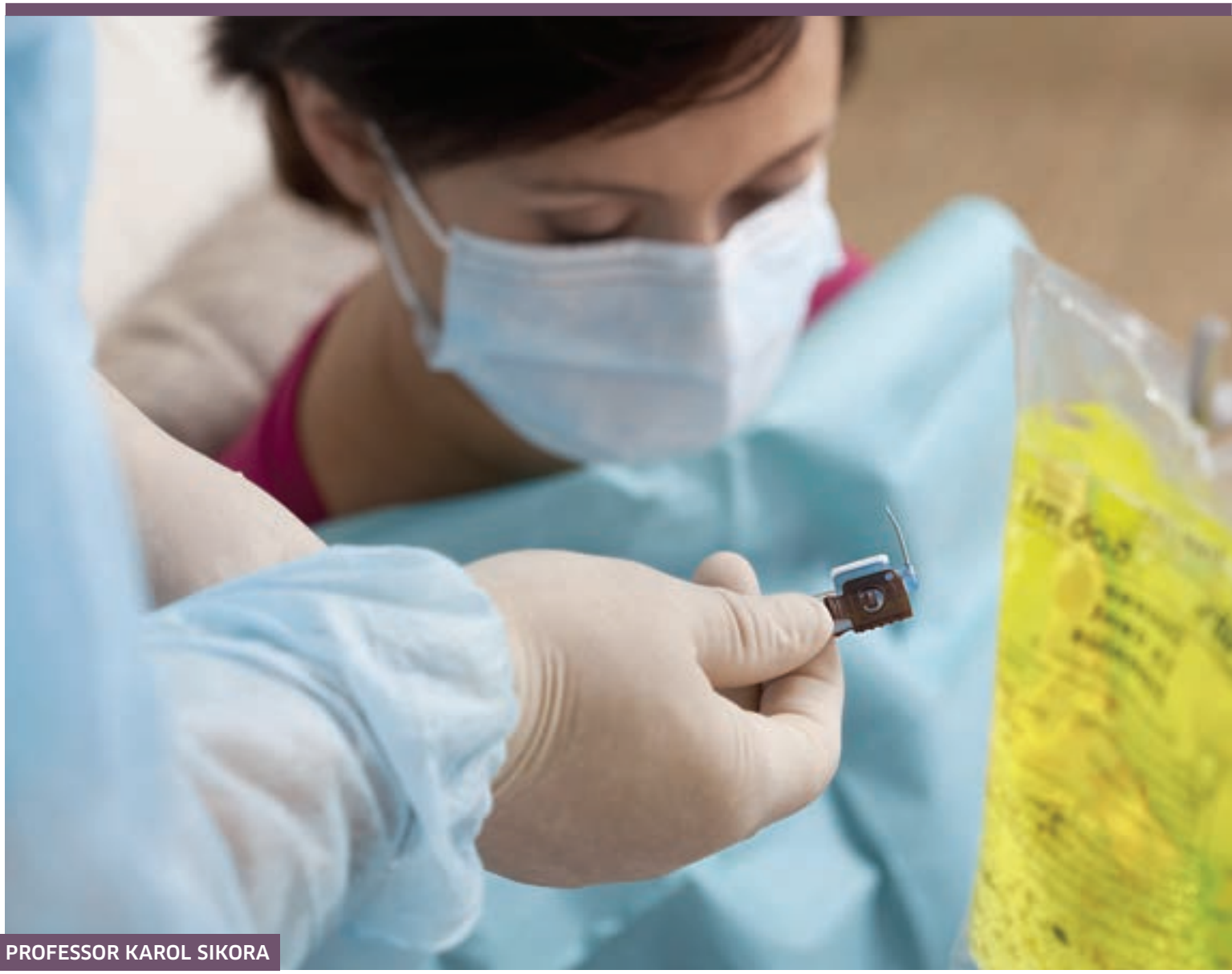
Action is needed quickly. Behind the astronomical backlog figures are real people waiting for procedures, many of whom are in pain or psychological distress. Inevitably, some patients will die while waiting for a procedure that the NHS was unable to deliver in time.

Millions of lives will remain "on hold" until the Government takes heed of this "New Deal", and places NHS surgery and elective care on a true road to recovery.

MORE INFORMATION

Royal College of Surgeons of England

rcseng.ac.uk



PROFESSOR KAROL SIKORA

We must all act urgently to stop the cancer backlog doing more damage

The crisis building in cancer care could pose even greater challenges for the NHS than Covid-19.

I never dreamed of setting up a Twitter account before March last year. I was having lunch with an oncologist friend of mine who was bragging about racking up a few hundred followers on Twitter. At that stage I thought a tweet was simply what the birds sang in the morning.

As concerns grew over the new virus and of the threat of hospitals becoming overwhelmed, I knew that it was inevitable that cancer patients would be forgotten. If I could pick up a few thousand Twitter followers and make the case for the lost cancer patients, then it would be worth doing.

What happened in March 2020 was unprecedented. The situation quickly spiralled out of control, and we were hit by the first wave. Cancer referrals dropped by 60 per cent in April 2020 compared with the previous year. Patients starting treatment following a GP referral dropped by 18 per cent. The numbers have fluctuated since and progress has been made, but almost everybody working in oncology accepts that there is an enormous backlog to deal with.

The impact of delays and disruption

A delay of a few weeks will not cause any significant issues. A few months or more, and the patient's prognosis will rapidly deteriorate. We cannot just put cancer patients on the shelf and expect to be able to return to their treatment several months later; cancer just does not work like that.

There have been major disruptions to treatment, but the most serious bottleneck is in diagnosis. There are an estimated 45,000 "missing" cancer patients – people who would have been diagnosed in a normal year but in 2021 have cancer without knowing it. This is the increasingly deadly problem we are facing.

Pictures of intensive care units filled with Covid-19 patients on ventilators have, understandably, deterred many from going anywhere near medical facilities. This has been combined with significant disruption to the primary care sector, further hampering diagnostic capacity.

We have also seen a reluctance to become a "burden" on the NHS during its hour of need. We were told to stay at home to protect the NHS and save lives, and a countless number of seriously ill people did just that. They protected the NHS but in doing so were not given the care that they needed.

Out of the 2,000 patients we have treated or diagnosed at Rutherford Cancer Centres, more than 700 have been within the past year. Many of them presented with a later-stage cancer than we would normally expect. Those people we would usually have seen in spring last year picked up the phone in autumn instead. The cancer grew and sadly their chances of survival shrank. I hear the same from colleagues in oncology across the country; it is a tragically recurring theme.

"If the cancer crisis had received a fraction of the attention that the pandemic has, countless lives would have been saved"

Professor Karol Sikora
Chief Medical Officer, Rutherford Health

Continuing failure to recognise the risk

One of the biggest problems with keeping the cancer crisis in the media spotlight is that the disease, while relentless, is relatively slow to develop. We have had numbers of Covid-19 cases, hospitalisations, deaths and vaccinations and other figures given in daily media bulletins, but cancer just does not work like that. Tragic individual stories unconnected to Covid have received some media focus, but nowhere near as much as the virus. When we look back in five years, the extent of the damage will be clear. Excess cancer deaths will be in their tens of thousands, many of them wholly preventable and among younger people.

If the cancer crisis had received a fraction of the attention that the pandemic has, countless lives would have been saved. I have often called for a press conference dedicated to non-Covid health issues, specifically cancer, but those requests have been ignored. These are uncomfortable truths for politicians and I doubt they want to shine a light on the adverse impacts of their own policies.

So where do we go from here? Sadly, so much damage has already been done that will be impossible to reverse. We can, however, mitigate further damage, through investment, awareness, training, staff, collaboration – we need a true national effort to get the cancer backlog under control.

Protons will play an increasing role in how we treat many different types of cancer. In June 2021 Rutherford Health released a report on proton beam therapy that shows how far behind many of our European neighbours we are in the UK, but also the progress we are making. We are training oncologists, building specialist centres and developing world-first artificial intelligence (AI) technology that can quickly distinguish the benefits of protons. In all my years in oncology, the most exciting developments are being made right now.

It is that flexible, innovative and pragmatic spirit we need on a national scale. One example of this I often give relates to using the equipment pretty much continuously. If we pay staff a fair stipend for doing so, they will work round the clock. Patients will certainly come and have a scan at 3am if it means massively expediting the whole process. It will take investment, but quite frankly, considering the money that has been spent on our Covid response, it will be a small price to pay.

The cancer crisis has often been referred to as a "ticking time bomb". I'm sad to say that this is no longer the case. People are suffering today, and many have already unnecessarily lost their lives. Now is the time for an urgent national response to this crisis. Put politics aside and let us not just tackle the backlog properly but improve cancer services in the UK forever.

YOSHIKO TARAPORE COOK

Data saves lives – can data catalyse NHS cancer recovery?

Will the promise of data to enhance patient outcomes and help the NHS through Covid-19 recovery come true?

Disruption to UK cancer services could result in 35,000 additional cancer deaths within the next year. Minimised or halted cancer screening activity and reduced referrals across all cancer types are resulting in delays in diagnosis, particularly of earlier stage cancer.

From referrals into hospitals onwards, disruption has been felt at every stage of the cancer pathway. Macmillan Cancer Support estimates that more than 650,000 people with cancer in the UK (22 per cent) have experienced disruption to their cancer treatment or care because of the Covid-19 pandemic.

Recent research by DATA-CAN, the UK's Health Data Research Hub for Cancer, in collaboration with University College London (UCL) Institute of Health Informatics, reveals ominous trends in cancer diagnostics. This found a 70 per cent decrease in urgent referrals and 40 per cent decrease in chemotherapy treatments during the initial phases of the pandemic.

The knock-on effects of delayed diagnosis and treatment are shrinking survival hopes for patients and placing additional strain on health services during an unprecedented period of disruption. It is vital that cancer services are put at the forefront of the restoration and recovery of the sector.

One in two of us will get cancer in our lifetime and improving cancer services is central to improving patient outcomes. Diagnosing cancer earlier, developing more efficient treatments, and improving access to innovative medicines are top priorities in the NHS Long Term Plan. The solution that links these issues together is data.

Data in real time

Data permeates our world today. The promise of harnessing data to its fullest potential is unimaginably vast, but the ability to access it routinely and quickly to make informed decisions in healthcare still varies.

The potential is there for all to see. Real time data that are delivered immediately after they are collected has driven national responses to Covid across the world and countless lives have been saved as a result. The common purpose of limiting the disastrous impact of Covid has mobilised the NHS to strive for enhanced connectivity, increased access to research data, and improved operational understanding. The question remains whether this data-driven momentum can be sustained, or if UK health systems will revert to often archaic approaches to data usage.

The draft national strategy sent out for consultation in June 2021 sets out how the government intends to unleash the revolutionary potential of health and care data while maintaining the highest standards of privacy, ethics, and accountability. The strategy places the UK on a path to build on the lessons from the pandemic and put data at the heart of all clinical decision-making and planning.

The Cancer Data Network (CDN), developed to support DATA-CAN by founding member IQVIA, offers a data-enabled approach to treating cancer. It does this through providing real time data to enable rapid

> "As a cancer physician, meaningful and real time data is currently unavailable. The Cancer Data Network (CDN) offered just this – to enable benchmarking, peer review and quality assurance of my practice while driving change at every opportunity"
>
> **Krishnaswamy Madhavan**
> **Consultant Clinical Oncologist, Mid and South Essex NHS Foundation Trust**

identification of patients suitable for a cancer trial and frontline cancer care quality analytics, including real time insights on how treatments are performing in the real world, and how this varies across cancer centres in the UK. This data enabled approach was shared at a DATA-CAN Patient Public Involvement and Engagement workshop in July 2021, where 73 per cent attendees were comfortable or very comfortable with their data being used for these purposes.

Leveraging the network, hospitals can view and analyse data that are updated every 24 hours. This level of near real time data ensures that when data are analysed they are also relevant and immediately actionable.

The Cancer Data Network: Principles for enhancing care

1. Rigorous patient privacy and data protection governance. The protection of patient privacy, patient wishes on whether their data should be used, and data handling regulation is of central importance. Only authorised users are able to see data, with protocols and processes in place and closely monitored. Any data that are extracted from the hospital are de-identified at source, opt-out applied, and made GDPR compliant – only then is it made available for approved researchers to access for approved research purposes within an auditable environment.
2. Speed and agility to benefit multiple stakeholders. Rather than replicating data processes, the CDN addresses the needs of many stakeholders throughout a hospital, as well as researchers' requirements. Data integration and visualisation are updated every 24 hours, enabling near real time data flow across the hospital.
3. Designed with patients and the NHS. It is important not just to provide patients and the NHS with data solutions but to involve them in the development of these solutions. Patient and NHS advisers (from clinical, nursing, information governance and data backgrounds) provide critical input to the vision, technology, and information governance, ensuring the CDN offers fair value to patients and the NHS.
4. Reduce the burden for the NHS. In addition to the development, deployment, and licence fees being covered by IQVIA, the CDN is designed to ensure that no manual input is required for it to operate. The data are integrated and visualised within privacy-protecting technology without intervention.
5. Ensure inclusivity. Cancer care is being challenged across the country, regardless of geographical region, hospital type or electronic medical record (EMR) platform provider used. It is important that the CDN is deployable across any NHS hospital throughout the UK.

Figure 1: Cancer Data Network solutions

"It is vital that cancer services are put at the forefront of the restoration and recovery of the sector"

Yoshiko Tarapore Cook
Programme Director, DATA-CAN

Figure 1 illustrates the core solutions provided within the CDN. They enable member hospitals to improve cancer service delivery, match patients to clinical studies, identify unwarranted treatment variations in care across other member sites, and make high-quality health data available for research.

The world of cancer treatment is constantly changing. Early signs are promising for recovery in cancer screening and for the restart of research. New cancer treatments are being developed and our understanding of cancer continues to increase. At the heart of this is a desire to improve patient lives and ensure that all patients have the best chance of being offered the most appropriate treatment options to maximise their positive treatment outcomes. Data networks that are powered by real world data, if securely and appropriately shared, have the potential to make this happen.

While the pandemic has created many challenges and pushed back cancer services and patient outcomes across the UK, we hope that the evolution of increased real time data usage continues to improve patient outcomes. We believe we can use today's data to help today's patients, not just tomorrow's.

70 per cent

of patients believe the CDN offers patients and the NHS 'fair' or 'great' value

MORE INFORMATION

IQVIA **iqvia.com**

LOTTIE MOORE INTERVIEWS DR KATHERINE HENDERSON

A&E has become the entire health system's safety net, not just the patient's

While the current spotlight is on reducing post-pandemic elective surgery waiting times, emergency departments have been left to pick up the health system's slack.

In March 2021 the government launched its Build Back Better campaign to restore and rebuild the UK after the pandemic. While NHS staff have been rightly lauded for their handling of Covid-19, waiting times for non-Covid related health needs are in desperate straits.

A&E is no exception. Dr Henderson reflects that even before the pandemic, four-hour waiting time targets had not been met since 2015. "We were increasingly under incredible pressure, talking about crisis in December 2019. It wasn't like we went into Covid all singing and dancing."

Dr Henderson notes that once the pandemic hit, A&E patient numbers drastically reduced. "For the first time in years, we had enough staff to see the right number of patients and the right number of beds to put those patients in. It lasted less than a month and we were right back in the thick of it." This brief spell served as a reminder that with the right resources, workforce and capacity emergency departments could function properly in the role prescribed to them; the safety net of the individual patient.

Dr Henderson recognises that while emergency departments were not fulfilling the whole population need at the time (because patients were not presenting themselves) they did a brilliant job of handling Covid. "We thought we would never have to go back to corridor care. But it was a wasted summer. We kept saying, 'recovery cannot just be about elective waiting times, we need to be planning for the next wave for emergency departments'. Guess what? The winter wave happened, and it was catastrophic for A&E."

Regulations around infection prevention control (IPC) have been a huge issue. While it was agreed that crowding in A&E departments during a pandemic would be unacceptable, Dr Henderson says there were situations when a hospital in a Covid hotspot was having to divert ambulances to hospitals in other areas because of limited space. As a result, patients from these hotspots were waiting alongside patients in hospital corridors less affected by the disease. "Which bit of infection control does that come under? Emergency departments just had to get on with it. This has remained a source of friction between us and the powers that be. There is a real feeling that IPC regulations are in place, but they don't apply to the emergency department."

The recovery narrative misses the mark

Dr Henderson argues that too much energy has been devoted to "known knowns" – the official waiting lists that existed before the pandemic. "The narrative coming out as 'the recovery narrative' has very much focused on waiting lists for elective procedures; those people who need their knees replacing, for example."

The more pressing concerns, Dr Henderson argues, are the "unknown knowns". Firstly, there are patients who have not presented their problems for the past 18 months. "Many of those patients haven't made it into primary care and so they present to us saying 'well actually my knee pain is now intolerable and this weird lump in my breast has got bigger'." Chronic health is another "unknown known", such as the waiting list for people with comorbidities that are getting worse.

"The problem for emergency departments is that for all of these groups, the 'known knowns' and the two 'unknown knowns', is that while they should have been getting continuity of care across the health sector, they now often just pitch up to the emergency department."

The current situation is desperate. "We get all the people on those elective lists who can't wait any longer [and] we get the people who are finally presenting their needs 18 months too late who can't get a GP appointment. We also get people with chronic problems that are out of control, again, who cannot access the GP. Now lockdown has lifted we naturally get more people coming through the doors. Throw into that the patients incoming with Covid and 'long Covid', as well as the massive mental health surge. And what do you have? An absolute crisis."

Honest conversations are needed

"We have never had a problem with being the safety net of the individual patient. That is what we are here for. But increasingly, we have become the safety net of every other part of the system. The narrative is, 'when in doubt, just go to A&E'."

Having highlighted the severity of the situation, Dr Henderson suggests the answer to this growing crisis must be found through honest and transparent conversations between the different health services and the public.

"The health service is not in a position where it can commit to reducing 18-week waiting lists. We have a huge amount of work to do and we have to make sure we are using current resources to their maximum. At the same time, we need to give the workforce a sense of hope by having a realistic long-term plan that identifies population needs as they stand today." Reducing the barriers between as many professional groups as possible is one way this can be done, so that GPs don't feel they need to push patients out of primary care and into A&E because referrals to specialists can't be made.

"Increasingly, we have become the safety net of every other part of the system. The narrative is, 'when in doubt, just go to A&E'"

Dr Katherine Henderson
President, Royal College of Emergency Medicine

"It is not in the best interests of the health service, the patient and the workforce to send people straight to A&E because of these systematic issues. How can we radically change the way a patient flows through the system that absolutely minimises the barriers that involve duplication and timewasting?"

The pressure on the workforce within emergency departments is clear. The RCEM's July 2021 report *Retain, recruit, recover: Our call for action to improve the urgent and emergency care system* found that 73 per cent of survey respondents indicated that workforce pressures in their emergency departments affected patient safety before the pandemic. As Dr Henderson comments: "We don't have a problem recruiting. The problem comes when staff say, 'I really enjoy it, but I just don't think I could do it long term'."

Safe care requires a sustainable workforce

The RCEM report proposes a framework for action, pointing out that: "Operational pressures are seen by staff as the most significant reason for considering reducing hours, changing careers or retiring early. We cannot deliver safe care in Emergency Departments without making the job sustainable." The first of its four recommendations is that government needs to "act now" to ensure there are safe numbers of staff in emergency care. The report also explicitly notes the need for more funding, an overhaul of current long-term health strategies and reduced patient crowding.

Dr Henderson says a 10-year workforce plan that ensures comprehensive training and sustainability is key to the future success of the emergency department. "In current rhetoric there is little big picture thinking, we need to change. The crisis in A&E could result in systemic issues for the entire health service. The reality is that we are an essential part of the way the nation responds to its medical needs."

Reflecting on her own career and the unique nature of emergency medicine, Dr Henderson says: "The variation is so attractive – I can deal with a dislocated shoulder, a heart attack and an ectopic pregnancy as well as the child with a pea stuck up its nose. The ability to flex your thinking is enormously appealing. It is never boring."

It is clear that the challenge facing the NHS must fully consider emergency departments if the UK is to "build back better". A&E will always have its lights on, but whether it can serve its public safely and efficiently requires serious intervention both within the wider health service and outside it.

MORE INFORMATION

The Royal College of Emergency Medicine

rcem.ac.uk

DAVID DUFFY INTERVIEWS DAVID FURNESS

What part can independent provision play in post-pandemic plans?

The role the private healthcare sector plays in supporting NHS recovery and renewal following Covid-19 has taken on profound importance.

Healthcare provision in the UK may be dominated by the NHS, but that still leaves a significant and now rapidly growing private (or "independent") healthcare sector. Since the onset of the pandemic in March 2020, this steady growth has had the afterburners applied to it.

The fragile state that the NHS has found itself in following successive waves of Covid-19, combined with ominous waiting lists, has led to a surge in private medical insurance, and the contribution of the independent sector to future plans for the health system has become more important than perhaps ever before.

The UK's independent healthcare sector is worth around £9 billion a year and in excess of 90 providers of acute, primary, community and clinical homes. Initially, Covid-19 led to a significant drop in privately funded healthcare as all clinical resources were called on to stem the tide of Covid cases in NHS emergency departments.

"Almost overnight the [private] sector transformed itself," says David Furness, Director of Policy and Delivery for the Independent Health Providers Network (IHPN), a representative body of the UK's independent providers with a membership that includes 69 providers in England alone.

Stepping up to relieve pandemic pressures

David describes the role that the independent sector played in providing a "pressure release" to the NHS in its hour of need. While the NHS diverted resources from every corner to tackle the growing number of Covid hospitalisations, some 3.2 million NHS patients were referred to the independent sector – business that is said to have consisted of £2 billion worth of government contracts. These patients came with a variety of urgent needs, and a significant mixture of planned care and specialisations. Further, the sector's entire CT scanning fleet was called on to boost diagnostic capacity and urgent oncology services

were rapidly required. "Independent providers stepped up, recognising the role we needed to play to go through this period and prevent the NHS from becoming overwhelmed," says David.

"I think the pandemic showed the independent sector at its best, putting patients at the heart of action and harnessing its ability to move rapidly and respond to a crisis."

It is this sector's "ability to respond", or rather its spare capacity, which has significant long-term implications for the role of private healthcare provision in the UK. More than five million people are currently waiting for an NHS operation, with almost 400,000 of those people already waiting for over a year. Huge waiting lists are nothing new to the NHS, but the disruptive impact of the pandemic has exacerbated the issue, forcing stretched health providers with beleaguered workforces to think outside the box in the name of recovery and renewal.

In response to this growing crisis, the IHPN has called for an "all shoulders to the wheel" approach, and a "sustained role" for the independent sector as the NHS looks to bring down waiting times.

While providers look for ways to divert resource and consolidate capacity, many patients are not waiting around for treatment. HCA Healthcare UK, which runs major hospitals in London, including Portland and the Lister, as well as providing some care at Guy's and St Thomas', reported last autumn that the number of people choosing to pay privately for surgery had doubled.

"I think the pandemic showed the independent sector at its best, putting patients at the heart of action and harnessing its ability to move rapidly and respond to a crisis"

David Furness
Director of Policy and Delivery, Independent Health Providers Network.

Working with the independent sector is becoming normalised in the NHS (where much of private healthcare provision was already being delivered), culminating in a deal worth £10 billion being struck to bring down the backlog. In the view of the IHPN, there have always been pragmatic ways of working with the independent sector; David points to the example of general practice, which was never fully assimilated into the health service upon its inception.

"We must dispel hostility to using the private sector. Ideology should not form barriers to people getting the treatment that they need," he says.

Enhanced collaboration

"At a local level, clinical teams are working together in ways that they have not before, with cultural barriers being broken down and system collaboration taking on new importance," explains David.

This collaborative working with the independent sector will clearly be essential for the NHS to navigate through this bleak period. As David points out: "The sector cannot afford to leave unused capacity, this would be a disservice to patients."

The health sector needs a long-term plan for reducing waiting, times and the IHPN wants independent provision to remain a key part of that. "We can be that release valve to keep services going," says David. It is also true that the independent sector can be, and has been, used to boost diagnostic capacity in innovative ways. For example, its contribution has been proposed to support he community diagnostic hub programme, promoted by Professor Sir Mike Richards, which will require immediate capacity to become a success.

No one can argue with the benefits of enhanced collaboration between different parts of the health and care ecosystem, but the question is, what will the make-up of UK health provision look like when or rather, if the NHS has recovered from an unprecedently difficult period. Those leading the NHS will need to decide whether long-term reliance on the independent sector in this way is truly the most sustainable option for recovery and renewal of the health and care sector.

MORE INFORMATION

Independent Healthcare Providers Network

iphn.org.uk

DORIS ANN WILLIAMS

"Don't wait; Act" on early diagnosis

Since the beginning of the pandemic, routine care and health screenings for diseases such as cancer, heart disease and diabetes have been severely impacted.

In late April 2020, as the Covid-19 infection rate started to decline, the NHS gave a rallying cry to those hesitant to access medical care, emphasising that the health system was very much open for business. However, more than a year on and with waiting lists reported to be at record highs, many patients are still waiting on routine care and testing. The statistics point to a big drop in appointments and highlight that between April and July 2021 there were around 5-10 million fewer GP appointments each month, compared to the same period in 2019.

Not only were there fewer GP appointments, but many BIVDA members saw up to a 70 per cent drop in routine demand for their diagnostic products during the early stages of the pandemic. Amongst others, there has been a significant decrease in clinical areas such as anaemia, down 29 per cent, HbA1c tests for people with diabetes down 14 per cent, and PSA for prostate cancer down 17 per cent. Without these routine checks and tests, thousands of people could be living with potentially life-threatening undiagnosed diseases.

The diagnostic blackhole

Clearly there were good reasons for not attending routine appointments in the early days of lockdown. However, many of those with a long-term chronic disease missed out on valuable tests to manage their condition. Patients on certain medications also missed opportunities to check that their treatments were not affecting their overall wellbeing. Statins, for example, are a fantastic therapeutic tool but need careful monitoring to ensure they are not affecting the liver.

People with new symptoms, who might have already been concerned about their health, have been reluctant to come forward for two reasons. Firstly, they've been worried about the risk of infection due to coronavirus. Secondly, constant media reports about the strain on the NHS mean people continue to be hesitant to get tests done, lest they become part of the problem.

"With every passing day, patients are potentially going undiagnosed, creating longer term health impacts"

Doris Ann Williams
Chief Executive, BIVDA

The importance of early diagnosis

So much of our healthcare is underpinned by the information from diagnostic tests. Almost everyone is familiar with the process of visiting a GP for a blood test, often to rule out a possible diagnosis, as much as to confirm the cause of your health problem. The GP can only tell so much from asking questions, taking your temperature or checking blood pressure. In fact, it's generally accepted that about 70 per cent of the information used to make clinical decisions for a patient's treatment comes from tests. Yet, during the pandemic, most people have either not seen a doctor, or have only had a remote consultation. Many have not had any testing done at all. This is worrying, and a shift is required to put these life-saving tests higher up the priority list for patients and healthcare providers alike.

Now is the time for the public to put previous fears to one side and seek advice, catch up on routine appointments and make sure their health hasn't been indirectly impacted by the pandemic. Over the last year, the NHS has learned a lot about how to manage the risks from Covid-19, both in primary care settings and in hospitals. The right precautions are in place to make sure visiting your GP or the hospital is safe. Ignoring routine monitoring, even if you feel well, can cause significant problems for your health in the future. In the same way, new symptoms need investigating so that they can be treated – why suffer unnecessarily? Life-threatening conditions such as heart disease and cancer need to be found early to allow for the best chance of successful treatment.

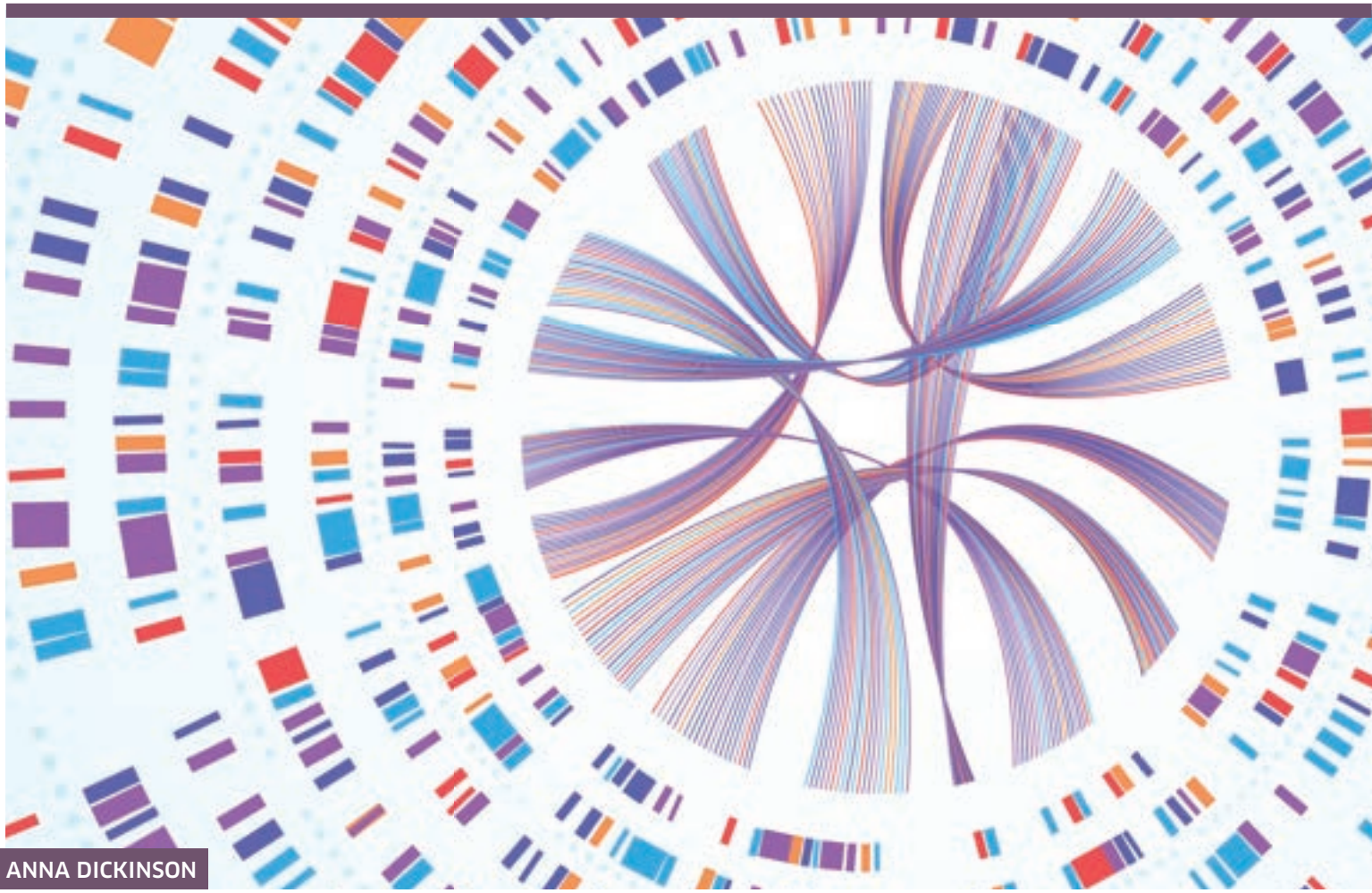
Save money and lives

Those worried about being a burden on the NHS need not worry. Tackling diseases early actually reduces the long-term strain on our health service, as treatments are much more effective and cheaper than in later stage illness.

It's now more important than ever to go out and get these routine health screenings done. With every passing day, patients are potentially going undiagnosed, creating longer term health impacts for themselves and putting strain on the NHS further down the line. That is why we are calling for people to go out and get their tests as part of our campaign "Don't Wait; Act". It's safe, it's sensible and it's time to get the nation's health back on track, minimising the long-term effects of the pandemic on our health service and the health of ourselves, family and friends.

MORE INFORMATION

BIVDA **bivda.org.uk**



ANNA DICKINSON

Socialising the genome: building a bridge between the public and the science

Anna Dickinson, Policy Analyst at Public Policy Projects, asks genomics experts Professor Anna Middleton and Vivienne Parry what can be done to encourage people to share their data to support valuable research, identification of those at risk of certain conditions and the development of treatments.

Emerging and developing fields of medicine, such as genomics, data science and artificial intelligence (AI), have the potential to transform how healthcare is delivered around the world. The ongoing Covid-19 pandemic has showcased this through the development of the vaccines and sequencing of pathogens to identify new variants. Nevertheless, as has been shown by high levels of vaccine hesitancy globally, many of the people these treatments are designed to help do not trust such advances.

Within the four walls of clinical and research settings, the advancements in healthcare offered by genomics are championed. However, the individuals who see such positives are mostly already active participants in the field, whether as practitioner, patient, or researcher. Outside this environment, people often are not exposed to genomics, and without an increase in engagement, the associated benefits will go unknown to the general public.

The question is how to engage the public with genomics. If even the word genomics has the power to confuse the average person, the science behind it might appear impenetrable. Following the expression coined by Professor Anna Middleton, Head of Society and Ethics Research at Wellcome Conneting Science, and Vivienne Parry, Head of Engagement at Genomics England, the idea of "socialising the genome" has become imperative.

Geno-what?

"Genomics" is a common buzzword that many are comfortable with in clinical, research and academic settings. However, efforts being made to engage the public are few and far between. Although the 100,000 Genomes Project introduced in 2012 began establishing a strong precedent by creating a "participant panel", it fails to appropriately engage the wider public who have very limited knowledge of genomics.

The intrinsic limitation that lies at the core of engaging the wider public with the work of genomics is that many feel alienated from, or do not understand, the fundamentals of this particular branch of science and medecine. But why should they? To generate public engagement in genomics, the derived benefits must be rendered easily accessible. This approach

"To generate public engagement in genomics, the derived benefits must be rendered easily accessible"

Anna Dickinson
Policy Analyst, Public Policy Projects

was showcased by the Your DNA, Your Say project, which gathered and assessed global public attitudes towards genomics and genomic data sharing, engaging 37,000 people from 22 countries and conducted in 16 languages. The message is clear; we need to build a bridge between the public and the science.

Professor Anna Middleton explains: "Research tells us that public audiences across the world are very unfamiliar and mistrusting of genomic data sharing and do not appreciate the benefits genomics can offer society. Without broad public support and awareness, there is a real risk of confusion leading to public backlash. We need to bring public audiences with us if genomic technology is to become a routine part of healthcare, and this means communicating in ways that have meaning for them.

Genomics continue to penetrate mainstream clinical practice, and so the need for the layperson to understand both what they are signing up to and where they are sending their genetic data becomes more pressing. This is particularly true in the context of the growing use of at-home tests provided by private companies such as 23andMe. Without first establishing an understanding of the fundamentals, the scope for people to develop a mistrust in how their data is used and why increases.

Progress made on newborn sequencing

As scientific understanding of genomics has risen, the cost of sequencing has dropped, and experts have begun pondering how the benefits of whole genome sequencing (WSG) can be stretched. For example, Genomics England, in partnership with engagement specialists Hopkins Van Mil, commissioned a new national public dialogue focusing on newborn screening, sense checking the public's response and awareness.

The resulting report, Implications of whole genome sequencing for newborn screening: A public dialogue, highlighted that overall "participants were supportive of the potential use of WGS for newborn screening". Screening at an early age provides the opportunity to identify individuals who are at a higher risk of particular diseases. Furthermore, where treatments are currently not available, those identified as being "high-risk" could be offered the opportunity to participate in research supporting new therapies and treatments.

This underlines a positive shift in the awareness and opinions of the general public. Nonetheless, more can and should be done. Even though the overarching attitudes reflected in the report were positive, the shared public sentiment was not without its hesitations. Questions were raised surrounding consent, data usage and storage, and the ethical frameworks that will govern the data management.

Why does engagement matter?

Genomics is an ever-growing and continuously developing branch of science and medicine and is advancing at a rapid rate. As developments continue to occur, their impact will reach more and more of the general public, with or without their knowledge. Increased engagement and awareness are therefore essential.

Vivienne Parry makes the point: "There are many aspects of genomics, like pharmacogenomics, that are beginning to reach people who don't think of themselves as ill. So engagement needs to go beyond patients to include the wider public, especially those who are disengaged. "

Levels of trust, engagement and, ultimately, participation differ greatly among not only those who are at the heart of healthcare services, such as clinicians and patients, but the wider public. Further examination indicates a high level of disparity between the trust and engagement offered by minority communities. Genomics possess the power to improve and benefit the health of everyone, but cannot do so unless the data used to conduct such necessary research reflects everyone.

MORE INFORMATION

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LOTTIE MOORE

We need to tackle the heart attack gender gap

Gender biases permeate every aspect of society, but the stakes are much higher in healthcare.

Spontaneous coronary artery dissection (SCAD) is an uncommon and underdiagnosed heart condition that currently cannot be predicted or prevented. It mainly affects young to middle-aged people, and 90 per cent of SCAD cases occur in women. Often electrocardiograms (ECGs) do not show abnormalities at the point at which a patient is experiencing this life-threatening condition.

When Sarah presented paramedics with symptoms of a serious cardiac event, they told her she was having panic attack. "As I was lying on my hall floor, I knew something awful was happening. A GP neighbour had correctly identified that I was having cardiac problems, but the paramedics took one look at me and said I was having a panic attack. I was a woman of a certain age – anxiety is common among perimenopausal women – and so I just got put into that box. "

Sarah was later diagnosed as having had a heart attack caused by SCAD, a lifelong heart condition. After a month of doing her own research, she found Dr David Adlam, a SCAD expert, who put her in touch with other SCAD survivors. One of these was Rebecca Breslin.

Rebecca was just 34 when she woke up during a SCAD heart attack. Dr Adlam was her cardiologist. In 2012 "there was little out there to Google other than autopsy reports", says Sarah. Consequently, Rebecca decided to form Beat SCAD, a charity that aims to promote awareness of the condition, support survivors and fund reseach

It is Increasingly apparent that both health research and data must do more to help people who suffer with this condition.

The awareness bias

There is a common misconception that heart disease is a male condition. Yet four women an hour are admitted to hospital following a heart attack every day. Research from the British Heart Foundation demonstrates that women are twice as likely to die from a heart attack as men. Inequalities in awareness, diagnosis and treatment of heart attacks are resulting in a "heart attack gap". Women are 50 per cent more likely to receive a wrong diagnosis initially, just as Sarah did.

Lack of awareness and public understanding results in both women and healthcare professionals failing to recognise heart attack symptoms for what they are. This is costing lives; in the UK women are twice as likely to die from heart disease as they are from breast cancer.

Sarah recognises that her own former biases about women and heart conditions motivates her work with

Beat SCAD now. "Coming from a professional background of marketing and communications, the power of storytelling and testimony is key to what we are trying to do here. We share our stories with professionals from across the health sector and you hear pennies dropping all over the place. "

Beat SCAD is working with ambulance services in England and Wales to raise awareness of SCAD and the fact that women have heart attacks too. Sarah and her colleagues give talks to paramedics on challenging bias when dealing with people who present with heart problems. Already this work has resulted in changes to some training syllabuses. While SCAD is an uncommon heart condition, it is the responsibility of healthcare professionals to be aware of its existence and, in particular, its prevalence among women of a certain age.

The data bias

Failure to ensure gender balance in cardiology research has had major implications for general awareness of the issue. The under-representation of women in clinical trials stems from the assumption that the male body represents the norm. Female considerations are generally reduced to matters relating to reproductive health.

Although cardiovascular disease is the leading cause of death among women worldwide, they are massively under-represented in cardiology clinical trials. Most guidelines aimed at managing heart conditions suffered by women are based on research primarily conducted on men.

"The under-representation of women in clinical trials stems from the assumption that the male body represents the norm"

Lottie Moore
Policy Analyst, Public Policy Projects

According to American Heart Association research, just three to 13 per cent of participants in cardiology clinical trials are women. The researchers concluded that there were no obvious eligibility issues but women were not being put forward for consideration.

While research is still in relatively early stages for SCAD, "there are a small minority of people who are very involved on a global scale", Sarah says. However, the fact that SCAD is an uncommon condition primarily affecting women "has resulted in a dearth of clinical information. There is a reluctance to fund research. Lots of clinicians tell you to go away and get on with your life. "

At Beat SCAD, the team have taken matters into their own hands. Part of their work as a small charity has involved the SCAD community itself campaigning for research and subsequently participating in research studies. "We supported Dr Adlam in his application for funding from the British Heart Foundation to carry out initial research and then 100 of us ended up participating", says Sarah. "That directly fed into the results shared in the 2018 European position paper and guidelines for diagnosing and managing SCAD that exist now. "

This data has also been used in collaboration with global SCAD research efforts, resulting in the publication of many papers and moving forward current knowledge about the condition. Beat SCAD has continued to fund Dr Adlam's research, which, among other things, has resulted in identification of the first genetic risk factor for SCAD.

The fact that such charities need to exist for women with uncommon heart conditions to be given a seat at the table should be a wake-up call for policymakers. Women such as Sarah are discriminated against twice over. Not only do gender biases affect women experiencing heart disease, but the perceived rarity of the illness also results in this bias being amplified further.

It is clear that policymakers, healthcare professionals and research governing bodies must make greater efforts to confront the gender bias in both awareness and research about heart conditions. This was also the conclusion of the *The Lancet* women and cardiovascular disease Commission: reducing the global burden by 2030, which aims to summarise "existing evidence, identify knowledge gaps in research, prevention, treatment, and access to care for women".

Sarah Coombes' passion to challenge the narrative is admirable. It is time for the rest of the health sector to follow suit.

MORE INFORMATION

Public Policy Projects
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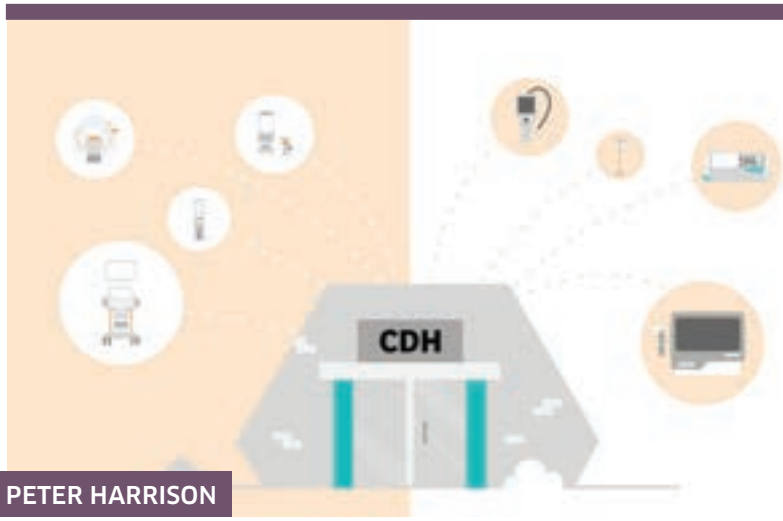


PETER HARRISON

A journey of diagnostic transformation starts with community hubs

Integrated care systems and hospital groups across the country are currently establishing scalable, digitally enabled, community diagnostic hubs. Siemens Healthineers gathered the views of health system stakeholders planning local diagnostic provision on the objectives and challenges of this approach.

In the first phase of community diagnostic hub (CDH) development, senior stakeholders made it clear there should be particular focus on planning for CDHs in a way that will tackle regional health inequalities and drive population health outcomes. It therefore seems logical that, with a backlog of examinations mounting, we should seize the opportunity to transform pathways. We should be ambitious and ensure that the Covid-19 pandemic legacy is one that serves to drive radical change.

While the pressures of Covid initially led to a sudden and unplanned drop in imaging demand, many of those we spoke to felt they had restored or were close to pre-Covid activity levels. The issue raised, however, was that the pre-pandemic capacity was not sufficient to deal with the growing patient demand. Add to this the inherent backlog of examinations generated by the Covid crisis and it becomes clear that overall diagnostic capacity needs to be re-examined. The consensus is that establishing new processes and workflows via CDHs will be critical to delivering the efficiency and capacity needed to transform diagnostic pathways.

A facility fit for purpose

Many stakeholders have expressed their vision for the CDH as a journey rather than a project build. This is necessitated by the rapidly changing healthcare needs of the UK population, which vary greatly depending on location. In the short term, stakeholders expect to witness a gradual shift in patient demand, transferring from settings such as acute hospital A&E and outpatient departments to the CDH. Additional pressures will also need to be accounted for, such as Covid safety.

In the mid to long term, as the CDH becomes an established feature of the healthcare landscape, it is likely more demand will be generated for additional services in this setting. With further changes on the horizon, healthcare professionals are clear that adaptability must sit at the core of CDH provision if it is to meet the needs of its local population.

To satisfy local pathway requirements, the sheer number of CDH build and design options has rapidly become evident. Popular options discussed have ranged from the establishment of a standard model, featuring defined imaging, pathology and physiological measurement provision to larger models, including additional services such as endoscopy, ophthalmology, phlebotomy or training academies established over time. As for the pathways these CDHs must accommodate, cardiac, respiratory and musculoskeletal considerations were most frequently cited. ENT and ophthalmology were mentioned as having a place too.

In terms of CDH location, the picture remains equally complex. Some seek to adapt existing estate, citing the prohibitive estate costs of establishing and connecting new facilities. Others found, after investigation, that there was simply no suitable space available that met the vision of the CDH. This has made alternative models, such as the development of new facilities or adopting a hybrid solution built over time, much more attractive options for some. There is one clear consensus that has been voiced to us; whatever the approach, it must be scalable, and tailored to local pathway requirements and the population it serves.

An intelligent workforce

The NHS Long Term Plan set out a workforce implementation plan, while recognising that workforce planning is complex and will always need to be highly adaptive. The spirit of innovation escalated by the pandemic has shown how rapidly the workforce can adapt, and there is a drive to extend this to the CDH to enable its aspirations to reform diagnostic provision. The additional capacity the CDH will provide to tackle diagnostic demand has the entire health system excited, yet one of the most frequently raised concerns is how to find the workforce to support this. Professor Sir Mike Richards' Diagnostics: recovery and renewal report recognises the challenge, calling for an additional 2,000 radiologists and 4,000 radiographers.

In the same way that innovation has the ability to transform pathways for the better, many hope that diagnostic reform will act as a catalyst to break down workforce silos and rigid job role definitions. For instance, consideration is being

given to enable assistant practitioners to support with routine CT (computerised tomography) or MR (magnetic resonance) provision, freeing up time for radiographers to focus on supervision and more complex examinations. Similarly, additional capacity requirements for reporting could be alleviated by sharing the imaging skill mix.

Over the longer term, and in the context of sustainability, many view the CDH as a suitable setting to accelerate training and apprenticeship programmes. These could not only upskill the existing workforce, but also attract talent from universities and other education settings. This is likely to require a blended approach to workforce education, leveraging virtual platforms. Innovations such as remote scanning assistance, imaging simulators and teacher-led virtual classroom courses can supplement traditional on-site clinical applications training. Ultimately, the aspiration for the CDH is one where knowledge is moved, rather than staff, to attract talent, empower the workforce and ensure all examinations are conducted to a high standard.

Digitalisation from the ground up

The need for additional workforce support extends to IT departments. It has been vocalised that more expertise will be needed, both from within the NHS and from external partnerships. Areas such as imaging, echocardiology and endoscopy have been particularly highlighted as those that could benefit from enhanced digitalisation in a CDH. At the granular level, this includes technological advancements such as artificial intelligence (AI) to support diagnosis and care planning. At a broader level, this encompasses the CDH IT infrastructure at large. Stakeholders have drawn comparisons with the efforts made by laboratory information systems and pathology networks that successfully scaled network connectivity across the UK at pace. It was agreed that while digitalisation was critical to CDHs, this must be supported by optimised pathways and processes.

"Despite the hurdles to overcome, the community diagnostic hub ultimately represents a significant step towards the panacea of same-day diagnosis"

Peter Harrison
Managing Director, Siemens Healthineers Great Britain and Ireland (GB&I)

The complexity of then digitising those pathways was often raised, in terms of data needing to flow between primary care, the CDH and secondary care while also building in the flexibility for data to run in both directions, such as for imaging reporting or reports back to a GP. It was also agreed that although RIS (radiology information systems) and PACS (picture archiving and communication systems) will go some way towards supporting a paperless CDH model, there needs to be focus on enhancing interoperability between different systems. Integration with electronic patient record and intelligent order communications was also raised as a priority, ensuring paper is removed from areas such as patient booking and scheduling tools, and removing issues such as double queries.

Ultimately, an intelligent, fully digitalised workflow infrastructure will be key to helping accelerate diagnosis and ensure "right study, right report, right time". Indeed, CDHs present an opportunity to accelerate the generation of diagnostic reports by potentially introducing "hot reporting", the generation of reports while a patient is still in the facility. The earlier such reports are generated, the sooner a diagnosis can be delivered and a treatment plan commenced.

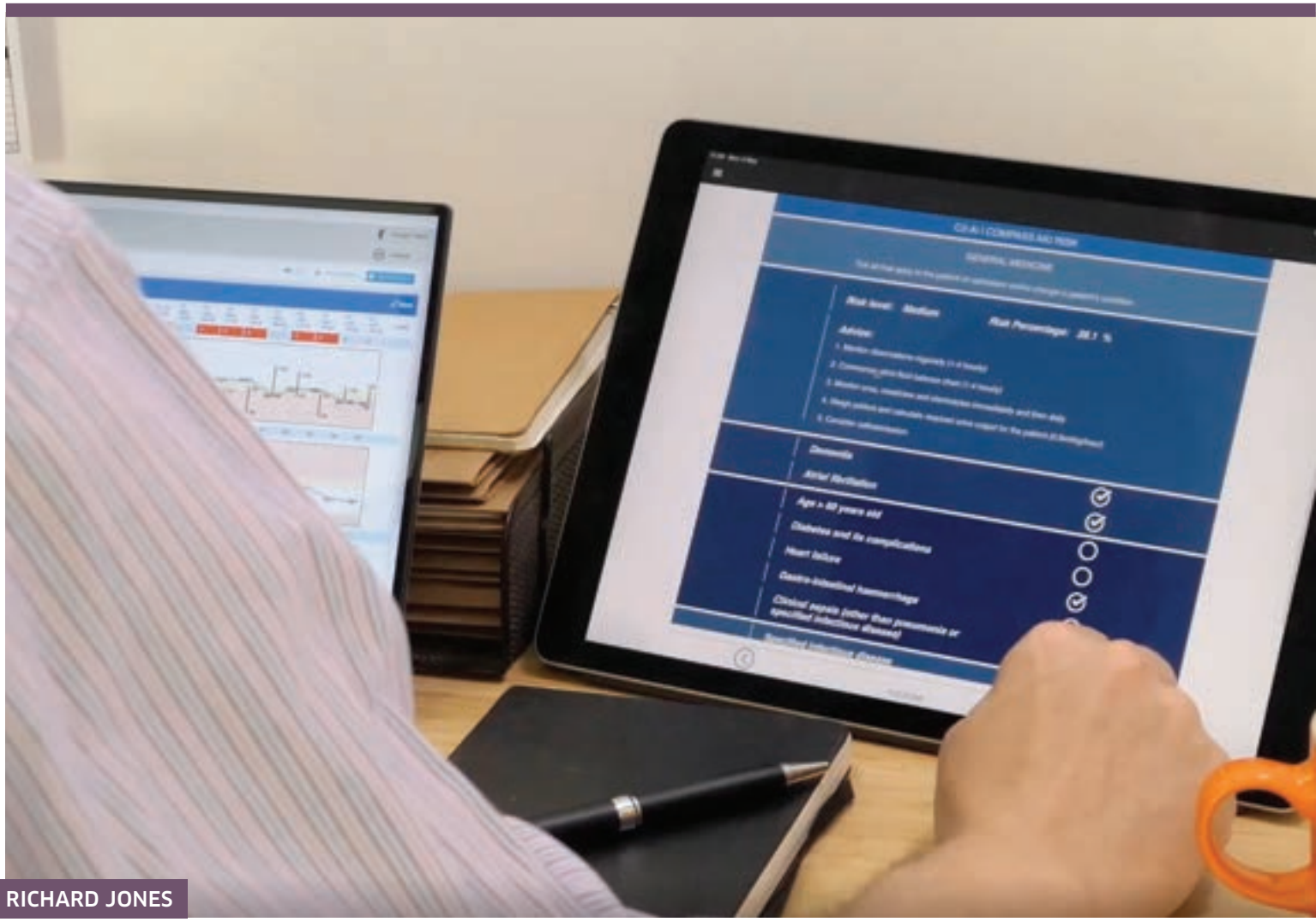
Recovering and renewing diagnostic provision

The pandemic has clearly exacerbated pressures on the NHS, and the long-term impact of Covid, including the scale of hidden diagnostic demand, remains to be seen. In the many years that Siemens Healthineers has been an advocate of community diagnostics, never has the case for diagnostic reformation and expansion been so clear.

There is a real drive within the health system to establish new diagnostic pathways, supported by new ways of thinking around service redesign, build, workforce and digital infrastructure. The system is realistic about the level of complexity involved and continues to work with government to secure the local funding needed to support this. Despite the hurdles to overcome, the community diagnostic hub ultimately represents a significant step towards the panacea of same-day diagnosis, bringing with it the opportunity to increase capacity, reduce waiting times and transform diagnostic provision for the benefit of the patient.

MORE INFORMATION

SIEMENS Healthineers **siemens-healthineers.com**



RICHARD JONES

Alleviating capacity shortfalls in hospitals

Halving avoidable conditions acquired in hospital can free up to 10 per cent of ICU capacity quickly and potentially save one life for every hospital bed.

Covid-19 looms over healthcare globally and will continue to have an effect for years to come. However, there are ways to alleviate issues in countries suffering capacity shortfalls in hospitals, and to return to 'normal' as quickly as possible.

While the rates of infection may be levelling off in some areas, and some countries are well advanced with their vaccination programme, there are many, including India, that are suffering severe capacity issues.

Hospital staff globally have done a wonderful job throughout this pandemic, showing their dedication and hard work at every turn, despite all the physically tough and emotionally exhausting challenges. Unfortunately, some patients contract conditions in hospital that are avoidable.

One common condition is hospital-acquired kidney injury (AKI). A study by researchers at University Hospital Southampton NHS Foundation Trust found that AKI was a significant factor for Covid-19 admissions to ICU and deaths. AKI was present in 31 per cent of Covid-19 hospital patients, and the condition along with hospital-acquired pneumonia (HAP) was associated with 27 per cent of admissions to ICU. The findings also showed that more than twice the number of Covid-19 patients with AKI died, compared to those without it.

Taking our performance in hospitals for this approach and working with Indian colleagues, we estimate that an Indian hospital could save one extra life per bed over a 12-month period through the reduction in cases of these avoidable conditions and increased availability for Covid-19 patients. There are also obvious benefits longer term in reductions in patients moving on to suffer from life-changing conditions such as chronic kidney disorder.

Accurately assessing risk

Hospital-acquired AKI and HAP cause an average of six and eight additional days in hospital, respectively. They are also found to increase the risk of death in Covid-19 patients, with AKI in particular being highlighted as problematic in guidelines issued by the National Institute for Health and Care Excellence (NICE) in the UK.

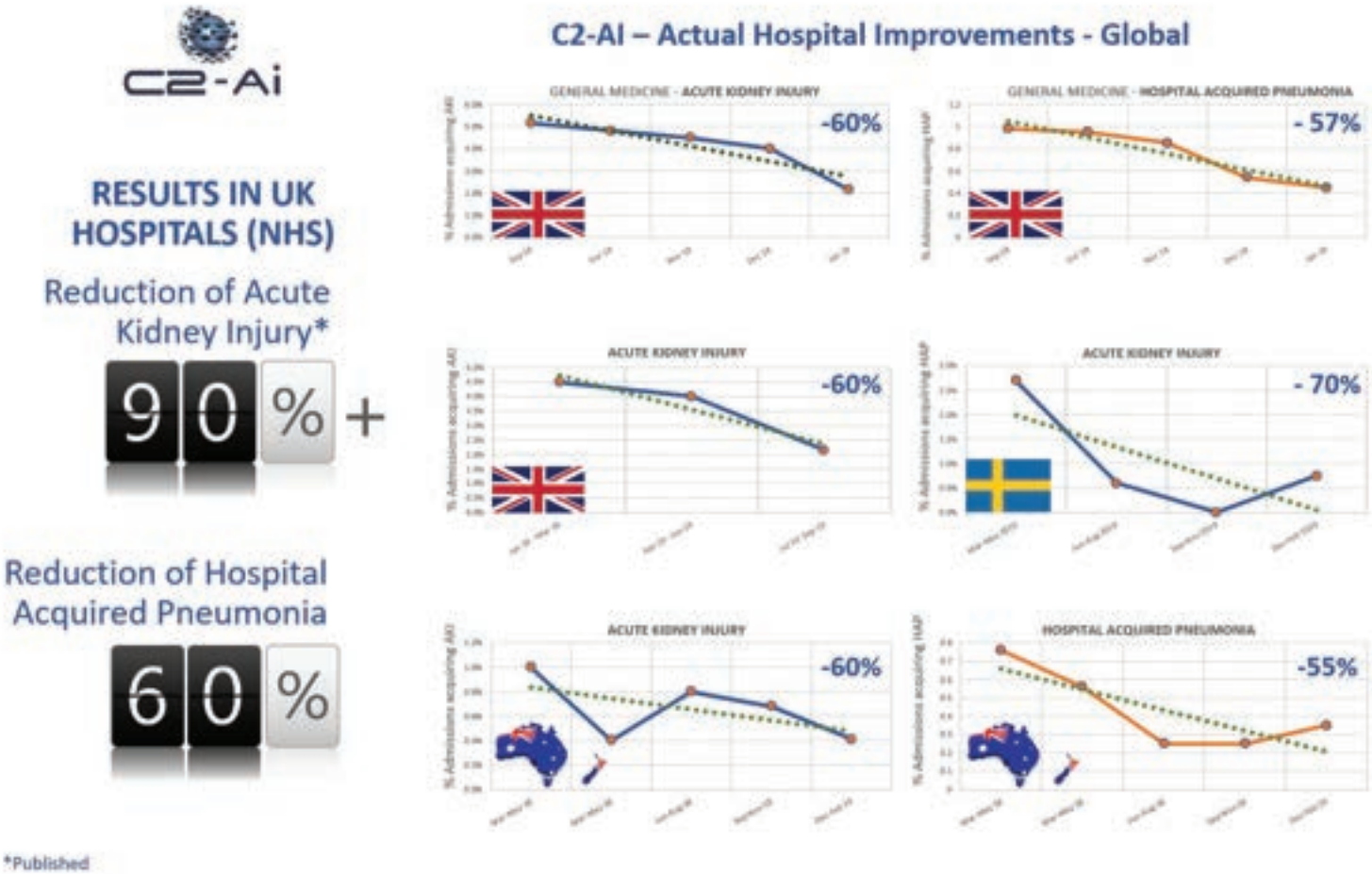
C2-Ai's Compass mobile app provides clinical staff with a tool for accurately assessing every individual patient's risk of developing the conditions in hospital, so that appropriate action can be taken to prevent significant numbers of AKI and HAP cases, reduce admissions to intensive care, and decrease associated morbidity and mortality. To be clear, this is prevention of these conditions – not identification when they have been acquired by a patient.

No complex integration is required and the app can be downloaded and supporting assessments within minutes. C2-Ai has been named by Healthcare UK as one of "10 Essential Digital Health Ideas for a Covid19 UK National Response" in part because of this approach. This technology helps decrease patient morbidity and mortality but also reduces pressure on staff.

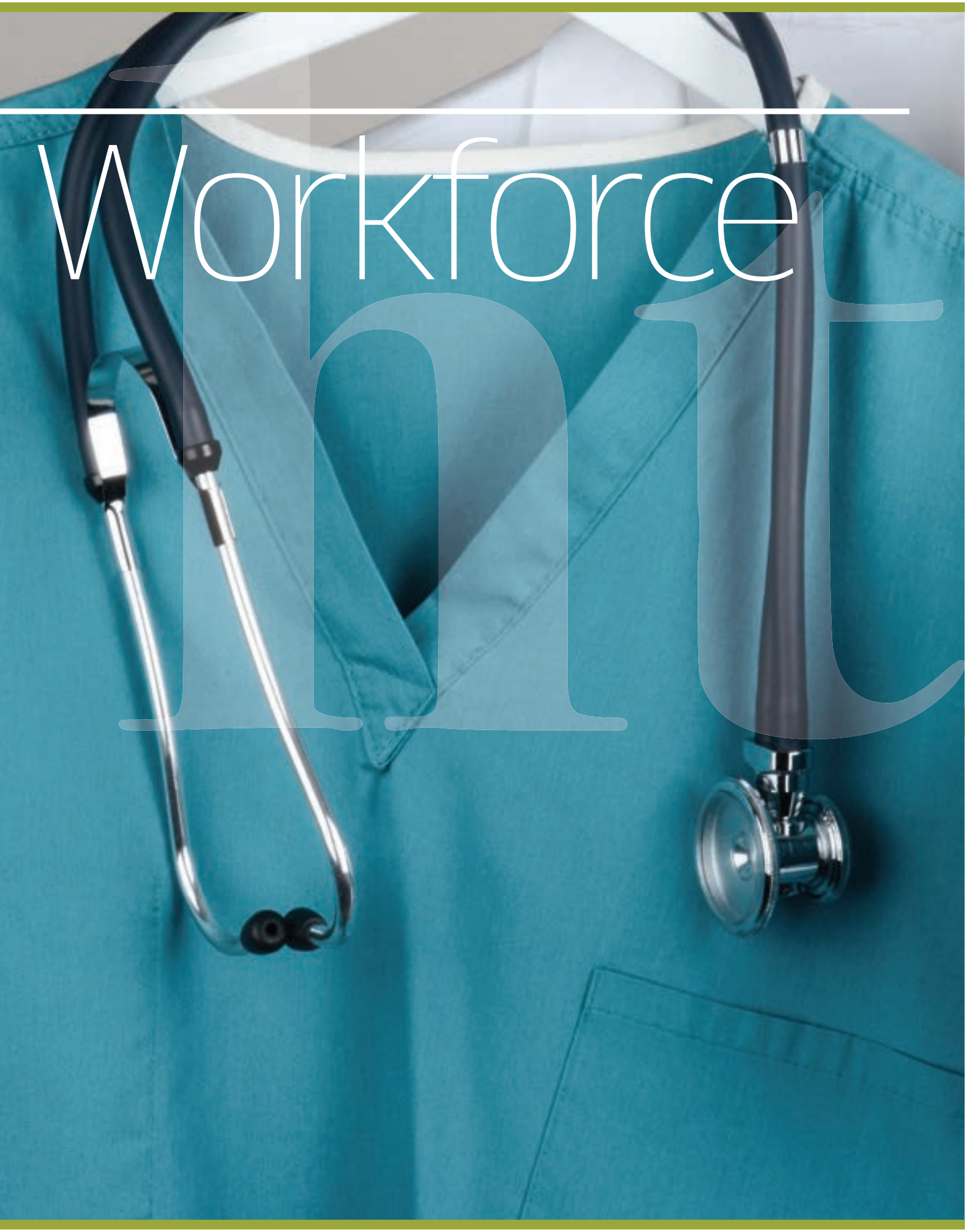
The Compass app from C2-Ai can be downloaded on to a smartphone and used by clinicians immediately, without the need to integrate or store data. The app can evaluate comorbidities and circumstances more quickly than might be done manually, with guidance on how to treat the patient provided. It is being used and trialled by several NHS trusts, based on approaches that have worked to reduce these conditions in several countries.

By assessing patients on admission for their risks of acquiring hospital-acquired acute kidney injury and pneumonia, the system supports clinicians with specific advice on care tailored to each patient – reducing the number of patients acquiring the conditions, and so preventing harm and saving lives.

Based on data from healthcare organisations using this technology, it is anticipated that this preventative approach can reduce overall AKI levels by 50 per cent through significant reductions in hospital-acquired AKI and reduce HAP by a similar amount. Preventing conditions from developing will always be quicker and demand less clinician time than treatment and, naturally, will be better for the patient. In addition, by freeing up bed capacity – particularly in ICU – such measures would help hospitals save money. The reductions in these avoidable conditions could reduce direct costs by $9 million annually in some countries during 'normal times', save up to 500 lives per hospital and also free up to 1,000 bed-days monthly (with up to 10 per cent of ICU capacity being freed). At a time when there is huge pressure on hospitals, these tools are clearly beneficial.



Workforce



DR ANAS NADER

Why it's time to end the great NHS bank robbery

Dr Anas Nader, CEO of Patchwork Health, stresses that the NHS must find more sustainable ways of plugging gaps in its workforce.

When £2.4 billion goes missing, you can usually guarantee that people will sit up and take notice. So why, when the NHS is forced to shell out this sum every year to patch over the consequences of "criminally" outdated workforce systems, is no one talking about "the great NHS bank robbery"?

Over the past 18 months, NHS hospital staff banks have consistently and unequivocally proven their worth. Although these reserve pools of healthcare workers – a valuable asset for every hospital – have existed for years to plug rota gaps and meet the ever-fluctuating demand for staff, they truly came into their own during the pandemic. It was staff banks that helped keep wards, theatres and departments safely staffed through peaks and troughs, enabling lifesaving care to continue, and filling a colossal number of urgent shift vacancies.

Nevertheless, despite the best efforts of managers and administrative teams, the analogue and anachronous operating systems behind staff banks are holding them back. Despite huge strides forward and much effort to make internal banks work, hospitals are still all too often forced to turn to private locum agencies to meet their staffing needs. Although agencies have their place and many offer a vital service, this over-reliance comes at a cost.

Published figures reveal that every year the NHS is forced to spend £2.4 billion of its increasingly stretched budget solely on agency locums. This is money that is desperately needed to tackle the crushing impact of Covid-19, money that could be invested in new treatments for patients or on delivering much-needed mental health support to burnt-out staff. We are spending too much money on reactive, short-term, temporary staffing solutions. This "bank robbery" is also reducing NHS trusts' chances of creating and sustaining internal pools of reliable temporary staff.

Storm clouds gathering

The escalating staff burnout crisis and the record-breaking elective care backlog are now placing crippling pressures on the NHS workforce.

With full-time NHS staff suffering "emergency levels" of burnout (as reported by the UK Parliament cross-party Health and Social Care Committee in June), Brexit disrupting overseas recruitment and one in five employees seriously considering leaving their roles, staffing shortfalls are set to get worse. If internal staff banks aren't able to respond to these ever-growing gaps in the full-time workforce, hospitals will have no choice but to plug them with agency staff.

Not only is this state of affairs draining budgets, the revolving-door nature of over-reliance on agency staffing makes building relationships between colleagues an impossibility and offers patients little to no continuity of care. We are moving towards a state of affairs far removed from the founding principles of the NHS, creating an unattractive, depersonalised work environment that poses a real risk to patient outcomes.

A rock and a hard place

Curing this chronic condition demands more than simplified "sticking plaster" solutions. If the NHS is to even come close to self-sustainable staffing, it is essential that we empower all trusts and integrated care systems to drive up their staff retention and strengthen their internal banks. The only way this will be achieved is by creating healthier, more sustainable career paths for all staff, releasing hospitals from the trappings of short-term "patch and pray" cycles and ushering in a new era of tech-powered staff banks designed around real human needs, and developing staffing policies that put wellbeing first.

"We need to make work better for those on full-time contracts and transform the internal staff bank"

Dr Anas Nader
CEO, Patchwork Health

Currently, NHS staff face a stark choice. Their first option is direct employment with a trust, meaning a rigid rota, a restrictive leave policy and too much red tape preventing movement between different trusts or hospital sites. Arranging to take annual leave at the same time as friends and family is a mammoth endeavour, gaining experience at a different trust is a process burdened with administrative hurdles, and even study leave for professional exams demands complex negotiation.

The second option is to work as an agency locum, a role that might offer higher wages and shift flexibility but can come at the expense of the stability of contractual employment, long-term relationships with colleagues and a sense of workplace belonging.

Too few take the third way of the internal staff bank, with its often "clunky" processes and inconsistent approach to shift alerts.

As things stand, NHS staff, whose primary motivation is to help their patients and their colleagues, must either remain inside a system that often demands the sacrifice of their self-determination and wellbeing, or exit the system altogether (which often means sourcing work through a private agency). It is hardly a surprise that so many are leaning towards the latter option.

Banking on rebuilding

But things could, and should, look very different. With the right tech tools and intelligent systems in place, trusts can create a new breed of staff banks that work for the NHS – and for workers – in 2021 and beyond.

We need to make work better for those on full-time contracts and transform the internal staff bank into the go-to option for all temporary staff. Both need to work for the clinicians as well as the NHS itself.

It is high time that we saw the roll-out of shared staff banks that enable pan-regional collaboration and the fluid redeployment of personnel in line with demand. These banks could offer the flexibility and choice that has been proven to improve staff wellbeing, while also giving managers easy oversight of data and demand, enabling joined-up workforce planning, preventing understaffing and ensuring continuity of patient care.

Most importantly, it is time that workers were treated like people, rather than names on a spreadsheet. The pandemic has shone a light on exactly how important a role is played by the healthcare temporary workforce, and this lesson should not be forgotten as we move forward. By putting people back at the centre of workforce management, humanity is restored to healthcare staffing, all made possible with the right user-friendly digital tech. This is the change that all staff groups have been crying out for, for too long. This is the change that will save money, save administrative time, and keep talented, dedicated people in their NHS jobs. Ultimately, this is a change that will ensure that all health and care staff are equipped to deliver the best possible care to patients.

MORE INFORMATION

Patchwork **patchwork.health**

RICHARD VIZE

The pandemic has reinforced a workforce crisis long in the making

The Covid-19 pandemic is worsening the global shortage of healthcare staff. Only sustained, concerted effort led by wealthier nations will avert a crisis.

Before the pandemic, the World Health Organization (WHO) projected that there would be a shortage of 18 million health workers by 2030, compared with demand for 80 million. While lower and middle-income countries would feel most of the pain, no-one would escape.

The pandemic looks likely to attract some people into healthcare careers while driving many more out. In the UK, inspirational stories about the contribution of nursing to the pandemic response has led to applications for nursing degrees jumping by a third to a record 60,000 this year, with surges in both school leavers and people looking for a mid-life change of direction.

But there is compelling worldwide evidence of healthcare staff suffering from depression, anxiety and insomnia during the pandemic, while industrial disputes and strikes have been seen in at least 84 countries, largely driven by poor working conditions and lack of PPE.

By September 2020, health workers accounted for roughly 14 per cent of all recorded Covid-19 cases globally, despite making up less than three per cent of the population in most countries. Research by the International Council of Nurses found that one in five national nursing associations reported increasing levels of nurses quitting, while 90 per cent reported increased numbers of nurses planning to leave once the pandemic subsided.

WHO Predictions:

- 18 million shortfall in health workers by 2030 with demand set for 80 million
- Health workers make up 14 per cent of global Covid-19 case
- Vaccinating 20 per cent of global population will require 1.1 million full-time health workers

"Countries cannot buy their way out of their workforce shortages by recruiting doctors and nurses from overseas. But they can do a great deal of damage by trying"

Richard Vize
Director, Public Policy Media

In one snapshot of staff shortages in the United States, the federal government found that on 10 April around one in eight hospitals had a critical staffing shortage, with long-term vacancies being compounded by Covid infections, staff quarantining and burnout. In Sweden in December, 13 of the country's 21 regions reported year-on-year increases in healthcare resignations.

Now every country needs yet more staff to address the impact of the pandemic on routine healthcare – experienced virtually everywhere – while ramping up their vaccine delivery programmes. The WHO believes that vaccinating 20 per cent of the global population in 2021 will require about 1.1 million full-time health workers.

"Reverse aid"

In addition to recovery and vaccination, the pandemic has served as the most powerful reminder of the need for all countries to invest in universal, resilient healthcare, adding yet more pressure to global recruitment.

The biggest risk in the coming years is that rich countries further ramp up their recruitment from developing ones, exacerbating the problem of what has been described as "reverse aid". The UK already recruits around 28 per cent of its doctors from abroad.

Recruitment agencies are targeting staff from developing countries to move to wealthier nations. One company soliciting staff in India for "lucrative pay and a high-quality lifestyle" cites the UK, Israel, Ireland, Norway, Canada and UAE as countries who would "extend a warm welcome to overseas healthcare workers".

In May, the WHO urged health ministers around the world to create another six million nursing jobs by 2030, amid fears that richer nations will again try to make up their shortfalls by attracting nurses from developing countries.

As Mark Britnell explains in his major study *Human: Solving the Global Workforce Crisis in Healthcare* countries cannot buy their way out of their workforce shortages by recruiting doctors and nurses from overseas. But they can do a great deal of damage by trying.

Wealthy countries need to increase substantially the number of doctors and nurses they train. England has taken a step in this direction by establishing five new medical schools. Importantly, they are located in areas which have traditionally struggled to attract sufficient medical talent, including East Anglia, Sunderland and Lancashire. Other countries need to follow this model.

Across the globe, national data on doctors and nurses obscures huge regional disparities, with almost every country struggling to ensure

sufficient coverage in rural and poor areas. In the US this is sometimes referred to as the "North Dakota problem", with doctors attracted to the lifestyle and income of places such as California rather than the country's poorer and remote areas.

As Britnell highlights, the need is not simply to recruit ever more staff to perpetuate existing care models and ways of working, but to encourage the rapid and large-scale adoption of new care models which improve prevention and healthcare productivity. Care assistants and other support staff need to be recruited en masse to straddle the boundaries between health and social care to deliver services in communities, hospitals and homes. Among other benefits this will free health professionals to practice at the limits of their clinical skills, supported by technology such as clinical decision support tools which will improve quality and safety and deliver more time to care.

The pandemic has also driven home the need to invest in public health staff to deliver vital work such as vaccine programmes, child and maternal health support and tackling obesity. About 350 million adults in Europe alone are now classified as overweight, and about half of these are obese.

Covid-19 is reinforcing old problems rather than creating new ones. Just as the disproportionate impact of Covid-19 has heightened our awareness of issues such as health inequalities and overcrowded housing, it has driven home the need for a global focus on increasing the size of the healthcare workforce, as well as reminding us of the importance of supporting the physical and mental wellbeing of each member of staff. And it is the wealthy countries that need to take the lead.

DR ANNA BRITTEN

Upskill radiographers to tackle the cancer backlog

Investment is needed in workforce development to make the most of radiotherapy professionals' abilities and deliver sustainable, modern services.

With Covid-19 cases still high, restrictions lifting and a predicted backlog of 13 million waiting for cancer treatment across the NHS, one thing is clear – we must act quickly to keep pace, and eventually put an end to the ongoing crisis in cancer care. Cancer services have adapted to the Covid "new normality" while attempting to treat in a timely manner all the cancer cases that have arisen before, during and after the multiple lockdowns.

Radiation therapy is well placed to help tackle the cancer care backlog, but improvements need to be made to services as they currently stand. With investment and recognition of the capabilities of staff to take on different responsibilities, alongside the use of innovation and technology to create faster workflows, it is possible to significantly increase capacity, improve quality of life and save lives.

The impact of Covid on cancer care

Cancellation of surgeries during lockdown is not the sole cause of the current care crisis. The change in primary care to online booking, with video or phone consultations, has led to a reduction in two-week wait cancer referrals. This has resulted in tens of thousands of patients needing urgent investigations and treatments.

The spectrum of Covid-related harm for cancer patients is wide and varied. It includes halting screening and prevention efforts, delaying timely diagnosis and staging of new patients, delaying initiation of therapy, interrupting ongoing treatment, delivering suboptimal palliative care, and disrupting clinical research. While all cancer treatments (systemic therapies, radiation therapy and surgery) were affected, radiation therapy was best able to step up to the mark, seeing the least reduction in its services (14 per cent fewer treatments compared to 31 per cent in systemic therapies and 29 to 40 per cent in surgery). There was even a rise in the use of radiation therapy as an alternative treatment to surgery.

At a May 2021 online cancer summit, All Party Parliamentary Group for Radiotherapy Chair Tim Farron MP, said that those working in cancer services

have the expertise needed to tackle the backlog. But only if ministers are willing to accept there is a crisis, deliver vital investment in cancer services and act quickly.

A flash survey by charity Action Radiotherapy in May 2021 looked at the impact of Covid on UK radiation therapy one year on. It found that, while 91 per cent of respondents felt that radiotherapy should play a significant or very significant role in reducing the Covid cancer backlog, there were also fears that the service would be unable to cope with the tsunami of cases that would be coming its way.

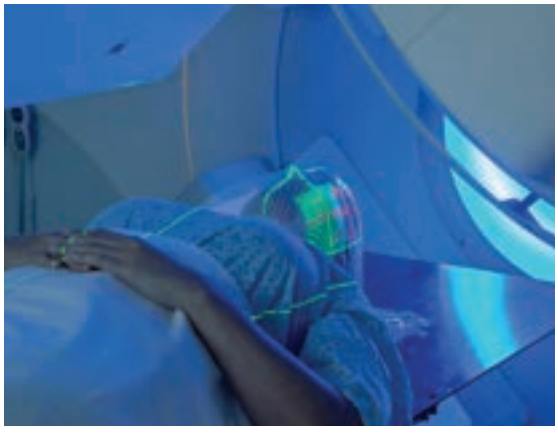
Therefore, to future-proof radiotherapy services, we need to create sustainability, which will require appropriate funding and a review of the way we currently work to drastically increase capacity.

Innovation, technology and upskilling; a bridge to better care

Most radiation therapy departments were able to continue to deliver a reasonable service throughout lockdown. However, figures from Public Health England show that 13,700 fewer patients were treated between April 2020 and January 2021, with some patients presenting with later-stage cancer who were therefore frailer than would normally be expected.

A European survey in February 2021 reported similar findings, including reduced use of palliative radiation therapy (intended to provide relief from cancer-related symptoms) and less treatment of the elderly. In addition, more treatment courses were interrupted and more curative courses of radiation therapy were given for indications normally treated with surgery. However, during this time of unprecedented conflicts, the need to adapt resulted in a move away from long-engrained radiation therapy protocols to more hypofractionation (and ultra-hypofractionation) aimed at compensating for a reduction in surgery and systemic cancer therapy delivery.

As well as adapting treatment schedules, it is also vital to recognise the abilities of staff to take on different roles that – if part of careful workforce planning – can significantly help to create capacity and introduce new technology. Focused training and upskilling radiographers to take on extra responsibilities will assist in accelerating implementation of advanced technologies, such as stereotactic ablative radiation therapy (SABR), and off-load certain tasks, including contouring, from radiation oncologists.



"There is little point in having highly sophisticated radiotherapy technology if the expert cannot use it effectively"

Dr Anna Britten
Consultant Clinical Oncologist, Sussex Cancer Centre, and Director of Medical Affairs, Elekta

Contouring is the most subjective step in the radiation therapy process and therefore prone to weakness in standardisation. But it also has the potential to significantly improve patient outcomes. It entails drawing accurately around the targets that need to be treated and the anatomy that must be avoided, thereby increasing precision and reducing side effects.

Radiation therapy technology has come a long way thanks to research and development. It is this constant innovation that is the reason why we now have accurate, fast and increasingly automated workflows for a treatment that is highly effective and very safe. With human supervision, artificial intelligence (AI) can be used to assist a fair proportion of radiation therapy workflows, ensuring greater capacity, improving access, enabling a reduction in the Covid cancer backlog and, more importantly, allowing staff to spend more face-to-face time with the patients.

However, there is little point in having highly sophisticated radiotherapy technology if the expert cannot use it effectively. This is why developing the users must happen in tandem with innovation. Education and training are therefore key to creating a sustainable and modern service, which sadly has been historically overlooked and underfunded with just five per cent of the NHS cancer budget.

The pandemic has meant that many radiotherapy professionals, radiographers included, are missing out on training and career progression opportunities. A greater importance and focus needs to be placed on this to ensure an expansion of radiation therapy services, which, with the introduction of innovations, will translate into better patient outcomes within a shorter time frame.

Elekta is focused on supporting and providing training for radiographers and radiation oncologists. Our cloud-based contouring and planning academies (ECA and EPA) deliver the necessary training to a global workforce dedicated to providing the best cancer care.

MORE INFORMATION

Elekta **elekta.com**

JO MADDOCKS

The role of 360° leadership feedback in NHS patient care

All-round performance assessments can have a profound impact on self-awareness and provide insights that develop and strengthen teams and organisations as well as individuals, even during a pandemic.

Getting leadership right in the NHS is fundamental to providing the best possible patient care, with numerous examples and evidence to support this. Some showcase outstanding leadership, others demonstrate the adverse and sometimes tragic consequences of inadequate leadership.

The role of the NHS Leadership Academy is to ensure outstanding patient care through building and strengthening leadership competencies and working with partners to deliver excellence. One such partner is PSI Services, a global assessment and talent management company. It works with the NHS Leadership Academy to provide 360° insight and feedback for leadership development and coaching.

Designed to evaluate behaviours related to nine essential NHS leadership qualities, the 360° assessment tool enables appraisal of leadership performance at individual and group level, helping to pinpoint areas where extra support is required. To date, PSI assessments have been completed by 59,000 staff and have achieved measurable improvements across the whole organisation.

PSI Services was given the role of developing a 360° questionnaire to support the competencies highlighted in the Healthcare Leadership Model (HLM360). Surrounding these competencies are desired behaviours integral to effective leadership and team-working that are measurable against HLM360.

Designed to provide feedback from several team members, assessments are completed by the individual, line managers, peers, direct reports and any other personnel that work with the individual. The resulting feedback provides a cross-section of views from which to form an analysis of performance against key competencies.

Those completing the 360° assessments are taken through a questionnaire. The answers are compiled into a performance report for the individual. The report compares the self-evaluation and evaluations from team members and aims to highlight strengths and weaknesses against the Healthcare Leadership Model.

The report forms part of a performance management review, designed to create a balance between self-awareness and the experience of others, so the individual gains a greater understanding of their strengths, weaknesses, and inconsistencies.

Figure 1: Sample performance report

Increased awareness of "blind spots"

Gary Tolometti, Learning and Leadership Programmes Manager at the Royal Free London NHS Foundation Trust, says: "The impact that the 360° reports have can be profound. We have many instances where an individual has become more aware of their blind spots and has improved dramatically as a result. Surprisingly, we often come across people who were not aware of how good they were and just needed that positive feedback to give them the extra boost and confidence to do even better. The overall impact is undoubtedly providing outstanding care for our patients."

As the 360° assessment tool is implemented across the NHS, it becomes possible to analyse data further to provide meaningful group assessments and feedback. Delivered by group facilitators, all of whom have completed training by PSI Services, the strengths and weaknesses of a group are identified to determine any additional training and coaching requirements. This information has been useful for assessing groups by NHS trust, clinical team and role.

The benefits of this 360° approach became particularly evident during the Covid-19 pandemic. The self-awareness, as individuals and as a group, allowed teams to hone their strengths to get through a period of considerable change and pressure. Operating as a fully functioning team was essential for staff wellbeing, resilience and care for patients.

Time to reflect on crisis leadership

Mandi Sherlock-Storey is Head of Leadership for NHS North East and Yorkshire Leadership Academy. During the pandemic, like many other services, she had to adapt services for NHS leadership colleagues. She says: "While a number of leadership programmes were stood down, the requirement for HLM360 feedback has persisted throughout. We are now delivering feedback sessions virtually and the process has transferred very well. Participants have consistently reported value in the opportunity to review their leadership, taking some time and space to reflect and recalibrate for crisis and recovery leadership."

A key element of the project was to enable facilitators to work with individuals to interpret and apply results from the feedback tool. PSI has trained almost 3,000 facilitators to perform this role, with consistently positive feedback; training was rated as excellent or good by 96 per cent of delegates.

Since the roll-out of HLM360, more than 25,000 feedback sessions have been completed, providing individuals with valuable insight into other people's perceptions of their leadership abilities and behaviour. This initiative has improved self-awareness and emotional intelligence, allowing individuals to identify their strengths and how best to apply them, as well as to recognise areas for continued professional development.

The assessment is available to everyone at all levels, not just those in official leadership positions, helping employees understand their own strengths and encouraging the essential behaviours required for the NHS. This in turn helps embed a culture of learning and development, with the aim of self-driven personal growth becoming the norm.

"The self-awareness, as individuals and as a group, allowed teams to hone their strengths to get through a period of considerable change and pressure"

Jo Maddocks
Chief Psychologist, PSI Services

Data to gauge training needs

Data from the assessments has also been extended to evaluate the impact of leadership development on subgroups, including different roles, regions, gender and ethnicity, demonstrating the power of 360° feedback not only for individual performance but to provide the data to better inform strategic decisions and accurately forecast training and development needs.

HLM360 has become the benchmark for ongoing performance management and PSI's research shows a statistically significant improvement in overall leadership performance, with a notably positive impact on direct reports' level of engagement.

For many, it has been a launch pad from which to improve and progress their leadership skills. David Chao, Consultant Oncologist at the Royal Free London NHS Foundation Trust, says: "This has been the most valuable and educational feedback in terms of self-development I have had in many years and possibly in my entire consultant career. All consultants and healthcare professionals should go through this exercise at regular intervals in their career."

Nine essential leadership qualities in the NHS

- Leading with care
- Sharing the vision
- Influencing for results
- Engaging the team
- Evaluating information
- Inspiring shared purpose
- Connecting our service
- Developing capability
- Holding to account

Healthcare Leadership Model, NHS Leadership Academy

MORE INFORMATION

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Digital Healthcare

ANDREW COGAN

A new model for consulting: Embracing digital delivery

Andrew Cogan, Head of Consulting at Siemens Healthineers Great Britain and Ireland (GB&I), explores how new ways of working were embedded during Covid-19 by Evelina London children's hospital and Siemens Healthineers.

The impact of Covid-19 on health systems is well documented, yet the full effect on NHS care and services remains to be seen. The NHS Long Term Plan, published in 2019, highlighted the need to do things differently, with a greater focus on planning and delivering services that meet the needs of communities. Digitalising healthcare was also made a priority, including providing better access to digital tools for staff. The pandemic has turned these ambitions into necessities, accelerating existing trends in remote work and digital adoption while demonstrating the need for different professionals to work together to better coordinate care.

Embarking on a transformation journey

In an ordinary world, delivering consulting services to one of the UK's busiest NHS trusts in the heart of London would not be without its challenges. As the UK was placed in a nationwide lockdown, the consulting team at Siemens Healthineers prepared for a different type of challenge. It was clear that traditional ways of working would need to be reconsidered as they began one of their most complex consulting projects with Evelina London.

Offering a range of services to young patients across south London and South East England, Evelina London has been caring for children and young people for over 150 years. As part of Guy's and St Thomas' NHS Foundation Trust, Evelina London aims to grow to meet rising demand for its services. It sought consultancy support from Siemens Healthineers as part of its plans for a new building attached to the existing hospital, due to be completed in 2027. The consulting team were engaged early in the process to ensure major pathways flowed and forecasted demand could be met before architectural designs were progressed.

Reinventing ways of working

Prior to the Covid pandemic, consulting workshops would take place in a traditional format, gathering stakeholders and employees from various departments in a room of as many as 80 people. These sessions would take place over several days and could continue for up to a week at a time. The main aim was to gain engagement from principal figures and to break the paradigms of existing health systems to optimise clinical workflows, pathways and patient experiences.

Evelina London has plans to grow to meet rising demand for its services

In light of lockdown measures and the social distancing restrictions that followed, initial scoping sessions took place as they never had before. These first steps into digital consulting quickly became a catalyst for deep learning and investment. Over the subsequent months, the consulting team at Siemens Healthineers developed an entirely new approach, employing a special configuration of digital tools and resources to transform the delivery of their services.

Tom Ward, Healthcare Consultant at Siemens Healthineers GB&I, led the project at Evelina London and shares his experience of the shift to digital consulting. "The Evelina London project came about just as lockdown began, meaning we weren't able to schedule face-to-face meetings. Moving these initial scoping and engagement sessions to a digital format had never been done before and this new model challenged our traditional approach."

Enabling the digital exchange of views

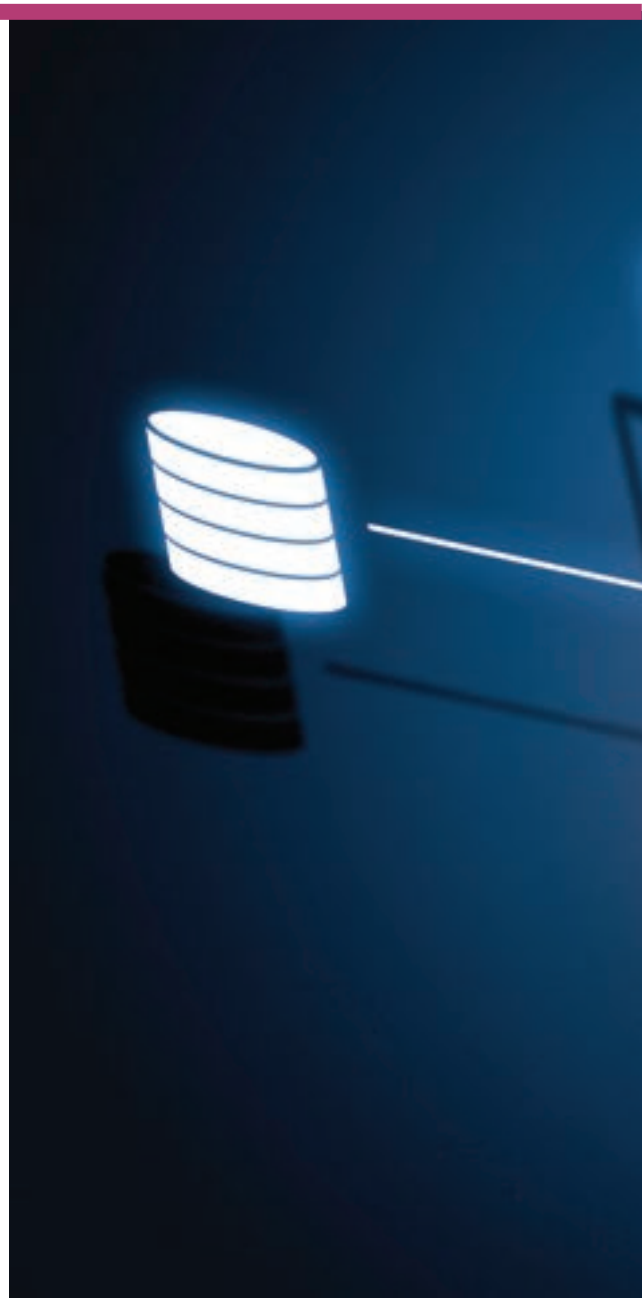
Before this, digital tools had a limited place in consulting workshops; now they are at the centre of Siemens Healthineers' provision. Sessions that once took place with sheets of paper and sticky notes are now taking place online, with virtual workshops and digital mapping software a staple of the "new normal". Attendees benefit from greater accessibility, joining sessions from wherever is convenient, including multiple hospital sites or home offices around the country.

Nick Bultitude, Head of Service Improvement at Evelina London, gives his thoughts. "We worked to bring together staff from all grades, skill mixes and backgrounds to help deliver a variety of perspectives. The agility afforded by digital delivery made the project more flexible and easier to accept for those with incredibly busy schedules.

"There were particular elements of the project that worked well virtually, with some of the more conceptual topics benefitting from being mapped out in front of us. This encouraged people to think outside of their specialisms and focus on the service as a whole. Digitally engaging with patients and families also had its advantages, and the consulting team were able to reach a more varied pool of individuals without them needing to travel to site or take time away from daily responsibilities."

"Siemens Healthineers is shaping the future of healthcare, utilising experiences of the global pandemic to reinvent consulting frameworks"

Andrew Cogan
Head of Consulting, Siemens Healthineers Great Britain and Ireland



This access to more varied feedback was true of patient spokespeople, clinicians and operational stakeholders, agrees Dr Claire Lemer, Paediatric Consultant at Evelina London and Evelina Expansion Clinical Transformation Director. "People go into healthcare because they want to make a difference but can sometimes become frustrated when faced with bureaucratic processes. This can hold individuals back from making changes and trying to improve."

Dr Lemer continues: "This kind of work, where you have clinical and non-clinical staff all in one place, recognises the value of their knowledge and empowers people to get involved. Engagement at that early stage from such a varied group helps to

inform change and build cross-team relations while preparing staff for when these methodologies are eventually introduced."

Shaping the new model for consulting

"Overall, we're very pleased with the outcome of the project", concludes Nick Bultitude. "A hybrid approach to consulting projects should be considered in the future. The use of digital tools helped to reassure us that we can achieve what has been set out in our proposal for expansion, and simulation resources helped to inform the design of space, workforce and flows to get maximum efficiency."

Covid has exacerbated existing challenges to the UK's health service and the impact of growing waiting lists and dwindling referrals suggest we are yet to see the true consequences of the past year, but the pandemic has provided a unique opportunity for change. "Covid-19 has expedited the adoption of digital tools", states Tom Ward. "The pandemic has extended our toolbox, and that's true in other areas of the health service too. Rather than replicating previous ways of doing things, we have openly welcomed this mindset of change and incorporated tools that allow greater engagement, process mapping and simulation to add value to our service."

Siemens Healthineers is shaping the future of healthcare, utilising experiences of the global pandemic to reinvent consulting frameworks. Looking ahead, the consultancy team continue to research and embed new methodologies and tools to help the NHS optimise operations, expand capabilities and advance innovation.

MORE INFORMATION

SIEMENS Healthineers siemens-healthineers.com

Final Word

The impact of our "recovery" must be felt equally

No one should be missing out on vital diagnosis or life changing treatment. With the latest NHS England figures showing 5.45 million people are waiting for hospital treatment in England alone, efforts are required to shorten waiting times across the board. Lessons must be learned from the stark health inequalities exposed during the pandemic, and solutions rapidly implemented with the crises not even yet behind us.

The mortality rates from Covid-19 unveiled a conglomerate of health inequalities in the UK. The first and second waves saw Black people and Pakistani and Bangladeshi people faced with the highest mortality rates respectively. These have also varied regionally, with mortality rates being almost three times as high in the most deprived areas of the country. The major efforts of the vaccine programme to address specific communities and build towards equity were essential in the pandemic response.

The NHS implemented two categories of initiatives, information and education and outreach. These were focused on sharing vaccine information to those who might not find it readily available, such as through a webinar or translated from English. It also involved making the vaccine more accessible in the community, including providing transport to a vaccine site. Crucially, initiatives were tailored to suit the specific needs of each community and the individuals who experience inequality.

While tackling health inequalities is outlined in the NHS Long Term Plan, now is a key moment to continue building on this commitment; taking it from plan to action. Disparities in access, experience and outcomes existed before the pandemic and in some instances, these inequalities have widened. During 2020, access to elective treatment fell further in the most deprived areas of England than in wealthier areas.

NHS England and NHS Improvement have issued guidance, as part of their commitment to tackle inequalities, to use data and local evidence to inclusively restore services. It is crucial to understand and target which groups might risk being left further down or worse entirely left off the waiting list. The NHS workforce is already working at maximum capacity, so the government must support efforts to reduce the backlog and enable initiatives like reducing inequalities in vaccine uptake.

No member of the population should be at a disadvantage due to circumstances out of their control. While restoring services and shortening waiting lists is crucial to lives across the nation, it will not truly benefit the whole population unless health equity is considered at every step of the way.

Niamh Macdonald
Deputy Editor, Hospital Times
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Community Diagnostic Hubs

Partnering to deliver the vision

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Siemens Healthineers has long been an advocate of community diagnostics, developing solutions to improve patient accessibility.

We are now working closely with our NHS partners to establish community diagnostic hubs (CDHs). These will support the separation of acute and elective diagnostics, providing extra capacity away from the traditional hospital setting.

We understand that every community diagnostic hub will be unique, influenced by integrated care systems and local patient pathway requirements.

As a trusted partner, we can help to piece these together and deliver your vision for community diagnostics in a sustainable and cost-effective way.

Find out more in our brochure, CDH: Partnering to deliver the vision

SIEMENS Healthineers