Response to NHS Chief Executive’s Open Call for Evidence and Ideas

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NHS Partners Network response to the NHS innovation review

About NHSPN
1. NHS Partners Network (NHSPN) is pleased to submit this response to the NHS Chief Executive’s Innovation Review.

2. NHSPN represents the widest range of independent sector providers of care to NHS patients. Our members deliver care ranging from primary to acute elective provision as well as out of hours and home-based services. More than 42,000 clinicians – surgeons, anaesthetists, GPs, nurses and other healthcare professionals – are engaged by NHSPN members. Collectively, this makes up the largest group of clinicians outside traditional NHS organisations and includes in excess of 26,300 doctors, 9,000 nurses and 6,600 other healthcare professionals.

3. NHSPN is one of the networks of the NHS Confederation – the independent membership body for the full range of organisations that make up the modern NHS.

Introduction
4. All of NHSPN’s members are innovators – as relatively new providers to the NHS, the rationale for commissioning their services has been to bring in new ways of delivering care, benefiting from improvements in care quality and efficiency.

5. Our members have a diverse range of ownership models including not for profits, charities, social enterprises, privately owned businesses and floated companies. They share a commitment to delivering excellent care quality at NHS prices. Their ownership models support problem solving from perspectives that are different from traditional NHS models, drawing on experience from other sectors and international healthcare models.

6. Use of independent sector providers working in cooperation and competition with traditional models is a very effective way of introducing new practices into healthcare for NHS patients. The introduction of new models of provision directly brings innovation and indirectly encourages uptake by traditional NHS organisations which are able to learn from new models of care. Our members frequently work with NHS Trusts to share learning and encourage uptake of new, more productive ideas.

Examples of innovative practice
7. We have cited some examples of innovative practice below which explains some of the breadth of approaches that members have brought to NHS patients:

   a. **Healthcare at Home’s partnership with the Christie NHS Foundation Trust**
   Healthcare at Home (HaH) has worked for over four years in partnership with the Christie to enhance the treatment choices available to early stage HER2-positive breast cancer patients by offering the choice of IV treatment with trastuzumab at a time and location
which is convenient to the patient, for example in the comfort of their own home.

By working with HaH, the Christie has avoided a significant burden of administering trastuzumab in hospital to over 200 patients per year including 3,600 trastuzumab treatment cycles. All treatment is carried out under the direction of the patient’s consultant, who retains ultimate responsibility for the patient’s care and with whom close contact is maintained at all times. Patients have access to a local 24 hours a day, 7 days a week HaH nurse on-call service and a dedicated patient hotline at the Christie and can be repatriated to the Christie at any point during treatment if they so desire. The results are a safe, efficient model of care, enabling the Christie to manage workload demands and capacity more efficiently and effectively, reducing demand on the hospital’s pharmacy and, most importantly, high-levels of patient satisfaction.

b. Care UK
By using Entonox for colonoscopy at St Mary’s Treatment Centre, Portsmouth, Care UK has improved safety and increased the speed of recovery. The use of Entonox (a gaseous mixture of 50% nitrous oxide and 50% oxygen) self-administered through a mouthpiece, gives rapid onset short-term pain relief and relaxation during colonoscopy with no risk of overdose and rapid recovery. Controlled trials have shown that Entonox is safe to use and significantly reduces anxiety during and after the procedure when compared to intravenous sedation. These trials also show it does not cause reduced oxygen saturation or hypotension during the procedure nor does it increase discomfort. Studies have also shown that it is safe to drive after endoscopy with Entonox after just 20 minutes recovery time and that no escort is required, unlike conventional sedation methods where driving is not permitted for 24 hours post procedure and an escort is mandatory. A recent audit of 40 patients who underwent colonoscopy using Entonox at St Mary’s NHS Treatment Centre, Portsmouth, demonstrated a 97% completion rate with comfort scores graded 1 by both nurses and patients (using a score of 1-4 with 4 being the most uncomfortable) and 98% of patients agreeing that the procedure had been more comfortable than they had expected. Overall 33% of patients at the unit now choose Entonox for their colonoscopy for the benefits that it provides. This choice is being extended to all patients attending Care UK endoscopy units.

c. Connect Physical Health
Connect Physical Health is currently developing an innovative new service called PhysioNow. This builds on a very successful innovation that Connect developed over a decade ago called Physioline. Physioline was one of the first significant adoptions of telephone-based consulting and is fully integrated into its community MSK pathway. Despite being more than 10 years old, this remains a novel service to many commissioners and one which has been used with great success in improving care for NHS patients. PhysioNow represents a new stage which allows consulting to take place online delivering an experience for patients which is similar to social networking. Connect Physical Health has received a grant from a local development fund to develop the programme, but commissioners are sadly reluctant to dedicate funds to a ‘new idea’, choosing instead to focus on other priorities. This is disappointing given the strong evidence base to suggest
that early advice prevents chronicity and will significantly reduce the burden on the NHS especially in the context of wider pressures from demographic changes and the increasing prevalence of long-term conditions.

d. UK Specialist Hospitals
UK Specialist Hospitals (UKSH) has achieved exceptionally high patient satisfaction levels – 99% of its patients would recommend UKSH to a friend or relative. There are many elements of UKSH’s care model that contribute to this, of which one significant innovation is its team of Patient Experience Coordinators. These staff play an integral role ensuring that care meets individual patient needs along carefully planned clinically-led integrated patient pathways. By ensuring everything is fully coordinated from the outset – before admission, at admission and then throughout every stage of individual patients’ journeys – care is delivered with exceptional efficiency and accuracy. As well as improving safety, delays and waste are minimised through low DNAs and high theatre utilisation. Opportunities for reassuring interactions with all levels of staff are embedded into the process leading to efficient high quality care consistently achieving 99% patient satisfaction ratings.

e. Barchester
Barchester has been involved in many different examples of innovative partnerships with NHS organisations. For example, its partnership with NHS Norfolk at Woodside View in Norwich utilises telehealth systems to allow remote monitoring of areas like blood pressure, pulse, respirations, temperature, weight, blood oxygenation, glucose monitoring, peak expiratory flow and remote electrocardiographic monitoring, resulting in quicker medical interventions and reduced hospital admissions.

Enablers and barriers to innovation
8. NHSPN’s members have positive and negative experience of bringing solutions to the NHS. Many of the original requests by commissioners to consider bidding to provide services came from the recognition that independent sector providers may be able to address long-standing challenges by introducing innovative procedures and solutions. Members have also experienced frustrations at various levels where the objectives of delivering efficient high quality care have been obscured by inappropriate processes or misaligned intentions. For example:

a. Approaches to regulation and commissioning can focus on detailed process measures rather than considering what those processes were originally designed to achieve. Members have cited examples where regulatory hurdles have delayed or entirely thwarted the implementation of evidence-based pathway innovations and modifications relating to the physical design of facilities that would improve care. Similarly, the over-specification of process details during commissioning can restrict providers’ scope to deliver great outcomes through innovative approaches.

b. Incentives are not always aligned across the system. As a result, care which could be carried out more effectively and at lower cost in the community, for example facilitated by
telehealth and other new technology still remains largely located in large acute hospital settings.

c. Information requirements. NHSPN strongly supports the DH’s policies relating to choice of provider and treatment supported by meaningful information. However, it is far from clear that many of the numerous requests for information from the large number of organisations that have regulatory responsibilities relating to healthcare contribute to better quality or more efficient healthcare provision. This duplication of information requirements places a significant burden on providers and distracts from innovation. Moreover, the requirement for process-driven indicators can require old ways of working at the expense of changes that would otherwise deliver better care. NHSPN recognises that the DH's fundamental review of data returns represents an attempt to address this and we therefore broadly welcome the approach outlined in the current consultation. We would stress that the issue of data duplication goes beyond simple 'bureaucracy' and has a real detrimental impact on innovation.

d. Learning across organisations and intellectual property (IP). The rationale for robust IP protection is clearly to support innovation that arises from research and development. Many NHSPN members invest heavily in ensuring that the organisations develop new and smarter solutions which will bring a competitive advantage. It is entirely appropriate for organisations to protect their IP – how that is then used becomes crucial to adoption and spread. Protected IP can create a compelling rationale for its owners to invest in measures to encourage its wider adoption. This, after all, is the driving reason for protecting the IP in the first place. However, innovations which have not been protected appropriately risk losing that commercial driving force and this disincentivises their most powerful advocates for wider adoption. There will of course be many innovations which are not appropriate for IP protection, but compelling mechanisms to promote their promulgation can still be advanced through other approaches such as joint ventures etc.

Learning from elsewhere about adoption and spread

9. Align incentives. All parties involved in decision making must be able to benefit from better outcomes. This means institutional vested interests must not be allowed to frustrate innovation because incentives are misaligned. The outcomes framework represents a good start, but there is more to be done. Ultimately, innovation changes processes that lead to outcomes, so remuneration needs to follow outcomes rather than be pegged to process measures wherever possible. Clearly this needs to be balanced with information and supported by evidence so that funding follows within an appropriate timeframe.

10. Manage risk proportionately. Innovation always involves change and therefore presents challenges to regulatory approaches that are based on existing ways of doing things. Best practice regulation from other sectors, e.g. aviation, shows that regulators can act in a 'consultative' manner getting involved early in the process both to troubleshoot and also to understand how new approaches are likely to improve performance.
11. Understand the nature of 'disruptive' innovation. Innovation is disruptive because it creates change. In most commercial markets this means that organisations have to make comparable improvements when faced with successful innovators or they will go out of business. NHSPN members recognise that health provision cannot simply be withdrawn in the same way that can occurs in other sectors, but it is important that this protection should not act as a 'comfort blanket' to discourage the adoption of innovation across health care providers.

Actions at national level in the NHS

12. Regulation. As explained above, regulatory approaches need to focus on outcomes rather than process so that they can respond quickly and appropriately to innovations which will improve care. National policy needs to focus more on outcomes backed up by practical engagement so that individual inspectors understand the organisations they are regulating in more detail and are willing to engage earlier in the process of innovation.

13. Align incentives. National policy needs to ensure organisations are rewarded on the basis of clinical outcomes and improved efficiency rather than according to processes wherever possible. It is important that commissioners and providers share the same overall objectives and are incentivised accordingly. NHSPN has welcomed the Outcomes Framework as a mechanism to achieve this, but this is a starting point rather than a comprehensive solution. It needs to be developed further to reach all areas of care provision.

14. A clear failure regime. As discussed above, in most marketplaces disruptive innovation displaces organisations that are unwilling to adopt more effective working practices. A key driver towards adoption of innovation is therefore the need to respond to other organisations' improved performance. To facilitate this in the NHS needs a clear failure mechanism. In most cases, the presence of a failure mechanism and the recognition that this is a real prospect will be sufficient to encourage many organisations to adopt new ways of working.

15. Enforce full cost allocation and accounting in public sector providers. It is right that innovative practices should only be adopted if they can be seen to be cost-efficient or deliver tangible improvements in care quality. To be able to make this financial judgement, it is essential that a fair comparison can be made between potential providers and of the effective use of NHS outsourcing. The lack of full-cost allocation and accounting within the NHS is a significant barrier to assessing the value of adopting different delivery models. It is also an indispensable step towards increasing efficiency and productivity within the NHS.

16. Developing strong commissioning and scrutiny structures. The NHSCB will need to encourage the development of robust commissioning based on objective evidence at a national level and also provide sufficient support to local commissioners to develop appropriate skills to commission on outcomes. Similarly, health and wellbeing boards will require guidance and training if they are to scrutinise decisions effectively.

17. Working across health and social care. NHSPN welcomes the DH's commitment to closer working across health and social care. There are clear benefits to greater cooperation and this could
potentially improve the scope for innovation in this area. Members would like to see more examples of radical pilots looking at pooled budgets and joint commissioning which could prove the value of more innovative approaches. One area that could be particularly beneficial would be creating incentives and mechanisms to encourage a more co-operative approach to preventing unnecessary hospital admissions and encouraging discharge to appropriate settings.

18. Simplify (standard) contracting arrangements. It is a characteristic of the contracts in the NHS standard contracts suite that they start from a one-size-fits-all mindset, aimed at securing standardisation of the way in which the NHS delivers its various services. This runs completely counter to innovation and there is a pressing need for simpler, more proportionate contracts for services that genuinely differ from the core NHS circumstances. In practice this would mean:
   a. a greater sense of proportionality to encourage smaller providers and new entrants, including specialist and not-for-profit organisations;
   b. a move away from models which tend to perpetuate historic delivery patterns rather than encourage innovation;
   c. removal of measures that simply do not make sense for new types of providers, e.g. change of control provisions;
   d. adequate recognition of national independent sector providers that provide innovative services across the country and to many different commissioners and local authorities.

Actions at a local level
19. Commissioners need to focus on outcomes rather than over-specifying processes to get there. This will allow innovative providers to devise new approaches which may be more efficient and deliver better outcomes. While the Outcomes Framework represents a helpful and welcome broad structure, it is clear that there are many areas, e.g. rehabilitation, assisted living and telehealth, where the framework only has tangential reach.

20. Regulators need to get involved at an earlier stage in the process of innovation, developing a deeper understanding of the operational and business models of those organisations they regulate. As providers of care to NHS patients become more diverse, individual inspectors need to develop a broader and deeper understanding of different models of care so that they can be more responsive and understand the rationale for changes to traditional processes.

21. Health and wellbeing boards will need to work closely with local commissioners and providers to ensure that the best decisions are made in the interests of patients. This should include a presumptive right to request information from these organisations including reports relating to innovation.

22. Preventing unnecessary hospital admissions and facilitating appropriate discharge. A multi-disciplinary approach is essential to reduce the number of unnecessary hospital admissions and also to improve the speed of discharge by ensuring that post-discharge care is available for appropriate patients. For example, we know that older people are still being admitted by risk averse care managers and GPs. Access to safe and accessible alternative facilities would be a more cost-
effective and better solution for many patients and their carers. Telecare and telehealth solutions (see examples above) could also be part of the range of alternatives made available.

**Actions by NHS partners**

23. Joint ventures and shared learning. NHSPN members have indicated their willingness to become more involved in joint ventures and partnerships to share insights and learning with NHS Trusts.

24. Working with regulators. Just as NHSPN members recognise that regulators need to adopt a more outcomes-focused approach that is based on a deeper understanding of the increasingly diverse range of care models for NHS patients, so members also recognise the importance of developing relationships with regulators to help them develop these insights. Members have actively welcomed the CQC's commitment to an 'account management' approach and are keen to help local inspectors understand the broad range of care models now available.

25. Working across health and social care. Members have been actively involved in working in partnership across health and social care barriers to develop more effective ways of working. For example, Barchester has worked on joint project with Devon PCT enabling a GP and pharmacist to work within homes on a part-time basis. In just one 75-bed home, Lucerne House, savings on prescribed drugs are estimated at £47,000 per annum.

26. Promoting healthy living and preventing ill-health. NHSPN welcomes the Government's focus on public health. Independent providers should be encouraged to participate in local planning initiatives to facilitate preventative measures. Given the breadth of experience that independent sector providers bring, in terms of specific care provision and also broader commercial, technology and communications experience, we believe that independent sector providers are valuable partners in developing more innovative approaches to promoting better health.

**Further information**

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