



Acute Care: Understanding the priorities of the NHS Long-Term Plan

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Following months of speculation, the NHS Long-Term Plan was finally published last week. A comprehensive policy document, it provides important insights on priorities that will shape NHS organisation and service delivery over the next five to ten years.

Within these priorities, a wide range of acute care services are set to receive significant attention. Alongside widely expected initiatives to improve the quality of emergency care and maternity services, where NHS provision dominates, there are policy objectives targeting specific clinical areas that will be of interest to the private sector and investors.

This note identifies potential opportunities arising from acute care priorities in the Long-Term Plan. They will be of interest to various companies operating across the healthcare industry spectrum. Private hospitals should be pleased to see clear references to using their capacity to reduce lengthy waiting lists, whilst the planned extension of diagnostic capacity and innovation in cancer care are both likely to require knowledge and technical support.

Key highlights

- **Elective care referrals to private providers may increase as a result of the continued effort to reduce waiting lists**
- **The NHS will need to purchase more diagnostic equipment and expand capacity to meet disease prevention targets**
- **The focus on improving cancer survival sends positive signals for innovative treatment options**

Elective care referrals to private providers may increase as a result of the continued effort to reduce waiting lists

The Long-Term Plan confirmed that reducing waiting lists for elective care and eliminating long waits will be a priority. Having acknowledged that NHS capacity has failed to keep up with demand, the Plan sets out expectations for CCGs to increase the amount of planned care over the next five years. It also reminds commissioners and NHS Trusts about their responsibilities to ensure patient choice, including through the use of the private sector to deliver elective care:

- Patients must be offered choice about where to have their treatment, including the possibility to make use of capacity in the private sector
- Those waiting over six months must be given the option to receive treatment at an alternative provider

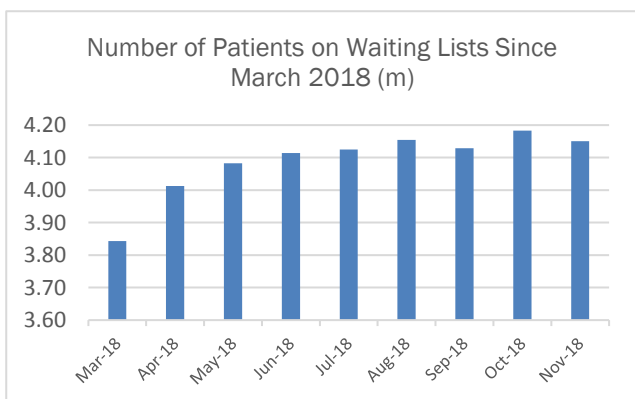
Private providers witnessed a significant slowdown in NHS referrals over the course of 2018. The Long-Term Plan will offer some reassurance to those more reliant on NHS referrals. Given that waiting lists reached unprecedented lengths in 2018, opportunities to support NHS providers reducing numbers are likely to arise over the next five years.

Details for this reduction are outlined in the recently published Planning Guidance. In the short-term, the objective is to keep the size of the waiting list to the levels of March 2018 (3.84m patients) by March 2019, before reducing the length of lists from April 2019. Latest available figures show that 4.15m patients were waiting for treatment in November 2018.

Reducing this number by over 300,000 may involve making use of existing staff by asking them to work additional shifts. However, given the size of the reduction expected from NHS Trusts, achieving it will require external support. Some Trusts, like Plymouth, have entered into partnerships with private hospitals to address demand pressure over the short-term. Whilst these approaches may be replicated in other forward-looking areas, private providers are more likely to be subject to agreeing ad-hoc outsourcing contracts.

Waiting Time Targets

Under the NHS Constitution, patients diagnosed with a non-urgent condition have a right to commence treatment within 18 weeks of referral. Metrics measuring this performance were introduced in 2012. They state that 92% of patients who have been referred for elective care should start treatment within 18 weeks of referral. This target was last achieved in February 2016.



Source: NHS England

Plymouth Trust and Care UK: an example of partnership to reduce orthopaedic waiting lists

Last October, University Hospitals Plymouth Trust entered into an 18-month partnership with Care UK for elective orthopaedic services. Under the terms of the agreement, NHS surgeons can perform non-urgent, non-complex operations at a hospital operated by Care UK. This is intended to free-up operating theatre capacity at Plymouth Trust and progressively reduce waiting lists.

Experience shows that the number of patients waiting for elective care has historically increased rather than reduced between November and March. This suggests that waiting lists will not reduce substantially by the end of winter. However, in recent months, there have been improvements in reducing the number of patients waiting over 52 weeks.

The reintroduction of financial penalties for NHS Trusts and CCGs breaching this upper limit is expected to sustain efforts towards arranging treatment for these patients. Penalties had been suspended since 2016/17 and were originally addressed to NHS Trusts only. Holding CCGs accountable as well means that they will have greater incentives to support NHS Trusts in achieving results and may provide administrative help, including outsourcing.

Demand for private sector support is likely to vary across NHS Trusts. Local areas are responsible for choosing their method to reduce waiting lists. Their decisions will be shaped by the size of local waiting lists, local relationships, and the ability to mobilise existing and additional staff. Finances will also influence the ability to outsource elective care. For example, reducing waiting list by 300,000 by March 2019 is estimated to cost between £400m and £600m. To put these numbers in perspective, NHS Trusts are expected to register a collective deficit of £558m in 2018/19. From April 2019, the expectation is that CCGs will have received sufficient funding under the NHS multi-year settlement to finance the increase in elective care activity.

The NHS will need to purchase more diagnostic equipment and expand capacity to meet disease prevention targets

Clinical priorities in the Long-Term Plan focus on prevention and enabling early diagnosis of diseases responsible for early deaths. Several existing screening programmes will be extended, with more to be announced following the conclusion of the review of current screening programmes and diagnosis capacity.

Screening programmes	Coverage extension and tests improvements
Bowel cancer	<ul style="list-style-type: none"> • Screening age lowered from 60 to 50 • Introduction of a new test to increase screening take-up
Cervical cancer	<ul style="list-style-type: none"> • Introduce HPV primary screening by 2020 to increase sensitivity and reliability of test results
Lung cancer and respiratory diseases	<ul style="list-style-type: none"> • Extension of lung health checks by 2022 • Increase the number and deployment of mobile lung CT scanners
Cardiovascular diseases	<ul style="list-style-type: none"> • Improve monitoring of those presenting high-risk of developing cardiovascular diseases • Expanding access to genetic testing for Familial Hypercholesterolaemia, with the goal to improve the number of people diagnosed from 7% to 25% over the next five years • Improving access to echocardiography

Implementing this vision of prevention and early diagnostic will require clinical and technical expertise which may not exist in the NHS currently. It creates potential opportunities for private organisations able to offer additional capacity. For instance, there are clear workforce shortages in radiology and radiography. The reorganisation of diagnostic imaging services into networks could help the NHS using its current capacity more efficiently. However, the networks are unlikely to be in place before 2023. In

the meantime, the introduction of a 28-day diagnosis standard for cancer by 2020 will put pressure on NHS services to deliver quick and definitive results to patients.

In terms of equipment, commitments to commissioning new CT and MRI scanners should be viewed as positive news by manufacturers. Some projects, such as Liverpool's new £20m diagnostic centre, are already under way. However, those interested in understanding the full size of the opportunity will have to wait until the announcement of capital budgets in the Spending Review later this year. In the meantime, the intention to deploy more mobile CT scanners, targeting lung health screening, in 2019 may offer opportunities to providers operating in this space.

The focus on improving cancer survival sends positive signals for innovative treatment options

Improving cancer survival has been confirmed as a major priority for the NHS over the next five to ten years. Building on previous initiatives such as the Cancer Drug Fund, the Cancer Strategy and elements of the Life Science Strategy, the Long-Term Plan aims to support the creation of a favourable environment for the life science industry.

Objectives around increasing adults, children and young people's participation in clinical trials will be of interest to cell and gene therapy developers working on cancer treatments. Increasing participation will be supported by systematic use of genome sequencing tests. From 2019, all children diagnosed with cancer will be able to access these tests. A similar programme will be rolled out for adults over the next decade. Test results will help matching patients with clinical trials, supporting data collection throughout the various stages of drug development. Access to patient data and tissue samples for research will also be facilitated by simplifying and clarifying patient consent.

The willingness to support innovation reflects the commitment to protect the life science industry from potential negative Brexit impacts, and make best use of the universal nature of the NHS to position the UK as a world leader for life sciences.

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