



Northampton General Hospital
NHS Trust

DELIVERING HUMAN VALUE

THE ECONOMICS OF HEALTHCARE
AUTOMATION IN LARGE-SCALE
HEALTH SYSTEMS



AutomationAnywhere.com/MakeWorkHuman/NHS

CONTENTS

Preface.....	3
Foreword.....	4
Series introduction.....	6
1. Executive summary.....	7
2. Unlocking value.....	8
Why calculating value matters.....	8
How is value measured?.....	10
Evidence criteria.....	12
3. Automation Viability Assessment (AVA).....	14
Short-term v long-term decision-making.....	15
4. Real life examples.....	16
HR examples.....	16
Finance examples.....	20
Clinical example.....	22
5. Conclusion.....	25

This series of papers present a vision of how Robotic Process Automation (RPA) can be a force for good across the global healthcare industry. This paper uses economic analysis from the UK's National Health Service (NHS) and their RPA Centres of Excellence to show how RPA can not only generate excellent Return on Investment (ROI) but also create added value in all sorts of other ways for the people working in it and those who rely on the services it provides.

Author



Dr. Ana Ohde
Senior Health Economist
(Northampton General Hospital NHS Trust, UK)

Contributors



Tremaine Richard-Noel
Head of Emerging Technology & RPA Programme Director
(Northampton General Hospital NHS Trust, UK)



Neeti Mehta Shukla
Co-founder, Social Impact Officer
(Automation Anywhere)



Dr Yan Chow, MD, MBA
Global Industry Leader, Healthcare
(Automation Anywhere)

FOREWORD



There is nothing like a pandemic to trigger superhuman feats in healthcare. Northampton General Hospital NHS Trust (NGH) and Automation Anywhere came together in 2020 to support the adoption of intelligent automation across the UK National Health Service (NHS), one of the largest healthcare systems in the world.

The NGH Automation Accelerator programme currently supports automation within over 35 NHS organisations nationwide and more than 250 local doctors' (GP) practices.

We seek to generate productivity efficiencies by developing automation solutions that:

- involve high volume transactional processes
- present significant time-gain opportunities
- unburden staff from repetitive, low value tasks

This paper illustrates the many types of value that automation of repetitive process can bring about in the NHS, including positive outcomes for clinical and non-clinical staff as well as for patients. The economic analysis used, which considers both short- and long-term added value, is applicable in all large healthcare systems around the world.

We are excited to have worked on this whitepaper with the NHS team so that we may pay it forward, to have all large healthcare systems and hospitals benefit from and build upon the experiences of the NHS.

Neeti Mehta Shukla

Co-founder, Social Impact Officer
(Automation Anywhere)

SERIES INTRODUCTION

One of the largest organisations in the world, the UK's National Health Service (NHS) has become a beacon for the world on how Robotic Process Automation (RPA) should be built and delivered to conserve precious organisation resources, and ultimately thousands of human lives.

This series of papers considers how the NHS's RPA journey will change the way healthcare systems around the planet view technology, and how intelligent automation can serve their patients and staff. Throughout this series, we're considering how RPA can, and should, be a force for good within modern healthcare systems across the globe.

We're putting a human lens on how RPA can help healthcare systems work smarter, not harder. We're interrogating what RPA really means, and asking "so what?" at every level of healthcare:

- at an industry level, including our expectations for the future of RPA in healthcare
- for the individuals and teams across the sector, and why culture change management is so crucial
- across organisations and businesses, including the operational impacts of RPA and the tight cyber security measures that come into play
- for patients, and how digital transformation through technology such as RPA can impact and improve the delivery of excellent patient care and experience

The first paper in this series, **RPA: A Force for Good in Healthcare**, set the scene for the adoption of RPA in the context of the National Health Service (NHS) in the UK, looking at how the Covid-19 pandemic had accelerated the need for innovation and how automation can optimise NHS staff working practices.

This second paper of the series uses a health economics lens to explore the human value as well as the financial value of transforming healthcare using RPA.

EXECUTIVE SUMMARY

In this paper, we use a health economics lens to show how RPA can help healthcare systems work smarter, not harder, for organisations across the sector, for the individuals and teams who work in them, and not least for the benefit of excellent patient care and experience.

We demonstrate how to measure and evaluate the cost-effectiveness of a range of RPA applications in a large-scale healthcare system, taking account of the human value that automation generates on top of the pure financial benefits.

We consider the people and processes involved in transforming healthcare with these tools and explore the intrinsic tensions between short-term investment and long-term benefits in the context of increasing budgetary constraints.

Not only does the transfer of repetitive processes from humans to bots save time, but it also reduces error and improves staff morale. This can have spin-off benefits for patient outcomes.

Our aspiration to improve the way people work is underpinned by our drive to create robust processes that optimise resources and add value in a way that shapes innovation across healthcare.

The NGH Automation Accelerator programme has had to prove its worth against the many hurdles that any proposed intervention in the UK National Health Service must surmount to show that it adds net value. If RPA is accepted by the NHS, it must surely be attractive to all large healthcare systems around the world.

2. UNLOCKING VALUE

Why calculating value matters

In economic analysis, alternative competing courses of action can be assessed by considering the value each generates and the costs each requires. The net value is the benefit remaining when costs are deducted.

In healthcare, benefits can come in many forms – for example, improved patient outcomes or more effective use of scarce resources. These are not always easy to measure, but being able to translate benefits into monetary terms is helpful when comparing what might seem like apples and pears. Expressing benefits as numbers give clarity: the numbers matter.



Economic analysis has made a powerful contribution to help us identify how the human value of RPA can be assessed alongside pure financial improvements when making a business case for change.

Tremaine Richard-Noel

Head of Emerging Technology & RPA Programme Director
Northampton General Hospital NHS Trust

When evaluating whether or not to implement a new intervention, standard practice is to compare the net value of that intervention against a 'do nothing' or status quo scenario.

This is particularly important in a large healthcare system such as the NHS, which provides healthcare free at the point of delivery to all citizens. Resource allocation follows the principle that goods provided have to maximise the benefit to society in a heavily regulated environment. Finite resources must be allocated carefully to allow services to be operated fairly and effectively for the whole population.

As with all large-scale healthcare systems, rigorous evaluation of programmes designed to generate efficiencies is essential to ensure that those resources are directed where they will create the greatest value.

In this paper, we use economic analysis to evaluate what net value various types of RPA might generate if they were introduced compared with the status quo. The conceptual framework we use is illustrated in **Fig. 1** below.

The Value Equation



Fig. 1: Conceptual framework for economic evaluation

How is value measured?

In lay terms, people ask whether an intervention is ‘value for money.’ In practice, there are many ways to assess this.

A commonly used financial indicator is Return on Investment (ROI). This is a ratio calculated as the gain or loss from an investment relative to its cost. Although ROI can be a useful marker to evaluate financial return, it can fail to capture other intrinsic or counterfactual benefits.

In healthcare, a new programme of care or intervention may lead to benefits in one or more of the following:



Clinical/Physiological Measure



Clinical outcomes measured by care professionals as part of their intervention



Patient Reported Outcome/Experience Measures (PROMs or PREMs)



The perceptions of patients and service users about the effects of care on their health or the way in which care was delivered



Operational Outcomes



For example, increases in flow rate through a care system to reduce wait times, such as in the Emergency Department or from referral to treatment



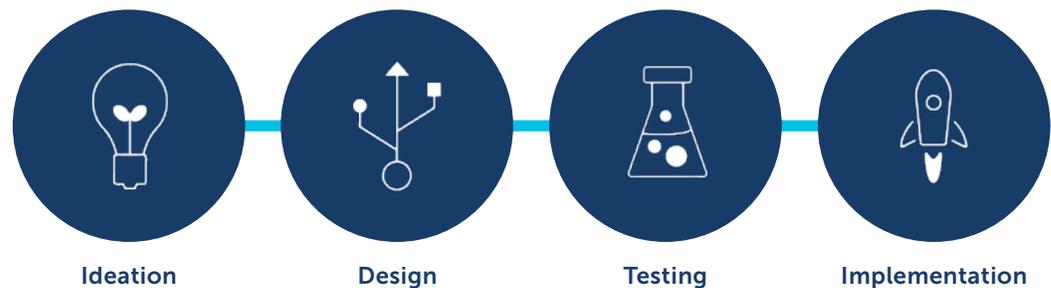
Human Resource Management (HRM) Outcomes



Improved morale and wellbeing of clinical and/or non-clinical staff, which may lead to higher productivity

In this paper, we particularly focus on the last of these, since RPA is most concerned with improving work patterns. Humans conducting repetitive manual processes can be relatively slow and error-prone. Automation can reduce error rate and time lost. Consequently, more output can be generated for the same cost or the same output for lower cost. This means productivity increases.

Given the significance of HRM impacts from RPA, we found that it is important to involve subject matter experts early – from the **ideation** phase through to **design, testing** and **final implementation**.



Their experience helps identify the additional benefits which might otherwise be hard to recognise given the heterogeneity, dependencies and diversity of administrative processes in the health sector.



It's proved invaluable to learn from all the subject matter experts at the ideation phase of automating a new process. Without their help, we wouldn't so easily be able to recognise the vast number of ways in which RPA contributes to better patient care.

Jade Ackers

Programme Director – Digital Productivity Transformation Directorate
NHS England

By contributing towards greater organisational efficiency, RPA can, for example, increase staff motivation, which in turn may have positive effects on the three other types of outcome above.

Targeted RPA can impact clinical outcomes indirectly. For example, automating an appointment list checking procedure might, in addition to creating administrative time-saving, reduce the clinical risk to patients who miss an appointment booking due to human error.

When indirect outcomes are achieved, there is a question of how these should be weighted. For example, where an intervention which is cost-neutral compared to the status quo improves a key health outcome, this might be given extra weight if the outcome aligns with strategic priorities or policy interventions.

Where a patient or service user values an outcome highly, this might also be given extra weight relative to one that is felt to be of more marginal benefit.

Similarly, if an intervention releases clinical time, this might be weighted more heavily than one which frees up the same amount of clerical time, since in purely financial terms the cost of a specialist doctor is three times that of an average clerical role, partly due to the scarcity of clinicians and nurses in the UK market. Account must be taken of the effects on clinical time released by interventions, even if these are primarily aimed at clerical staff.

Evidence criteria

What type of evidence do we need to consider when measuring the value of an intervention in healthcare? The NGH Automation Accelerator programme has had to surmount many barriers to prove its worth.

Real-World Evidence

Randomised clinical trials (RCTs), which study carefully curated subgroups of patients under strict conditions, have been the gold standard to develop scientific evidence to support the use of new medicines and other interventions. However, 80% of the factors that contribute to a patient's health status lie outside the traditional bounds of a health system. These include the patient's income, location, education, behaviour and so on. To improve health status, one must consider the impact of these non-medical factors. Thus, health authorities are now [emphasising the importance of real-world evidence \(RWE\)](#). Whereas RCTs study smaller subsets of patients, RWE studies look at broader, more complex 'real-world' populations.

Triple Aim

On top of this, the UK Government has stated it is no longer sufficient to consider the immediate impact of an intervention on a patient's health outcomes alone. Its [reform of health and social care](#), taking effect from July 2022, puts a duty on NHS bodies that commission services together 'to have regard to the wider effect of decisions.'

This so-called 'Triple Aim' requires NHS bodies that commission and provide services to consider the effects of their decisions on:

- **the health and well-being of the people of England** (including inequalities in that health and well-being)
- **the quality of services provided** or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services)
- the **sustainable and efficient use of resources** by both themselves and other relevant bodies.

Some commentators have added a fourth aim, namely that the effects of an intervention on the work life and well-being of care professionals should also be taken into account.

Since there has recently been an upsurge of investment in digital innovation in the NHS, it is important for RPA technologies to be able to show that they meet the requirements of the Triple – or Quadruple – Aim.

NICE Evidence Standards Framework

In the UK, the [National Institute for Health and Care Excellence \(NICE\)](#), which provides guidance to the NHS, has developed its own Evidence Standards Framework (ESF) to ensure that new health technologies are clinically effective and offer economic value.

The ESF aims to make it easier for commissioners to make informed and consistent decisions about the level of evidence presented to them. This approach is meant to be dynamic and value-driven with a focus on offering real value to patients and the system. It follows a risk-based functional classification stratified as Tiers, where the burden of evidence demanded is proportional to the risk to patients. Automations fall in Tier A as innovations that impact on the system rather than patients directly, and therefore require only minimum standards of evidence to be presented to demonstrate acceptability. This indicates NICE's readiness to consider digital innovation as a force for good in health.

The framework used to assess the compliance of RPA interventions with NICE's ESF is shown in **Fig. 2** on the next page.

How to apply the NICE evidence standards framework



Fig. 2: Framework for assessing compliance with NICE ESF

3. Automation Viability Assessment (AVA)

The Automation Viability Assessment (AVA) tool, developed at Northampton General Hospital NHS Trust (part of the University Hospitals of Northamptonshire Group), offers a mechanism to assess whether an RPA offers a value opportunity. This analytical tool has been designed by the Automation Accelerator team to support the evaluation and prioritisation of competing RPA use cases.

The principles employed for the measurement of RPA use cases are **relevance** to the intended purpose, **proportionality** in data capture to measure effects, **discrete number of indicators** that focus on the primary outcome and removal of **optimism bias** by objective quantification.

AVA examines a range of factors to calculate technical efficiencies:

- 

The time saved from the implementation of the automation from a payer perspective, including error correction and seasonality factors
- 

The direct or indirect health outcomes derived from the RPA
- 

Additional counterfactual savings from a broader perspective
- 

The initial and ongoing costs of implementation given by complexity factors
- 

The time horizon or duration of the automation

The output from this assessment early in the process gives a solid justification for the continuation of the project.

The AVA output is expressed as a decision matrix that consists of a short-term (year one) net benefit computation on one axis, and the expected health outcome effects on the other (as collected from subject matter experts in the early engagement phase).

In the UK, NICE recommends adopting new health technologies that demonstrate a cost-per-Quality Adjusted Life Year of at least £20,000 to £30,000. It is thus prudent to consider interventions that have a positive health impact on patients at a relatively low additional marginal cost.



Fig. 3: AVA matrix

The AVA matrix (**Fig. 3 – Above**) supports decision-makers ‘to accept’ or ‘not to accept’ the innovation while allowing for an ‘indecision frontier’. This ‘grey area’ captures projects that show a demonstrable positive impact on health outcomes but where return on investment is cost neutral or slightly negative.

Short-term v long-term decision-making

In the NHS, financial flows are such that there is typically a focus on in-year cost efficiencies. However, it is important to assess financial metrics across the life cycle of an automation, as some projects that are initially cost-neutral or cost-negative in year one will yield a significant positive return in year two or even year three.

As a result, some interventions, for which the true value is manifest only after longer than one year, may be rejected and the health system deprived of its benefits. This is why it is important that clear expectations are set out not only for the size of returns, but also when these returns might be realistically delivered. There may sometimes be a case for staged planning, where stage B decisions are made only after stage A results, to allow some agility, flexibility and recognition of uncertainty.

4. Real life examples

Automation Anywhere applied the AVA tool at Northampton General Hospital (NGH), at Black Country Healthcare NHS Foundation Trust and at George Eliot Hospital NHS Trust to evaluate the potential benefits of RPA in several different scenarios, described below. We look at five examples in particular, although they are merely representative of thousands that we are in the process of implementing.

HR examples

HR mailbox and attachment sort

At NGH, the payment system for staff whose employment status has changed either because they are leaving, are joining or have had a change in contractual circumstances requires an email and attachment to be sent to the HR team. Members of this team have to monitor an inbox for these emails, open them, check them for accuracy (returning them if incorrect), classify them, save the attachment in one of three different folders and then archive the email. Performing this simple repetitive process day after day is tedious and management find it difficult to keep people motivated in their roles.

The task takes over 12 minutes and is carried out on average 52 times per working day by each member of staff, who are on the administrative Band 4 salary on the NHS pay scale. In high recruitment periods, transactions increase. Using this information, and smoothing over the year to take account of seasonal variations, we can calculate the cost of the process to the NHS, which determines the value of the productivity gain if the process can be removed from manual intervention.

Looking at the alternative, automated process, the implementation cost is a function of the build complexity. Since this is a relatively simple process containing few steps and one decision point, no loops back and few applications, the build is graded as low to medium complexity and the cost is determined accordingly.

To consider benefits of the RPA, we assess the time-gained value of the productivity associated with removing the repetitive task from the HR team and any direct or indirect impacts.

This high volume transactional process presents a time-gained associated technical efficiency of circa 2,400 hours per annum. The net benefit in Y1 is £27,519, and extending the time horizon to Y3 offers a cumulative productivity gain of £163,244.

The process does not impact patient outcomes directly or indirectly, so it ranks low on the health outcome measure. However, if mistakes are made, staff are not paid on time, which can be sensitive. Feedback in interviews from subject matter experts in HR shows that errors create not only ill will among staff, but also potential reputational damage.

“If you’re known as an employer who doesn’t pay on time, it hurts your reputation among recruiters as well as staff.” - HR specialist

This leads to additional value being placed on the automation as a result.

The cost of implementation is deducted from the valuation of the benefit to the NHS to generate a net value for the short and long term. Plotting the cost against the net value using the AVA tool then identifies whether the RPA should be accepted or rejected – or whether it sits in a grey area.

For this process, the result falls in the decision quadrant to ‘Accept’ (see Fig. 4).

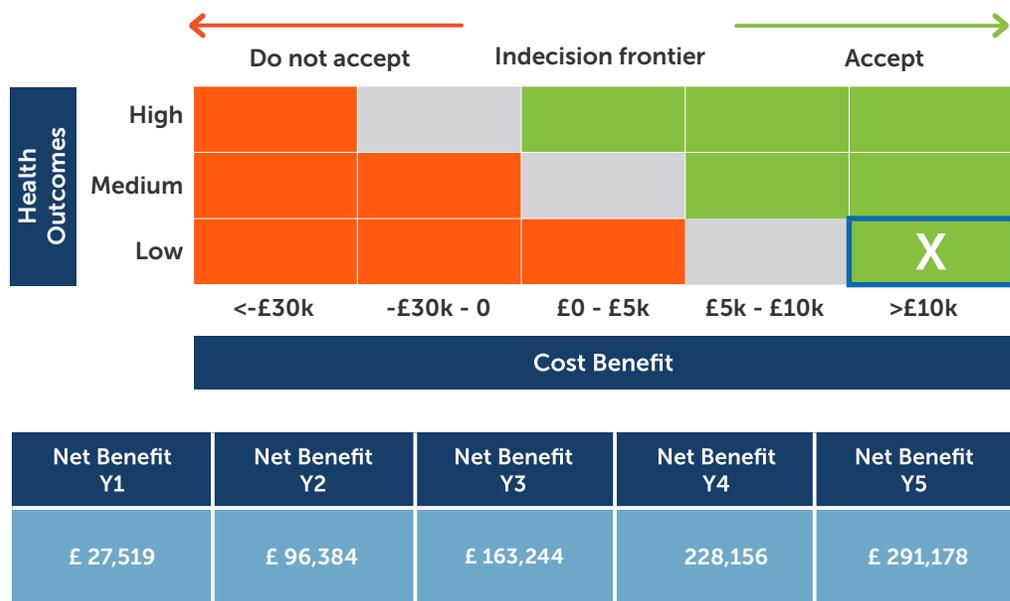


Fig. 4: AVA plot for HR mailbox and attachment sort

The decision to develop this automation was favourable, not only because of its financial implications but because of the impact on staff and the added reputational benefit to the trust.

Sickness triggers

Since the NHS is concerned to ensure staff well-being while at the same time wishing to prevent and address unreasonable absence, it employs HR procedures to monitor and support personnel who report sickness absences frequently. Policy thresholds are set for absences of certain types and frequency, triggering a sickness review when the threshold is passed.

The process involves creating a list of personnel who have had any form of sickness within the last month. The HR team will calculate who has reached the trigger point defined in the organisation policy and, for those concerned, notify their manager to conduct a Stage 1 absence meeting.

This can be a never-ending, time-consuming and inefficient exercise as the sickness dates need to be calculated and the data is often out of date by the time it is accessed. A member of staff could have accrued further absences by the time the report is produced.

Automation reduces time in the management of absences and flags early warning signs when a member of staff needs help. According to subject matter experts, the counterfactual benefit derived from not missing preventable absences, although difficult to predict, presents a further productivity opportunity in time gained and less reliance on bank and agency cover.

“Preventing staff abusing sick leave can save on scrabbling around at the last minute to find high-cost agency cover.” - HR expert

Another added benefit is the reduction of errors due to manually calculating triggers, often using outdated information.

“Sometimes we waste time with a Stage 1 absence review when the individual has not actually passed the threshold – just because of poor data.” - HR expert

The manual calculation process occurs monthly and involves approximately 700 transactions taking an average time of 15 minutes each per member of staff. The seasonal component can be accounted for with a smoothing adjustment over the whole period of 3%.

The pure transactional process represents a time-gained associated productivity efficiency of over 1,990 hours of clerical personnel per annum if it is automated.

Besides the evident productivity gains, when deciding whether to go ahead with this process consideration was given to the value offered from a wider perspective. Enhancing the capability of the team to act in a timely manner and tackle problems that may escalate if measures are not put in place was regarded as a priority.

The pandemic has placed an extra burden on already stretched health workers leading to exhaustion and raised levels of anxiety that in turn demand a higher level of alertness and support from managers. Generating early warnings to prevent absenteeism was considered a core objective in the department where RPA had an important role to play.

“Spotting someone early who has an underlying health issue – a stress-related mental health issue for example – can be invaluable in helping the employee and helping the Trust.”- HR expert

In terms of the cost of automation, the build is of low complexity and carried out by administrative staff on a salary scale ranging from B3 to B5. We take a conservative approach regarding the life-cycle of the automation, treating it as three years, although it is highly likely that the time horizon of this RPA extends beyond this.

This results in cumulative net benefits in year one of £20,029, of £74,203 in year two and of £126,799 in year three.

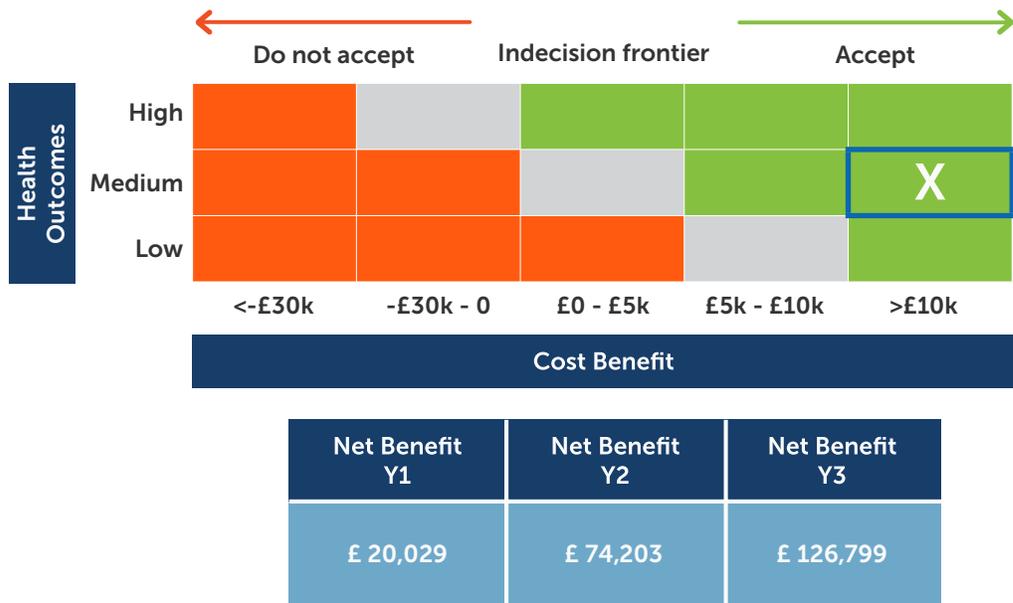


Fig. 5: AVA plot for sickness triggers

Finance examples

GP batch load

When a patient registers with a new General Practitioner (GP) practice, their electronic care record must be updated to include the details of the new doctor's name and practice. This administrative process is critical to keep patient records up-to-date and to link core registers to service provider payments.

Checking for and correcting discrepancies in the register is a weekly process. It takes five minutes on average for each transaction and there are approximately 250 transactions per week. The pure time-gained associated productivity efficiency resulting from automating this high-volume transactional process represents over 4,500 hours of clerical personnel per annum.

Besides this, subject matter experts identify other benefits. Clinical or confidentiality risks may arise if a patient in need of an intervention cannot be reached and treatment is delayed or another GP is contacted due to errors in the patient record.

"We've had critical scan results be sent to the wrong GP when a patient moves house. This can delay treatment and compromise patient care."
- Practice manager

Implementing the automation is graded as medium complexity to be carried out by administrative and analytic staff on a salary scale B4/B5 and the life cycle of the automation is conservatively regarded as three years.

On this basis, cumulative net benefits are assessed as £97,460 in year one, £232,251 in year two and £363,116 in year three.

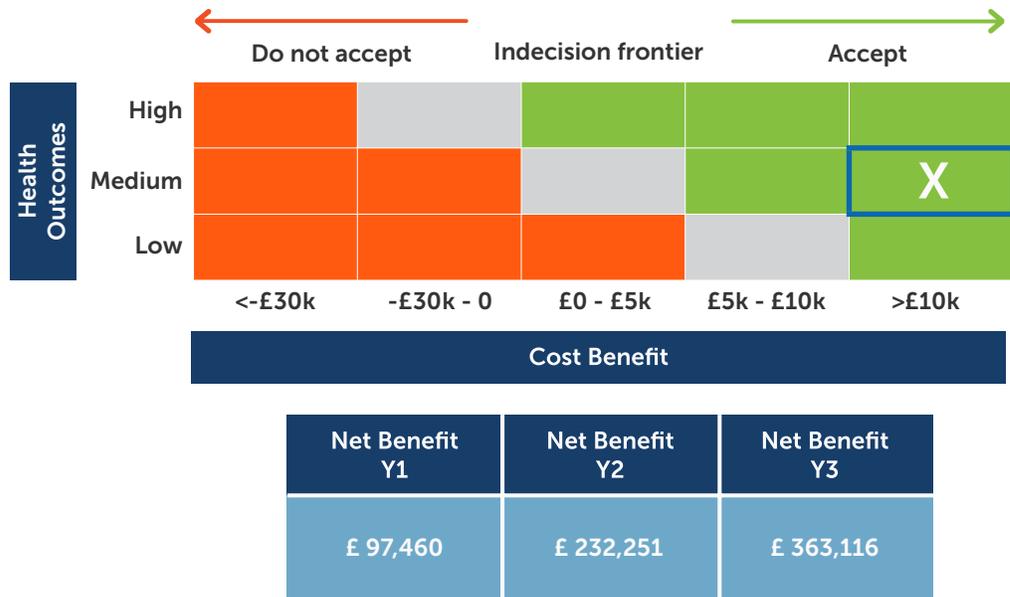


Fig. 6: AVA plot for GP batch load

Invoice processing

Invoice processing consists of reviewing invoices for payment to agency staff who work in the Trust on a temporary basis. The finance team receives these as an attachment via email and has to take a number of steps to match the invoice to a register and verify the details to trigger payment to the agencies that provide the personnel.

This is a laborious, high volume, repetitive task linked to payment schedules within the hospital. It occurs on a daily basis, involving approximately 1,120 transactions with an average time of five minutes each. The pure time-gained productivity efficiency associated with automation represents over 20,500 hours of clerical personnel per annum.

Subject matter experts note that if agencies are not paid in a timely manner, they may refuse to provide staff to the hospital. If optimum capacity levels cannot be met, this affects the Trust’s ability to care for patients safely, with potentially damaging clinical and reputational consequences.

“It’s a competitive market for staff out there. If you muck up payments, agencies can take their personnel elsewhere.” - Finance expert

“When we’re short-staffed, it really represents a risk to quality of care – and our CQC ratings.” - Senior manager

To automate this process is graded as of medium complexity for administrative staff on salary scale B4 and the life cycle of the automation is conservatively regarded as three years.

On this basis, cumulative net benefits in year one are £660,047, in year two £1,325,130 and £1,970,842 in year three.

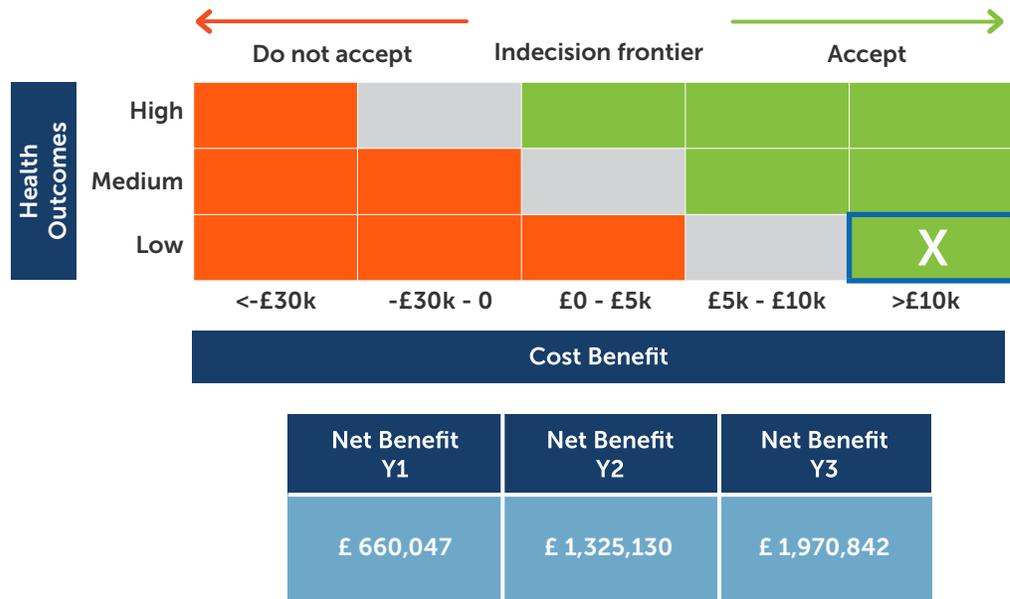


Fig. 7: AVA plot for invoice processing

Clinical example

Referral to treatment (RTT) pathways

Following an outpatient appointment, clinicians record the patient outcome, which typically will be one of the following:

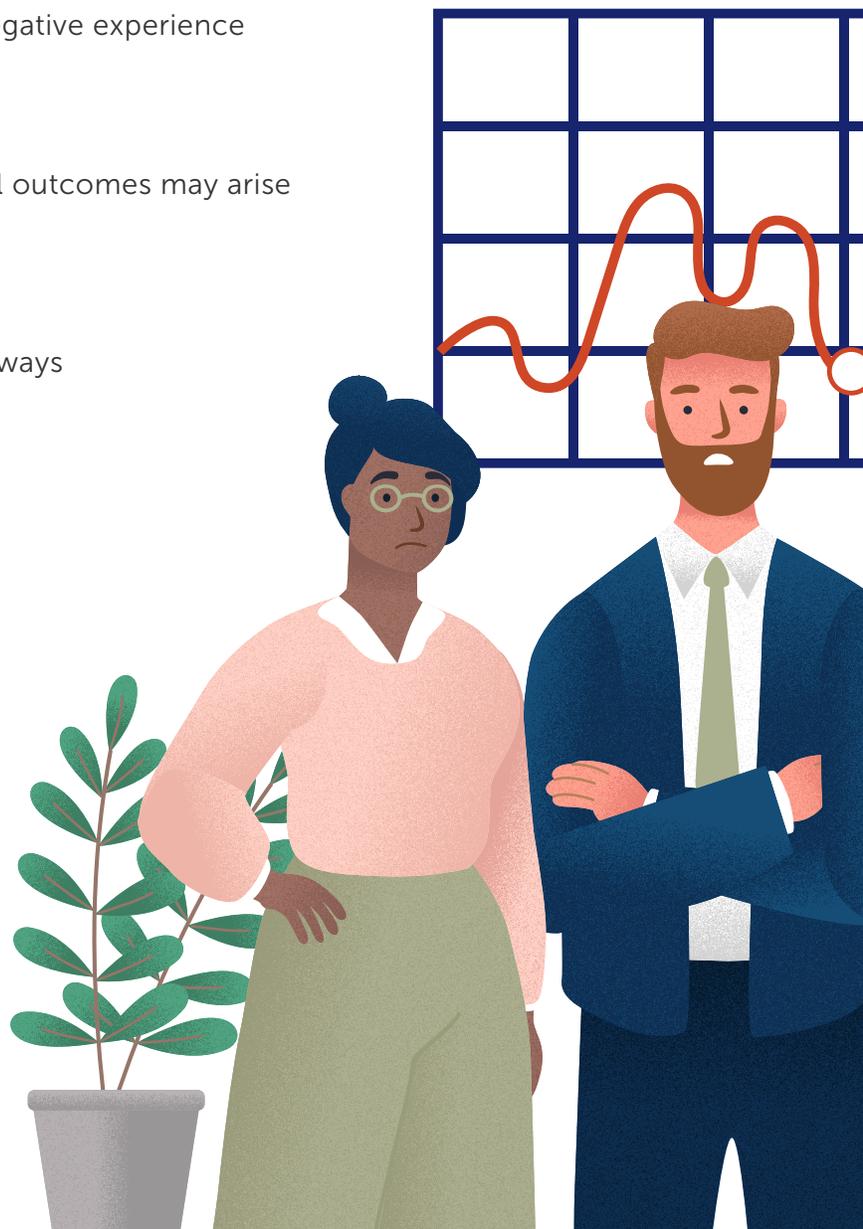
- The patient may need to be added to the waiting list for a clinical appointment or sent for a diagnostic test
- A response is required by the clinician or the patient for a decision to be reached, triggering further waiting
- Treatment/advice has been given and the patient is discharged
- The patient refused treatment

The information is captured by the clinician in an Excel spreadsheet on a portal and sent as an attachment via email several times a day. This is processed into the hospital clinical system, which updates the patient's status on the Referral to Treatment (RTT) pathway.

This high-volume transactional process occurs on a daily basis, with approximately 560 transactions taking an average of six minutes each. The pure time-gained productivity efficiency associated with automation represents around 12,500 hours of clerical personnel per annum, without taking account of additional time required to correct any errors arising.

The manual nature and intricacy of these tasks, which involves having to print information and alternate between systems, generates delays in the RTT pathway and can lead to inputting errors. According to subject matter experts, if errors are made several unfavourable outcomes are possible:

-  Patients may be missed or misplaced on the waiting list
-  Patients may have a negative experience
-  Adverse patient clinical outcomes may arise
-  Delays in elective pathways
-  Reputational damage
-  Financial penalties



“Patients find it so frustrating if the follow-up to their appointment doesn’t go as they expect – and who can blame them?”
- Senior NHS manager

“If we keep getting referrals wrong, it’s bad for patients and it’s bad for the Trust.” – Senior NHS manager

In terms of implementation cost, administrative staff on a salary scale B3 to B5 carry out the activities related with this automation which is graded as of medium to high complexity. These estimates are currently being reviewed as the project involves a few stages where statistics change depending on the breakdown of tasks involved in the end-to-end automation. The life cycle of the automation is conservatively regarded as three years.

Net Benefit Y1	Net Benefit Y2	Net Benefit Y3
£ 363,340	£ 748,749	1,122,932

Taking all this together, cumulative net benefits are £363,340 in year one, £748,749 in year two and £1,122,932 in year three.

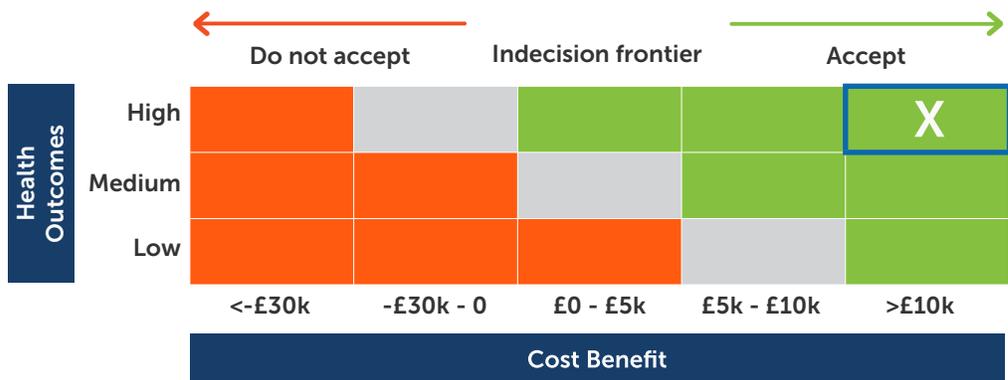


Fig. 8: AVA plot for RTT pathways

Conclusions

The five examples above are just an illustrative snapshot of over 3,000 such automations underway in the NGH Automation Accelerator programme. They show that RPA can make a valuable contribution to healthcare, not only from its direct effect on increasing productivity by transferring tedious repetitive tasks away from staff, but also through a range of indirect effects. These can only be appreciated by involving subject matter experts from an early stage in an assessment of the problem and its solution. Their input can surface a whole range of benefits that would otherwise be invisible.

Taking account of these indirect outcomes and giving due consideration to the length of time over which the benefits will be realised is the most appropriate way to assess whether or not to implement an automation solution.

Using this economic analysis, we have found that each automation introduces added value ranging from tens of thousands to millions of pounds.

Experience in the NHS, which is particularly rigorous in its evaluation owing to its public funding and highly regulated nature, suggests that the potential benefits of automation are enormous for large-scale healthcare systems worldwide.

It is so imperative and immensely helpful to evaluate with an economic lens the value that technology can bring to a large scale operation like the NHS. Even more important is to understand the human value it delivers every day.



The value of an automation programme is that it can be amplified at scale simply by following a sequence of steps based upon past work and reusable modules. As a result, future development becomes less and less expensive for the benefit derived.

Dr Yan Chow

MD, MBA, Global Industry Leader, Healthcare Automation Anywhere



[RPA] has enabled us to do to the things we thought were unimaginable in the past. I've stopped thinking about additional staff and now think about increasing our digital workforce. It has completely changed the way our team think of and understand RPA. I now have people randomly coming to see me to say the bot is completely revolutionary.

Sonny Yuan

Workforce Information Analyst and RPA Project Lead
Newcastle Upon Tyne Hospitals NHS Foundation Trust



ABOUT AUTOMATION ANYWHERE

Automation Anywhere is the world's leading cloud-native automation platform on a mission to help millions of organizations to grow better. We built automation that empowers businesses to transform the way they adapt, innovate and scale.



ABOUT NORTHAMPTON GENERAL HOSPITAL AND THE AUTOMATION ACCELERATOR PROGRAMME

Northampton General Hospital (NGH) NHS Trust's Automation Accelerator programme forms one of two Robotic Process Automation Centres of Excellence in the UK's National Health Service (NHS), with a team of dedicated experts leveraging technology to transform the way we work across the NHS.

In 2020, Northampton General Hospital and Kettering General Hospital announced the formation of a Group Hospital Model: University of Hospitals Northamptonshire (UHN). NGH alone provides general acute services for a population of 380,000 and hyper-acute stroke, vascular and renal services to almost 700,000 people living throughout Northamptonshire. We are an accredited cancer centre, providing services to 880,000 people who live in Northamptonshire and parts of Buckinghamshire.