HealthInvestor round table

Capsticks

Tomorrow's world: Drivers for success in a changing health market

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Tomorrow's world: Drivers for success in a changing health market

When Aneurin Bevan founded the National Health Service in 1948, he may have struggled to imagine the scale of the challenges facing his creation in 2014. Guaranteeing equal access to healthcare – free at the point of delivery – was a major ambition in an age where men, on average, died some eight months after retirement. In an era where male life expectancy approaches 80 years of age, and vast numbers of the population are living with chronic conditions, the NHS is struggling to meets it original obligation – not least in a period of severe financial constraints.

While the enormity of today's health service would have been a surprise, it is fair to say that Bevan would recognise the structure of today's NHS as broadly similar to the tripartite system he founded, where care provision was delivered in primary, community and hospital settings. But as UK healthcare enters into a period of austerity, ongoing structural change and political uncertainty, it is clearer than it has ever been that the NHS needs to modernise – and while this represents a huge challenge to its leaders, it also creates unprecedented opportunity for innovation.

To consider how the UK healthcare system can make this a reality, then, *HealthInvestor* and the specialist health law firm Capsticks held a round table discussion with sector leaders to consider what it takes to succeed in this challenging environment.

Vernon Baxter: I'd like to start with the word innovation – we use it a lot in healthcare, but what does it actually look like in practical terms. Roger, can we start with you?

Roger Killen: I look at healthcare and think it's very, very rich in resource, particularly human resource. The quality of the staff in the NHS is kind of amazing, but how well is that resource allocated? If you do start to support that workforce, then you really can improve resource allocation. You improve flows of care, you can lower the costs of care and you improve the outcomes of care.

Vernon Baxter: Karol – you've worked in both public and private sectors, do you agree?

Karol Sikora: Having gone into the private sector, it's really refreshing that we don't have any notes – everything's on the cloud. Even the detailed radiotherapy and chemotherapy schedules, they're all up there somewhere. I don't really understand the whole business, but it works. Having been clinical director for 15 years at Hammersmith, you didn't know how much anything cost and the doctors all messed around with you. They still do in the private sector, but you do have control, you know the budget, you know how much it will cost to implement a change, and you're able to innovate with new technology.

Vernon Baxter: Jenny, Beacon is something of a new entrant to the market – can you see the UK embracing these developments?

Jenny Palmer: I work for a US company which is based on an insurance system where every single health interaction has

a transaction against it, so there's a very rich data set. We know when you look at a stepped care model of delivery at the higher end, care is much more expensive and we want to get people through a genuine recovery down to lower intensive setting. So I fully believe in the principles of what we're trying to achieve. We are now in a position where we have got a very healthy pipeline, but it's got some way to go and it surprises me that more hasn't been done given the stark challenge and the cost to the economy of the whole of the mental health problems.

Mike Clifford: The key word at the moment seems to be integration. The NHS gets it; they know they've got a flat or declining budget. The commissioners are looking at these big contracts where they get an integrated solution through a prime contractor model. We're seeing this at places like Staffordshire, where two contracts are out for cancer and end of life care, worth about £1 billion. We've just been advising the winning bidder on the Cambridgeshire contract which is £800 million over about five years. So we are seeing some real innovation on the part of the NHS being driven by the commissioning regulations to some extent.

Allan Johnson: When CCGs first formed they did a very good job of declaring what their intentions were and I think we all got very excited by that. I don't think they were able to achieve as much in their first year as they thought they would and I think they were impacted by lots of other things. It's not because they were sitting on their hands doing nothing. They've been fantastically busy. A lot of them have struggled to fill some of the positions that they've had and we've seen a lot of change. There's more going on and they might just be developing a rhythm to commissioning. However, the macro system is not one that is encouraging change in the NHS. There isn't a reward there for investing in your own system for benefits downstream whether it's in a GP practice or in a community nursing set up. In fact it's not that there is no incentive, you also can't afford to do that.

Mike Clifford: Parts of the NHS will always wait for commissioners and the system to dictate how they can change. The really innovative people are providers who are getting together and providing the solutions up front to the commissioners.

Karol Sikora: When you deal with the NHS, you can go as a partner to the provider to supply extra capacity. Another way is to go direct to the commissioner, but that's much riskier and subject to sabotage. Then the third way, which is neutral and probably a win-win is to say we'll manage your private patients for you and we'll do it as a joint venture. So you increase capacity for the NHS patient and we'll take the private and give them a different experience. It's like business class and economy class on a plane. But it really is difficult to get to people with the power to make any decision and that's our biggest problem.

Giles Johnson: Ultimately it boils down to the ability to predict. If you can take the patient population of a certain geography and say we know this is what's going to be suffered over the next year, you can then obviously contract that quite easily. The problem with the contracts is either how tight and prescriptive they are, or how loose and framework-like. The more there is a commitment and a hard prediction, the more providers can bid with lower margins. The issue of profit is a very emotive one and a very important part of the debate.

Roger Killen: Actually all the data is there, but so often it's on bits of paper here, and bits of paper there. With the Learning Clinic, I thought I'm going to make it so convenient for the clinician to provide that data that we'll be able to analyse it at scale – and that's when you start getting really informative pictures about what's happening in terms of the care.

John Muolo: I used to sit on a CCG as an executive director, only during the ▶

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time when we did the intention and then I left. You want to make things more efficient, but then you need to find the money to pay for it – they don't match.

Mike Clifford: But I think procurement practice also comes into this. I can think of a couple of examples where a hospital has looked at a managed equipment service and they, in their own business case, have booked the savings, but three and a half years later they're still getting round to signing it. I know there are conversations to be had, but if it takes over three years to do a managed equipment service contract, that's worrying.

Jayne Cassidy: In Kent, two trusts are in special measures and one's being inspected this week, but the incredible frustration is we are a 100-bed capacity, five theatre hospital with an intensive care unit open but NHS patients are unable to use our hospital. I've been talking to CCGs for nearly a year now to get into contract for opening in April. But actually getting into a contract to run services for patients as an 'unqualified' provider is very difficult. The NHS are bringing me into crisis calls to say there's no beds in Kent, and I go, 'I've got 10 beds, have them'. It doesn't appear to be that it's a funding issue, it's almost an inability to contract with a new provider with no track record. Our track record comes with our consultants, and we've got good outcomes and good data, but it does appear that people have an inability to contract if it's not the right time of year to be talking about it.

Jenny Palmer: As another 'no track record' organisation, we've actually got 18 years' worth of data that shows people with mental health problems actually spend most of their money in acute care. We've said multiple times that the big win here is in acute, if you can only put a capitated amount of money around these people, but it feels right now like it's a massive step too far. Our skill is in coordinating these complex people across the whole system, but we haven't found commissioners who have the commercial savviness and also the level of seniority where they can make that decision.

Rachael Heenan: This is actually about drivers for success, and we've talked quite a bit about the problems. So how do we empower the workforce? How do we show them the way?

Karol Sikora: It's interesting because there's a trust issue, as well as a knowledge gap. So the commissioners have to trust the providers, but I can imagine as a commissioner, often they almost sound too good to be true. Therefore there's a suspicion it must be down to cherry picking. Also, as individuals, they have nothing to gain. They don't have equity. They don't get a pay rise. They don't get bonuses. Why should they work the weekend and improve things? The rest of us do have that extra level of incentive. What it means is, the risk therefore has to be vested on the provider side – you've got to just go and sink considerable sums of money and time, and trust the fact that your understanding of the local market means that the patients will come, one way or another, and the commissioners will eventually get it. It feels as if all the risk and trust is pushed on to that side of the fence.

Jayne Cassidy: There's no incentive for the staff within the NHS to get involved. They see nothing in it for them. Except trouble.

Vernon Baxter: One thing that appears to have gone quiet is the choice agenda? Why is that?

Jenny Palmer: There are, I think, 51 mental health trusts across the country. Generally there's one trust for two counties. So with patient care there's absolutely no choice of provision and it's interesting listening to the conversation about up front capital investment because as a business, we're about recovery and in mental health that's not about farming people and beds, it's the exact opposite model. Again, commissioners are used to procuring beds and that's what they understand and what's in it for them. What actually am I procuring from you, what are you going to do? That's a very difficult cycle to change.

Mike Clifford: I think there's a bit of cynicism around price. There is a real sense that the NHS cannot lift its head above getting the distinction between the cheapest bid and the one that delivers the most value for money. That's what they're meant to deliver under procurement. But the feeling private sector providers have is, that it's the one who can come up with the smallest number.

Vernon Baxter: What impact would price competition have on the funding challenge?

Karol Sikora: Given the size of the forecast deficit of £30 billion there's no way any government could increase tax to recover that. Inevitably we're going to see a cutting back of NHS care provision and a dampening of demand somehow. But it's very difficult to do that with a population that is used to getting everything completely for free. In our case in cancer, the cancer drugs fund is going to be cut drastically next year. So all round you can feel it, this clawing back and the idea of the private sector coming along to provide more efficiency makes such good sense. We can all do it because we're all specialised. It's like an airport where you've got different airlines using the airport infrastructure. It would make specialist healthcare cheaper.

Allan Johnson: I don't believe you can limit primary care in this system. If you create the bottleneck at the entry point to the NHS, people get frustrated and go straight to the more expensive bit. If I were responsible for the whole budget for that patient, then I want them to come in to the GP early, because the data should tell me there are people at risk and if I can fix them before they know they're broken, then I stand a better chance of being able to deliver really good healthcare to them.

Vernon Baxter: Isn't it the role of CCGs to make these arguments?

Jenny Palmer: Our experience with CCGs is that they are willing to have that sophisticated conversation, but as soon as they do, their head is right above the parapet. Then they feel incredibly exposed.

Allan Johnson: And that's not because they're timid. They're not. It's just that the NHS changes so often. So are you going to invest all your time and effort and then somebody's going to change it next May?

Karol Sikora: No-one knows what's going to happen there and all three parties are posturing themselves about the NHS in ▶

a completely disruptive way. It's all just catching votes without actually having a plan. It's just appalling that we tolerate this as a public, you know. If NHS is really the number one concern, why can't the politicians come up with a proper plan that they would stick to?

John Muolo: When I sat on the PCT that eventually became a CCG, some women who worked there for a long period of time said this was the fourteenth change that they'd seen in their career. They had no reason to really go for it because it kind of went back to where it always has been.

Vernon Baxter: Going back to Rachael's point about drivers of success – what is it going to take to succeed is this market?

Karol Sikora: It's just persistence and patience. That is the most difficult thing and it drives investors mad. They say 'when will you get the contracts?' In the old days I was a professional beggar for cancer charities. It's the same answer – you'll have to wait. There's nothing you can do to speed it up. We're incentivised financially and our staff are by getting contracts, and it leads to change and increasing scale of operations but the other side is not incentivised in that way so it's rather difficult. Persistence is the thing.

John Muolo: If I was a funding company, I would look for a company that brought care to more

people by less expensive professionals in less expensive settings. That's the type of innovation I would look for if I was actually putting money into these things.

Giles Johnson: We have a mantra at CiL which is you understand the economics first and the politics second. Get your moral compass right, so that you can look commissioners in the eye and when they challenge you on the profit motive you know you've got a good answer, and then you can iterate that and work very hard to navigate the politics. The politics will always change, nationally and locally.

Roger Killen: The system needs to spend more money on prevention because it is astonishing that such a small cohort of patients require so much healthcare resource. You've got to have a system that case manages these complex patients.

Jenny Palmer: Where we've got most traction has been by bringing the stats and evidence based on 20 years' experience to say 'we know the caseload you should be managing, we know how to follow up on people'. It's doing those activities that are very close to clinical care, but are not clinical care, and doing them in an evidence-based way. ■

The above is an edited transcript and is not reported verbatim. The panel met in central London on 9 October. For information on HealthInvestor round tables, call Elizabeth Matthews on 020 7451 7058 or email elizabeth.matthews@investorpublishing.co.uk

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THE FINAL WORD

While there are undoubted obstacles for new entrants and existing businesses in the healthcare market, our clients' experience is that there is a lot to be positive about, and this debate reflected that.

Evidence from the NHS Support Federation is that there has been a threefold increase (to £13 billion) in the value of tenders advertised in the last year, incorporating a greatly expanded list of services (up from 40 to 70 service lines). Importantly, more than half of the contracts awarded since April 2013 have gone to non-NHS providers.

And the driver for this? Participants were divided as to whether it was due to more mature and ambitious commissioning or changes to procurement and competition rules themselves which require commissioners to focus on key outcomes and in particular through integration.

Whichever it is, the large scale integration contract for cancer and end of life care in Staffordshire; the five-year £800 million contract for older person's healthcare in Cambridge and Peterborough; and the outcomes based five-year MSK £120 million contract awarded to Circle Healthcare suggest that the market is changing.

Our panel concluded that while some of the traditional obstacles still exist (such as 'stop/start', unclear and abortive procurements, or an unbalanced focus on 'cheapest' rather than 'value for money' and the reluctance to adopt new technologies without a strong evidence base), there are good opportunities out there for independent providers who are prepared to look for ways to support the system in a move away from its traditional, risk averse mindset to deliver improved care for patients. ■

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