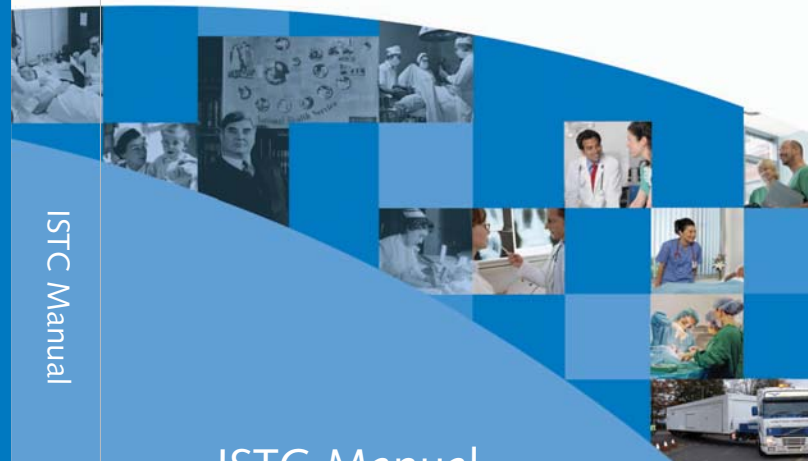


ISTC Manual

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Disclaimer

This manual is intended to provide readers with a general overview of Wave 1 of the ISTC Programme. Although every effort has been made to ensure that the information contained in this manual is accurate as at December 2005, no guarantee can be given as to its accuracy. It should not be considered as giving, or being a substitute for, legal, commercial, financial or clinical advice on any individual scheme or the IS Programme generally, nor as a definitive statement of Department of Health policy. Readers are encouraged to visit www.dh.gov.uk for updates to this manual and for further information about the IS Programme generally.

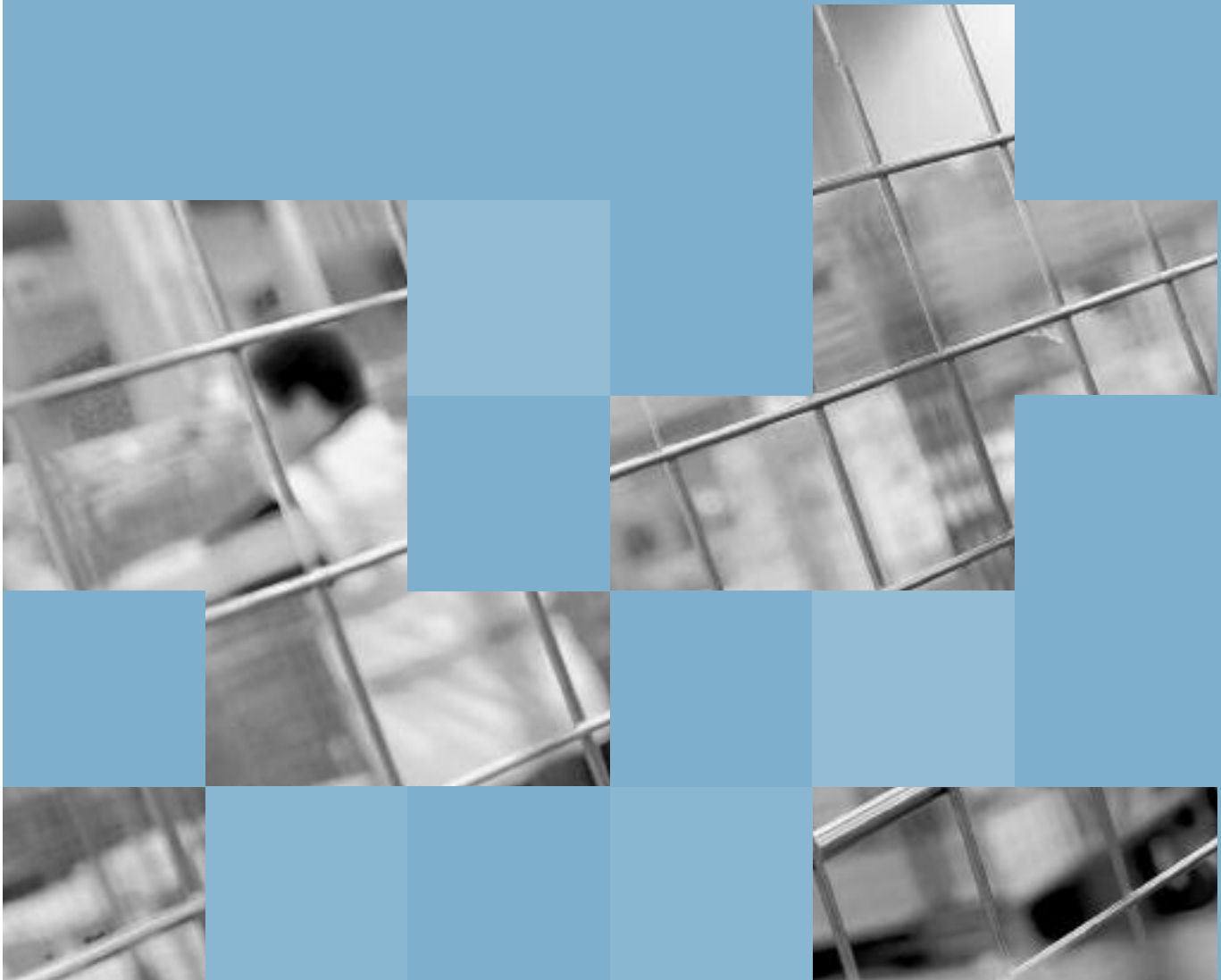
Section A

Overview



1

1. Overview



1 Overview

1.1 Scope

1.1.1

The purpose of this manual is to explain the background to Wave 1 of the Independent Sector Treatment Centre (ISTC) Programme, the key issues relating to it and the ways in which Wave 1 works in practice. This manual is not intended to cover other aspects of the IS Procurement Programme such as the General Supplementary Procurements, the MRI Procurement or Wave 2 of the ISTC Programme on other pathfinder projects (e.g. CWICs & Chlamydia) in England.

1.2 Content of the Manual

1.2.1

This manual is divided into three sections as follows:

1.2.1.1

Section A – Overview;

1.2.1.2

Section B – Clinical;

1.2.1.3

Section C – Operational Issues.

1.2.2

The sections are subdivided as follows:

1.2.2.1

Section A consists of the following sub-sections:

- (a) this sub-section 1;
- (b) sub-section 2, which sets out the background to the recent healthcare reforms and the key thinking and drivers behind them;

- (c) sub-section 3, which sets out the ISTC Programme concept and how it fits in with the key aims of increasing capacity and delivering choice;
- (d) sub-section 4, which sets out the specific aims of the ISTC Programme;
- (e) sub-section 5, which sets out the key principles upon which the ISTC Programme is founded; and
- (f) sub-section 6, which sets out the key terms of the generic Contract which forms the basis of the contractual relationship between the NHS parties and the Independent Sector (IS).

1.2.2.2

Section B consists of the following sub-sections:

- (a) sub-section 7, which sets out the clinical aspects of the ISTC Programme and explains the performance management regime; and
- (b) sub-section 8, which sets out the clinical governance issues which underpin the ISTC Programme.

1.2.2.3

Section C consists of the following sub-sections:

- (a) sub-section 9, which deals with staffing and workforce related issues;
- (b) sub-section 10, which sets out how training is provided in ISTCs;
- (c) sub-section 11, which reviews the different property and infrastructure solutions that have been adopted as well as the requirements with which Providers are contractually obliged to comply;
- (d) sub-section 12, which sets out the non-clinical services which Providers are required to provide;
- (e) sub-section 13, which sets out the ways in which the NHS monitors and manages the Contracts once they are up and running;
- (f) sub-section 14, which sets out the Information Management and Technology (IM&T) requirements with which the Providers must comply;

- (g) sub-section 15, which sets out the ways in which the NHS assures the integration of ISTCs into local NHS healthcare economies;
- (h) sub-section 16, which sets out the ways in which the Sponsors make payments to the Providers and the instances when Providers can suffer financial penalties for any failure to perform the contractual services to the required standards; and
- (i) sub-section 17, which sets out what happens when the Contracts are terminated or expire.

1.2.2.4

Section D consists of:

- (a) the Glossary.



2

2. Background to the ISTC Programme



2 Background to the ISTC Programme

2.1

The ISTC Programme is part of a major initiative to create additional capacity within the NHS to reduce waiting times and introduce choice for patients.

2.2

The key policies that support the ISTC Programme are set out in the following documents:

2.2.1

The NHS Plan: a plan for investment, a plan for reform (July 2000)

2.2.2

The DH Prospectus *Growing Capacity* (December 2002)

2.3

The NHS Plan sets out that:

- By 2005, no patient should wait more than three months for an initial out-patient appointment and no longer than six months for any in-patient treatment they may need; and
- By 2008, the wait for in-patient treatment is set to reduce to three months.

2.4

In October 2002, the DH conducted an extensive forward planning exercise, during which all Strategic Health Authorities (SHAs) were asked to identify, in conjunction with their respective Primary Care Trusts (PCTs), any anticipated gaps in their capacity needed to meet the 2005 waiting time and the provision of patient choice.

2.5

The result of this exercise led to the identification of a large number of capacity gaps across England, particularly in specialities such as cataract removal and orthopaedic procedures.

2.6

Growing Capacity re-iterated the waiting time targets for 2005 and 2008 as set out in the NHS

Plan. It concluded that, in order to sustain lower waiting times while continuing to treat patients according to clinical need, a permanent structural increase in the volume of health care services delivered to patients would be required. Delivering that increase in permanent capacity is a core function of the ISTC Programme.

2.7

A national consultation on choice survey, published on 1 September 2003, sought the views of a wide number of stakeholders, the public and NHS staff, as well as patient and professional groups, on how to extend choice in a way that would create more personalised care whilst also promoting equal access and fairness in keeping with the principles upon which the NHS is founded. The findings indicated that patients a) want to become more involved in decisions about their healthcare; b) want the right information in order to make such decisions about their choice of treatment; and c) want services to be shaped around their needs.

2.8

Growing Capacity and the NHS Plan set out the following objectives:

2.8.1

That IS Providers will increase their contribution to the care of NHS patients and may provide up to 15% of elective surgical procedures and an increasing number of diagnostic procedures by 2008; and

2.8.2

By 2008, patients will have the right to choose from any healthcare Provider that meets the Healthcare Commission's standards and that can provide the relevant care at rates which are equivalent to the then NHS tariffs, are affordable and represent value for money.

3. The ISTC Programme Concept



3

The ISTC Programme Concept

3.1

The ISTC Programme is designed to fit in with the key objectives of providing the NHS with additional clinical capacity and increasing patient choice.

3.2

Wave 1 of the ISTC Programme was announced in October 2002. It will provide up to 171,000 FFCEs a year over five years and represents an investment of approximately £1.6 billion.

3.3

The first Wave 1 ISTC Contracts were signed in September 2003.

3.4

The first ISTC (Daventry) commenced service in October 2003.

4. Aims of the ISTC Programme



4

Aims of the ISTC Programme

4.1

The ISTC Programme is intended to be an efficient and cost-effective use of Independent Sector (IS) capacity and capability to reduce waiting times and offer more choice to NHS patients. ISTCs provide elective surgery procedures for a range of conditions, including orthopaedic procedures and cataract removal.

4.2

The additional capacity offered by the IS is an important part of the NHS's strategy to reduce waiting times. As dedicated and streamlined facilities, ISTCs are able to offer patients scheduled procedures at pre-booked times with many procedures being completed during the day, allowing patients to return home quickly without the need for prolonged hospital admission. ISTCs are generally separate units and so are unaffected by emergency or seasonal demands that can affect other providers in the NHS.

4.3

The additional capacity offered by the IS also creates the opportunity for more patient choice. This is because the ISTCs are able to offer innovative solutions which enable patients to access care where they need it, for example by providing clinical services from mobile or modular units, by utilising under-used existing NHS facilities or by constructing new facilities.

4.4

The core objectives of the ISTC Programme are to:

- (a) assist the NHS in reducing waiting times;
- (b) support the shift from secondary to primary care;
- (c) expand plurality of provision;
- (d) promote innovative service models; and
- (e) contribute to the long-term development of relationships between the IS and the NHS in the attainment of local NHS targets.

4.5

The ISTC Programme envisages that the IS can help achieve these objectives by:

- (a) providing additional capacity to the NHS;
- (b) offering innovative thinking and solutions in terms of delivering safe, high quality services and, in doing so, achieve value for money;
- (c) complementing existing NHS-provision and working as part of an overall programme of care for the patient that is integral to that of the local health economy; and
- (d) being viewed by the patient as constituting an integral part of the NHS, with care remaining free at the point of delivery.

5

5. Key Principles of the ISTC Programme



5 Key Principles of the ISTC Programme

5.1 NHS Principles

5.1.1

The ISTC Programme is intended to complement existing NHS services. The services offered by Providers as part of the ISTC Programme must be delivered in accordance with NHS principles, i.e. with treatment free at the point of delivery and available according to clinical need, not ability to pay.

5.1.2

The ISTC Programme is one of a number of initiatives designed to modernise the services provided by the NHS and encourage a situation where there is plurality of healthcare providers which will, in turn, bring more choice, more innovation and more efficiency. Creation of a sustainable IS market is intended to:

- help raise standards throughout the NHS;
- give NHS patients more control over their own health and the services available to them;
- offer NHS patients a wider and more diverse range of treatments and providers; and
- improve patient access to healthcare services.

5.2

Innovative and Diverse Solutions

5.2.1

The ISTC Programme is not intended to offer a “one size fits all” solution to the aims of increasing capacity, reducing waiting times and improving

patient choice. Rather, the ISTC Programme has been designed to allow the IS to work in partnership with local healthcare economies to provide solutions which reflect and cater to local requirements. The ISTCs are being set up and run by leading international IS healthcare companies, which have extensive experience of running elective surgical centres and diagnostic facilities. The ISTC Programme encourages the IS to utilise its experience to offer innovative solutions to local requirements. No ISTC is quite the same as another, although all ISTCs are required to comply with certain key principles and relevant requirements (in addition to all regulatory standards) which are discussed below.

5.2.2

Various innovative solutions have been adopted and the variety is most easily seen in the ways in which Providers have chosen to provide the facilities from which the ISTCs operate. In all cases, the Providers have sole responsibility for the design and, where applicable, refurbishment or construction of the various facilities. The range of solutions that has been adopted is as follows:

- mobile solutions where the Provider supplies clinical services from mobile units which can be set up on agreed sites to improve access to healthcare services for patients in remote areas;
- construction of new facilities whether on sites owned by NHS bodies or on private sites;
- refurbishment of existing NHS facilities; and
- utilising existing IS capacity.

5.3

Additionality

5.3.1

The policy of Additionality underpins the IS supply of services under the ISTC Programme. The policy of Additionality for Wave 1 of the ISTC Programme can be described as follows:

“HM Government's policy of increasing the current clinical and human resource capacity of the NHS which operates by seeking to ensure that Independent Sector providers of clinical services to the NHS provide such services using human resource capacity which is genuinely in addition to that available to Health Service Bodies by way of doctors or other healthcare professionals directly employed or engaged by those or other Health Service Bodies from time to time.”

5.3.2

The policy of Additionality is designed to prevent a draining of NHS human resource capacity, which would be likely to result from Providers recruiting healthcare professionals who are currently employed or engaged by the NHS. Such recruitment could result in a fall in overall capacity and defeat the purpose of the ISTC Programme as a whole. Additionality is also seen to carry with it a number of ancillary benefits (e.g. bringing additional knowledge and innovation to the NHS).

5.3.3

In support of the policy of Additionality, Providers on Wave 1 of the ISTC Programme are, in general terms, prevented from:

“employing or engaging for the purposes of providing the services under the Contract any doctor or healthcare professional who has been employed or otherwise engaged by a Health Service Body within the previous six month period.”

5.3.4

In order to operate the Additionality policy reasonably and fairly, an exceptions mechanism has been put in place. This mechanism allows Providers to apply for a waiver of the contractual Additionality restriction where they wish to employ or engage an individual in circumstances which would otherwise breach the Additionality restriction. Waivers may be granted on an exceptional case by case basis where the Sponsors are satisfied that an individual's recruitment to the ISTC Programme will not undermine the fundamental principle of Additionality. Waivers may, for example, be granted to those categories of healthcare professionals who have for some time been performing a purely administrative or managerial role within the NHS.

5.4

Workforce issues

5.4.1

The ISTC Programme is designed to contribute to the additional levels of elective surgery activity needed to meet waiting time targets. This requires a genuine increase in capacity, including workforce capacity. The Additionality policy is designed to prevent a draining of NHS human resource capacity. In addition, on some schemes (which involve a transfer of activity from the NHS to the Provider), the Retention of Employment Model will be deployed as the mechanism to ensure that there is no unintentional transfer of NHS staff to the Provider. Under the Retention of Employment Model, relevant staff will remain employed by the NHS and either redeployed by the relevant Acute Trust and/or given the opportunity to be seconded to the Provider (on either a part-time or full-time basis).

5.4.2

The Retention of Employment Model has been the subject of consultation (both at a national and local level) with trade unions and staff side bodies. This model has already been rolled out for a number of NHS hospital PFI schemes. The adoption of the model in the context of the ISTC Programme supports the policy of long-term staff retention in the NHS, which is one of the objectives of the ISTC Programme.

5.5

CNST

5.5.1

The NHS's Clinical Negligence Scheme for Trusts (CNST) covers NHS patients treated in ISTCs. This means that Providers do not need to insure in the commercial market against the risk of clinical negligence in relation to NHS patients. The CNST is a risk-pooling scheme of which all PCTs and Acute Trusts are currently members. In return for an annual contribution, members of the CNST are indemnified against damages and out-of-court payments which may be awarded to NHS patients and/or their dependants in the event of negligent care or treatment.

Accordingly, NHS patients have exactly the same rights and protection in respect of clinical negligence in an ISTC as they would have if the treatment had been provided in an NHS hospital.

5.5.2

The NHS Litigation Authority (NHSLA) administers CNST on behalf of the Secretary of State for Health. Its responsibilities include:

- setting the level of annual contributions payable by members to the CNST fund. Those contributions are determined on the basis of the quantum of current claims and an actuarial assessment of the risk presented by the PCT or Acute Trust concerned. The latter is determined on the basis of the number of whole-time equivalent staff that the relevant member has engaged in particular clinical areas, each clinical

area being weighted according to its inherent risk (obstetrics and gynaecology, for example, being weighted higher than other areas of clinical practice). Members' contributions may be adjusted upwards or downwards depending on their claims history and level of compliance with relevant risk management standards;

- setting risk management standards for PCTs and Acute Trusts. The aim is to seek to mitigate the risks borne by the CNST as a whole by encouraging members to adopt best practice in areas such as the keeping of patient records, obtaining informed consent from patients before surgery etc.; and
- claims handling. The NHSLA handles claims made by or on behalf of NHS patients or their dependants. It has a panel of solicitors which acts on its behalf. The vast majority of claims are settled out of court, if negligence has been established.

5.5.3

Current legislation does not allow Providers to be members of the CNST in their own right. The protection of the scheme is therefore extended to Providers by means of a contractual indemnity from referring PCTs under the provisions of the ISTC Programme Contracts. As the PCTs are themselves protected by the indemnity afforded by the CNST, they are in a position to hold the Provider harmless against claims by NHS patients. The Contracts impose a range of obligations on the Providers in relation to the CNST, including:

- assuring compliance with relevant risk management standards; and
- setting out the actions the Provider must take when faced with a patient claim.

5.5.4

PCT contributions to the CNST fund will be adjusted by the NHSLA to take account of the referrals they make to ISTCs. Providers are not required to make contributions to the CNST fund. However, the Providers may be required to contribute to a Sponsor PCT's contributions if its claims history is worse than the NHS average for a comparable casemix.

5.6

Payment

5.6.1

Take or Pay

5.6.1.1

The Contracts provide the IS with a revenue stream that is guaranteed for a period of five years and are structured on a “Take or Pay” basis.

5.6.1.2

It is necessary to guarantee the Providers' revenues for a five year period in order to benefit from the competitive pricing structures that the Providers are thus able to offer.

5.6.1.3

The contracting mechanism through which these guarantees are provided is known as the Minimum Take. This is the minimum revenue amount guaranteed to be paid by the Sponsors to the Providers in return for delivering the contracted services. Each Contract allocates a proportion of the Minimum Take to each Sponsor. By signing the Contract, a Sponsor therefore commits to pay its share of the Minimum Take.

5.6.1.4

Substitution

Providers and Sponsors may agree substitute procedures, which are equivalent to those procedures set out in the original contracted casemix. This provides additional flexibility for the Sponsors and helps them manage changing local healthcare requirements during the life of the Contract.

5.6.2

Brokerage

The Contracts contain provisions which allow for brokerage amongst the Sponsors and other PCTs or referring Health Service Bodies which are not a party to the Contract. This means that should a particular Sponsor not require all of the services it has commissioned from a Provider in a particular month, it is possible for other Sponsors, other PCTs or other referring Health Service Bodies to utilise (and pay for) that capacity. These brokerage provisions do not alter the services that the Provider is contractually obliged to supply nor the location from which the Provider is obliged to supply the services but they do allow such services to be provided to the patients of, for example, another PCT which is not a party to a Contract with the Provider.

5.6.3

Role of the Secretary of State for Health

The Secretary of State is a party to most of the Contracts in order to guarantee the payment obligations of the Sponsors. This is intended to give the IS Provider assurance that the Sponsors' payment obligations will be met. It results in a better price per procedure because Providers do not have to factor into their prices any risk that the Sponsors will not be able to meet their payment obligations.

5.7

Training

The ISTC Programme is designed to allow for training of NHS staff in ISTCs so that NHS staff can benefit from the opportunity to access new and innovative working practices.

5.8

Private Patients

The main aim of the ISTC Programme is to increase the capacity available to treat NHS patients and the general principle is that ISTCs should only be used to treat NHS patients. However, some of the Contracts do allow Providers to treat private sector patients where it is clear that the Provider has sufficient capacity to treat additional patients and that there will be no detrimental effect on NHS patients. In such instances, the Contracts provide for revenue sharing arrangements to be put in place between the relevant NHS parties and the Provider.



6. Contract Structures



6 Contract Structures

6.1

All the Contracts are based on a single generic model contract. This was done in order to facilitate the agreement of standard commercial terms with the IS whilst minimising the need for costly and lengthy negotiation. It is an approach that has been commonly adopted in relation to other initiatives, such as the Private Finance Initiative.

6.2

However, as noted above, the ISTC Programme aims to encourage innovative solutions and so scheme-specific amendments have been made to each of the Contracts to reflect the solutions offered by the IS, as well as the particular circumstances of the relevant local healthcare economy.

6.3

The Contracts are therefore designed to provide a standard commercial framework for the establishment and operation of ISTCs while retaining flexibility in order to satisfy any local requirements. The key generic provisions that apply to all the Contracts awarded as part of Wave 1 of the ISTC Programme are set out below.

6.3.1

Overview

The Contracts set out the terms on which the Sponsors are to purchase clinical services from the Provider based on an agreed casemix.

The Contract term is five years from the date of commencement of the services i.e. it does not include any construction period.

6.3.2

The Services, Referrals and Staffing Arrangements

The Contracts set out all the clinical and non-clinical services (e.g. maintenance of the Facilities) which the Provider must supply.

The Contracts also set out the ways in which the Sponsors may make referrals to the Provider. A referral is the beginning of the process leading to patients being treated by the Provider and triggers the corresponding payments to be made by the Sponsors.

The Provider may sub-contract certain services from Acute Trusts where this is agreed locally.

The Provider must supply its own staff in compliance with the Additionality policy. Other staff may be seconded to the Provider by Acute Trusts where this is agreed locally.

6.3.3

Payment

The Contracts sets out the terms on which the Sponsors must pay the Provider the Minimum Take for each year of the Contract term. The fixed annual amount is payable in 12 monthly instalments. The Sponsors must pay the contracted fixed annual amount whether they refer all the contracted procedures from the Provider or not. It is crucial therefore that the Sponsors properly manage the referrals made to the Provider.

Each individual Sponsor is responsible for a proportion of the Minimum Take. This proportion is set out in the relevant Contract.

The Contract provides a Brokerage mechanism whereby PCTs who are not a party to the Contract can make referrals to the Provider via one of the Sponsors. This enables the Sponsors to ensure that the flow of referrals is properly managed so that they can meet their obligations in relation to the monthly Minimum Take.

The Sponsors can purchase, and the Provider must supply, additional clinical services up to a value of 105% of the fixed annual amount. Payments for these additional clinical services are calculated using the same unit prices as are stated in the Contract. The Provider is not obliged to meet any demand for additional clinical services that the Sponsors may have over and above a value of 105% of the fixed annual amount. However, if the Sponsors wish to purchase additional clinical services and the Provider has the capacity to provide them over and above the 105% threshold, the payments for these additional services are calculated using different cost bases which are agreed between the parties.

Many of the Contracts include a provision that, in the event that any of the Sponsors is unable to make any payment due to the Provider under the terms of the Contract, the Secretary of State will make the payment on its behalf. Please refer to section 5.6.3.

6.3.4 Clinical Standards

A key principle reflected in the Contract is that the standard of care delivered by the Provider must be at least equivalent to that provided by the NHS. However, it is not the intention of the ISTC Programme that Providers should be required to adopt the same working, clinical or management practices used in the NHS.

This principle is reflected in the Contract in the following ways:

- the Provider must provide the clinical services in accordance with agreed clinical standards;

- the Contract sets out agreed patient care pathways in relation to each surgical procedure;
- the Provider can only begin to provide the clinical services once the Facilities satisfy certain Healthcare Commission standards and it has received all other necessary registrations and permissions from the Healthcare Commission;
- all staff employed by the Provider must be registered with an appropriate professional body; and
- the Contract allows the Patients' Forum of each PCT, which makes referrals to the Provider and the Local Health Authority Overview and Scrutiny Committee, to access the Facilities and review the services.

6.3.5 The Patient Experience

Another key principle is that the general patient experience provided by the Provider must be at the very least equivalent to that provided by the NHS.

This principle is reflected in the Contract in the following ways:

- the Provider must give to each patient details of the relevant Sponsor's Patient Advice and Liaison Service; and
- patients are to have access to the NHS complaints regime as well as to the Provider's own internal complaints systems.

6.3.6 Performance Management

The Contract provides for a system of joint reviews to be held on a quarterly basis between the Sponsors, the Provider and other interested NHS bodies to review the Provider's performance of the services against agreed Performance Indicators. If any problems are identified, agreed plans (at the Provider's cost) are to be put in place to rectify those problems. If the Provider fails to comply with such plans, it can suffer financial penalties.

The Contract recognises that even in the best-run facilities, sometimes things can go wrong. The general position is that the Provider is responsible

for dealing with any problems and the costs arising from them. If the Provider does not have the facilities or staff to deal with a specific problem, the Provider must arrange a transfer to a healthcare provider with the appropriate facilities, usually the local NHS Acute Trust. This position is reflected in the Associated Costs payments which the Provider must pay in the event that a procedure goes wrong or a patient reacts badly to surgery.

6.3.7

Insurance Issues/Medical Negligence

The Provider is able to benefit from the Sponsor's membership of the Clinical Negligence Scheme for Trusts (CNST). This means that if patients make claims for medical negligence, the CNST will cover the costs of any such claims. The Provider must, however, comply with the requirements of the CNST scheme and make certain financial contributions.

Further details are provided in section 5.5.

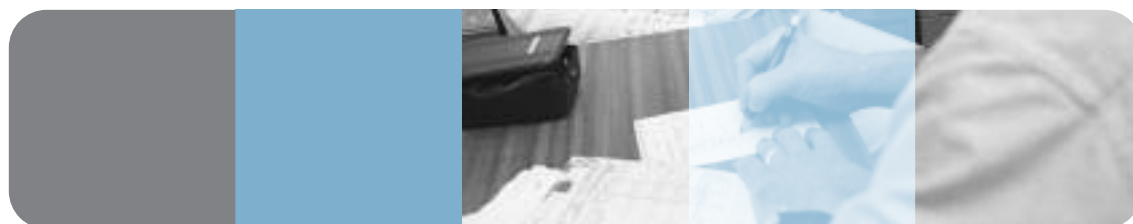
6.3.8

What happens if things go wrong?

The NHS Representative (who is appointed by the Sponsors) has the right to remove from the Facility any person (whether employed by the Provider or otherwise) whom he/she thinks is unsuitable and to prevent them from providing any of the services.

If there is an emergency situation, the NHS representative can "step-in" and run the Contract for a certain period of time in place of the Provider.

In certain circumstances where the Provider's performance falls below acceptable levels, the Secretary of State (or in some cases some other NHS body) may terminate the Contract with immediate effect. Generally, in other circumstances, the Secretary of State can terminate on three months notice.



Section B

Clinical



7

7. The Clinical Services





Introductory Notes

This section sets out the generic model on which Contracts are based. In the light of different current and planned arrangements across the NHS, and changing circumstances in which NHS commissioning and provision take place, it does not describe the detailed arrangements of, for example:

- (a) referral arrangements (e.g. from general practices, by a referral management centre etc.);
- (b) exclusions based on co-morbidity (some ISTCs may be on a NHS site, others are standalone at a considerable distance from the nearest healthcare provider with an ITU/HDU); or
- (c) discharge arrangements.

The arrangements described in this document apply only to England. In other countries within the UK, other Government departments are responsible for policies and operational decisions regarding commissioning of services for residents of these countries.



7

The Clinical Services

7.1

What are the clinical objectives of the ISTC Programme?

The general aims of the ISTC Programme as set out in section 4.

In clinical terms, ISTCs offer an opportunity for Providers to design how best to meet the requirements the NHS specifies when tendering Contracts.

Identifying and securing innovation is important as part of the drive to modernise the NHS. Ideally, innovation should be justified in terms of scientific evidence.

However, it may be necessary to rely on substantial experience elsewhere. The Contracts ensure that patients are protected by requiring the Providers to deliver the clinical services in accordance with Good Clinical Practice and to a standard at least equal to that provided by the NHS.

7.2

Are patients treated in ISTCs as private patients or NHS patients?

Patients treated in ISTCs are NHS patients and not private patients and, to emphasise this, ISTCs are required to use NHS branding. ISTC patients have the same rights as patients treated by NHS providers. For example, they have access to Patient Advice and Liaison Services (PALS) and the NHS complaints system.

7.3

What is a Treatment Centre?

Treatment Centres are intended to offer elective rather than emergency care, and generally involve a surgical procedure. Some surgical procedures may be carried out by non-surgical specialists, for example medical endoscopists. Some procedures may be diagnostic rather than therapeutic, for example diagnostic endoscopies. Treatment Centres may be run by the NHS (NHSTCs) or run by the IS (ISTCs).

7.4

What is the difference between an IS Provider and an NHS provider?

IS Providers are commercial enterprises whereas NHS providers are owned by the government. However, as already stated, patients treated by IS Providers remain NHS patients. Standards in ISTCs are intended to be at least equivalent to that of NHS providers, and are regulated by the Healthcare Commission which is the same body which monitors standards in the NHS.

7.5

Are there other IS initiatives besides ISTCs?

The IS Procurement Programme includes services other than ISTCs, such as MRI scanning services. The organisation of these services is different from those described in this section which is concerned solely with ISTCs. As stated above, the purpose of ISTCs is generally to provide elective surgical procedures.

7.6

How are the services provided by IS providers integrated with the NHS and other organisations?

A Patient Pathway describes the entire journey of the patient from initial GP referral until the conclusion of their treatment. This involves interactions with both the NHS and the Independent Sector.

The Patient Pathway starts with the patient perceiving that (s)he has a problem. At some point, (s)he contacts the NHS, usually – but not always – the GP. The GP may decide immediately, or later, that referral to a surgical specialist is clinically appropriate. If the patient and referring clinician agree that a referral of the patient to an ISTC is appropriate for the patient's needs, the care passes, via the referral interface, to the Provider, and then passes back, via the discharge interface, to the NHS.

This process should be seamless, in the same way that any referral from primary care to an NHS provider, and back again, should be seamless. Seamlessness is achieved by having agreed referral and discharge protocols, and a shared understanding by each Provider of what comes before and after the care offered in an ISTC, and by the NHS parties of what takes place in the ISTC. It is critical therefore that the points along the Patient Pathway, where the patient enters and exits the

care of the Provider, are clearly understood by both Providers, Sponsors and Commissioners. This is shown diagrammatically in figure 1.

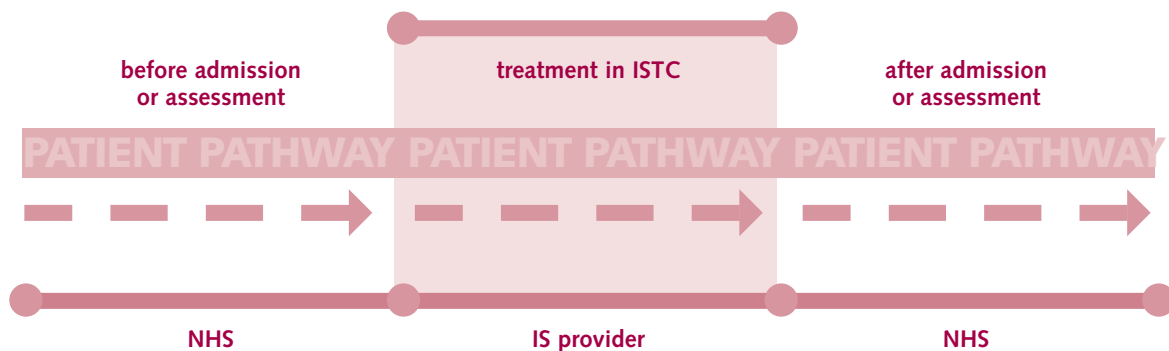
Although the individual Contracts specify only what is required from Providers (because the Providers are the parties who are obliged to perform the clinical services under the terms of the individual Contracts), good practice has dictated that Contract specifications are drawn up on the basis of a complete Patient Pathway. This includes the NHS contribution to the pathway both before and after the clinical services supplied by the Provider, as well as the contribution of other organisations, such as Local Authority Social Services Departments (LASSDs).

Clearly, specifying the significant elements of the patient's care which are to be provided by the Sponsors, or another third party (not being the Provider, such as LASSDs), helps to ensure that:

- (a) all significant aspects of the patient's care have been considered;
- (b) responsibility for all significant aspects of the patient's care has been explicitly assigned;
- (c) the patient's care is seamless; and
- (d) rectification plans can be drawn up to include areas in which Sponsors need to make improvements to the services provided by the Providers.

Figure 1

Relationship between ISTC Contract and overall patient pathway



7.7

How do the Contracts for ISTC services differ from arrangements with NHS providers?

Unlike service level agreements between NHS parties, the Contracts between the NHS parties and the IS for ISTC services are legally enforceable. They contain extensive provision for performance management, including Performance Indicators (PIs) appropriate to the ISTC Programme and specifications which meet the needs of the NHS bodies which tendered the Contracts. Patient Pathways lie at the heart of the Contract. Inevitably, these focus on the services which the Contract requires of the IS Providers. However, as indicated, these should be seen as one, albeit important, element of the total Patient Pathway of care. It is important for NHS commissioners to achieve a best fit between those parts of the pathway which are delivered through NHS providers, independent primary care contractors and the ISTCs, in order to ensure the best possible care and patient experience.

7.8

Who decides what goes into the Contracts?

PCTs and SHAs define the requirements set out in the Contracts. These include, for example:

- (a) casemix;
- (b) physical status of the patients;
- (c) restrictions on the basis of age (e.g. excluding children) or social circumstances (similar to the criteria that might be used in respect of day surgery patients being treated in an NHSTC or an NHS day surgery unit); and
- (d) severity thresholds below which an operation should not normally be performed.

7.9

What pathways are in the Contracts?

The Patient Pathways in the Contracts are generally based on the following key principles:

- (a) as far as practicable Patient Pathways must be specified for all procedures to be performed by the Providers;
- (b) in order to avoid the costs and time required to specify the detail of all the procedures to be performed by the Providers, there should be:
 - (i) one pathway for each procedure accounting for >5% of the expected casemix;
 - (ii) one pathway for each Activity Group accounting for >5% of the total casemix but where no one procedure accounts for >5% of the expected casemix; and
 - (iii) one pathway for each specialty providing services in the ISTC where the previous two criteria leave a specialty without a pathway.

Overall, the aim is to generate pathways covering a minimum of about 80% of the total casemix.

7.10

What are the objectives of the Patient Pathways set out in the Contract?

The purpose of setting out Patient Pathways in the Contracts is to:

- (a) define each key clinical step along the Patient Pathway to allow the clinical model and assumptions to be evaluated and quality assured;
- (b) set out the points along the total Patient Pathways at which the patient is admitted to or is discharged from the ISTC so that it is clear whether the Provider or an NHS party is primarily responsible for the patient's care and treatment at any given point;

- (c) reflect the Sponsor's understanding of what they wish to commission.
- (d) rule out practices which the Sponsors consider undesirable; and
- (e) be sufficiently clear to provide a sound basis for performance management.

7.11

What is the difference between Patient Pathways as set out in the Contracts and integrated Patient Pathways?

The level of detail of the Patient Pathways set out in the Contracts is sufficient to underpin the performance management system, i.e. it allows no room for disagreement between Sponsors and Provider as to whether the care given by the Provider was consistent with that required under the terms of the Contract. However, a Patient Pathway in the Contract does not generally specify what should be done to a patient at an operational level.

Integrated Patient Pathways (or other similar protocol-driven approaches to managing the processes of care) are more detailed and more procedural than the Patient Pathways set out in the Contracts. They contain such elements as:

- (a) tests, charts, diagrams;
- (b) risk assessment tools;
- (c) information collection forms;
- (d) boilerplate text for letters;
- (e) information leaflets; and
- (f) scales for measurement of clinical effectiveness.

The Patient Pathways set out in the Contracts can be considered to be “summaries” of the clinical services, which the Provider must supply. In practice, it is usual

for the Sponsors and the Provider to agree detailed practical arrangements to give effect to the Patient Pathways set out in the Contracts. The key point is that the Sponsors do not wish to be too prescriptive about the ways in which the Providers must deliver the clinical services. The Sponsors are primarily concerned with outcomes which leaves the IS free to deliver care in innovative ways.

7.12

How are the Patient Pathways used as reference standards of care within a Contract?

The standard of care to be delivered by the Providers under the terms of the Contracts should be judged by reference to the following (in the order indicated):

- (a) relevant explicit requirements set out in the Contract for the situation being considered, for example the Contracts require the Providers to provide the services in accordance with Good Clinical Practice, specified NHS Requirements and, where relevant, specific policies of particular Acute Trusts;
- (b) where the Contract does not specify explicitly the requirements for the situation being considered, relevant explicit requirements set out in the Contract for similar situations;
- (c) where the Contract offers no explicit requirements for the situation concerned or similar situations, implicit requirements in the Contract should be used; and
- (d) where the Contract offers no clear or clearly relevant statement of the care which the Provider is expected to supply then generally accepted standards applying to a similar situation and/or similar casemix in the NHS are to be used.

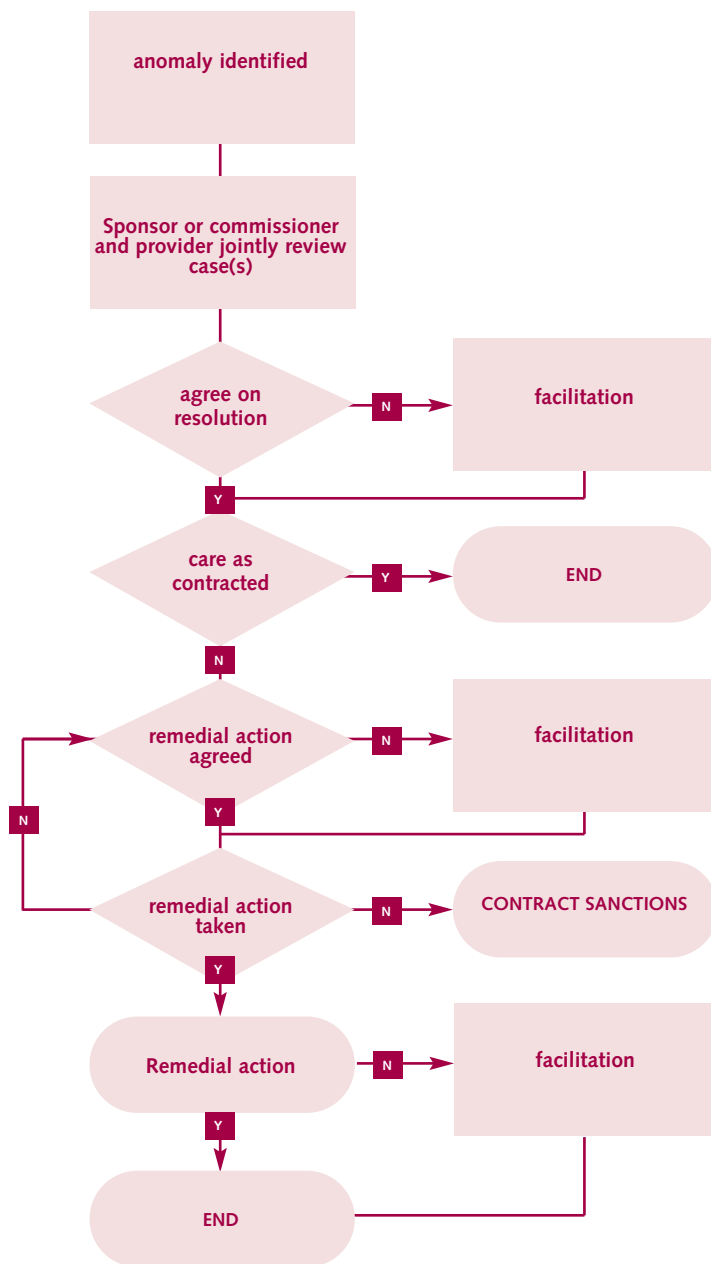
7.13

How are Patient Pathways used to audit care?

The Patient Pathways define what the Sponsors have purchased from the Providers.
 Figure 2 shows how the Patient Pathways form part of the performance management framework.

Figure 2

The place of pathways in the performance management systems



7.14**Are Contract Pathways a substitute for clinical judgment?**

The Provider's clinicians cannot cite the terms of the Contract as a reason for having knowingly given inappropriate treatment to a patient. The Contracts clearly state that the Provider must supply the services in accordance with Good Clinical Practice. If a clinician considers that the Contract specification is not appropriate to a particular patient's clinical needs, the clinician should not treat the patient where this is a reasonable option and should refer the patient back to the referring clinician. In an emergency or urgent situation, the Contract is again clear that meeting the needs of the patient overrides any explicit or implicit requirements of the Contract.

7.15**What flexibility is there in the Contract to change the casemix?**

Much of both the clinical and the commercial aspects of a Contract are developed in the light of an identified casemix. For example, the type of staff, the facilities and the organisation of care will depend on the type of cases the Provider expects to deal with, and in what proportions. There are therefore constraints on the types of patients that can be referred to an ISTC.

To provide the Sponsors with the maximum flexibility, consistent with obtaining good value for money and safe Clinical Services, the Contracts allow the Provider and Sponsors to agree mechanisms for like procedure substitution.

7.16**What reports do Providers supply?**

The Providers must report monthly to the Central Contract Management Unit (CCMU) of the Commercial Directorate. Reports consist of the dataset required for performance management – the performance management framework and the Key Performance Indicators are described in section 8.

The Provider must also make Hospital Episode Statistics (HES) returns, in the same way as NHS providers do. These allow PCTs and other interested parties to maintain a complete overview of healthcare activity covered by HES in a population, whatever type of facility the patient is treated in.

As discussed in the sections on performance management, the Providers are required by the terms of the Contracts to report to the NHS any Serious Untoward Incidents as they occur, and to provide copies of internal investigations and inspections by external bodies. For more details please see section 16.

7.17**Who is responsible for what?**

The Contracts define:

- (a) who is responsible for making sure that something happens (e.g. the Provider or the referring clinician);
- (b) who is responsible for carrying out a service (e.g. Ambulance Trust, the Provider, referring clinician, Social Services Department); and
- (c) who pays for the service (e.g. the Sponsors, the Provider, Social Services Departments etc.).

7.18

Who organises transport?

Where agreed in the Contract, the Provider must provide transport. Where agreed, the Contracts specify eligibility criteria, including:

- (a) which patients should be actively offered transport;
- (b) which patients should receive transport on request; and
- (c) whether it is the Provider's or Sponsor's responsibility to determine eligibility.

Transport may relate to outpatients, daycases, and inpatients.

Transport for urgent and emergency journeys will be organised by the Provider as part of the Healthcare Commission requirements if there are unexpected problems or complications.

7.19

Who determines that an ISTC is a suitable facility for treating NHS patients?

ISTCs (like all other Independent Sector healthcare facilities in England) are required by law to be registered by the Commission for Healthcare Audit and Inspection (usually called the Healthcare Commission) under the Care Standards Act 2000. The Healthcare Commission considers every aspect of an ISTC: the buildings, staff, protocols etc. The registration process is independent of the Department of Health and the NHS.

The Healthcare Commission inspects ISTCs in accordance with Care Standards legislation, regulations and National minimum standards.

Other bodies, such as local authority environmental health departments and Patient Advice and Liaison Services (PALS), representing the interests of NHS patients, visit ISTCs and make reports.



7.20**How are the Provider's clinical staff, especially surgeons, appointed and managed?**

The Provider's staff are required, by law, to be registered with the appropriate body. For example, the relevant body is the General Medical Council (GMC) in the case of doctors, the Nursing and Midwifery Council in the case of nurses, and the Health Professions Council in the case of physiotherapists. The Contracts also set out these requirements so that it is clear to the Providers which of their staff need to be registered.

The lead consultant level medical staff are all on the specialist register of the GMC. This is consistent with the regulations for appointing consultants in the NHS and the requirements of the Healthcare Commission.

The route to gaining specialist registration depends on where the doctor qualified. Doctors who have qualified in another European Economic Area (EEA) country can apply directly to the GMC for automatic recognition of their specialist qualifications.

Doctors who have qualified in the rest of the world have their eligibility for specialist registration assessed, on a case-by case basis, by the Postgraduate Medical Education Training Board (PMETB), which in 2005 replaced the Specialist Training Authority and implemented a new, competency-based system of registration. The doctors have to apply to PMETB for a Certificate of Completion of Training (CCT) in the relevant speciality. Once they have a CCT issued by PMETB they may apply to the GMC for both full and specialist registration.

Surgical specialists in ISTCs are appointed by Providers who use existing or adapted recruitment policies and procedures to ensure that the appointee is able to perform to a high standard.

In order to obtain registration for a facility, the Provider must satisfy the Healthcare Commission that it has an acceptable governance structure.

7.21**What is the general approach to quality in ISTCs?**

The Contracts set out an extensive framework to ensure that Providers deliver the services to appropriate standards. The main elements are:

7.21.1**Clinical audit**

All Providers are required to contribute data about hip and knee replacements to the National Joint Registry and to collect the National Cataract Dataset (where they are undertaking relevant procedures). In addition, the Providers are required to conduct annually, as a minimum, at least six methodologically satisfactory clinical audits/service reviews as part of a rolling programme in relation to the Services being provided and as agreed by the Joint Service Review (JSR) i.e. jointly by Sponsor and Provider. Under the rolling programme, in year one there will be six separate subjects; in year two, six separate subjects not covered in year one; in year three, six further subjects not covered in years one and two etc. The audit must be carried out according to accepted good practice (see, for example, the National Centre for Clinical Audit publication on clinical audit, NCCA: London, 1997), including peer review. A report of each audit (including objectives, methodology, findings, interpretation, and action taken) is made available to the JSR.

In general, the Providers are encouraged (where they are not required to by the Contract) to audit positive and negative clinical outcomes routinely.

7.21.2**Quality plans**

The Providers are contractually required to have Quality Plans, agreed with the NHS, for a range of clinical and non-clinical aspects of the services, including for example:

- (a) clinical governance;
- (b) clinical audit;
- (c) risk management;
- (d) internal quality assurance/quality improvement service reviews;
- (e) standards of hygiene;
- (f) equipment standards;
- (g) temperature control; and
- (h) standards of catering.

7.21.3**Inspection by the Healthcare Commission**

The Healthcare Commission has the power to ultimately withdraw registration if a Provider fails to achieve the required standards.

7.21.4**Registration of staff**

The qualifications of staff are vetted independently, as is a clinical governance framework which applies to those working in an ISTC in the same way as it would in an NHS provider.

7.21.5**Performance management system**

There is a comprehensive performance management system, including an interlocking set of Performance Indicators. These are covered in section 8.

7.21.6**Measuring patient satisfaction**

An important component of quality assurance is to measure patient satisfaction. The Commercial Directorate has been working with the Healthcare Commission to develop a new patient satisfaction survey tool which will be used not only in ISTCs but also in comparable NHS provider facilities, to provide a benchmark for patients, NHS commissioners and the Department of Health.

7.21.7**How can ISTCs and NHS facilities be compared?**

The Commercial Directorate has also been working with the Healthcare Commission to develop a survey instrument which will allow straightforward comparisons between ISTCs and comparable NHS facilities to be made.

The Commercial Directorate has also been working with colleagues responsible for the NHSTC programme to ensure that the Performance Indicators chosen for the ISTC Programme will also be suitable for the NHSTC programme, except where they are non-comparable (such as "additional" ISTC staff, which does not apply to NHS provider facilities).

Over time, it will become easier to benchmark Providers against NHS facilities, and Providers against one another. This in turn will help facilitate patient choice.



8

8. Clinical Governance





8 Clinical Governance Issues

8.1

Overview

The clinical governance arrangements for the ISTC Programme are rigorous and they closely mirror those found in the NHS. The Providers are contractually obliged to ensure that they have robust clinical governance arrangements in place. These arrangements are carefully scrutinised during the procurement process before Contracts are awarded. In bidding for Contracts, bidders must demonstrate that they are compliant with applicable NICE guidance. Patient Pathways are closely reviewed by clinical advisors, acting on behalf of the Sponsors, to ensure that the Patient Pathways and clinical specification meet the needs of the local health economy.

The clinical governance arrangements that each Provider must put in place for clinical governance of each ISTC which it operates are monitored by the Central Contract Management Unit (CCMU) of the Commercial Directorate of the Department of Health to ensure that clinical governance processes are in place and are rigorously applied.

8.1.1

The Reporting Structures

The Contracts contain detailed provisions relating to the management and review of each Provider's delivery of the services. The main body responsible for performance management is the Joint Service Review (JSR) which reports to the Contract Management Board (CMB). The JSR involves the Provider, the Sponsors and the Contract Manager. The CMB involves the Sponsors and the Contract Manager, with a reporting line to the Head of CCMU. JSR and CMB issues are ultimately reported to the Programme Board of the Central Clinical Procurement Programme (CCPP) which is part of the Commercial Directorate.

8.2

Key Performance Indicators, Provision of Data and Joint Service Reviews

Providers are obliged to submit applicable Key Performance Indicator (KPI) data on a monthly basis. This information is validated on a quarterly basis by the National Centre for Health Outcomes Data (NCHOD). The validated information identifies intra-centre trends and will be used to benchmark Provider performance against like-for-like care providers. This information is reviewed by the JSR, who may commission a Joint Service Investigation (JSI) if there is an inadequate Provider explanation for a threshold breach of a Key Performance Indicator. If the JSI concludes that the Provider has been in breach, a rectification plan may be drawn up, outlining expected actions by the Provider within a stated time frame. If the Provider fails to implement the rectification plan, the Contracts allow for the Sponsors to impose financial penalties. The ultimate sanction against a Provider in extreme circumstances is the termination of the Contract.

Clinical outcomes audits and data are expected to be delivered as part of the Performance Indicator information data set and are considered at JSRs.

Providers are contractually obliged to participate in speciality datasets, such as the National Joint Registry or the National Cataract Dataset. Providers must also return Hospital Episode Statistics (HES) data.

8.3**Registration of Facilities and Staff**

All Providers are subject to rigorous inspection arrangements as IS suppliers of healthcare services. If Providers are registrable under the Care Standards Act 2000, they are subject to a mandatory inspection by the regulatory arm of the Healthcare Commission. The inspections are held a minimum of once a year and may be announced or unannounced.

All professional staff must appear on the appropriate register of their professional body. All doctors must appear on the specialist register for their speciality.

Doctors working for Providers in ISTCs do not work as consultants in the same sense as NHS doctors as they may not have teaching, academic or administration responsibilities. They are specialists in their respective fields and, as such, are not appointed through a consultant's appointment panel as is found in the NHS.

Practice Privileges must be granted before any doctor can work in an ISTC. These should be granted after review by the Medical Advisory Committee, where doctors who may also work in the NHS would participate. The numbers of procedures that each doctor performs are checked during this process.

8.4**Risk Management**

The Providers must demonstrate compliance with the key foundation elements of clinical governance. They must demonstrate to a body of subject matter experts that they have used clinically effective information to develop their Patient Pathways.

Management of risk is a key part of the clinical governance framework for Providers, who are expected to maintain risk registers and perform risk assessments and mitigate any unacceptable risks to ensure patient safety.

Incident management is a vital part of the clinical governance process. Where serious incidents occur, a JSR is convened which may result in a separate JSI to identify the root causes behind the incident. Recommendations are made and the Provider is assisted in developing an action plan. Providers are also required to report incidents to the Healthcare Commission under section 28 of the Care Standards Act 2000 as amended by the Health and Social Care Act 2003.

Recruitment of Additionality compliant staff has been thoroughly covered with Providers, so that they are aware of the vital importance of induction and language familiarisation before beginning their duties. Specialists should also be interviewed to ensure that they are willing and able to follow the Patient Pathways set out in the Contracts.

8.5**Insurance**

All Providers are able to benefit from the Sponsors' participation in the CNST. This is the medical negligence indemnity scheme administered by the NHS Litigation Authority. Further details relating to the CNST Scheme are set out in section 5.

8.6**Ensuring Patient Satisfaction**

Patient satisfaction is a key quality indicator for ISTCs and such information is collected under the Key Performance Indicator dataset and evaluated by the JSR. The Healthcare Commission is presently in the process of developing a uniform patient satisfaction survey to be used across all care settings.

Section C

Operational



9

9. Workforce





9

Workforce

9.1

Obligations in Relation to Provider-Recruited Staff

In relation to those staff that the Provider recruits in addition to the seconded staff provided by any relevant NHS Trust, the Provider must operate in accordance with requirements set out in the Contract. The provisions included in the Contract are subject to scheme specific negotiations, but in general terms they cover the following key areas:

(a) Work permits

The Provider must ensure that its staff have all necessary permits and/or entitlements to work in England at all times when they are engaged in performance of the services.

(b) Qualifications and registration

The Provider must ensure that all its staff are appropriately qualified and registered with the relevant professional body for their specialism and licensed to practice in England.

(c) Language skills

The Provider's staff must have appropriate knowledge of and ability to converse in English.

(d) Criminal records checks and health screening

The Provider must subject all staff (both UK staff and those from overseas) to checks into past criminal convictions prior to recruitment to the ISTC Programme. Similar checks apply in relation to pre-employment health screening.

Obligations on the Provider are also imposed in the Contract in relation to resourcing, training, and personnel policies and procedures. The Contract includes provisions relating to the circumstances in which the Provider's staff can be refused admittance to facilities and their compliance with alert letters.

The Contract has been developed on a scheme specific basis to take account of the circumstances of the relevant local healthcare economy. However, in general terms, the obligations that have been imposed on Providers include the following:

- (i) compliance with the code of practice for NHS employers involved in the international recruitment of healthcare professionals;
- (ii) compliance with PASA national contracts framework agreement for the supply of nurses, doctors and allied health professionals; and
- (iii) compliance with HSC requirements which have now been superseded by "safer recruitment guidance".

Providers must also ensure that any recruitment agency partners selected to source overseas staff fully understand the requirements of the code of practice for the recruitment of healthcare professionals, including immigration requirements relating to permits, registration, occupational health and Criminal Records Bureau processes. Necessary lead times must also be factored into recruitment plans.

Provisions are also generally included in the Contracts dealing with:

- (A) performance management;
- (B) Working Time Directive compliance;
- (C) provision of workforce information;
- (D) mobilisation; and
- (E) management systems.

9.2

Secondment Arrangements

On some schemes it has been agreed that NHS staff may be seconded to work for the Provider within an ISTC.

In most cases, the secondment arrangements will form part of the implementation of the Retention of Employment (ROE) model which is described below.

Under the secondment arrangements, the relevant NHS Trust will continue to employ the seconded staff, who will be managed on a day-to-day basis by the Provider. Detailed provisions in relation to the split of responsibilities between the NHS Acute Trust as employer and the Provider as manager are set out in the Staff Services Agreement, extended into by the relevant NHS Trust and the Provider. In general terms, the NHS Trust will remain responsible for the management of staff careers, subject to any input from the Provider that may be agreed. Therefore appraisals, implementation and monitoring of Agenda for Change, and any formal HR processes such as disciplinary hearings and grievances, will remain the responsibility of the relevant NHS Acute Trust. Consistent with the principle of the transfer of clinical responsibility to the Provider, day to day operational management of the clinical work of the seconded staff rests with the Provider.

The Staff Services Agreement includes detailed provisions dealing with such matters as the selection of the staff to be seconded, circumstances in which secondments will come to an end or be temporarily interrupted, and secondment charges.

9.3

Retention of Employment Model

9.3.1

On some schemes (which involve a transfer of activity from the NHS to the Provider) the Retention of Employment Model will be deployed as the mechanism to ensure that there is no unintentional transfer of NHS staff to the Provider. Instead, under the Retention of Employment Model, relevant staff will remain employed by the NHS and either redeployed by the relevant Trust and/or given the opportunity to be seconded to the Provider (on either a part-time or a full-time basis).

9.3.2

The Retention of Employment Model has been the subject of consultation (at both a national and a local level) with Trade Unions and staff side bodies. This model has already been rolled out on a number of NHS hospital PFI schemes. The adoption of the model in the context of the ISTC Programme supports the policy of long-term staff retention in the NHS, which is one of the central aims of the ISTC Programme.

9.4

Workforce Plan

Providers must also provide a workforce plan which must stipulate labour costs by speciality and category of staff per session/Whole Time Equivalent. This workforce plan is set out in the Contract.

9.5

Additionality

Additionality is a key policy which governs the Provider's recruitment of staff. For full details, please refer to section 5.3.



10

10. Training





10 Training

10.1

The importance of training within ISTCs

Many surgical anaesthetic and other activities that will be provided in ISTCs are part of the core training requirements of NHS staff. Through the provision of modern facilities and delivery of new ways of working, ISTCs can provide NHS staff with the opportunity to access new and innovative work practices in these areas.

ISTCs will also provide the opportunity for training and transfer of knowledge in the following areas:

- innovative clinical techniques and new ways of working;
- management of patient flows and processes leading to greater clinical productivity; and
- management of clinical services, including outcome measurement.

The training of NHS staff in ISTCs is particularly important in instances where clinical activity is transferred from traditional NHS settings to ISTCs. In such circumstances the training attached to the transferred activity is expected to be replicated in the ISTC setting.

10.2

How will NHS training be organised in ISTCs?

NHS training in an ISTC setting will be directed and overseen as it is now in NHS settings. The Deaneries, the Higher Education Institutions, the Royal Colleges, the Nursing & Midwifery Council, the Health Professions Council, PMETB, the Faculties, Workforce Development Confederations or Directorates and NHS Trusts will all retain their existing roles in facilitating and overseeing NHS training when that training is transferred to an ISTC setting.

The organisation and direction of NHS training within ISTCs will be modified as NHS training policy and practice evolves and develops, in line with, amongst other things, Modernising Medical Careers.

10.3

What type of NHS training will take place within ISTCs?

Training in ISTCs will, in line with current NHS practice, be multi- and inter-professional.

NHS consultant trainers who are seconded to Providers will provide their NHS medical trainees with supervised face-to-face training based in ISTCs. Similarly, NHS nurse and therapist mentors can provide training, guidance and support to pre- and post-registration clinicians.

Training for other professions is also expected to be provided in ISTC settings, for example, radiologists, radiographers, pathologists and GP registrars where appropriate.

The current understanding is that only training and supervision by NHS consultants satisfies requirements for NHS training of junior doctors, so that only seconded NHS consultants may be involved in training and supervision of junior doctors in an ISTC setting.

The Commercial Directorate and the DH's National ISTC Training Steering Group are seeking clarification on this issue. The expectation is that in due course NHS staff will be able to receive training and supervision from any appropriately registered and qualified clinician working in an ISTC, which will greatly aid the transfer of innovative clinical techniques and care patterns and increase the flexibility for NHS Trusts and Providers in rostering and scheduling procedures.

10.4**What other training activity will take place in ISTCs?**

The Providers are contractually committed to the provision of continuing professional development and training for their own staff. This training will include induction and the training required to operate within the ISTC safely, and training for continuing professional development.

Some Providers have entered into formal agreements with overseas clinicians' home governments requiring training and development to be provided for those clinicians while based in the UK so that they can return to their country of origin with new skills.

The DH is in discussion with companies that are keen to establish national and international clinical exchanges for doctors, nurses and therapists. There is also further ongoing discussion to establish a medical forum based on international university medical schools.

10.5**Accreditation: differences between ISTC and NHS settings**

ISTCs are part of the national independent healthcare sector and are regulated by the Healthcare Commission. NHS trainers carry forward their present training accreditation but the facilities/equipment/techniques used may differ from where they have trained previously.

NHS Trusts and their NHS trainers and trainees have to be accredited for training by the Postgraduate Medical Education and Training Board (PMETB) and its agents, the medical Royal Colleges (or NMC and HPC). NHS Trusts must apply for training

accreditation to PMETB and are subject to inspection by the appropriate Royal Colleges. Where training is transferring to an ISTC, the Royal Colleges will report to PMETB as to whether they believe the ISTC is a suitable training facility. Training cannot take place in an ISTC until approval has been obtained from PMETB.

10.6**Programming of NHS Training**

Local training requirements are to be confirmed by the DH in partnership with local stakeholder groups.

The Providers and the NHS Trusts responsible for the trainees will aim to work together to programme NHS training, by session, case and procedure, well in advance. NHS trainers and trainees will have the opportunity to be involved in appropriate cases throughout the Patient Pathway.

10.7**Monitoring**

The development and conduct of NHS training in ISTCs will be overseen at national and local levels.

The National ISTC Training Steering Group is led by DH training leads and is integrated with local NHS workforce leads. It is a multi-professional and multi-agency group (including Providers) charged with monitoring and developing training policy and practice within ISTCs.

Local ISTC Training Steering Groups have now been established for most schemes. Their role is to bring together all appropriate local training stakeholders to support NHS training at the local ISTCs, to assist in the local accreditation process and the confirmation of training requirements and programming for the scheme.

10.8

Funding

The funding of training within the NHS is complex and this has resulted in various arrangements being adopted on Wave 1 Schemes governing any flow of funds in relation to training. The funding of NHS training is being reviewed generally, and the expectation is that this will enable a more consistent approach to be adopted in future, linked to the developments noted below.

10.9

Going forward

To date, on Wave 1 ISTC schemes where NHS training has needed to be accommodated, the Contracts have included provisions governing the basis on which that is to happen.

Going forward, the expectation is that for each ISTC scheme there will be a direct contractual relationship between the Provider and the relevant Deanery (or other appropriate SHA function or successor body) governing the terms on which appropriate components and training are to be delivered by the Provider.





11

11. Infrastructure and Property





11

Infrastructure and Property

11.1

What are the Provider's obligations regarding the provision of Treatment Centre Facilities?

- (a) The environment in which patients are treated by Providers must:
- meet statutory legislation;
 - meet mandatory NHS requirements relevant to the procedures being carried out; and
 - be fit for purpose as determined by the Healthcare Commission under the Care Standards Act 2000 and any supporting legislation relevant to the nature of the Facilities and any related non-clinical services.
- (b) Except where sites have been identified by the Sponsors as being mandatory, the Provider is responsible for determining details of the location, mode of delivery (new build, refurbishment, conversion, temporary/mobile/other, as appropriate) and the layout of the Facility.
- (c) The Provider is also responsible for reaching agreement with third parties for the use of the site, property or facilities as applicable.

11.2

Who is responsible for the design and development of the Treatment Centre Facilities?

- (a) In keeping with the general principle that the Sponsors are only purchasing services from the providers and that it is up to the Providers to determine how best to provide these services to the required standards, the Provider is responsible for undertaking all activities connected with the development of the Facilities including obtaining planning approval, conducting surveys and investigations, construction and commissioning (including the procurement of infrastructure and utility services of sufficient capacity to meet the requirements of the proposed Facilities).
- (b) The Provider is responsible for ensuring that all consents required for the development of the site are obtained and for implementing each consent within the period of its validity and within its terms.
- (c) The Provider has sole responsibility for design and construction activities related to the Facility and will remain responsible for design and construction standards and the adequacy, stability and safety of all operations on site in connection with the construction (where relevant) and operation of the Facility.
- (d) The condition of the site is the sole risk of the Provider and the Provider is responsible for all necessary surveys and investigations appropriate to development of the property, including: geotechnical, subsoil investigations, deleterious and hazardous materials, contamination, environmental surveys, measured site survey (including levels, trees, natural features, roads, any existing structures affected by the work, existing utility service runs and access points), hazards and obstacles.

- (e) Where relevant, the Provider is responsible for all heritage and archaeological issues on the site and its environs (including Listed Buildings Consent and sites for which English Heritage is responsible) and any other archaeological consultations including additional consents and liaison with local archaeological and academic groups, local authority officers and English Heritage, or other work arising from this process.
- (f) Providers are responsible for providing suitable access into and within the Facility for all users, including the disabled.
- (g) Providers must provide to the Sponsors sufficient information relating to the design of the proposed Facility to demonstrate that the procurement requirements will be satisfactorily addressed during scheme development. The design proposals must also show that the Facility will enhance the patient experience and comply with all matters relevant to the provision of good design as defined in the Government publication entitled "*Better Design for Public Buildings*".
- (h) Providers must demonstrate that the proposed Facility design satisfactorily accommodates process flows for patient movement and the movement of goods and services, both inside and outside the Facility, including the segregation of clinical areas.
- (i) Providers must demonstrate that the proposed Facility integrates with the existing infrastructure, if any, including physical, operational and services interfaces, and does not introduce compromises or conflict in the operation of critical activities.
- (j) Providers must demonstrate that the safety and security of staff, patients and visitors have been adequately addressed.
- (k) Providers must demonstrate, by using drawings and specifications, that the quality of the proposed property solution justifies the costs claimed in the Provider's financial model and that it has considered, in sufficient detail, the interfacing of its proposals with the existing

building fabric and configuration of the site (if any).

- (l) Providers must design any infrastructure in sufficient detail to enable a firm price to be submitted and must demonstrate, in detail, that they have allowed in their costs for the full scope of any construction work.
- (m) Providers are responsible for establishing the energy saving strategies that are to be incorporated into the Facility design.

11.3

Are Providers required to utilise NHS Facilities where these are available?

- (a) Providers are encouraged to consider utilising existing NHS facilities and, where appropriate, to explore the scope to utilise existing NHS infrastructure for the provision of services.
- (b) However, other than mandatory sites identified by the Sponsors in specific procurements, the general position is that the Provider is under no obligation to use NHS facilities or services and must make its own assessment of the most appropriate built environment that will best meet the Sponsor's objectives.
- (c) Subject to the specific requirements of individual procurements, alternative locations or infrastructure facilities to those available within the NHS may normally be proposed should the Provider consider that alternative locations are geographically suitable and can be demonstrated to meet the Sponsor's objectives.

11.4

What standards are applicable to Providers building on NHS sites?

All standards applicable to non-NHS sites are equally applicable on NHS sites including the CDM and Health and Safety Regulations. In addition, the requirements listed below also apply.

- (a) The Provider must confirm and warrant that it has – or is able to procure – the competence, resources and capacity to observe, perform and discharge all the obligations, requirements and duties of the “Client” arising under the CDM Regulations in connection with the works and where necessary the provision of the services.
- (b) The Provider is responsible for demonstrating that all necessary consultations for approval under the requirements of the NHS Fire Code, and integration with any existing fire strategy on NHS sites, have been made and that the Provider’s fire strategy is compliant with the NHS Fire Code, notwithstanding the requirements of Building Regulations and the requirements of the local authority Building Control Department.
- (c) The Provider is also required to comply with certain provisions included in the Contract, specific to the NHS site and its environs including aspects such as safety, access, disturbance to others (noise, dust, vibration, damage, etc.) and the use of site amenities.

11.5

What provisions apply to the use of existing facilities?

- (a) In offering or proposing any existing property for use in the provision of the services, the Provider must provide details of any known encumbrances, restrictive covenants, other impairments to the use of the property, such as the known use of deleterious materials in its construction. They must also provide evidence of planning approval for the proposed use with any planning conditions placing limitations on when or how the property is used.
- (b) The Provider must supply (for inspection by the Sponsor) a copy of any lease to be entered into with the Landlord.
- (c) The Provider must demonstrate that, where the construction of any proposed Facility involves decanting of existing uses or phasing, it is designed in such a way as to work at each phase in a manner that meets with the planning authority’s requirements and does not disrupt the operation of the surrounding infrastructure at any stage.



11.6

What provisions apply to the use of mobile facilities?

- (a) Where the Provider elects not to use an NHS offered site for mobile facilities, the Provider is responsible for all services.
- (b) On offered NHS sites, the Provider must satisfy itself that the locations offered are suitable sites from which to provide the mobile services.
- (c) On NHS offered sites, and subject to specific procurement requirements, the relevant NHS Trust (with assistance where necessary from CCP's central Infrastructure Support Team) will normally be expected to identify the utility services that they are able to provide and the relevant NHS Trust will be responsible for carrying out the enabling works necessary to set up the site suitable for a mobile unit to access and operate from the offered location. This may include, as appropriate, the construction of a suitably sized pad to Highway Standard and the provision of power, water, drainage and communications termination points, all within five metres of the operating location. Generator-provided power may be an acceptable alternative depending upon specific local circumstances.
- (d) Providers should establish the requirement for any further information or additional investigation in line with the responsibilities stated and are responsible for any provisions or services considered necessary for the use of a mobile Facility, where these are additional to, and have not been specifically identified as being provided by (or the responsibility of), the relevant NHS Trust.
- (e) The Provider is responsible for all costs in connection with supply, transportation, set up and operation of the mobile Facility including maintenance of the unit, services installations, equipment and supply connections to the termination points provided on the NHS host site.

- (f) Where sites are to be used by mobile PET/CT scanner units, additional provisions apply due to the use, storage and disposal of radioactive materials.
- (g) Particular requirements also relate to the use of dedicated toilet facilities and the need for site approval from the Environment Agency.

11.7

What happens if the construction period overruns?

- (a) Providers will be responsible for providing a Programme, and regularly reporting progress against that Programme, to demonstrate that all relevant tasks in the design and implementation of the Facility, leading to it becoming operational, have been taken into account. The Programme is a legal document and is set out in the Contract.
- (b) Should it become apparent during implementation that any Facility will not be available in accordance with any Programme set out in the Contract, or an extended Programme as agreed between the Sponsors, it will be the responsibility of the Provider to propose an interim solution to procure the services until such time as the permanent Facility is available and to bear any additional costs arising from failure to meet the agreed Programme. It is important to note that the Contracts set out that the Providers are only paid once they begin delivering the services. Clearly, it is in the Provider's interests to ensure that any construction period does not over-run.

11.8

What are the legal arrangements for the Provider’s use of sites, including NHS controlled sites?

- (a) The Provider is responsible for entering into any lease or licence relating to a site.
- (b) The Provider must ensure that any lease or licence to be entered into for the use of a property to provide the services is, as a minimum, compatible with the proposed duration of the services or any extension that might subsequently be agreed and awarded.
- (c) On NHS sites, a generic lease has been developed for use by the Provider and the relevant NHS trust with local customisation in mind.
- (d) For mobile units operating on NHS sites, a generic licence has been developed for use by the Provider and the relevant NHS trust with local customisation in mind.

11.9

What are the provisions for handover of the Facility, where the Contract is terminated or expires?

- (a) The procedure for transfer of the Facility to the NHS will be specified in the relevant Contract.
- (b) Unless otherwise agreed as part of the Contract, the handback condition for any property should be in accordance with or the equivalent of NHS Estate Code Category Condition B.
- (c) In the event that the Facility does not meet the agreed standard for the condition at handback, the provisions of the Contract regarding reinstatement and/or compensation shall apply.
- (d) The Provider must ensure that on expiry or termination of the Contract, the benefit of any warranties or guarantees arising from the procurement of any Facility, including those applicable to built-in equipment, furnishings and fittings, can be novated, assigned or otherwise transferred to the Sponsor, in the event that the Sponsor takes over responsibility for the Facility.



12

12. Non Clinical Services





12

Non Clinical Services

12.1

Who provides Facility Management (FM) Services?

All necessary FM Services are provided by the Provider unless specific FM Services are identified in a sub-contract as being provided by an NHS Trust or other third party. This is the case where the Sponsors have mandated that the Provider must use a particular Trust to provide sub-contracted services or where a Provider decides to sub-contract provision of certain of the Services to a Trust.

12.2

What FM Services are included?

Although not intended to be comprehensive, the scope of the FM services required would normally include at least the following:

- (a) Catering/refreshments/vending – establishing arrangements for and the provision of services to support the Facility, including staff and visitors, and incorporating these in the design and services provision;
- (b) Cleaning services – establishing arrangements for maintaining a safe, hygienic and pleasing environment;
- (c) Deliveries – material deliveries and supplies, including medical supplies, and all goods associated with the provision of FM Services, access arrangements, loading/unloading, materials handling and storage/distribution;
- (d) Facility Management – establishing arrangements for and providing a high quality, effective Facility Management Service, which will provide the best possible experience for patients, staff and visitors using the Facility;
- (e) Fabric and Mechanical and Electrical Maintenance – establishing the requirement for and the provision of planned preventative maintenance, procedures for reactive repairs and procedures for recording all maintenance works through to task completion;
- (f) IM&T support – establishing arrangements for and the provision of IM&T support and maintenance, including infrastructure, fast response telephone support and escalation;
- (g) Linen and laundry – the provision or hire of a linen and laundry service, including assurance that adequate stocks of linen are held on site;
- (h) Pest control – establishing arrangements for and providing routine inspections and preventative measures by a specialist pest control sub-contractor;
- (i) Reception, postal and telephony services – establishing arrangements for and providing reception and telephony services at all times during the hours that the Facility is operational;
- (j) Security – providing security appropriate to the area in which the Facility is to be located given the nature of its use, the perceived risk to staff, patients and visitors and the risk of unauthorised access;
- (k) Staff work wear – establishing arrangements for and the provision of staff uniforms, gowns and functional clothing;
- (l) Sterile services – establishing arrangements for and the provision of sterile services required for the Facility; and
- (m) Waste management – establishing arrangements for and putting in place procedures for waste management.

12.3

What standards does the Provider have to meet in providing the FM Services?

- (a) The Services provided must meet the standards prescribed by legislation, utility supply company requirements and mandatory NHS requirements, and be compliant with national standards specific to the Service being provided.
- (b) Cleaning services must meet the requirements of the National Standards of Cleanliness for the NHS including, where applicable, the Revised Guidance on Contracting for Cleaning (December 2004).
- (c) Sterile services must be obtained only from accredited suppliers or be provided in full compliance with guaranteed legislative procedures.
- (d) Waste management procedures must be in compliance with applicable waste disposal and environmental protection legislation.
- (e) Providers must conform to the standards and guidance on the following matters in the Government's NHS Plan, and in accordance with details available on the NHS Estates and Patient Experience websites:
 - standards for better hospital food, including availability of meals outside normal meal times;
 - standards for hospital cleanliness;
 - standards for ward housekeeping;
 - standards for privacy and dignity and the elimination of mixed-sex accommodation; and
 - provision of bedside TV, radio and telephone.
- (f) The Provider must produce a Facility Manual, to be available on completion of the building. This must include health and safety information and record keeping required at the site, such as information on safe working practices, COSHH assessments and the Fire Log. The Manual should cover the building construction and all FM Services. It should also hold copies of component and equipment manufacturer's recommendations, warranties and guarantees.
- (g) The Provider must put into place procedures to operate a Quality Management System (QMS) covering the following services:
 - assessment of Facility and equipment performance against predefined expectations, design criteria and standards;
 - analysis and reporting of performance failures with particular focus on failures outside acceptable tolerances;
 - identification of areas for improvement and innovation; and
 - programme for continuous improvement.

(h) The Provider must ensure that procedures are in place to carry out a regime of regular internal and external quality audits covering the following services:

- fabric condition surveys;
- compliance audits (for compliance with legislative requirements);
- day-to-day visual checks of equipment;
- maintenance and quality process audits;
- management process audits;
- Health and Safety audits; and
- compliance with the requirements of the Healthcare Commission for maintenance of premises certification.

12.4

What are the legal arrangements where FM Services are to be supplied by the NHS?

On NHS sites, a generic sub-contract has been developed for use by Providers and relevant NHS Trusts. This is allied to a specification of the services to be provided including Service Level Agreements and performance criteria.

12.5

What are the implications of the Provider's sub-contractor(s) failing to supply FM services?

The general principle is that the Provider is responsible for delivery of the Services. This remains the case even where the Provider sub-contracts provision of certain of the Services to third parties. Where such a sub-contractor fails to provide services to the Provider as it should under the relevant sub-contract and that in turn results in failure by the Provider to deliver the Services, the Contracts set out mechanisms for dealing with any consequences arising from the Provider's failure to deliver.





13

13. Contract Management and Service Integration





13

Contract Management and Service Integration

13.1

Introduction

Contract Management and Service Integration reflect two of the key aims of the ISTC Programme, these being:

- (a) to ensure that Sponsors and the wider healthcare economy in a particular geographical area, with access to an ISTC, make use of the capacity offered by the ISTC in the most efficient ways possible; and
- (b) to ensure that patients receive treatment which is at the very least equal to the quality of treatment provided by NHS providers.

This section describes how these aims are achieved.

13.2

Service Integration

Service Integration, which can be defined as ensuring that the services provided by ISTCs are integrated into the health economies they are procured to support, is critical for the success of the ISTC Programme.

The most fundamental aspect of Service Integration is ensuring that all parties are aware of, and understand, their respective responsibilities and accountabilities governing the delivery of the services from the Providers.

Figure 4 on page 86: ISTC Programme – Central Contract Management Unit (Contract Process), figure 4 illustrates the key stages of Contract development.

13.3

Central Contract Management Unit

The Central Contract Management Unit's (CCMU) primary role is to support the management of the Contracts following procurement to ensure a consistency in performance management across the ISTC Programme. CCMU is part of the general framework which ensures that ISTCs are run to the highest standards in order to ensure the best possible patient experience.

The purpose of the CCMU is to:

- (a) facilitate effective management of the Contracts;
- (b) deliver ISTC Programme targets;
- (c) act as a point of reference, support and resource for Contract Management Boards and their constituent Sponsors;
- (d) monitor progress towards achievement of overall Programme targets; and

The principal issues that CCMU addresses to facilitate successful implementation, and to ensure the effective performance of Contracts, are:

- (A) managing the mobilisation period, during which:
 - (i) effective project management of any build/refurbishment programme is achieved;
 - (ii) clear processes and procedures are identified and established; and
 - (iii) active management – to ensure a seamless experience for patients using the procured services – is achieved through establishing necessary conversion procedures and interfaces with established services;

- (B) ensuring adherence to ISTC Programme-wide policies and strategies; and
- (C) the collection and processing of mandatory monitoring and key performance indicators to monitor and manage the performance of individual schemes and the ISTC Programme as a whole.

The CCMU achieves its role through:

- (D) providing resources to Sponsors to support Contract management locally;
- (E) setting corporate and clinical governance standards;
- (F) collecting and analysing data from the schemes for benchmarking performance;
- (G) evaluating Provider performance; and
- (H) establishing of operational “best practice”.

13.5

Contract Management Board

The CCMU advocates that the early appointment of a Project/Contract Management Board (CMB) is key to the success of the ISTC Programme, and critical to ensuring that the appropriate governance arrangements, both corporate and clinical, are established.

For each Contract, a CMB is established. The CMB operates as the principal management body in respect of those functions relating to governance issues within the NHS which have been ascribed to the Sponsors under the Contract. It comprises each of the NHS parties to the Contract or their specific delegates.

The Department of Health (DH) requires that one of its representatives sits on each of the CMBs. This allows the DH to support the local healthcare economy and promotes the flow of information between the NHS parties and the DH.

The primary function of the CMB is to ensure that the services procured under the Contracts actually deliver the quality and quantity of healthcare provision contracted for.

The CMB is the formal body through which the Sponsors collectively exercise their contractual obligations while ensuring that, at a local level, the services procured under the Contracts integrate with the existing local healthcare economy.

13.6**The NHS Representative**

The Chair of the CMB, or another senior CMB member nominated by the CMB, normally undertakes the duties and responsibilities set out in the Contracts of the NHS Representative. The NHS Representative acts as the principal contact point between the NHS parties, the Secretary of State (where relevant) and the Provider, and with the delegated authority of the Sponsors.

In addition the NHS Representative discharges a number of functions with respect to the operation of the Performance Management Regime including acting as Chair for Joint Service Reviews.

13.7**Contract Manager**

A Contract Manager is appointed by the Sponsors for each Contract. The Contract Manager is responsible to the CMB for the management and administration of the Contract, and to the CCMU for managing the Contract to achieve the ISTC Programme's targets.

The Contract Manager acts with the delegated authority of the CMB and NHS Representative. The Contract Manager's principal roles are to:

- (a) manage and administer the Contract;
- (b) monitor that the Provider performs its obligations under the Contract;
- (c) ensure that the Sponsors discharge their obligations under the Contract;
- (d) support the NHS Representative;
- (e) manage the Contract in support of the targets of the ISTC Programme;

- (f) manage change to reduce impact on the Contract to an acceptable level;
- (g) provide management information to the CMB; and
- (h) provide management information with respect to Contract performance to the CCMU.

13.8**Service Integration Delivered Through Partnerships**

The CMB, through the Contract Manager, ensures that an effective partnership is developed between the Sponsors and the Provider to achieve delivery of the services and ensure the best possible experience for patients.

CCMU sees successful partnerships as being characterised by:

- (a) building on the strengths of the participating organisations and allowing them to pool resources, avoid duplication, and maximise impact;
- (b) filling service gaps and increasing access to services; and
- (c) attracting new resources and using them efficiently.

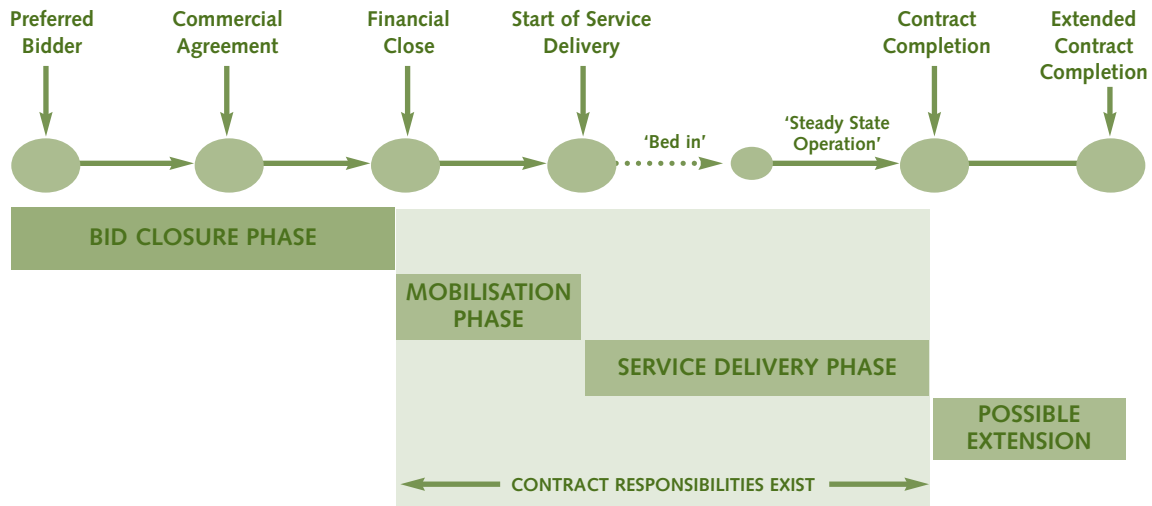
CCMU also sees the following as being critical to success:

- (d) senior level commitment;
- (e) understanding the balance of responsibility between the parties;
- (f) having the necessary skill-mix;
- (g) understanding organisational cultures;
- (h) clear shared goals;
- (i) regular evaluation; and
- (j) achievable outputs/outcomes.

Figure 4

ISTC Programme – Central Contract Management Unit

Contract Process



13.9

Change Control and Contract Variations

Each of the Contracts contains a mechanism which allows the Sponsors and/or the Secretary of State to vary the terms of the Contract either during the mobilisation phase (if relevant) or the operational phase of the Contract. This ensures that the Contracts remain flexible and allows the local healthcare economy to adapt to, for example, changes in referral patterns during the life of the Contract.

13.10

Changes Requested by the Secretary of State/Sponsors

All Secretary of State/Sponsor changes should be raised through the Contract Manager and NHS Representative, and may need to be agreed by the Contract Management Board. Once the change has been approved by the Sponsors, the following procedure should be followed:

- (a) The NHS Representative must submit to the Provider a document entitled a "Change Enquiry". There is no set format to this document but it must contain details of the proposed change, specify which schedules or provisions of the Contract the proposed change will affect, and state whether the Provider will be required to pay any money as a result of the proposed change or whether the Secretary of State will cover any such costs.

- (b) The Provider is required to respond to the Change Enquiry within 10 working days. It may object to the Change Enquiry by submitting an Objection Notice to the NHS Representative. The NHS Representative may then either:
- (i) accept the Objection Notice and therefore withdraw the request for change; or
 - (ii) refer the matter to the specified Dispute Resolution Process. This would be appropriate only if the Objection Notice fails to contain any of the pre-determined “Grounds for Objection” set out in the Contract (for example, if the change would be against the law or would be a departure from good industry practice or good clinical practice).
 - (iii) If the Provider does not object to the Change Enquiry within the allocated time, the Provider must serve a Response Notice containing details of how the changes will be implemented.
 - (iv) Within 10 working days of receiving this Response Notice both the Provider and the Sponsors will meet and discuss the proposed changes and will try to agree to the change and the practicalities of implementing it. If there is something that cannot be agreed, then this can be referred to the Dispute Resolution Procedure.
- (v) If all the terms for the change have been agreed, then the Sponsor provides a Change Confirmation which contains details of the change.
 - (vi) A Change Enquiry can be withdrawn at any time prior to the issue of a Change Confirmation. However, if a Change Enquiry is withdrawn then the Sponsor will be liable to pay any costs that have been incurred by the Provider whilst dealing with the matter.

13.11

Provider Change

The Provider may suggest that the terms of the Contract be varied. However, the Sponsors have no obligation to accept such a change.

Moreover, the Contracts state that any change requested by a Provider must not result in any increase in the unit prices agreed for each procedure. If the change proposed by the Provider results in a saving to the Sponsors of the amounts to be paid to the Provider under the Contracts, then such savings are to be shared equally between the Provider and the DH.





14

14. Information Management and Technology





14

Information Management and Technology

14.1

Overview of IM&T Requirements

14.1.1

What is the overall approach to IM&T within the Contract?

The Contract is in essence a clinical procurement and not an IT procurement. The IM&T solution must therefore support the overall delivery of the clinical services. The unavailability of the National Programme for IT (NPfIT) or any of the IM&T Systems does not relieve the Provider from its responsibility for fulfilling its obligations to provide the Services.

The main objective of the IM&T workstream of the ISTC Programme is to procure appropriately managed information services to support the delivery of the clinical services including integration into the affected local health economy and Connecting for Health (CfH).

The performance of Providers is not assessed against technical specifications for equipment, software, and hardware but for robustness, suitability of the information services and their timely implementation measure against the milestones provided.

The Provider is free to choose IM&T Systems as necessary to provide the required information services and the responsibility for the selection, design, provision, implementation and operation of IT systems rests at all times with the Provider. The Contract does not allow Providers to transfer technical risk for IT back to the Sponsors, for example through the acceptance of system design proposals.

14.1.2

Who is responsible for the design, procurement, implementation, installation, operation, maintenance and support of the IM&T Systems?

The Provider is responsible for and is the first point of contact for all IM&T services being provided (even if the Provider sub-contracts provision of the IM&T services to third parties).

14.1.3

What IM&T Services does the Provider have to support?

The precise IM&T services depend on the individual Scheme and are detailed in the Contract and generally include:

- (a) Referrals and Booking Service;
- (b) Patient Discharge and/or Reporting Services;
- (c) Patient Record Services;
- (d) Patient Flow Management;
- (e) Patient Communications;
- (f) Contract Management Information;
- (g) Commissioning Data Sets;
- (h) Clinical Data set Information;
- (i) Local Performance Management and Commissioners Information; and
- (j) Central Management Information.

14.1.4

What systems will the Provider be expected to implement for the clinical services?

The Provider is expected to have at least a Patient Administration System (PAS) to support the registration, booking and tracking of patients and be able to provide Contract management and information returns.

Depending on the clinical services, other systems may be required including Radiology Information System (RIS) and Picture Archive and Communication System (PACS) and Pathology systems. These are detailed in the relevant Contracts. Some of these systems may be provided by a NHS Trust where the Provider's property solution involves constructing the ISTC on land owned by a NHS Trust or where the Sponsors mandated that the Provider must provide the services from land owned by an NHS Trust.

14.1.5

What is the approach to NPfIT Systems?

The Provider will need to comply with the NPfIT Systems including Choose and Book, NHS Care Records Service, Electronic Transmission of Prescriptions, National PACS and N3 (the new NHS network). A standard approach for integrating with NPfIT has been developed by the NPfIT and Providers need to build system interfaces to achieve this.

14.2

Interfaces and Links to the NHS

14.2.1

What interfaces and links to the NHS are required?

The Provider is required to establish interfaces, both electronic and possibly manual, to the existing NHS systems both nationally and locally. It is expected that most interfaces and links to the NHS will be over N3. Where the ISTC is constructed on an existing NHS site, direct connection of networks (LANs) may be possible but the details will need to be approved by CfH. The interfaces are detailed in the Contracts.

14.2.2

Can the Provider sub-contract IM&T Systems to the Sponsors?

Yes, if the Contract provides for such sub-contracting, and subject to any approvals required in accordance with the relevant contractual provision.

14.2.3

What is the IM&T Information Governance Policy?

The Provider must meet, at minimum, the prevailing NHS Standards and follow the NHS guidelines for Information Governance, as detailed in the section entitled "Information Governance" in part C of the IM&T schedule.

14.3

Key IM&T Milestones & Timescales

14.3.1

Timescales

- (a) Prior to the entry into the Contract the Provider and the Sponsors need to agree on the following key areas:
- (i) Testing of Provider systems and processes;
 - (ii) Compliance with NHS Standards, NPfIT etc.;
 - (iii) Agreement of Patient Pathways;
 - (iv) Referral Process/Booking Patient Process;
 - (v) Patient Records Process;
 - (vi) Discharge Process; and
 - (vii) Contract Management Information.

The Provider then uses this information to develop the five key documents as set out in section 14.4.2.

14.3.2

What are the key/critical IM&T Milestones for the project?

The following are the four key Milestones identified within the Contract –

IM&T Requirements Definition and Planning Milestone

IM&T Systems Design Milestone

IM&T Ready for Operation/ Acceptance Testing Milestone

IM&T Completion Milestone



(a)

IM&T Requirements Definition and Planning Milestone

The Provider must complete due diligence, services specification and implementation planning activities. The Milestone is achieved when the following deliverables have been reviewed and approved by the NHS Representative:

- (i) IM&T Services Specification;
- (ii) IM&T Implementation Plan; and
- (iii) IM&T Phasing Plan.

(b)

IM&T Systems Design Milestone

The Provider must complete all necessary IM&T system design activities. The Milestone is achieved when the following deliverables have been reviewed and approved by the NHS Representative:

- (i) design specification;
- (ii) IM&T Interfaces Specification; and
- (iii) IM&T Services Test Specification.

(c)

IM&T Ready for Operation/Acceptance Testing Milestone

The Provider must conduct and successfully complete all tests defined in the IM&T Services Test Specification to meet the Ready for Operations Test and delivered the required supporting documentation including:

- (i) the Disaster Recovery Plan; and
- (ii) the IM&T Exit Management Plan.

Dependent on the Contract, generally there is no formal “acceptance” of the IM&T Services as the Contract is not an IT procurement Contract. Instead, the Provider is granted an “Authority to Proceed” with the supply of the IM&T Services if they achieve the relevant test criteria required for the successful completion of this Milestone.

If this stage is not successfully completed, the Provider will be liable for IDPIs (Immediate Deduction Performance Indicators) for each service defined in the IM&T Services Test Specification that has either not been tested or has failed.

The granting of the “Authority to Proceed” does not operate to transfer risk to the Sponsors and does not prevent the Sponsors from later rejecting the IM&T Services if the Provider fails to achieve a subsequent Milestone.

(d)

IM&T Completion Milestone

The Provider must complete all migration, commissioning, system implementation, training, and documentation activities to the satisfaction of the NHS Representative.



14.4

Management of IM&T

14.4.1

How are the IM&T Services defined and managed?

The Provider's Five Key Documents assist in managing and defining the IM&T services and the Provider is required to keep them updated from time to time during the term of the Contract as part of the IM&T services.

14.4.2

What are the five key documents

(a) IM&T Services Specification

This defines how the systems and technical architecture, which the Provider intends to implement, meet the required standards for the IM&T services. It also describes how the systems to be used will support the full Patient Pathway, the procedures to be followed, the maintenance and support arrangements, the disaster recovery and the business continuity arrangements.

(b) IM&T Interfaces Specification

This defines the specific interfaces that will be implemented as part of the IM&T services. It describes the interfaces between the Provider's systems and the Sponsors' systems and any other systems necessary to provide the IM&T services i.e. interfaces with NPfIT Systems such as Choose and Book, PACS etc. These may be either electronic systems or non-electronic systems subject to the specific requirements of the interface.

(c) IM&T Implementation Plan

This describes all the relevant tasks associated with the implementation of all interfaces and the IM&T requirements set out in the Contracts. It defines the timescales and deliverables for IM&T in line with the overall implementation plan for the IM&T services and incorporates the key milestones identified within the Contract.

(d) IM&T Phasing Plan

This plan defines the anticipated changes to the IM&T system configuration arising from NPfIT and other local NHS or Provider known projects. Using the service commencement design as a baseline, the plan describes the subsequent phases of systems configuration during the Contract term. The Sponsors are required to commit to implied modifications of the appropriate local systems necessary to meet the phasing timescales.

(e) IM&T Test Specification

This document defines the IM&T tests which the Provider must conduct to ensure the readiness of the IM&T Systems. It also defines the criteria for "Ready for Operations" as part of the mobilisation process.

14.4.3**What other deliverables is the provider required to provide?****(a) Disaster Recovery and Business****Continuity Plan**

The Provider must develop a Disaster Recovery and Business Continuity Plan (Disaster Recovery Plan) covering infrastructure both on and off site and any third party agreements required in accordance with the terms of the Contract. This is to ensure adequate continuity of services in the event of a serious failure of the IM&T systems and the efficient restoration of the IM&T services.

The Plan must include a policy document detailing potential incidents and how the Provider will address the continuation of the IM&T services if any of these incidents occur. The Provider must install appropriate infrastructure both within the ISTC and off-site in order to support continuous delivery of the IM&T services and retention of data. The Provider must comply without existing business continuity plans which the Sponsors have in place.

(b) IM&T Exit Management Plan

The Provider and the Sponsors must agree a planned procedure which the parties will comply with in the event of expiry or earlier termination of the IM&T services in order to:

- (i) enable and effect a smooth transition of the IM&T services to an alternative service provider or back to the NHS; and/or
- (ii) bring the relevant IM&T services or relevant part of the IM&T services to a satisfactory conclusion.

14.4.4**When is there a right to conduct an IM&T Audit?**

If the Sponsors have a reasonable concern that the Provider is failing to provide the IM&T services to the required standards set out in the Contract, the NHS Representative may request that the Provider gives access to the ISTC and any other of the Provider's premises from which IM&T services are provided in order to conduct an IM&T Audit.

14.4.5**What information flows must the Provider provide?**

All Providers are required to provide a number of information flows that are critical to support central DH reporting policy, statutory obligations or CCMU obligations for Contract management. These are detailed in the Contracts.

14.5**IM&T support of critical management functions****14.5.1****How does IM&T support the overall Contract management strategy?**

IM&T is there to support Contract management in terms of making sure that the data required to manage the Contract are provided. These data need to be agreed upfront within the key documents (see section 14.4.2).

The Provider must develop systems and processes that will provide appropriate information to enable the Sponsors and the Provider to monitor activity volumes and performance of the clinical services accurately.

The Contract also requires the Provider to compile reports in respect of the Performance Indicators.

14.5.4

What are the mechanisms for managing IM&T with the Contract?

For each Scheme, an IM&T working group is established, with Sponsor and Provider representation, to deal with day-to-day management of the IM&T Services.

If any disputes arise relating to IM&T issues during the term of the Contract, the Contract sets out an escalation route for the parties to follow.

14.6

IM&T standards

14.6.1

What standards must the IM&T Services comply with?

All Providers must use IT systems which comply with NHS information management and technology standards. The latest version of the IM&T Standards are available online and are detailed in the relevant Contracts.

14.7

Other Items

14.7.1

What training in the IM&T systems will be provided?

The Providers are responsible for the provision of all appropriate training for clinical staff to enable its IM&T systems to be incorporated into its operational processes. The Providers must also engage in training programmes associated with NPfIT or other relevant NHS IM&T requirements at their own cost. This includes for example "train the trainer" programmes for Choose and Book. Training obligations are set out in the Contracts.

14.7.2

What information will the Provider require from the Sponsors?

The Sponsors must give the Provider adequate access to survey, discuss and evaluate existing systems to help the Provider develop the five key documents, in particular the interface specification. This should include:

- (a) detailed information regarding existing systems, including any programme of upgrade or replacement work;
- (b) detailed information regarding future systems, including any programme for new services i.e. NPfIT;
- (c) detailed Information of the data standards they require the Provider to adhere to or change to.



15

15. Contractual Remedies for the NHS





15

Contractual Remedies for the NHS

15.1

Introduction

Successful implementation of the ISTC Programme requires robust management structures and the establishment of balanced and effective management interfaces between the NHS and the Provider.

Unfortunately there may be occasions where, during the construction phase or operational phase of a scheme, issues arise which cannot be resolved without recourse to the Contract. This section is intended to identify how the Contract provides the Sponsors with specific remedies to deal with certain situations.

The Contract provides differing levels of protection to the Sponsors, ranging from the ability to require information on (or access to) elements of the operations to allow the Sponsors to have a complete picture of how the project is progressing so that they can manage it effectively. In certain instances, the Contract even allows the NHS to exercise rights of self-help and effectively step-in and perform obligations where the Provider is failing to do so. The Contract also recognises that, in certain circumstances, the appropriate incentive for the Provider to perform (and the remedy for the NHS if the Provider fails to perform) is the payment of money by the Provider to the Sponsors. The Contract also contains a number of specific payment obligations, usually in the form of an indemnity, from the Provider, which the NHS can rely upon.

15.2

Dispute Resolution Procedure

The Contract provides that, except where expressly provided for in the Contract, in the event that there is a dispute between the parties the Dispute Resolution Procedure should be followed. It is designed to provide a relatively rapid means of addressing issues so that problems can be resolved quickly so that the impact of the dispute on service delivery is kept to a minimum.

15.3

NHS Representative

The Contract gives the NHS Representative specific rights to inspect and monitor the Provider's performance during both the construction and the operational phases. He is entitled to monitor the progress of the works upon giving reasonable notice. The Contract provides that, following such inspection, the Provider and its relevant sub-contractors should take into account reasonable comments of the NHS Representative. This remedy provides the NHS Representative with a right to examine how all elements of the Contract are being progressed. However, after exercising such right, the NHS Representative may need to use some of the other contractual rights summarised below in order to try to resolve a particular problem.

15.4

Access to Works

The Contract provides a specific right to the Secretary of State, each Sponsor, the NHS Trust (where relevant) and the NHS Representative (during the Construction Phase) to have unrestricted access at all reasonable times during normal working hours to view the works on reasonable prior notice, allowing progress of the works to be monitored. These rights are subject to the relevant safety procedures applying to the site or sites where the Facilities are being constructed.

Further, the Contract requires the Provider to hold monthly progress and site meetings. The Secretary of State, each Sponsor, the NHS Trust (where relevant) and the NHS Representative also have rights to attend these monthly meetings and any other meetings of the Provider and its sub-contractors which the NHS Representative reasonably requests.

These provisions are intended to enable the Sponsors not only to monitor the progress of the construction or refurbishment of the ISTC but also to identify any potential issues before they have a significant impact on the project as a whole. Early identification of such issues means there is a greater chance that these can be managed without recourse to the particular dispute mechanisms within the Contract and any adverse consequences mitigated.

15.5

Patient Concerns

The ISTC Programme requires the direct delivery of clinical services by the Provider to patients. In order to ensure that the correct patient-focused service delivery is being provided, the Contract requires the Provider to deal with patients in an appropriate manner and correctly respond to their concerns.

Specific obligations that the Sponsors can enforce include requiring the Provider to carry out or co-operate with Patient Satisfaction Surveys (this is in addition to the minimum performance standard levels set out in the Contract).

The Provider is also required under the terms of the Contract to provide specific co-operation and assistance to the Patient Advice and Liaison Service and to take account of all recommendations made by it.

In addition to these requirements, the Provider must put in place a complaints procedure and give the NHS representative and relevant referring NHS Bodies details of a complaints manager. When actually dealing with patient complaints, reports must be provided to the NHS, and the Provider is specifically obliged to indemnify the Secretary of State, the NHS representative and any relevant Health Service Body against any costs and expenses in connection with investigating and resolving any complaints made by, or on behalf of, any patient against the Provider.

The whole intention of the Contracts is therefore that the patient experience should be at least equal to the treatment they would receive from the NHS.

15.6

Rights of Audit

In order to ensure that the Sponsors can effectively manage the Contract, there are specific rights of access and audit granted to the Sponsors including the following:

15.6.1

The Provider must allow the NHS Representative to conduct an audit of the financial records.

15.6.2

The Provider must allow the NHS Representative, the local counter-fraud specialist, other Sponsors, any person authorised by a local counter-fraud specialist, a security management specialist nominated by a Sponsor, or a person duly authorised to act on behalf of the NHS CFSMS to review arrangements put in place by the Provider in respect of security and anti-fraud provisions; and

15.6.3

The Provider must provide reasonable assistance and co-operation to any auditors appointed by the Audit Commission (including the Comptroller and Auditor General). This includes providing access to any documents which they may require.

15.7

NHS Step-In

The Contract contains rights for the NHS to effectively step-in to the Contract to remedy any poor performance in any of the following circumstances:

15.7.1

The NHS Representative, acting reasonably, considers that a breach by the Provider of any obligation under the Contract may create an immediate and serious threat to the health and safety of any patient or may result in a material interruption in the provision of one or more of the services;

15.7.2

The Provider has accrued more than 18 Warning Points (explained in section 16.2.8, summarising the Payment Mechanism and Performance management Regime); or

15.7.3

The Provider is not in breach of its obligations, but the NHS Representative considers that in any event the circumstances constitute an emergency.

If one of the events specified above occurs, then the NHS Representative (acting reasonably) may require the Provider to take such steps as are necessary to rectify the state of affairs. More importantly, if the NHS Representative considers that there is not sufficient time, or that the Provider is unlikely to be willing and/or able to take the necessary steps, then the NHS Representative can take such steps as he considers to be appropriate (either himself or by engaging others to take any such steps) to ensure the provision of the relevant services are of the standards required by the Contract.

These rights of step-in also occur if the Provider, having been notified, subsequently fails to perform or if the NHS Representative determines that there is an emergency.

The general position is that the Contract requires the Provider to reimburse the Secretary of State for its reasonable costs, losses, expenses or damages resulting from stepping-in.

15.8

Collateral Warranties

On schemes where new facilities are to be constructed by the Provider, or where the Provider will refurbish existing facilities, the party that will carry out the construction is required to enter into a warranty in favour of the Secretary of State and/or the Sponsors. The warranty requires that the building contractor warrants, to the Secretary of State and/or the Sponsors, due and proper performance of its obligations under its building Contract with the Provider. If a sub-contractor or consultant has been appointed, they too would also have to provide a collateral warranty in favour of the Secretary of State and/or the Sponsors in the same form as that provided by the building contractor.

Under the terms of the warranty, the building contractor warrants that it will owe the same contractual duties to the Secretary of State and/or the Sponsors as it would to the Provider, i.e. that it will comply with all the terms and complete the works in accordance with the building Contract.

The building contractor is further required to warrant that it will exercise all reasonable professional skill and diligence, that the works will satisfy all relevant performance specifications and that it will seek consent from the Secretary of State and/or the Sponsors before departing from or varying the terms and conditions of the building Contract.

The building contractor also warrants that it will take out and maintain professional indemnity insurance.

The warranty covers the potential issue of a "step-in" by an NHS party to the building Contract. If this situation occurred, the building contractor agrees that the NHS party is entitled to enforce the terms of the building Contract as if it were the Provider.

Pursuant to a step-in, the relevant NHS party is entitled to novate and transfer the Provider's rights and liabilities under the building Contract either to itself or to another entity. The warranty contains procedures for the exercise of these step-in rights and for the novation of the building Contract as well as the NHS party's entitlement to assign all its rights under the warranty without consent.



16

16. Payment





16

Payment

16.1

Introduction

16.1.1

Purpose of this section

The Payment Mechanism is part of each Contract and sets out, broadly, how much and under what circumstances the Provider will be paid for the provision of the services in accordance with the terms of the Contract.

16.1.2

Key principles

The key principles of the Payment Mechanism are that:

- (a) it supports the notion of partnership between the Provider and the NHS parties;
- (b) it focuses on quality and service rather than punishment and sanction;
- (c) the Provider receives a predictable cash flow;
- (d) the Provider assumes the risk of patient management; and
- (e) the Sponsors assume the risk of patient provision.

16.1.3

Key aims

In addition, there are four goals which were considered when creating the Payment Mechanism. These are to:

- (a) allow Sponsors flexibility in the provision of referrals;
- (b) allow the Provider flexibility in the scheduling of treatment;

- (c) provide clarity on performance monitoring, and the permitted redress under the Contract through the imposition of sanctions for underperformance; and
- (d) provide clarity around which party pays for what and when.

16.1.4

Overview of the Contract payment provisions

- (a) The key sections of the Payment Mechanism are as follows:
 - (i) definitions;
 - (ii) referral protocol;
 - (iii) Sponsor's "Minimum Take" obligations;
 - (iv) payment; and
 - (v) performance management regime.
- (b) The following parts of this section address each of these key areas as follows:
 - (i) section 16.2.2 deals with how referrals are made and managed by the Sponsors;
 - (ii) section 16.4 deals with:
 - (A) the guaranteed amount that the Sponsors are contractually obliged to pay the Provider during each month of each year during the life of the Contract;
 - (B) the flexibility that is built into the system to help the Sponsors manage referrals;
 - (C) how much the Provider is entitled to be paid;
 - (D) the financial consequences of failure to complete activities by the Treat by Date; and
 - (E) the financial consequences of DNAs; and
 - (iii) section 16.2.8 deals with the Performance Management Regime.

16.1.5**Standard form Contracts**

The Payment Mechanisms in use on each of the Wave 1 ISTC Contracts are based on a standard form document. However the payment provisions for each scheme do vary due to either Provider-led issues or local health economy issues. This section provides an outline of the structure of the majority of the Payment Mechanisms used on Wave 1 Schemes.

16.2**Key Concepts****16.2.1****Key terms**

Outlined below are some of the key concepts used in the Payment Mechanism.

Activity

An Activity is a unit of treatment purchased by the Sponsors from the Provider. Activity is specified by Healthcare Resource Group (HRG) for procedures.

Activity Group

Each Activity is assigned to an Activity Group within which procedures are grouped where they can generally be undertaken by the same set of staff and equipment.

Excusing Cause

A circumstance where, due to the actions of a third party, the Provider has failed to meet a Treat by Date or a threshold set for a Performance Indicator which entitles the Provider to relief from sanctions.

Marginal Price

The agreed price set out in the Contract which the Sponsors agree to pay for referrals over the contracted capacity of 105% of the Minimum Take.

Minimum Period

The period of time relating to each procedure between the date of the referral and the earliest date on which the Provider can begin providing treatment. This period of time is intended to give patients sufficient notice before attending the ISTC for treatment.

Minimum Take

The minimum amount guaranteed to be paid to the Providers by the Sponsors in return for delivering the services. This is expressed as a value, rather than a number of activities, to allow for variances due to substitutions between activities within an Activity Group.

Reconciliation

At the end of each quarterly period and at the end of each Contract year, a comparison is made between the value of activities completed by the Provider and the Minimum Take. The Sponsors must make up any shortfalls.

Substitution

Activities within Activity Groups may be substituted for each other by the Sponsors, so long as the total value of referrals constituting the Minimum Take is maintained.

Take Point

The month in which the patient's treatment is recorded for financial accounting purposes. This may be different from the month in which the referral is made and the month in which the Treat by Date occurs.

Treat by Date

The date by which the patient must be treated by the Provider. This is specified as a certain amount of time from the date when the Provider receives the referral. The time period varies across different types of procedure. This concept is designed to ensure that waiting times for patients are closely monitored and reduced.

16.2.2**Referrals**

- (a) The Contract sets out the ways in which the Sponsors (and any other NHS bodies who are permitted by the Contract) may make referrals to the Provider. It is crucial that the Sponsors (and the local health economy where NHS bodies other than the Sponsors are entitled to make referrals to the Provider by way of the Brokerage system) work together to manage the referral of patients to the ISTC to ensure that the capacity that the Sponsors are buying from the Provider is used in the most efficient way.
- (b) Generally, there will be a time lag between the date on which the referral is made and the date of the patient appointment. However, the Contract allows for patients to opt to be treated on a standby basis at short notice. This flexible approach allows the Provider to fill slots in its schedule that have become vacant at short notice due to, for example, a late cancellation by another patient and therefore increases the efficiency of the ISTC.
- (c) The Provider may reject referrals where it thinks that the patient is not suitable for treatment in the ISTC. Such rejections are monitored as part of the performance management regime to ensure that:
 - (i) the Sponsors are referring the correct categories of patients; and
 - (ii) the Provider is not "cherry-picking" patients.

16.2.3**Minimum Take/Guaranteed Payments**

- (a) The Sponsors are committed to pay to the Provider 100% of the value of the Minimum Take in each Contract year unless the Provider:
 - (i) fails to complete procedures by the relevant Treat by Date;
 - (ii) fails to complete any procedures due to DNAs; or
 - (iii) fails to meet the performance threshold standards and fails to rectify the situation which led to such failure to meet the performance thresholds.
- (b) The commitment to pay to the Provider 100% of the value of the Minimum Take in each Contract year remains where procedures are not carried out due to:
 - (i) any failure on the part of the Sponsors;
 - (ii) any circumstances set out in the Contract which allow the Sponsors to withdraw a referral before the patient has been treated; or
 - (iii) circumstances where the Provider is entitled to reject a referral on clinical grounds.

16.2.4**Flexible system of managing referrals and Minimum Take obligations**

- (a) The Contract sets out how many Activities within each Activity Group each of the Sponsors has committed to buy during the life of the Contract. However, referral patterns will change over the life of the Contract and so a certain degree of flexibility has been built into the Contracts. This flexibility also allows the Sponsors to manage the referrals they make to the ISTC to ensure that they utilise the capacity that the Minimum Take represents.
- (b) Flexibility is built into the Contract at six levels:
 - (i) the Brokerage system allows a Sponsor to let another PCT or other referring Health Service body to utilise any unused allocation of referrals that it has not used;

- (ii) flexibility between Activities within Activity Groups through substitutions;
 - (iii) flexibility between Activity Groups (if agreed);
 - (iv) in any month, the Sponsors may make referrals between 95% and 105% of the contracted Minimum Take;
 - (v) Take Point flexibility – this allows the Sponsors to control when an Activity counts towards the Minimum Take; and
 - (vi) treatment window i.e. the Provider can schedule a patient appointment at any time after the end of the Minimum Period and before the Treat by Date.
- (c) Overall, this approach results in a very flexible mechanism for making and managing referrals while also allowing the Provider to plan on the basis of a guaranteed revenue stream which in turn has cost benefits for the Sponsors.

16.2.5

Completed activities/incomplete activities

One of the key contractual principles is that the Provider must complete the treatment set out in each referral by the relevant Treat by Date for that procedure. However, the Contract recognises that there may be certain circumstances which mean that the Provider is not able to complete a particular treatment by the Treat by Date. These circumstances can be categorised as one of the following:

- (a) where neither party is at fault;
- (b) where the patient does not attend a relevant patient appointment (DNA);
- (c) where the Provider is at fault.

An explanation of these circumstances is set out below.

(a) Circumstances where no party is at fault

These circumstances include instances where:

- the patient cancels his appointment more than 48 hours before the date scheduled for the patient appointment. If this circumstance occurs, the Provider must attempt to rearrange the patient appointment on at least two further occasions;
- the Provider cancels a patient appointment more than 48 hours before the date scheduled for the patient appointment. The Provider may need to cancel a patient appointment because, for example, the preliminary assessment of the patient may reveal that they are no longer suitable for the procedure for medical or social reasons. For example, the patient may have caught an infection and the Provider would then attempt to fill the vacant slot in its schedule by treating another patient on a stand-by basis. Again, if this circumstance occurs, the Provider must attempt to arrange another patient appointment on at least two further occasions; or
- prior to or during a patient appointment, the patient is, or threatens to be, violent. If this circumstance occurs, the Provider is not obliged to arrange any further patient appointments in respect of that patient. The patient is simply referred back to his GP.

(b) DNAs

A DNA occurs when a patient does not attend a patient appointment arranged between the patient and the Provider and the patient has either not given 48 hours notice to the Provider or gives no notice. If a DNA occurs, the Provider must attempt to arrange at least two further patient appointments in respect of that patient.

(c) Circumstances where the Provider is at fault

These circumstances include situations where:

- the Provider cancels a patient appointment within 48 hours of the date when the patient appointment was scheduled to take place; and
- the Provider cancels the patient appointment at any time without good medical grounds (for example, the Provider does not have enough staff to operate the theatre).

The financial implications

As stated above, the general rule is that the Sponsors pay the Minimum Take to the Provider. However, this general rule is modified in several ways if the Provider fails to complete any treatment by the relevant Treat by Date as follows:

(A) Neither party is at fault

The Sponsors must make additional referrals to replace the patient appointment that was cancelled i.e. the Minimum Take is maintained. In addition, where a patient appointment is cancelled because a patient is violent, some of the Contracts provide that the Sponsors must pay any costs that the Provider already incurred in treating that patient.

(B) DNAs

Where a patient appointment is cancelled because of a DNA, the Sponsors do not have to make a replacement referral i.e. the Minimum Take is reduced by the value of the cancelled procedure.

(C) Cancellation due to Provider's default

Where a procedure is cancelled due to the Provider's default, the Provider must either complete the procedure at some other time at its own cost, or reimburse the NHS the cost of completing that patient's treatment elsewhere. In addition the Sponsors do not have to make a replacement referral i.e. the Minimum Take is reduced by the amount of the cancelled procedure.

16.2.6**Bedblocking**

The general rule is that where a patient is medically fit to be discharged from the ISTC but a required discharge plan is not in place, the Sponsors must pay the Provider an agreed amount set out in the Contract for each night that the patient has to remain in the ISTC.

16.2.7**Payment**

- (a) The Sponsors make payments to the Provider on a monthly basis in arrears.
- (b) The basic amount will be determined by the value of the relevant Minimum Take for each Contract month.
- (c) Adjustments will be made quarterly for:
 - (i) excesses or shortfalls in referrals made during that quarter;
 - (ii) marginal pricing for any referrals accepted by the Provider over 105% of the Minimum Take;
 - (iii) any adjustments for incomplete activities; and
 - (iv) any deductions to be made for performance failures.

16.2.8**Performance management review**

A process for performance management of ISTC Contracts was developed following detailed consultation with potential IS Providers, Sponsors, Royal Colleges and other parties.

The process involves monitoring a set of Performance Indicators within each ISTC Programme. These Performance Indicators are designed to monitor performance against the key performance standards thresholds set out in the Contract, particularly in relation to clinical performance. Each Performance Indicator has a specified threshold, below which a review, investigation or other sanction may be triggered.

The Commercial Directorate has issued

measurement criteria and methods to provide consistency.

A breach of Performance Thresholds does not automatically result in investigations or rectification plans.

A Joint Service Review is undertaken regularly between the Provider, Sponsors and NHS Representative on each scheme to assess Provider performance data, the results of any investigations, performance against rectification plans (if any) and complaints (if any).

Where a Provider fails to comply with an agreed rectification plan, it may incur warning points and revenue deductions, with the most serious cases of under performance potentially leading to Contract termination. See figure 5 on page 113.

Warning Points/Sanctions

Warning Points (and Revenue Deductions) apply by Performance Indicator in response to unrectified provider deficiencies.

There can only be one rectification plan issued per Performance Indicator per quarter. See figure 6 on page 114.

16.2.9 Performance Indicators

(a) Overview

The Performance Indicators are an essential element in the Performance Management system for the ISTC. They are designed to provide an indication of areas of potential concern but not, of themselves, to indicate that care is unsatisfactory. Providers are obliged to provide accurate and timely Performance Indicator data for regular quarterly review by the Joint Service Review. Both Sponsors and the Provider are expected to act reasonably and to adopt a neutral stance in their approach to Performance Indicator figures and their assessment.

(b) Performance Indicators

- (i) The Performance Indicators that the Sponsors require to be reported are set out in the Contract. For each Performance Indicator a threshold is defined.
- (ii) The Provider is obliged, as a minimum, to use the following measurement methods to determine the standard achieved against the Performance Indicators:
 - (A) case records (electronic and/or paper) containing all relevant observations derived from patient history-taking, professional observation, investigations and any other relevant source;
 - (B) clinical audit and peer review, or equivalent approach to clinical quality assurance/quality improvement; and
 - (C) patient surveys, using prescribed instruments which have been scientifically validated.

The Sponsors may also expect to be involved in the clinical audit process.

- (b) The main types of Performance Indicators set out in the Contracts include:
 - (i) the proportion of DNAs;
 - (ii) the proportion of procedures cancelled for clinical or non-clinical reasons;
 - (iii) the conversion rates of patients continuing on to a surgical procedure after an outpatient appointment;
 - (iv) the rejection rates where patients are referred for an Activity not undertaken by the Provider or not suitable to be undertaken within the ISTC;
 - (v) the proportion of patients transferred to another provider of healthcare services (whether NHS or otherwise) for inpatient treatment;
 - (vi) the average length of stay for each HRG;
 - (vii) clinical outcomes;
 - (viii) timeliness, completeness and accuracy of Provider performance data;

Figure 5

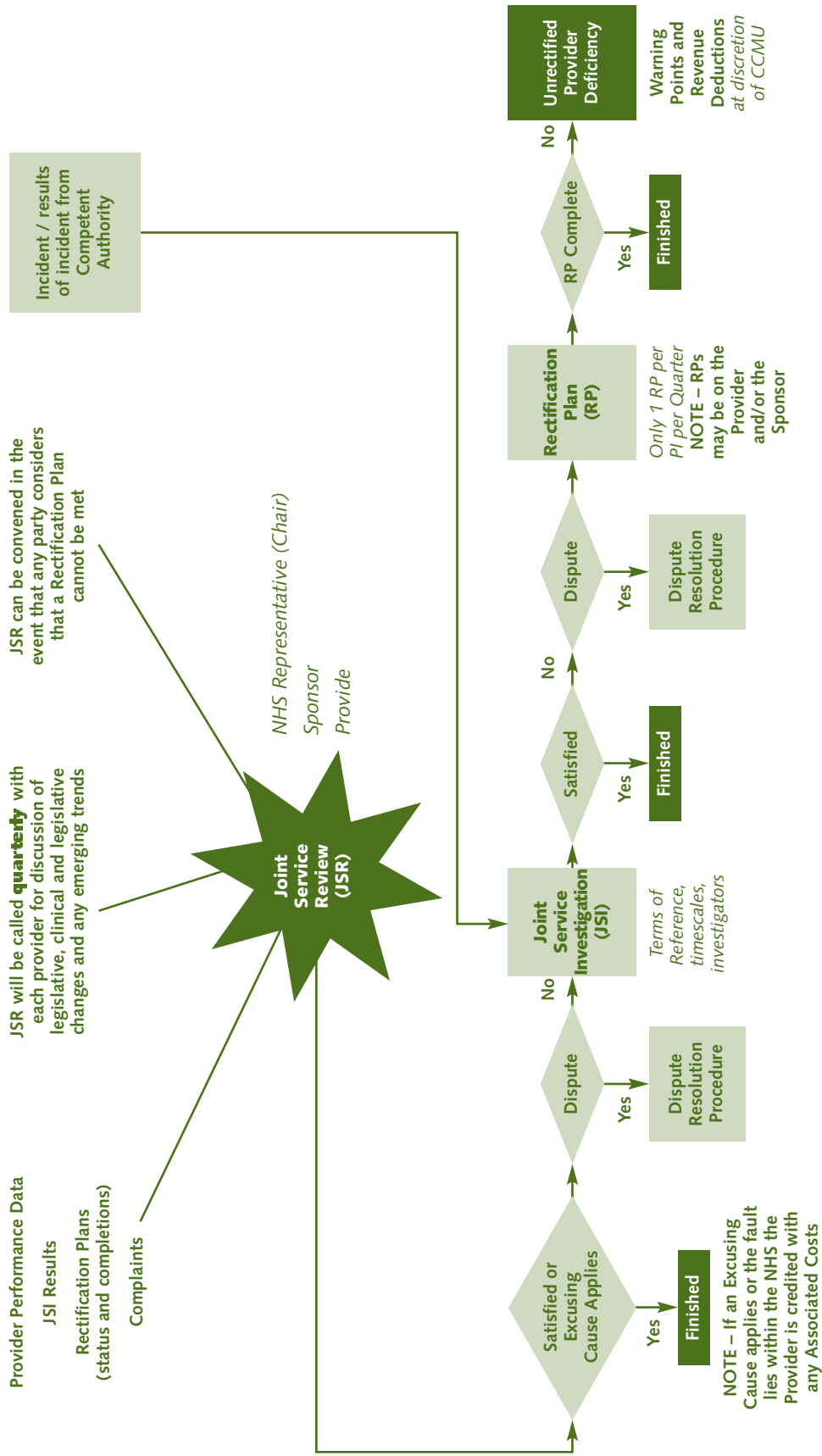
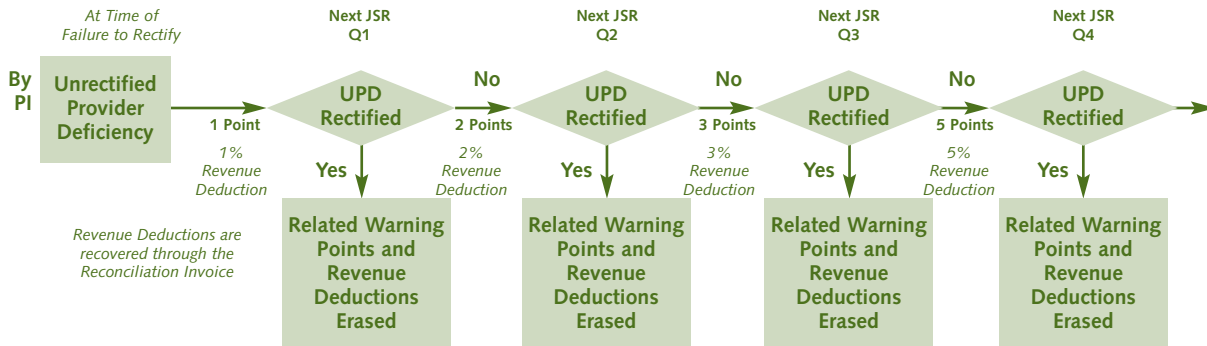


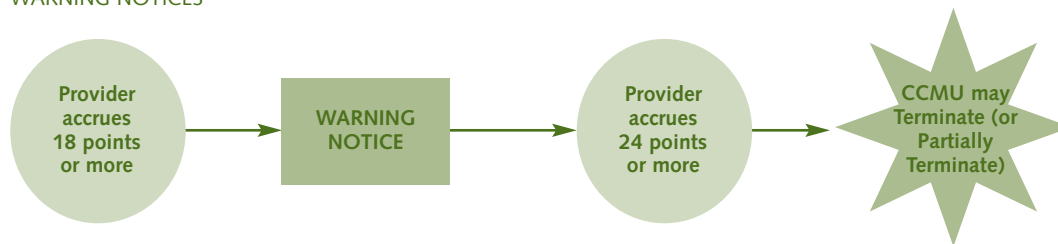
Figure 6



NOTE – in each subsequent quarter a further RP can be issued against the PI where the cause for the Provider Deficiency and therefore the RP is different and further Warning Points can apply if the RP is not implemented

WARNING POINTS CAN BE ACCRUED ACROSS ALL PIs SIMULTANEOUSLY

WARNING NOTICES



- (ix) outcomes of patient satisfaction surveys;
- (x) the rate of patient complaints;
- (xi) patient complaints handling;
- (xii) the number of incidents which are reportable to the NPSA or other statutory body;
- (xiii) compliance with the requirements of the Additionality policy;
- (xiv) the condition of the Facility;
- (xv) any incident of breach of security;
- (xvi) any breach by the Provider of confidentiality or data protection; and
- (xvii) any failure to meet Treat by Dates.

16.3

Referrals

16.3.1

Key aims

The referral process is designed to:

- (a) ensure that appropriate information about the patient is transferred from the relevant Sponsor to the Provider;
- (b) provide flexibility through standby patients; and
- (c) provide flexibility by allowing patients and the Provider to arrange mutually acceptable times for patient appointments.

16.3.2

Management of referrals

(a) Co-ordinating referrals

It is crucial that the Sponsors carefully manage the referrals process in order to achieve the maximum utilisation of the capacity purchased from the Provider. This is normally achieved by ensuring that all Sponsors, and any other bodies that are allowed to make referrals under the terms of the Contract, make their referrals in the first instance to a central co-ordinating body. This body is responsible for placing patients in the Forward Order Book. The Provider can access the Forward Order Book to arrange patient appointments.

(b) Figure 7 sets out the way in which a central co-ordinating body might co-ordinate referrals from several Sponsors to an ISTC. Note that separate arrangements are put in place between the various NHS bodies to cover these arrangements.

16.3.3

Patient Supply Process (PSP) and Forward Order Book (FOB)

(a) Introduction

(i) Intention:

This section sets out the process whereby Sponsors ensure that sufficient referrals will be made to IS Providers to enable them to meet Minimum Take commitments.

(ii) Scope:

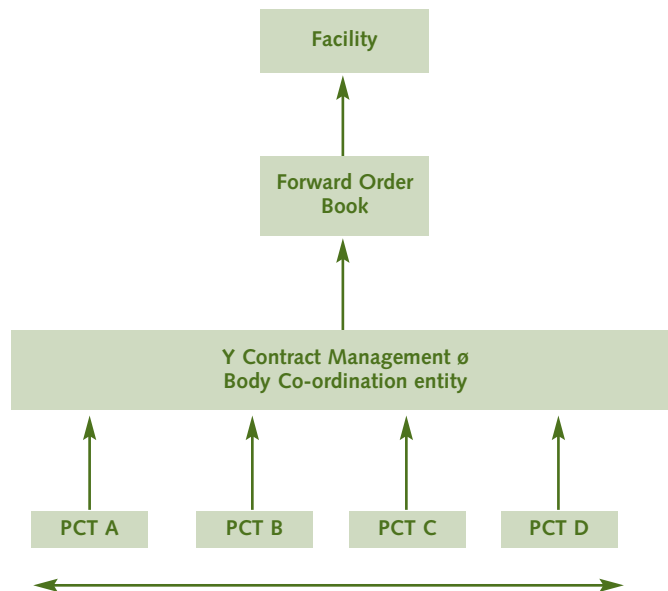
(A) The PSP is the mechanism by which patients will be referred into ISTCs.

(B) It has two parts:

- (1) a Patient Flow Management System (PFMS); and
- (2) a Forward Order Book (FOB).

The PFMS is internal to the NHS. It is the system by which patient referrals from a number of different sources are co-ordinated prioritised, where appropriate, and tracked.

Figure 7



The FOB is managed and produced by the NHS, but it is accessible to the Provider. It is a bank of referrals from which the Provider can draw in order to fill its schedules. By having sufficient numbers of patients in the FOB, the Sponsors ensure that there are sufficient referrals to utilise the capacity represented by the Minimum Take that they have purchased.

(b) Patient Supply Issues

(i) Principle

(A) Essentially patients are:

- (1) referred from a number of sources;
- (2) co-ordinated into a single flow that is carefully managed to meet Minimum Take obligations; and
- (3) placed on a list that the Provider can draw from to fill its schedules.

(B) The key stages are discussed in more detail below.

(ii) Referrals

(A) Referrals to the ISTC could come from a number of different points.

Typically there may be a number of Sponsors and each Sponsor will have a number of referring GPs. Dependent on local arrangements and contracted activity, each GP could refer patients to the ISTC for investigations (diagnostics), out-patient appointments (assessments) or directly for procedures. The casemix for these referrals may span a number of Activity Groups, as agreed between Sponsors and the Provider.

(B) Referrals for procedures could also come from one or more NHS Trust consultants (following NHS outpatient consultations with consultants based at a NHS Trust) or from existing NHS waiting lists held by one or more NHS Trusts.

(C) Over the course of a year, the value of referrals made by each of the Sponsors to the Provider should add up to the proportion of the Minimum Take for that Sponsor as set out in the Contract. This is

discussed in more detail below.

(D) Referrals of all patients for whom the Sponsor is responsible will count towards the Minimum Take for that Sponsor i.e. referrals from GPs, referrals of Sponsor patients from NHS outpatient consultations and referrals of patients from NHS waiting lists.

(iii) Patient Flow Management

(A) Each Sponsor is responsible for a separate and defined proportion of the Minimum Take. Each Sponsor's proportion of the Minimum Take is set out in the Contract. This means that each Sponsor will have obligations to refer sufficient patients to enable all of the Sponsors to meet their obligations to make referrals up to the Minimum Take.

(B) Referrals from each Sponsor could come from a number of sources. These referrals will need to be co-ordinated to ensure that overall, the Sponsors meet (and do not unintentionally exceed), the Minimum Take commitment.

(C) Although each Sponsor has a separately defined Minimum Take, the Contracts allow for the Sponsors to "trade" Minimum Take capacity with one another. For example, in a given month, one Sponsor could under-refer in a particular Activity Group and another could over-refer in the same Activity Group by agreement between the Sponsors. This allows the Sponsors to ensure that they are not paying for Activities which they do not actually purchase for their patients.

(D) Referrals to the ISTC are therefore managed across all Sponsors for that ISTC. If there is a lead Sponsor it may be the best organisation to do this.

(E) Inputs to the PFMS are referrals from all Sponsors (including GPs, NHS consultants, NHS waiting lists) across all Activity Groups. The output from the

PFMS is a flow of patients (into the FOB) sufficient to meet (but not exceed, unless the Sponsors intend to make additional referrals above the contracted level of 105% of the Minimum Take) the Minimum Take obligations of the Sponsors as a whole in each Activity Group.

(iv) Forward Order Book

- (A) The FOB is essentially a list of patients that have been referred to the ISTC. Each patient will have a Treat by Date allocated to him, which is the latest date by which they must have reached an agreed stage of their treatment (or diagnostic test or outpatient consultation).
- (B) The FOB is managed and owned by the Sponsors but is accessible by the Provider.
- (C) As soon as a patient is listed in the FOB, he is available to the Provider for booking into the ISTC schedules (subject to an agreed minimum period of notice (the Minimum Period) and to agreement with the patient). The Provider can take patients from the FOB in any order, as long as the Treat by Date is met. In this way, Providers have the flexibility to populate their schedules in a way that will maximise their efficiency.
- (D) The size of the FOB will be controlled by:
 - (1) the rate of referrals from the Sponsors;
 - (2) the rate at which patients are taken from the FOB and put into the Provider's schedules by arranging Patient Appointments; and
 - (3) the initial loading of the FOB (to be agreed between the Sponsors and Providers).

(v) ISTC Schedule

- (A) This is where the Provider books patients into appointment slots for consultation/treatment; and
- (B) It is a Provider owned and operated system and does not need to be accessible to Sponsors.

(vi) Rate of Referral

- (A) This is the rate at which patients enter the FOB. It is the key parameter to ensuring that Sponsors provide sufficient patients to enable them to fully utilise the Minimum Take. The following applies to each relevant element of the Minimum Take (i.e. investigations, assessments and procedures).
- (B) Each patient referred into the FOB will have a "Take Point" allocated to them by the Sponsors.
- (C) For each month, the value of referrals with a Take Point in that month must add up to the monthly Minimum Take \pm 5%. This must apply to each Activity Group.
- (D) There will be a number of patients referred to the ISTC that do not attend (DNA). The referral rate will therefore be increased by the estimated number of outpatient or pre-operative DNAs in each Activity Group.
- (E) There will be a number of conversions from Outpatient Assessment to surgical procedure. The number of referrals for procedures will therefore need to be reduced by the expected number of such conversions in each Contract month.

16.4

The Payment Mechanism

16.4.1

Overview of pricing and payment

- (a) Providers are required to deliver, and be paid for, completed Activities along the Patient Pathway. Each Provider's unit prices are wholly inclusive of all input costs whether supplied directly by the Provider or subcontracted from other organisations (including the NHS).
 - (b) The Sponsors make payments based on Activities completed under a "Take or Pay" arrangement, with a guaranteed Minimum Take expressed in terms of an amount of money (defined as the annual procedure casemix multiplied by agreed unit prices and adjusted for inflation).
 - (c) This commitment is measured by reference to referrals made with Take Points in the relevant Contract year, not by reference to when the Activity stated in the referral is due to be completed.
 - (d) The level of Minimum Take generates revenue of an agreed amount in each year of the Contract, based on the referral of patients within an agreed casemix. Any failure to refer sufficient compliant cases is a risk borne by the Sponsors.
 - (e) Payments made by Sponsors are subject to financial deductions for certain categories of shortfalls in performance against a series of Performance Indicators. The Sponsors are also not always obliged to make full payments in the event that the Provider fails to complete an activity by the relevant Treat by Date.
- 16.4.2**
- ##### Principles of the payment model
- (a) The Payment Mechanism set out in each of the Contracts sets out the terms and conditions for payments to (and in some instances from) the Provider, emphasising quality assurance rather than sanctions, joint management of issues and a partnership approach.
 - (b) The key principles of the Payment Mechanism are that it:
 - (i) gives the Provider an assured income (Minimum Take);
 - (ii) obliges the Provider to ensure that it has the capacity to provide clinical services up to 105% of the Minimum Take;
 - (iii) sets out the referral process in harmony with the clinical specification;
 - (iv) allows the Sponsors to refer 5% additional referrals without further consultation with the Provider;
 - (v) allows the Provider to exercise discretion in accepting work over 105% of the Minimum Take;
 - (vi) sets out flexibilities between Activity Groups to enable both Provider and the Sponsors to increase flexibility within defined parameters;
 - (vii) gives the Provider:
 - (A) flexibility to plan treatments to optimise efficiency;
 - (B) minimum periods between referrals and Treat-by Dates; and
 - (C) the right to reject certain referrals (e.g. in instances where patients become violent);
 - (viii) obliges the Provider to attempt to (re)book certain patients (for example, cancellations, DNAs and patients who are temporarily unfit) three times;
 - (ix) sets out payment terms;
 - (x) sets out the financial consequences to the Provider of any failure to deliver the Activity stated in a referral, and where Excusing Causes apply;
 - (xi) sets out the Performance Management Regime including:
 - (A) details of monthly performance review processes; and
 - (B) the Providers' obligations to provide performance data.
 - (xii) details the Performance Indicators thresholds and Associated Costs;

- (xiii) details the process to review, investigate and rectify performance where appropriate; and
 - (xiv) details the sanctions (either warning points or revenue deductions) that can be applied where the Provider fails to complete a rectification plan.
- (c) The payment model consists of:
- (i) payment of the guaranteed Minimum Take in monthly instalments;
 - (ii) potential deductions for failure to meet Performance Indicators;
 - (iii) any payment due to the Provider at the Marginal Rate for work completed over 105% of the Minimum Take;
 - (iv) any deduction from the Provider's revenue stream for Associated Costs due from the Provider; and
 - (v) sub-paragraphs (ii), (iii) and (iv) above are reconciled and paid on a quarterly basis.

The monthly payment can be represented in general as follows:

$$P = (\sum NaUa) + (\sum MaVa) - Pd - Ac$$

Where:

- Na,b = number of contracted episodes of procedure a, b, etc.
- Ma,b = marginal activity
- Ua,b = unit price per procedure a, b, etc.
- Va,b = marginal price
- P = Total Payment
- Pd = The performance deductions for failure to achieve target standards against the Key Performance Indicators
- Ac = associated costs

16.4.3

Minimum Take

- (a) The Minimum Take is determined separately for each Activity (subject to casemix substitution between the Activities in an Activity Group or, where agreed, between Activity Groups described below) and is multiplied by the unit price for each Activity. It is expressed as an annual monetary amount which is profiled over each month of the Contract.
- (b) The Sponsors must pay the Provider the agreed profiled financial value of the Minimum Take each month. Variations (plus or minus) in the number of referrals to the Minimum Take are calculated quarterly in arrears. Conversely, where the Provider has completed Activities in excess of the quarterly profile of the Minimum Take it is paid for the additional procedures which it completes at an agreed rate set out in the Contract called the Marginal Price. This principle will also apply to the annual reconciliation detailed below.
- (c) The Provider must ensure that it has the capacity to provide Activities up to 105% of the contracted Minimum Take for each year.
- (d) In addition to the above, there will be an annual reconciliation to determine the overall consumption of the Minimum Take obligation and to confirm the final annual financial amount due from the Sponsors. Where the actual value of all referrals made in any one year is greater than the Minimum Take for that year the Sponsors must make an additional payment at the Marginal Rate.
- (e) In general, where the Sponsors have made sufficient referrals but the Provider has not completed the Activity for the Minimum Take in any year (unless Treat by Dates are in the subsequent year) then the Sponsors only pay for procedures that were actually completed (i.e. the Minimum Take payment will be reduced).

- (f) Where the Sponsors have not made sufficient referrals, the financial value of the Minimum Take will be paid. The quarterly adjustment, which may be a negative sum, will be carried forward to be offset against the future monthly Minimum Takes in the same Contract year. The last payment prior to Contract expiry will be made three months in arrears to ensure that any amount due from the Provider in respect of the quarterly or annual adjustment can be set off against sums due to the Provider at the expiry of the Contract.
- (g) The Minimum Take comprises two elements:
 - (i) Assessments (A): Referrals which require an Outpatient Assessment and any routinely necessary investigations for that type of referral; and
 - (ii) Procedures (P): Procedure packages include pre-admission assessment, required diagnostics, the surgical procedure in full and all care as specified in the Patient Pathways (including, for example, necessary physiotherapy). The total numbers of surgical procedures in the Minimum Take will take into account the likely number of “P” accruing from “A” as well as those transferred from the waiting list or directly from an appropriate referral point.
- (h) The unit prices for surgical procedures include any necessary pre-operative assessment to ensure that the patient still requires surgery, remains fit for surgery, and is fully informed as to both administrative and healthcare arrangements.

Figure 8

Monthly Minimum Take – Flexibility



- (i) Figure 8 illustrates the ways in which the Sponsors can use the built-in flexibility to manage referrals.
- (j) Figure 8 also shows the way in which the Take Point concept allows the Sponsors to manage the referrals made to the Provider. It also demonstrates the relationship between the key concepts of Minimum Period and Treat by Date.

16.4.4

Casemix Substitution

- (a) Certain Activities may be substituted for others as set out in the individual Contracts. The Minimum Take is defined as a value but based on a casemix which will allow substitution between different Activities within an Activity Group that are similar in respect of key inputs and process. Usually, this will mean that the same clinical staff and theatre facilities can be used for each Activity, but may take different lengths of time or require different consumables, either of which could affect cost. Thus the Minimum Take is not defined at an individual Activity level but by Activity Groups of substitutable Activities.
- (b) The Contract also allows for some flexibility during the life of the Contract in terms of casemix and volume, subject to agreement and suitable notice (and without undermining the Minimum Take commitment).

16.4.5

Additional Capacity

- (a) The Contract requires the Provider to provide 5% additional monthly operational capacity (with unchanged casemix and substitution arrangements) over and above the Minimum Take. The Sponsors have the right to refer patients up to this limit. The Sponsors must pay for any Activities carried out over 105% of the Minimum Take (as part of the annual reconciliation) at the rate specified as the Marginal Price.
- (b) The Marginal Price is set out in each Contract and differs between schemes.

16.5

Performance Management Regime

Please refer to section 16.2.8 which sets out in detail how the Performance Management System works in practice.



17

17. Expiry, Termination and Handback





17

Expiry, Termination and Handback

17.1

Introduction

Each ISTC scheme is intended to provide for the supply of clinical services for a period of five years. If commencement of the services is delayed, services may still be provided but via an interim facility.

The Contract sets out what is to happen on expiry of the Contract term and this section identifies the options available to the NHS parties, the method of exercising each of them and the consequences of following each in turn.

There are several circumstances where the Contract may be terminated prior to the expiry of the five years term. These are set out in the Contract which also contains detailed provisions identifying the procedure for termination and the consequences of termination. Section 17.3 contains a more comprehensive summary of events which may lead to termination and the options available to the NHS in dealing with them.

This section summarises how the clinical services will be brought to an end and patients transferred in a manner which ensures that patient care is not compromised.

In addition to being Contracts for the provision of clinical services, in many circumstances new facilities will have been constructed by the Provider, possibly on NHS land, and again the Contract contains detailed provisions on the handover of these facilities on expiry or early termination. The Contract also regulates any transfer of assets, Contracts and workforce.

Whilst early termination is not something which can, necessarily, be predicted, the contractual consequences of it occurring are clearly set out in the Contract.

17.2

Expiry

Each Contract states that it will come to an end after a period of five years. That term runs from a specified date when it is intended that service provision should commence.

In the event that the Contract works smoothly, it will expire automatically, in which case the provisions dealing with payment and transfer of assets as set out below in this section will come into operation.

17.2.1

Option to Extend

The general position is that the Secretary of State has the option to request an extension of the Contract for a period of up to five years beyond the predicted expiry date on terms to be agreed with the Provider. The Secretary of State must provide at least one year's notice of this request and it will also require the agreement of the Provider to the terms of the extension.

17.2.2

Consequences of Expiry

If a decision has been made not to extend the Contract, then it will expire on the expiry date set out in the Contract. The parties will have to comply with their respective obligations on expiry which are set out in the Contract. The NHS parties have a number of rights on expiry and these may need to be exercised by notices prior to expiry.

17.3

Early Termination

The Contract is expected to operate for its full contractual term, but there are circumstances which may lead to an early termination.

Circumstances which may lead to early termination fall into the following categories:

- (a) the Secretary of State voluntarily terminating the Contract early;
- (b) an NHS event of default;
- (c) a Provider event of default;
- (d) an event of force majeure; and
- (e) destruction and non-reinstatement of the Facilities.

This section provides an outline of the procedures that apply should any of these events occur.

17.3.1

Voluntary Termination

The Secretary of State has reserved an option to terminate the Contract at any time on giving three months written notice to the Provider.

This is not an option which is subject to negotiation with the Provider, but an absolute right for the Secretary of State. The Provider is compensated for early termination by the payment of compensation and this is discussed further below. This right gives the Secretary of State complete flexibility in the way in which it manages the provision of clinical services as it is able to end the Contract at any time to take account of policy, demand or other changes it is also part of the key protections for patients.

17.3.2

NHS/Sponsor Default

There are limited circumstances where the NHS parties may be in breach of the Contract such that the Provider is entitled to terminate it.

Circumstances where this may occur are limited to a material breach which affects the ability of the Provider to perform its material obligations under the Contract for a period of not less than 60 business days or non-payment by the Secretary of State or a Sponsor of a specified financial amount.

Sponsors should ensure that they do comply with their obligations under the Contract to prevent the risk of termination claims by the Provider.

Further, the default amount for non-payment has generally been set at a reasonably high level so that failure to pay a nominal amount, perhaps through an administrative error, will not trigger this event of default. Only non-payment of significant monies has the potential of leading to termination.

Should either of the events described above occur, then within a reasonable period of the Provider being aware of it (and so long as it is still continuing), the Provider may either:

- (a) suspend performance until the default has been remedied, or if it is not capable of remedy, it has been demonstrated to the reasonable satisfaction of the Provider that the relevant party is unlikely to repeat that default (it should be noted that at no time may the Provider do anything to endanger the safety and/or wellbeing of patients, nor may it suspend performance for a period of in excess of 20 business days); or
- (b) serve notice on the Secretary of State and each Sponsor and Trust, if relevant, of the occurrence of the event of default, providing details of the same, and if that default has not been remedied within 60 business days at the latest (10 business days in respect of non-payment) the Provider may serve notice on the Secretary of State (with a copy to each Sponsor and the Trust if relevant) terminating the Contract with immediate effect.

17.3.3

Provider Default

A failure by the Provider to comply with its obligations under the Contract may well have an operational impact and this and the options for managing this have been addressed in section 16. These failures may also be categorised as a default which may lead to termination and these, along with other specified situations, are categorised as Provider events of default. The Provider events of default are not unusual for Contracts similar in nature to the Contracts and the Provider events of default include:

- (a) insolvency of the Provider or its guarantor;
- (b) the Provider committing a material breach of the project operations which has a material and adverse effect on the delivery of the services or the provision of the services ceasing;

- (c) a conviction in respect of any material offence committed by the Provider related to the provision of the services;
- (d) a change in control of the Provider;
- (e) a failure by the Provider to comply with the restrictions on assignment;
- (f) the Provider being awarded a total of 24 or more warning points;
- (g) the Provider losing any registration, licence or other necessary consent to provide all or any part of the services;
- (h) a failure by the Provider to reach the longstop date;
- (i) where relevant, the termination of more than a third of the number of facilities as a result of destruction following an insurable event, force majeure or partial termination;
- (j) a failure by the guarantor to comply with its obligations under the guarantee;
- (k) any guarantee relating to the Provider's obligations under the Contract ceasing or possibly ceasing to be in full force and effect; and
- (l) the Provider failing to comply with its obligations in respect of insurances (including failure to comply with any of the CNST provisions).

On the occurrence of any of the Provider events of default, the Provider has an obligation to give notice to the Secretary of State with a copy to the NHS representative.

Furthermore, some of the events of default are likely to manifest themselves in poor provision of the services or may otherwise come to the attention of the Sponsors.

After being notified of – or otherwise becoming aware of – an event of default by the Provider, the Secretary of State has the option to terminate either the Contract in its entirety by notice with immediate effect or, in some circumstances, it must provide the Provider with an opportunity to remedy the default. Should the Provider fail to remedy the default in the manner agreed or at all then the Secretary of State may terminate the Contract with immediate effect.

17.3.4

Corrupt Gifts

One specific area of Provider default relates to corrupt gifts. Where the Provider or an individual for whom the Provider is responsible commits a prohibited act (the full list of which is included in the Contract) which effectively equates to offering, giving or agreeing to give any kind of gift, consideration, inducement or reward for doing or forbearing to do anything in relation to the Contract, then in certain circumstances this may lead to the termination of the Contract for Provider default.

17.3.5

Force Majeure

An event of force majeure is one of a limited list of events set out in the Contract including war, civil war, terrorism, or nuclear or chemical contamination which may prevent the parties from performing their obligations under the Contract. If an event of force majeure arises, then the parties may be relieved from liability in respect of performance of their obligations under the Contract. Should an event of force majeure continue, then the parties shall endeavour to agree modifications to the Contract which may be equitable having regard to the nature of the event of force majeure.

Where they fail to agree on appropriate amendments or modifications to the Contract within six months of the date on which the party affected

by the event of force majeure served notice on the other party, then either party may, if the event of force majeure is still subsisting, serve notice terminating the Contract with immediate effect.

17.4

Partial Termination

If the Provider commits a material breach of its obligations under the Contract which has a material and adverse effect on the delivery of the services or ceases to provide the services which affects one or more (but not all) of the facilities, this will be a partial event of default by the Provider.

In these circumstances the Secretary of State may elect to not terminate the Contract as a whole but apply the partial termination provisions of the Contract.

Following notification by the Provider of a partial event of default or the Secretary of State becoming aware of this then the Secretary of State may serve written notice on the Provider requiring it to remedy the partial event of default or set out a programme for remedying the default.

Where the default is not remedied or the Provider does not follow the programme for rectification then the Secretary of State may terminate the Contract in respect of the affected facilities and the provisions set out below relating to the consequences of termination will apply in respect of those parts of the project which are to be terminated.

The Contract will continue in full force and effect in respect of the non-terminated parts of the Contract.

17.5

Consequences of Termination

17.5.1

Transfer of assets

The Contract sets out a list of assets which the Provider has agreed the Secretary of State will have an option to acquire on expiry of the Contract. These may include the building from which services are provided and equipment contained within it. No later than six months prior to the expiry date, the Secretary of State must notify the Provider whether or not it wishes to exercise its option to require the transfer of the assets to the Secretary of State. The Secretary of State may choose to instruct the Provider to transfer the transferable facilities to any other health service body or any other person as the Secretary of State may require.

This option to nominate a third party gives the Secretary of State control over the assets needed to provide the services should it choose to provide for their delivery by any replacement health service body or independent sector provider. If the Secretary of State exercises this option, then the transferable facilities will, on expiry, transfer to the Secretary of State (or as otherwise directed by the Secretary of State).

The assets, which are to transfer, can include Contracts and the Provider has an obligation to novate or assign these to the Secretary of State, or as directed, and the Provider is also under an obligation to use reasonable endeavours to ensure that the manufacturers' warranties in respect of any mechanical and electrical plant and equipment are transferred to and are made available to the transferee.

It is important to note that, where the Secretary of State does exercise its option to acquire assets on expiry of the Contract, these assets will transfer directly to the Secretary of State (or such other person as the Secretary of State nominates), and not to the Sponsors or any NHS Trusts, unless they are the health service body nominated by the Secretary of State.

Where the Secretary of State requires a transfer of the assets under its option to acquire them, then the procedure contained in the Contract relating to handover will operate and this is summarised in section 17.6 below.

17.5.2

Payment of Compensation on Termination

In all circumstances the Secretary of State is obliged to make a compensation on termination payment in accordance with the terms of the Contract. This is a standard position in a Contract of this type. The amounts payable by the Secretary of State are subject to a number of deductions which include amounts already outstanding under the Contract and the increased costs of delivering or procuring the delivery of the services to the date that the Contract would have expired.

17.5.3

Patients

In a number of circumstances the Contract states that it shall terminate immediately upon the giving of a relevant notice of termination. In practice, the cessation of operations at an ISTC and the transfer of it and the responsibility for clinical provision to the NHS or a new IS provider will be significantly more complicated. The Contract provides that the Provider must co-operate fully with the Secretary of State, the Sponsors and any successor provider in order to achieve a smooth transfer and, in particular, to avoid any inconvenience or risk to the health and safety of patients. In particular, the Provider is not entitled to withdraw any treatment to patients already in its care where it may be unsafe to do so. It should be noted that the Provider will be entitled to payment for the provision of the services during this transfer period.

17.5.4

Accrued Rights and Obligations

The Contract provides that whilst the rights and obligations of each of the parties under the Contract will cease and be of no further force and effect upon termination, there are two provisos. The first of these is that the parties will be able to enforce any pre-existing rights and obligations under the agreement as at the date of termination. For instance the Provider will be entitled to payment for services provided prior to termination and will continue to be liable for any outstanding contractual claims, again, prior to termination.

The Contract also provides that certain obligations continue to remain in force after termination or expiry of the Contract, of these the most important are the provisions relating to indemnities, insurance, confidentiality and the patient record provisions.

17.6

Handover

Whilst the Contract is principally a Contract for the provision of clinical services, the amounts paid by the NHS also include an element for the maintenance of the facilities from where the services are carried out. It is also a requirement that those facilities are maintained to a certain standard for the delivery of clinical services.

As outlined above, on expiry or early termination of the Contract, the Secretary of State may call for the transfer of the facilities to it or any third party whom it nominates. The Provider must handback the facilities in a state complying with the handback requirements listed in the Contract.

The parties will need to schedule a joint inspection of the facilities not less than 12 months prior to the expected expiry date (on early termination this inspection will be carried out immediately following a notice of termination).

Where, following the inspection, it is found that the facilities are not in a condition which is consistent with the handback requirements, then the Provider will need to provide to the NHS Representative proposals setting out how it will make good these deficiencies, including an estimate of the costs of carrying out these works. The NHS Representative then has the opportunity to provide comments on these with a view to agreeing the scope of the works, a programme for the works and the price for the works.

Once the scope of the handback works has been agreed, then the Provider has an obligation to carry these out in accordance with the agreed programme at its own cost (the Secretary of State does have an option on early termination to carry out the works itself, in which case it can make a deduction against termination payment for the cost of carrying out those works).

Once the scope of the works, the programme and price have been agreed, the Secretary of State can require that a bond is provided by the Provider for the benefit of the Secretary of State for an amount equal to the cost of the work. This is intended to provide some protection should the Provider default on its obligation to carry out the handback works.

The Contract contains procedures for agreeing when the works have been carried out with the proviso that where the works had not been carried out then the Secretary of State is entitled to deduct a sum equal to the cost of ensuring their completion from any termination amount to be paid to the Provider.

Section D

Glossary



18

18. Glossary



18

Glossary of Terms

Activity

A unit of treatment purchased by the Sponsors from the Provider.

Activity Group

Each activity is assigned to an Activity Group within which procedures are grouped where they can generally be undertaken by the same set of staff and equipment.

Additionality policy

Refers to the policy of increasing the current clinical and human resources capacity of the NHS, which operates by seeking to ensure that IS Providers of clinical services to the NHS provide such services using human resource capacity which is genuinely in addition to that available to the NHS.

Associated Costs

The amounts which the Provider is obliged to reimburse to the relevant Sponsor in respect of the costs to the NHS of treating complications and other non-routine events associated with a particular surgical procedure. The Sponsors do not need to be able to prove that the Provider was negligent in order to claim any Associated Costs.

Authority

The Secretary of State for Health.

Brokerage

Provisions within the Contract which allow Sponsors, and other PCTs or referring Health Service Bodies that are not party to the Contract, to utilise and pay for capacity should a particular Sponsor not require all of the services it has commissioned from a Provider in a particular month.

Casemix

The types of treatments and activities, which Providers are contracted to deliver to patients by the Sponsors.

CCPP

Central Clinical Procurement Programme of the Commercial Directorate of the Department of Health.

CD

Commercial Directorate of the Department of Health.

CDM

Construction (Design and Management) Regulations 1994.

CCMU

Central Contract Management Unit of the Commercial Directorate of the Department of Health.

Choose and Book

The NPfIT electronic booking service for the direct booking of any NHS patient into secondary care ISTC facilities or into clinical and/or diagnostic services.

CMB

Contract Management Board.

Contract Management Board

The principal management body through which Sponsors seek to ensure that the services procured under the Contracts deliver the quality and quantity required.

Contract Manager

The person in CCMU who is responsible for overseeing the management and administration of the Contract.

Connecting for Health

The DH agency responsible for the delivery of the NPfIT.

Contract

The Contract entered into between the Sponsors of a particular ISTC scheme and the Provider. On some schemes, the Secretary of State and a NHS Trust (if relevant), may also be parties.

DNA

When a patient does not attend a patient appointment arranged between the patient and the Provider, and the patient has either not given 48 hours notice to the Provider or gives no notice at all.

Excusing Cause

A circumstance where, due to the actions of a third party, the Provider has failed to meet a Treat by Date or a threshold set for a Performance Indicator which entitles the Provider to relief from sanctions.

Facility

The location and equipment, whether permanent, temporary or mobile, which the Provider is using to deliver the clinical services.

Facilities

The premises at which the Services are performed by the Provider.

FFCEs

First Finished Consultant Episodes.

FOB

Forward Order Book.

Good Clinical Practice

The use of standards, practices, methods and procedures conforming to the law and the exercise of that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced provider of clinical services providing services the same or similar to the services set out in the Contracts at the time those services are provided.

HDU

High Dependency Unit.

Health Service Bodies

Includes NHS Trusts, GPs and SHAs.

HES

Hospital Episode Statistics.

HRG

Healthcare Resource Group.

IM&T

Information Management and Technology.

IS

Independent Sector.

ISTCs

Independent Sector Treatment Centres.

JSI

Joint Service Investigation.

JSR

Joint Service Review.

LASSD(s)

Local Authority Social Services Department(s).

M&E

Mechanical and Electrical.

Minimum Period

The period of time relating to each procedure between the date of the referral and the earliest date on which the Provider can begin providing treatment. This period of time is intended to give patients sufficient notice before attending the ISTC for treatment.

Minimum Take

The minimum amount guaranteed to be paid to the Providers by the Sponsors in return for delivering the services. This is expressed as a value, rather than a number of activities, to allow for variances due to substitutions between activities within an Activity Group.

N3

The wide area network connecting NHS organisations, managed for the NHS by a third party service provider.

NHS

National Health Service.

NHS Trust

NHS Acute Hospital Trust.

NHSCRS

NHS Care Records Service.

NHS CFSMS

NHS Counter Fraud and Security Management Service.

NHS Representative

The person named in the Contract as the representative of the NHS parties.

NHSTCs

National Health Service Treatment Centres.

NICE

National Institute of Clinical Excellence.

NPfIT

National Programme for IT.

PALS

Patient Advice and Liaison Service.

Patient Pathway

The overall process which assesses and delivers healthcare services according to individual patient needs.

Payment Mechanism

The schedule to each Contract that sets out, broadly, how much and under what circumstances the Provider will be paid for the provision of services in accordance with the terms of the Contract.

PCTs

Primary Care Trusts.

Performance Indicators

The quantifiable measurements Providers are contractually obliged to collect and submit on a monthly basis. These are an essential element in the

Performance Management system for the ISTC Programme and they are designed to help the Sponsor and the DH to monitor whether certain quality thresholds are achieved.

PFI

Private Finance Initiative.

PMETB

Post Graduate Medical Education and Training Board.

Provider

The Independent Sector supplier providing services under the Contract.

Reconciliation

At the end of each quarterly period and at the end of each Contract year, a comparison is made between the value of Activities completed by the Provider and the Minimum Take. Sponsors must make up any shortfalls.

Retention of Employment Model

The mechanism used to avoid unintentional transfer of NHS staff to the Provider.

SHAs

Strategic Health Authorities.

Sponsors

Commissioning PCTs which are responsible for patient referrals to Providers, as outlined in the Contract.

Take Point

The month in which the patient's treatment is recorded for financial accounting purposes. This may be different from the month in which referral is made and the month in which the Treat by Date occurs.

Treat by Date

The date by which the patient must be treated by the Provider. This is specified as a certain amount of time from the date when the Provider receives the referral. The time period varies across different types of procedure.