Project reset: An opportunity for the NHS

By **Kelsey Rees** - 17th September 2020

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In the second of our three-part series exploring the impact of the Covid-19 pandemic on the private healthcare market, Check4Cancer chief medical officer Professor Gordon Wishart and Philip Housden, managing director of healthcare consultancy Housden Group, examine the opportunities for the NHS to reshape services in partnership with independent sector providers

The Covid-19 national health emergency may have delivered to Trusts the best opportunity for many years to reshape not just their own NHS services but also impact on their local private hospital competitors too.

In recent months, the crisis has taken primacy over all other priorities. This has led to a range of unprecedented actions for Trusts including both the temporary takeover of independent sector hospitals and the close-down of NHS Trust private capacity, directing both to NHS activities. Our previous article reflected on the impact of this on the relations between insurers and independent providers and in this second article we explore future opportunities for NHS services and how interactions with the independent sector could develop.

A report by the Independent Healthcare Providers Network (IHPN) published on 6 July highlighted some of the outstanding partnership working where providers and their staff from across the independent sector and NHS have worked beyond their traditional organisational boundaries to ensure both Covid-19 and non-Covid patients get the best possible care through a wide range of significant service changes and innovations, including:

• The physical move of some NHS service departments, such as chemotherapy and infusion therapies, diagnostic imaging, scopes, trauma and outpatient clinics into independent sector hospitals

• Independent hospitals theatre and bed capacity delivering priority time-critical surgery for NHS patients including cancer surgery and transplants

• The sharing/loan of key equipment such as ventilators and of scarce staff skills for the Nightingale Hospital network and elsewhere

AS SERVICES RESTART, THE CONSTRAINT ON CAPACITY IS ALREADY DRIVING INNOVATION TO ACHIEVE PRODUCTIVITY GAINS AND CHANGES IN WORKING PRACTICES

In turn, and in addition, within Trusts the crisis prompted many changes to the operational delivery of services, including staff working patterns which has potentially freed up office space and car parking, moved outpatients to telemedicine, as well as lowered demands on beds. These changes may have a permanent impact on estate and job planning. Some
Trusts are making clear that this is what the new 'normal' will look like and are aiming for the NHS to 're-set'. An example is Barking, Havering and Redbridge's 'No Going Back' approach.

The Covid-19 emergency has raised levels of uncertainty about what the new 'normal' will look like now that restrictions are easing and the NHS is 're-set'. A key element is the significant reduction in capacity driven by infection control measures. This will impact on every local healthcare economy dynamic and the interplay between NHS and private care demand and also between NHS and private patient supply.

As far as private patient services are concerned, some hold the view that the temporary closedown will have had a long-term adverse impact on both independent hospitals and NHS PPUs. However, although there are a number of complex and seemingly competing challenges for the NHS there remains also a great deal of long-term opportunity opening up because of this crisis.

Firstly, the crisis response has shown that the NHS/Trusts and the independent sector can act and think differently. As services restart, the constraint on capacity is already driving innovation to achieve productivity gains and changes in working practices.

The Covid-19 restrictions on activity have also led to a great deal of pent-up demand for NHS services, with waiting lists perhaps ballooning to 10 million, with 40,000 waiting over 12 months. In addition, there is also pent-up demand for private care with the 10% of the population with insurance having had little or no service availability for three months.

The public's support for the NHS is stronger than ever and awareness of the importance of patient safety and critical care back up has been significantly enhanced – for patients and also from consultants with private practice.

The future provision of services by independent hospitals to meet the needs of consultants for dedicated capacity in theatres and beds is uncertain, given the ongoing relationship with the NHS which is to be continued to at least 31 October 2020 and will stretch beyond in some form.

Opportunities for the NHS

The above factors together all point towards an optimistic view of NHS commercial opportunities including growth prospects for PPUs upon future re-opening. Many Trusts already have private patient services and capability, and although these have been largely suspended and redirected in recent months several are also now re-opening services. These Trusts remain potentially well placed to take advantage of this market opportunity over the long term, although vulnerable in the short term to requisition of capacity should there be a second and subsequent spikes in the pandemic.

The remaining Covid-19 period, specifically the extension to the contract with the independent sector, offers significantly important preparation time for planning to be ready to exploit this once-in-a-generation opportunity to reshape local private patient markets for the NHS's benefit: particularly on the supply side. This opportunity is now open to all Trusts whether or not they have had a private patient service in the past.

There is work to do to understand the full potential and then to enable Trust readiness, including developing and/or enhancing the in-house private patient service offer to patients and consultants. However, this requirement does come at a time when the management resources of the NHS are stretched meeting the pandemic, waiting times and access pressures while juggling reductions in throughput, capacity and staff.

Here are some examples of the opportunity to illustrate the depth and breadth of the potential.

On campus third party resource

Several Trusts have on-site and contiguous third-party healthcare facilities. These could be independent sector treatment centres and some are private hospitals or diagnostic service providers. The contracts with these third parties periodically come up for review/renewal. Therefore, the local NHS should consider the costs and benefits of moving the present temporary arrangements (of operational control) to a permanent basis.

This will vary on a case-by-case basis and the production of a business case and recent examples in Kingston Hospital and in Mid Cheshire show that this is possible and quickly delivers additional built capacity to the Trust. Such capacity can be absorbed within the Trust and used flexibly and intensively with a fluid boundary between volumes of NHS and private patients to ensure high occupancy and throughput.

Elective and diagnostic activity

Trusts now face significant volume and access demands, both for elective care and a return to pre-Covid-19 emergency and non-elective pressures. These are putting a strain on capacity, notwithstanding the productivity gains likely to have resulted from Covid-19 learnings, requiring Covid-free pathways and the use of independent sector providers for screening backlogs and provision of future investigations. In a wider context, Trusts are increasingly being placed in the role of lead purchaser for all activity within a specialty, essentially sub-contracting for independent sector capacity, and this change therefore enables the Trust to manage the local market for NHS funded care. What form of future relationships should be set up to make the most of the total local healthcare economy capacity? Specifically, what style of long term contracts might be established with one or more independent hospitals in order to derive the maximum benefits for the NHS?

There is impact here on both NHS and private patient services and volumes as Trusts will be in a strong position to identify specific services and procedures that they could choose to keep/attract onsite to fit with the agreed NHS forward service strategy. This strategy and resulting site and service reconfiguration (including estates strategy) should throughout take account of both private patient services and NHS demand.

Recent innovative examples include the five-year £19.1m contract between Somerset NHS FT and Rutherford Health to deliver diagnostic capacity and the Adanac Health and Innovation Campus, a joint development between University Hospitals Southampton NHS FT and Prime to develop a nine-acre site for office, research, industrial, residential/non-residential care and retail.

Complex surgery and patient safety

There is an imperative Patient Safety driver for all higher value/cost private patient activity such as cardiac and certain cancer treatment services, being best delivered from an NHS campus with 24/7 backup and level 3 critical care resources. Trusts have recently increased critical care capacity and much of this temporary capacity will be made permanent. This reliance on the NHS infrastructure has been highlighted by the Covid-19 crisis and made clear to the general public, and before that by the Paterson scandal and resulting Inquiry findings. This raised awareness will drive consultant preferences for their private practice as well as patient choice. This in turn will have a significant impact on the case mix that private hospitals undertake in the future.

To avoid all the most expensive insured patient treatment and care simply defaulting to the NHS supports Trusts taking a more proactive approach to engagement with the independent sector. This proactive approach includes commissioner support for identification of registered GP patients with private medical insurance on referral and the asking of insured status on arrival/admission by NHS Trusts. It should also involve Trusts thinking through for which specialties they specifically want to manage the local private patient volumes, perhaps to enable support for investment in expensive equipment (eg surgical robots) as well as to ensure common pathways of treatment and care. This most complex insured volume alone will be enough to produce a positive business case for investment in the minimum sized private patient inpatient accommodation. Therefore, the NHS commissioners’ and Trusts’ strategies can impact on future shape of the services that private hospitals provide – and do not provide.

Conclusions

Covid-19 has delivered to the NHS the best opportunity for many years to deliver a reshaping of services, not just within individual Trusts, but to lead that process across their whole healthcare economy.

NHS COMMISSIONERS' AND TRUSTS' STRATEGIES CAN IMPACT ON THE FUTURE SHAPE OF THE SERVICES THAT PRIVATE HOSPITALS PROVIDE – AND DO NOT PROVIDE

The potential opportunity for rapid speed of such change is also unprecedented. That reshaping towards a more integrated service model should take account of:

• All Trust sites and services

• Separation of pathways for 'Hot and Cold' and also 'Infectious and Non-infectious'

• Both NHS and private patients

• Both NHS sites and services and the independent sector considered across the piece

• The interfaces between NHS partner organisations referring to and from one another

• Whole population management: need and services and skill mix supply

• Most, if not all, Trusts are well placed within their local market to benefit from the current more proactive engagement with the independent sector, and this should include consideration of the Trust's own private patient services growth

• Covid-19 is therefore an opportunity to enhance, accelerate and support wider site and service strategic objectives for both core NHS and private patient services.

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