NHS0021

Written evidence submitted by the Independent Healthcare Providers Network

About IHPN - The Independent healthcare Providers Network (IHPN) represents independent healthcare providers of both NHS and privately funded clinical services, from acute, diagnostic, clinical home healthcare, primary and community services.

Summary
Before the onset of the Covid-19 pandemic, independent providers delivered more than 500,000 surgical procedures every year, as well as almost 10% of all NHS-funded MRI scans, with almost half of all NHS community services providers found in the independent sector. This partnership working was further strengthened during the pandemic, including through the national independent/NHS hospitals contract whereby the entire independent hospital sector made available their beds, staff and equipment to the NHS – as mentioned in the recent NAO report on NHS Backlogs and Waiting Times, this ensured that some 3.3 million vital non-covid treatments could continue, significantly easing pressures on the NHS. A similar partnership was also set up with independent diagnostics providers who delivered over 250,000 NHS scans in the first year of the pandemic. Likewise, independent community providers across the country worked with their NHS colleagues to repurpose their services and ensure that vital treatment and care could continue.

Since the pandemic, independent healthcare providers – and IHPN on their behalf – have been working proactively with NHS England, the Department of Health and Social Care, senior Government advisors, and NHS local systems across the country to facilitate the so-called recovery. While national contracting arrangements established during the peak of the pandemic have lapsed, independent providers have committed to significantly increasing the capacity they dedicate to NHS-funded activity for the foreseeable future. The initial target for this has been to reach 120% of pre-covid activity levels within the independent sector (IS), with longer term ambitions to extend this further. Unfortunately, to date referrals to the IS through the electronic referral system (eRS) have actually remained below pre-pandemic levels across the majority of specialties.

It is within this context that IHPN and the IS view the current crisis facing NHS waiting lists. The latest NHS performance figures show a record waiting list in excess of 5.8 million – this is in addition to the "missing waiting list", up to 7.7 million people who would ordinarily have been expected to be referred since the beginning of 2020 but have not been, largely due to factors associated with the pandemic.

Our clear view is that tackling the NHS backlog in both acute, diagnostic and primary/community care must be the number one priority for all parts of the healthcare system, with the development of a clear long-term plan by the Government and NHS setting out how patient access to care will be improved. This is something that will be strongly welcomed by the public, given that polling consistently shows that tackling NHS waiting times should be the number one priority for the health service.

Given the scale of the challenge, it's vital that an "all shoulders to the wheel" approach is taken regarding cutting the NHS backlog, and that lessons are learned from the early 2000s when significant additional independent sector capacity was successfully brought into the NHS to help bring down waiting times. Indeed, while independent healthcare providers have long played a key role in the provision of NHS acute, primary, community and diagnostic treatment, there is huge potential for them to play an even greater role in helping get services back on track.

Going forward, it's important that these NHS/independent sector partnerships are strengthened even further, notably through: ensuring the establishment of long-term, stable contracting mechanisms with the independent sector to bring in new capital, capacity and innovation; strengthening patient choice and giving people greater control over where they are treated and how quickly; implementing fair pricing models which incentivise providers to treat as many patients as they possibly can; and developing inclusive local system working to ensure local areas make use of all available capacity and look at new ways of bringing in vital investment and innovation.

Scale of the challenge

NHS waiting lists are at their highest ever level in a generation, with over 5.8 million people currently waiting for elective treatment. In addition to a large and growing waiting list, patients are also waiting longer for treatment. While the NHS Constitution states that 92% of patients should begin their treatment within 18 weeks, currently:

- 36% of all people waiting (2 million people) had already waited longer than 18 weeks
- 22% of all people waiting (1.2 million) had already waited longer than half a year;
- 5.5% of all people waiting (301,000) had already waited longer than 1 year;
- 2.3% of all people waiting (123,000) had already waited longer than 18 months

It is also important to note that NHS waiting times – even pre-pandemic - have been rising steadily since 2013 when they were at their lowest ever level. The 18 week referral to treatment target has not been met since February 2016. Indeed, analysis conducted by IHPN in January 2020 estimated that the number of people waiting for NHS treatment would hit almost 6 million by the end of the current Parliament in 2024 if pre-pandemic trends continued.

Likewise there is significant pressure on diagnostics services. Over one in four patients (26%) had been waiting over six week target for a diagnostic test in September 2021, with the diagnostic waiting time standard not being met since 2013.

And while there is less official data collected on backlogs in the community health sector (though significant numbers of patients e.g. for community ophthalmology will be picked up through the NHS' Referral to Treatment data), a significant number of community services were asked to stand down or limit provision during the pandemic, which has created significant pent-up demand. These services span across the community health sector, including audiology, community paediatric services, community nursing services and nursing and therapy teams support for long term conditions, outpatient clinics, podiatry services, rehab and endoscopy services.

As part of our work, IHPN has carried out data modelling on possible recovery pathways. Our projection is that, assuming 60% of the so-called 'missing waiters' re-enter the system over the next 12 months, then the NHS would have to operate at approximately 115% of overall 2019 elective activity levels in order simply to restore the waiting list to December 2019 levels (4.42 million) by March 2024. In addition, historical data would suggest that a more practicable and realistic *stretch* aim for NHS activity over this period would likely be just 108% of 2019 levels.

How the independent sector can support the NHS in tackling the backlog

Given the scale of the challenge facing the NHS in tackling the NHS backlog, there will be no "silver bullet" to improve access to care. However, we believe the independent sector has a key role to play in supporting the NHS in cutting waiting times and improving access to NHS services.

Our modelling suggests that if the NHS could reach 108% of 2019 activity levels by August 2022, then the independent sector would, in parallel, need to increase its capacity for NHS-funded elective activity to between 175%-200% of 2019 activity levels to return the waiting list to December 2019 levels by March 2024.

We believe that this is an achievable aim, and that there is the desire within the sector to play a full role in the recovery programme. As part of this, the sector can provide even greater capacity to local systems than is currently the case, with a number of key levers being used to achieve this.

Stable long-term contracting mechanisms

Tackling the NHS backlog is likely to take many years to achieve, and it's therefore vital that sustainable, long-term measures are introduced to ensure the system has enough capacity to meet patient demand in the next decade.

A significant barrier in realising this aim is the frequently last-minute nature of planning guidance, financial settlements to trusts, and other indicators from NHSE and DHSC to local health systems. Planning guidance for the second half of the 2021/22 financial year was published less than 24 hours before it was due to come into effect. Clear guidance on what criteria can be used for trusts and CCGs to access the ringfenced-portion of the Elective Recovery Fund that supports independent sector activity is still not widely available. This continues to create significant uncertainty for all parts of the healthcare system and has made it much more challenging for both commissioners and providers to plan for service recovery in the coming months.

This is affecting not only providers commissioned by the NHS locally, but also independent organisations on the "Increasing Capacity Framework", which has been established to help bring in independent capacity and cut waiting lists. While NHS organisations can adapt their approach at relatively short-notice, independent providers, as commercial entities, need longer lead-in times to adapt contracting and activity models – six weeks or more being ideal.

More broadly, however, there remains a significant appetite within the independent health sector to support the NHS over the coming years, including through capital investment for new and remodelled services which can benefit NHS patients. This is likely to be more nimbly deployed than public capital and entail less public sector risk, and could play a significant role in increasing NHS capacity if sustainable, long-term contracting mechanisms are put in place.

The benefits of long-term NHS/independent sector partnership-working was demonstrated through the establishment of Independent Sector Treatment Centres in the 2000s. These centres were introduced in 2003 to provide services to NHS patients but were owned and run by organisations outside the public sector under five-year contracts. This new approach helped bring in new investment and capacity to the NHS and successfully helped reduce waiting times. It is perfectly possible that this could be replicated again given the current pressures on the system.

This long-term approach to NHS contracting is currently being taken forward through the new NHS Community Diagnostics Hubs, whereby there is a 3-5 year timeframe for their development along with a range of different partnership models that can be used. This could be replicated more broadly.

Strengthening patient choice and empowerment

Patient choice was introduced in the NHS in the early 2000s as a key way of both driving up efficiency and quality in healthcare, as well as ensuring NHS patients who are unable to pay for private care can have greater control over where they are treated and how quickly. While these legal rights for NHS patients to choose where they receive care if they need to see a consultant for diagnosis or treatment (including in an independent provider) have been in place for well over a decade now, patient awareness of these choices remains low, with polling consistently showing that less than half of the public are aware of their right to choose.

We therefore welcome the commitment in the current Health and Care Bill to ensuring that patients have genuine choices over who provides their care, and would be keen to see these strengthened through e.g. regular measurement and reporting by NHS England over patient experiences of whether they have been offered choices about their care. It is particularly important that patients are able to make choices at the point of referral about who provides their care and any move towards

introducing Single Patient Lists in ICSs should ensure that choice is not undermined, given the efficiencies that come from patients themselves choosing their preferred provider. Likewise, as the Health and Social Care Select Committee have previously made clear, it's important that patients retain the right to receive treatment outside the area served by their local Integrated Care System.

We have significant concerns that, as things currently stand, the patient choice process – primarily through 'Choose and Book' and the eRS – is not functioning for a large cohort of patients across a large number of local NHS systems. Many NHS trusts have moved to a centrally managed patient list, taking decisions centrally on which patients can and should be transferred to local independent providers. This approach first and foremost helps mitigate health equality concerns – trusts are able to fill available activity slots with those patients who have waited the longest. However, this method is by its nature extremely inefficient in terms of overall patient volume.

Pre-pandemic, approximately 80% of independent sector elective activity originated via eRS referrals. However, data shows that, among the top six specialties by volume in the independent sector, only opthalmology referrals are currently above 2019 levels; the majority of these referrals coming from high-street optometrists, and not from primary care as with other specialties. Among other specialties, the most recently available data showed orthopaedic referrals down 8% compared with 2019, dermatology referrals down 30%, gastrointestinal and liver referrals down 35%, ear, nose and throat referrals down 51% and gynaecology referrals down 32%. In order to maximise elective activity in the independent sector and give the overall recovery efforts the best chance of success, these eRS referral trends need to be reversed as a matter of urgency.

Fair and transparent NHS pricing systems

The introduction of the NHS national tariff and the Payment By Results (PBR) system have played a significant role in incentivising providers to treat as many patients as possible. This has led, for example, to hip and knee procedures and other procedures being done at scale. Given the scale of the backlog, any future payment system that the NHS develops must continue to provide incentives for procedures to be carried out at pace and scale, as well as be transparent and provide a level playing field for providers whether they are from the NHS or independent sector. Current provisions in the Health and Care Bill, however, risk undermining this approach, and should be urgently looked at by the Department of Health and Social Care and NHS England to avoid unresponsive payment models such as block contracts – which disincentivise activity.

Inclusive system level working

With local systems needing all the capacity they can get, it's vital that the new Integrated Care Systems which are being introduced through the current Health and Care Bill take an inclusive approach and work with all local providers – including those in the voluntary, social enterprise and independent sector – to bring in new capacity as well as new ideas and ways of working.

However, as the Health and Social Care Committee has previously made clear in their inquiry on the NHS White Paper, there are real risks that new ICSs could be dominated by the views of the statutory NHS provider sector and fail to draw on the experience and expertise of other equal partners in the health and care sectors. Likewise, we agree with the Committee's comments that the establishment of a new procurement process in the NHS could inadvertently establish practices that "favour incumbents and excludes innovators" - impeding the adoption of new and better ways of cutting the backlog.

It's also important to note the potential disruption of structural change in the NHS at a time when focusing on tackling the backlog should be the absolute priority for local areas. Any structural changes in the NHS inevitably divert people's attention towards organisational matters rather than delivering care for patients, and we would like to understand how these challenges may be remedied during the reorganisation.

December 2021