Independent Healthcare Providers Network

10 Year Plan for Health
Consultation response

December 2024

Q1: What does your organisation want to see included in the 10-Year Health Plan and why?

The Independent Healthcare Providers Network (IHPN) is the membership network for independent healthcare providers. We represent over 100 organisations, providing care in over 1800 sites across the country and employing over 150,000 staff. Our members play a key role in the delivery of healthcare across the UK, treating millions of NHS and private patients every year across a range of services including acute hospital care, primary care, community care, clinical home healthcare, insourcing and diagnostics.

In total, the sector delivers 10% of all NHS elective activity – including one in five elective operations – and more than 100,000 NHS patient care episodes every week. The sector delivers 20% of all NHS funded images and scans, and accounts for 12% of all community services contracts. Independent sector is not in addition to NHS capacity, but a core part of existing provision.

Independent providers therefore play a vital contribution to the health of the country – supporting patients to prevent ill health through early interventions and health and well-being services, providing treatment to those who require elective surgery, and connecting hospital services back into the community, through rehabilitation and other community support.

In our submission to Lord Darzi's independent investigation of the NHS in England, we said that care is not integrated properly between NHS and independent providers, obligations around patient choice are disregarded, planning and contracting arrangements are suboptimal, and training arrangements are siloed within the NHS.

As a result, the ten-year plan should seek to address these issues to make best use of the capacity, training and innovation the independent sector can provide, in service of improved patient access, choice and outcomes.

Integrating planning, contracting and care delivery: Many providers already play important strategic roles in their local NHS systems. However, we believe the independent sector has an even greater role to play in the NHS' future, helping to reduce elective care backlogs and supporting the health of the nation. The ten-year plan should recognise the shift from short-term contracts and relationships, often at a local level, to one of long-term strategic support, within systems and at a national level. This can be best enabled by streamlined data- sharing, including access to a patient's shared care record, clearer patient pathways between providers, and stable, longer-term contracts to encourage innovation, improvement and service resilience.

Encouraging patient choice: From a patient perspective, the independent sector is well placed to offer choice, convenience and ease of access to those using NHS services. Polling from Savanta ComRes, commissioned by IHPN, found that 73% of people believe they "should have a right to choose where I receive my NHS treatment, including with an independent/private sector provider", and 71% of people reported being

happy to travel more than 30 mins outside of their local area to get faster treatment. As attitudes towards access, speed and location of care continue to develop, patient choice is an integral part of effective healthcare provision. The plan should illustrate what meaningful choice can look like in practice - how it can work more effectively, how it will be measured, and how system assurance will work to ensure that all parties are contributing to upholding the standards around choice established in the NHS Constitution.

Optimising workforce training and development: The independent sector is ready and willing to contribute to the wider work of the NHS as well as direct patient care. Recent reports by the IHPN such as Tomorrow's World have explored the appetite amongst members to play a greater role in workforce training and development, and data shows that independent sector providers are already training more than 15,000 people a year, including 5,000 nurses. With NHS England's Long Term Workforce Plan committing to doubling the number of medical school training places and increasing adult nursing training places by 92% by 2031/32, the ten-year plan should reflect the independent sector's existing contribution to workforce development, and set out how trainees and qualified staff can more easily move between NHS and independent settings to continue their professional development.

Q2: What does your organisation see as the biggest challenges and enablers to move more care from hospitals to communities?

Independent sector providers are an integral part of community provision, helping to both keep people out of hospital and support patient discharge from hospital sooner, reducing pressure on acute services and keeping people well. Independent providers represent 42% of NHS community service provision, illustrating the crucial role our members play in supporting people stay well. As the NHS looks to the next decade, the independent sector is ready to play a fundamental part in shifting care from hospital to home.

Clearly defining what is meant by community care will help remove the first barrier to realising this shift. Community providers are incredibly diverse – with some of our members working at the interface between hospital and community, helping to bridge different care settings, while others provide traditional community and nursing care, offer diagnostic services in community settings or even provide healthcare services on the high street. They recognised a clear opportunity to do even more out of hospital, which would support patient access, reduce pressures on hospitals and see care delivered in the most appropriate settings. To ensure this transition isn't overly skewed by local priorities and funding arrangements, we would support a "universal offer" for community services so that every system delivers the same baseline service provision, avoiding a postcode lottery. We welcome the progress that has been made by NHSE on this, but it is important that the universal offer is sufficiently specific / detailed to ensure a minimum standard / scope of service so that the offer and experience for patients is not widely different across different parts of the country.

However, commissioning and care delivery focuses primarily on addressing the component parts of healthcare. Long-term plans primarily concern the ability of NHS Trusts to meet existing service demand, rather than considering the overall healthcare needs of a community. This leads to significant inefficiencies

in care pathway management, particularly in terms of resource allocation, which can lead to a focus on funding secondary care at the expense of primary and community care.

A key enabler to making this shift happen is the way in which funding streams flow in community settings. Members have told us about the way in which short term contracts, for as short as three to six months, both inhibited investment and created risk for both commissioner and provider. Ways in which this might be addressed could include longer term contracts, payment via tariff rather than block contract and incentivising community care through other funding mechanisms. For example, members working in diagnostic services cited the establishment of community diagnostic centres (CDCs) as a real opportunity to move care to locations frequented by patients. Longer term contracts of 5-7 years were seen as necessary to make investment in these services viable, both in allowing time for building the physical infrastructure and aligning contract terms with the lifespan of the diagnostic equipment.

Expansion to the range of services where patient choice applies would also be a key means of bringing in much needed new capacity to local health systems. For example, analysis by IHPN found that if one third of all current CDCs had been independent sector-led it would have resulted in a reduction in capital spend of approximately £500 million. Finding appropriate financial vehicles to allow private capital is essential to leverage money from the private sector.

Extending patient choice to diagnostics and using contracting models such as Any Qualified Provider (AQP), which is currently used in NHS elective care, would also make it easier for local areas to utilise independent sector capacity, rather than bids for new CDCs being signed off centrally as is currently the case.

Q3: What does your organisation see as the biggest challenges and enablers to making better use of technology in health and care?

IHPN members are positive about the contribution better use of technology can make to patient experiences and outcomes, as well as the health and care system more generally. In particular, members spoke of the opportunities provided by telehealth platforms, whether in providing virtual ward support, diagnostic services or virtual appointments for primary care clinicians, therapists or community care providers. They foresaw an environment where patient choice can be enabled and supported through digital consultations, appointment booking through mobile apps and access to health information and support.

However, members also identified some barriers to the most effective shift to improved health through technology. In many cases, these challenges were structural, rather than patient-facing. Members shared the following challenges that limited integration between NHS and independent sector providers, blocking patient pathways and inhibiting meaningful patient choice:

- The Electronic Referral System (eRS) provides so called ‘choose and book’ functionality, wherein accredited providers list available appointments,and have these appointments booked either directly by the patient or by the referring clinician. IHPN’s analysis of internal provider data indicates that

more than 88,000 listed eRS slots go unbooked every month – potentially representing more than 1million additional NHS patient appointments that could be delivered in the independent sector annually if eRS was used more efficiently.

- Triage services – such as Referral Advice Services – can circumvent access to choice. IHPN members have shared a number of examples of this – with systems contractually requiring primary care to refer only to the RAS, and/or with Referral Advices Services effectively managing provider activity by placing a cap on how many patients it might refer to any given provider.
- Access to patient care records not being routinely shared with independent providers – imposing a significant obstacle to offering more joined-up care and a better – and safer – patient experience.

Interoperability was also seen as a challenge, both for NHS organisations working with each other, and with independent sector partners. Members cited enablers such as minimum standards for third-party technologies on NHS accredited registers, straightforward and functional application programming interfaces (APIs) and consistency in the use and commissioning of software as crucial in creating a platform from which providers of all kinds can offer the best possible care. Successful examples of interoperability-focused IT projects such as the national imaging registry, that enables images and scans to pass between different organisations regardless of provider type, should be encouraged.

Q4: What does your organisation see as the biggest challenges and enablers to spotting illnesses earlier and tackling the causes of ill health?

Independent sector providers play a crucial role in providing preventative services and treatment – not least in the delivery of occupational therapy, musculoskeletal services and health and wellbeing support through gyms and fitness centres. IHPN members recognise the importance of shifting care to a much more preventative model, in order to keep people well and reduce financial pressures on the NHS through lower-cost interventions, such as joint pain programmes in workplaces.

Members highlighted inconsistencies in preventative care commissioning that led to barriers to effective service delivery. In particular, many highlighted the challenges local authorities face in terms of funding as limiting the amount of public health activity they're able to deliver. This was in some cases worsened by commissioning mechanisms failing to incentivise holistic approaches to preventative care. For example one member shared that, in a contract for screening services, performance was only measured and held accountable for core service delivery, despite also specifying patient engagement as part of the contractual offer. In more routinely measuring, and ensuring accountability for, a wider range of preventative activity, commissioners could better ensure that system aims and priorities are successfully delivered.

Commissioners could also make better use of patient data in order to spot illness earlier. Members highlighted the opportunity for more predictive commissioning through data-sharing agreements. This could help to meet strategic aims such as CORE20PLUS5, by incentivising engagement with people who are most at risk of ill-health.