Independent Healthcare Providers Network
NHS CONFEDERATION

Working together to deliver the NHS Long Term Plan

How NHS and independent sector partnerships are future-proofing the health service for the decade ahead

Introduction

Since its inception in 1948, the NHS has always been a partnership between publicly-owned providers and independent organisations – including GPs, pharmacies, charities, and social enterprises and the independent sector – all of whom are committed to delivering high quality care to NHS patients, free at the point of use.

As the NHS looks ahead to the next decade with the publication of its recent long-term plan, this publication showcases numerous examples of how the independent sector is already working in collaboration with the NHS to deliver the healthcare priorities outlined in the plan, from innovative and accessible primary and community services, through to integrated diagnostics services supporting early diagnosis of cancer and other diseases, to high-quality and accessible elective surgery, which plays a key role in cutting waiting times for patients.

The NHS Long Term Plan is a hugely ambitious document, which aims to save up to half a million lives through a greater focus on prevention, early diagnosis and the delivery of cutting edge treatment, and we believe it's vital that all parts of the health sector, including voluntary, social enterprise and independent providers, come together to help deliver the important goals which will benefit millions of NHS patients every year.

Indeed, the key themes in the plan are around better integration and collaboration of NHS services, not only to reduce bureaucracy and duplication, but most importantly to deliver more patient-centred care which works for the needs of individuals, not organisations. We strongly believe that integration should be about all NHS services, whether delivered by the public, independent or voluntary and social enterprise sector, working together to provide seamless patient care, rather than one organisation providing everything itself.

As the case studies in this publication demonstrate, NHS partnerships with the independent sector work, with a clear commitment from both partners to putting patients first. And as the NHS moves into the next decade, it's vital this collaboration continues and the NHS utilises the expertise, investment and innovation from all their partners to ensure our NHS is fighting fit in the years to come.

STATED AIM

"We will boost 'out-of-hospital' care and dissolve the historic divide between primary and community health services."

The NHS Long Term Plan (p13)

The Long Term Plan sets out how the NHS will move to a new service model where patients get more options, better support, and properly joined-up care at the right time.

This includes a new guarantee that over the next five years investment in primary medical and community services will grow faster than the overall NHS budget, rising by over £4.5 billion a year by 2023/24.

CASE STUDY

The Practice Group

In Leeds, The Practice Group has developed a strategic and practical approach to coordinated and mutually supported community and primary care services. Through clear allocation, communication and collaboration between themselves and community services, the service - located out of The Practice Harehills Corner in Leeds - has increased capacity for seeing patients, improved care outcomes and reduced inefficiencies in a complex local NHS system.

Following increased pressure on local GP services caused by the closure of a local practice and an increase in patient numbers by 12 per cent, The Practice Group came up with an integrated approach to help people access primary services. The approach was designed to make sure the patient was seen by the right person, that their care was approached in a holistic way that improved their overall health and that practical and logistical steps were taken to cut down on inefficiencies.

The Practice Group created a six-point strategy:

1. personalised care planning to help identify and reduce the risk of comorbidities
2. employing an advance nurse practitioner to free up GPs for more complex cases
3. appointing a designated care coordinator to signpost patients to holistic care services, including exercise classes and social care programmes
4. collaborating with other service providers as part of the Leeds initiative to share capacity effectively
5. working closely with local pharmacy to enable them to deal with a designated list of minor ailments
6. making it easier for patients to manage their appointments online, resulting in boosted appointment attendance and a higher proportion of appointments made with the correct practitioner.

As a result of this approach the practice saw:

- a reduction in 'Did not attend' rates
- a reduction in prescribing spend through increased collaboration with other health, social and third sector providers
- a change in demographic of people most regularly attending the surgery
- a reduction in the number of appointments each patient needed to attend on average per year.

CASE STUDY

One Medical Group

One Medical Group has been instrumental in combining primary and community care to create a streamlined care pathway for frailty, through developing 'Bounce Back' clinics at Windermere and Bowness Medical Practice, part of OnePrimaryCare. The service was developed to capture a range of patients who were deemed as potential fallers at the earliest opportunity, reducing the risk of falls and preventing admissions to hospital and increasing pressures on A&E departments.

The proportion of 65+ is set to grow from around 18.2 per cent in mid-2017 to 20.7 per cent by 2027, 10 per cent of whom have frailty, an ageing process which weakens the body and puts them at greater risk of disproportionately adverse outcomes following minor events such as falls.

One Primary Care set up its Bounce Back clinics with the aim of reducing:

- the number of falls
- the need for unplanned GP visits, A&E attendance and admission
- social isolation.

It also sought to:

- improve mobility and self-care
- improve understanding and concordance with medication
- increase quality of life
- providing a wrap-around service close to home and closer links with acute and community providers, third sector and wider cross-organisational teams.

OnePrimaryCare's Windermere and Bowness Practice was set up as part of the Bounce Back Clinics to serve the South Lakes Community which encompassed nine GP practices. Because of estates challenges, it was decided to divide the practices into three hubs, with the team rotating across each hub in order to run the clinic effectively and best serve the community.

After initially using the Electronic Frailty Index, the identifying criteria used by many across the healthcare sector, it was quickly discovered that it was not an accurate measure of how frail a patient is as a stand-alone. Subsequently, bespoke guidelines were developed which would consider people classed as 'pre-frail'.

The service presented an opportunity to integrate primary, community, acute and secondary care, ensuring the patient had a streamlined care pathway, allowing for an efficient wrap-around system which centred on the patient. As GPs were able to play such an integral part of the community, they could refer their patients early, having noticed signs such as weight loss, unkemptness, or loss of confidence and independence.

Having proven popular with patients, GPs and other service providers, Bounce Back Clinics continue to grow from strength to strength with more than 100 patients benefitting from the service during its trial period. A paramedic is being added to the pathway, creating a full circle of service for the patient and supporting nurses, physiotherapists, pharmacists, and third sector partners. Age UK has acknowledged the success of clinics' trials and has become a strong advocate for the clinics and provides a reciprocal referral system.

Forty-two patients have attended the Bounce Back Clinic over the pilot with 40 per cent attending their review appointment at 12 weeks. More than 100 patients were referred from GP surgeries to Bounce Back Clinic.

97% of patients rated the overall service as excellent.

The service is a cost-effective, reproducible model with ease of accessibility providing flexible succession planning, and a solution ready for future commissioning. It is being watched nationally and its methodology is being embedded in a national document in order to enhance care in nursing homes.

STATED AIM

"The NHS will reduce pressure on emergency hospital services."

The NHS Long Term Plan (p18)

While boosting 'out-of-hospital' care makes sense in its own right, there are very substantial pressures across the NHS in looking after emergency patients, not least due to the pressures from an ageing population.

The plan commits to expanding and reforming urgent and emergency care services to ensure patients get the care they need fast, relieve pressure on A&E departments, and better offset winter demand spikes.

This includes implementing urgent treatment centres (UTCs) to give localities a consistent offer for out-of-hospital urgent care, eg booking appointments through NHS 111, and receiving unscheduled urgent primary care and working with other parts of the system so patients are assessed and appropriately directed to NHS specialists promptly.

A single multidisciplinary Clinical Assessment Service (CAS) will also be embedded in NHS 111, ambulance dispatch and GP out of hours services from 2019/20 to provide specialist advice, treatment and referral from a wide array of healthcare professionals.

CASE STUDY

Care UK

Care UK has a proven track record in delivering Integrated urgent care services for large populations, demonstrating that investment in clinical expansion of the CAS model is exceptionally cost effective through improving access for patients, eliminating duplication and reducing unnecessary attendances to local NHS hospitals.

By expanding the range of clinicians within the CAS, even relatively modest levels of investment can bring about significant changes in emergency department and ambulance usage as well as in referrals to overloaded GP services.

In supporting patients' mental health needs, NHS 111 services were previously reliant on triage via NHS Pathways, and without direct access to specialist mental health professionals, directed almost all patients presenting with urgent mental health needs to local emergency departments and ambulances. After embedding a mental health nurse within the CAS structure, this specialist clinician successfully and compassionately managed the patients by telephone, enabling the overwhelming majority of patients to avoid ending up in A&E or requiring ambulances.

In integrating out-of-hours pharmacy support into the CAS, significant numbers of patients contact NHS 111 because of concerns around their prescriptions – including missed doses, accidental overdoses, side effects or urgent advice on dosage, drug interactions or allergies. Almost all these patients were previously directed from NHS111 to GP services or even to hospital. By including a pharmacist in the CAS, these queries can be answered promptly and safely by telephone.

In mental health provisions, over a four-month period in an Integrated urgent care service which supports a population of more than 6.5 million people,

including a mental health nurse in the CAS resulted in fewer than **20%** of cases needing to be referred to either A&E or ambulance – compared with **85%** of cases being referred to A&Es or ambulance when there is no CAS.

In integrating out-of-hours pharmacy support into the CAS, including a pharmacist in the CAS in a large Integrated urgent care service resulted in less than 5 per cent of cases being directed to emergency departments or ambulances. More than 50 per cent of patients had their concerns resolved with advice. Some patients could be safely referred back to their own GPs for ongoing management or, where clinically necessary, to the out-of-hours GP services.

STATED AIM

“Digitally-enabled primary and outpatient care will go mainstream across the NHS.”

NHS Long Term Plan (p25)

The Long Term Plan aims to make ‘digital-first’ primary care the norm. Every patient in England will have a new right to choose this option – usually from their own practice or, if they prefer, from one of the new digital GP providers – enabling every patient to swiftly access convenient primary care.

CASE STUDY

Care UK

Care UK has developed ‘Practice Plus’, which aims to make general practice accessible and sustainable by enabling digital clinical tools at local scale. More than 3,500 new patients have joined this Brighton-based GP practice over the past six months. The new practice model applies digital innovation and harnesses remote, as well as practice-based, clinical resources to enable:

- appointments and support appointments within 48 hours
- telephone calls answered within 30 seconds
- a suite of digital tools to give patients the ability to manage their appointments, check their symptoms and get clear, personalised and clinically safe advice.

A simple, fast, online registration process takes only a few minutes to complete and validates new patient registrations on the same day, giving a near immediate ability to book a health check or first appointment, reducing the potential for unregistered patients to go straight to costlier acute settings.

An online Personal Health Hub allows patients to create profiles and utilise the full digital model to make appointments and to check their symptoms through a clinically robust symptom checker. Clinical call centres, which provide the NHS 111 urgent care services, provide telephone-based alternatives for patients who don’t yet want to be fully ‘digital first’.

Clinically robust digital or telephone triage, better enables self-care advice as an alternative to an appointment, allows point of care tests to be undertaken prior to initial appointments and reduces overall demand by removing unnecessary or multiple appointments.

As a result, registered patients, no longer facing long telephone queues at 8.00am, or long waits for appointments, are less likely to visit emergency departments or become unplanned admissions.

The model demonstrates that clinically appropriate digital tools, combined with fast call centre-based telephone access, both reduce numbers of unregistered patients and contribute to a consistent reduction in the proportion of registered patients attending local emergency departments during the winter period.

By drawing patients from within a single CCG – which had recognised a significant issue with unregistered patients – the service has avoided significant distortion of local NHS budgets.

Implementation of digital innovation within local NHS commissioning boundaries, rather than across multiple CCGs, also preserves ease of access to face-to-face appointments and home visits where clinically required, creating a combined model which is wholly inclusive. No patient groups are discouraged or barred from registration and the practice can meet the needs of all patients within the community, regardless of health conditions and need.

Innovation has often seen faster adoption in urgent care and out-of-hours settings. Practice Plus takes a non-disruptive approach to implementing digital primary care within in-hours general practice, easing workforce challenges through utilisation of flexible online and telephone consultations for patients and flexible working practices for GPs and health professionals, building capacity for commissioners and speeding patient access.

99% of calls answered within **30 seconds**

STATED AIM

"Better care for major conditions: Cancer"

The NHS Long Term Plan (p56)

Cancer survival is the highest it's ever been and thousands more people now survive cancer every year but the Long Term Plan makes clear that one of the biggest actions the health service can take to improve cancer survival is to diagnose cancer earlier.

The plan sets a new ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters of cancer patients.

This will help ensure that 55,000 more people each year will survive their cancer for at least five years after diagnosis.

CASE STUDY

InHealth

InHealth is a longstanding provider of expert diagnostic tests, scans and assessments for patients throughout the UK and Ireland. For over 20 years, it has worked with the NHS, patients and private providers to respond to the changing healthcare environment to deliver clinical and operational excellence. It works across prevention, diagnosis, and pathways and interventions, helping to reduce waiting times, increasing patient access, speeding up diagnoses, supporting challenging financial constraints and improving the overall patient experience.

Oxfordshire CCG and the Oxford University Hospital NHS Trust (OUH) were already delivering a two-week-wait (2WW) service but sought to deliver a local, community-based service with shorter waiting times for patients – both routine and 2WW – where referrals could be managed within nationally set Referral to Test (RTT) and local cancer targets.

InHealth has taken the lead in developing straight-to-test community endoscopy in the UK, offering innovation such as trans-nasal endoscopy with low levels of sedation. InHealth has worked with Oxfordshire CCG over the last five years, delivering services to the local community of Witney and welcomed the opportunity to expand on the services currently delivered, by offering services from two locations (Witney and Bicester) for both routine and the new 2WW pathway.

InHealth supports Oxfordshire CCG in a number of their objectives, namely: to improve local access, bring care closer to home, improve cancer outcomes, reduce delays in diagnostic pathways and integrate care pathways between providers, while seeking to increase the proportion of cancers diagnosed earlier at stages 1 and 2 with a robust clinical 2WW cancer pathway for patients with suspected cancer. This includes pre-assessment, clinical triage and advice, clinical consultation, procedure and aftercare advice for both patients and referring clinicians.

A close working relationship with cancer multi-disciplinary teams and histopathology departments ensures a seamless pathway for onward referral, should cancer be suspected, avoiding the need for the GP to refer to secondary care and ensuring no unnecessary delays are created within the pathway.

As a result of this partnership, InHealth currently sees an average of 600 patients per month at their sites in Witney and Bicester, 55 per cent of which are routine and 45 per cent urgent 2WW, averaging an RTT of

urgent 2WW procedures: **6–9 days** against a target of 10–14 days & routine procedures: **29–32 days** against a target of 42 days.

Sharon Barrington, head of planned care and long-term conditions at Oxfordshire CCG commented: "Oxfordshire Clinical Commissioning Group awarded the contract for delivery of the 2WW endoscopy pathway to InHealth as they demonstrated an in-depth understanding and experience of delivering this type of service, including clinical quality improvement and operational management of a standalone service. InHealth is always keen to deliver the right service and work closely with the CCG to ensure this is delivered.
She continued: "For people in Oxfordshire, this means that they have access to a more local service, with easy parking and choice of sites. The service is community based, which is potentially less stressful and intimidating than attending an acute hospital site. The CCG are very focussed on achieving excellent outcomes for patients by diagnosing cancer as early as possible and the InHealth service provides that capability."

STATED AIM

"Better care for major health conditions: Short waits for planned care – MSK"

The NHS Long Term Plan (p73)

Low back and neck pain is the greatest cause of years lost to disability, with chronic joint pain or osteoarthritis affecting more than 8.75 million people in the UK.

More than 30 million working days are lost due to musculoskeletal (MSK) conditions every year in the UK and they account for 30 per cent of GP consultations in England.

The plan aims to expand the number of physios in primary care networks to ensure they can be accessed without a GP referral and improve online access to better enable self-management.

CASE STUDY

Connect Health

Connect Health has worked in partnership with Nottingham West CCG and Nottingham North and East CCG to provide the MSK service since April 2016. In this time, Connect Health has worked closely with the CCGs to improve access to and user experience of musculoskeletal services (including physiotherapy assessment).

The Nottinghamshire County Joint Strategic Needs Assessment identified in 2008 that diseases of the MSK system and connective tissue are one of the top ten admissions to hospital – 10 per cent higher at the time than the England average of 7.4 per cent. Connect and the CCGs recognised the long-term burden placed upon sufferers by everyday pain and impaired function, and its associated impact on social functioning and mental health.

Connect Health set out to improve service delivery and ease of access by integrating musculoskeletal services together into a single pathway, removing complexity and seeking the best possible outcomes. Following the award of the full community service contract in Nottingham West and Nottingham North and East, Connect streamlined patient access to one single point of contact and MSK triage. They sought to deliver more routine and advanced MSK services in a community setting, to reduce the number of patients having to go into secondary care and to reduce associated costs.

The team consists of sports and exercise medicine consultants, a consultant physio bringing expert clinical leadership, extended scope practitioners, injection therapy and diagnostic referral management; in-house orthopaedic consultants offering expert and pre-operative appointments.

The streamlined services saw a 30 per cent reduction in elective trauma and orthopaedics referrals to secondary care between 2016/17 and 2018/19 which saved £2.6 million in trauma and orthopaedic elective and day case spend in just one year.

Waiting times significantly improved year on year from **84 days** to **12 days** for physio face-to-face appointments

and innovative rehabilitation pathways support sustained physical activity with 25 per cent of patients now joining a gym on discharge. The PhysioLine enabled patient empowerment and improved rapid access and 95 per cent of patients said that they would recommend the service to friends and family.

CASE STUDY

Horder Healthcare

Horder Healthcare is a leading independent healthcare provider and charity based in Sussex that delivers high quality orthopaedic care, as well as supporting the NHS Long Term Plan with providing direct access to MSK First Contact Practitioners (FCPs) as part of the Sussex MSK Partnership East (SMSKPE) contract.

As the main provider of advanced practitioners (APs) working within the SMSKPE catchment, Horder's team of APs are involved in the development and implementation of FCP services in GP surgeries across the region. Horder's staff assisted with the Chartered Society of Physiotherapy fellowship project helping in the development of the FCP role, outlining the necessary clinical experience, qualifications and competencies required to fulfil the role safely and effectively.

Through Horder's commitment to providing quick, elective care it provides physiotherapy services, APs and consultant-led clinics to the local MSK service. This enables choice, reduces waiting lists and increases patient access to NHS services following local protocols for optimal and locally agreed evidence-based care pathways. Horder's APs have been instrumental in implementing new and revised clinical pathways for the region. APs are locally commissioned by SMSKPE to provide assessment, treatment and diagnostic services at the interface between primary and secondary care, ensuring that shared decision-making principles are applied and appropriate and mutually agreed clinical practices are observed.

The Horder Centre itself is then one of the panel of choices available to patients as a secondary care provider of elective orthopaedics. Clinical outcomes following surgery at the Horder Centre following hip or knee replacement, as recorded on the National Joint Registry, are some of the best in the county and well above the National average.

As an independent healthcare provider, Horder is providing 6.4wte (whole time equivalent) AP staff resulting in excess of 1,500 clinics in 2018/19 to the local area, creating approximately 12,000 NHS patient contacts. The Horder physiotherapy service accepts around 750 new patient referrals each month from local GPs for NHS treatment.

Internal quality improvement projects have been implemented to improve waiting times and patient outcomes, resulting in

80% of patients reporting significant improvement in their clinical condition.

The Friends and Family Test (FFT) in the physiotherapy department has demonstrated that 99.7 per cent of patients were 'likely' or 'extremely likely' to recommend the service provided by Horder. New services have included the implementation of the ESCAPE programme at two of our sites with plans to implement it at our third site in the coming months.

STATED AIM

"Better care for major health conditions: Short waits for planned care – planned surgery"

The NHS Long Term Plan (p73)

For those patients that do need an operation short waits are important - cataract extraction, joint replacements and other planned surgery all help people stay independent and yield important quality of life gains.

The Long Term Plan recognises that treatment capacity has not grown fast enough to keep up with patient need, and the number of patients waiting longer than 18 weeks has been steadily increasing.

The NHS has been allocated sufficient funds over the next five years to grow the amount of planned surgery year-on-year, to cut long waits, and reduce the waiting list, including making use of available Independent Sector capacity.

CASE STUDY

KIMS Hospital

As the largest independent hospital in the county, KIMS Hospital feels it has a responsibility to ensure the people of Kent have options for accessing their healthcare. This includes bringing secondary care NHS services to the local community in a primary care setting as set out by the NHS Long Term Plan.

Over the last two years, the hospital has developed a series of orthopaedic outreach clinics across the county. This includes their flagship clinic based in Whitstable at Estuary View Medical Centre, part of the Whitstable Medical Practice and Vanguard site.

Working collaboratively with the GPs at Whitstable Medical Practice, the local area and triage services, patients can be referred directly to an orthopaedic consultant based at Estuary View Medical Centre. All appointments, including initial consultation, x-ray, pre-admission assessment, post-operative follow-up and post-operative physiotherapy are carried out in the primary care setting. The patient only attends KIMS Hospital for their surgery.

The clinics have been very successful with a 60 per cent conversion to surgery. KIMS Hospital attribute this to the fact that GPs are able to refer their patients to the right consultant first time. For those patients who are referred to KIMS Hospital for their surgery, they benefit from significantly shorter waits for their care.

On average patients are treated **within 17 weeks** from referral (against a national target of 18 weeks) for orthopaedics, compared with local NHS hospitals where patients often wait in excess of 35 weeks.

KIMS Hospital has received positive feedback about the service from both patients and GPs. Patients like the ease at which they can receive their care and not having to travel far for appointments. GPs appreciate the ease of access to consultants and ability to talk through patient cases. The triage services are able to access the consultants to refer cases for review saving time for them and the patients. The consultants value the service and the benefit it offers to their patients.

Conclusion

In many ways the NHS has changed beyond recognition in its 70-year history. The 2019 NHS Long Term Plan is an acknowledgement that it needs to change still further to continue to serve patients over the decades to come. But one constant among all this change is the model of partnership that lies at the heart of NHS provision. The partnership between independent and state-owned providers was there in 1948, is here in 2019, and will be a key contributor to the success of the long-term plan over the next ten years. Whether it be GPs, pharmacies, charities, social enterprises, private hospitals or other private companies – the support is there to deliver the capital, capacity and capability the NHS needs to meet growing demand and changing needs.

As the NHS looks to implement the Long Term Plan for the next decade, it is vital that these partnerships, just a few of which are showcased in this document, are strengthened to meet the needs of both current and future generations. The clear commitment all partners to the NHS have in delivering high quality, innovative and accessible care to patients, free at the point of use, has undoubtedly helped sustain the public's confidence in the service for so long. And as we look towards the decade ahead of the NHS, long may this continue.

Independent Healthcare Providers Network
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IHPN is the trade association representing the widest range of independent sector providers of clinical services ranging through acute, diagnostic, primary and community care, as well as dental services. Our members are drawn from both the for-profit and not-for-profit sectors and include large international hospital groups and small specialist providers.

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