



# The Government's Response to the Health Committee's Report on Independent Sector Treatment Centres

Presented to Parliament by  
the Secretary of State for Health  
by Command of Her Majesty  
October 2006





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# The Government's Response to the Health Committee's Report on Independent Sector Treatment Centres

## Introduction

1. This Command Paper sets out the Government's response to the Health Select Committee's Fourth Report of Session 2005–06, Independent Sector Treatment Centres (ISTCs).
2. The Government welcomes the Committee's Report and welcomes, too, the opportunity to set out in more detail the background to the ISTC programme and the benefits for patients.
3. Our intention to use the independent sector to benefit patients was first set out in *The NHS Plan* which recognised the role the independent sector could play to benefit NHS patients.
4. The Treatment Centre programme, with some facilities run by the NHS and some by the independent sector, has delivered on this commitment and contributed to substantial reductions in the time that patients wait for treatment. In creating a more diverse provider base, to support greater choice for patients, it is a vital component of the Government's wider programme of health investment and reform.
5. The first ISTC opened in October 2003 and there are currently 21 ISTCs providing services to NHS patients. These facilities, along with the mobile ophthalmology service, have performed nearly 80,000 elective procedures and provided over 38,000 diagnostic assessments. They are firmly part of the NHS family, delivering NHS services to NHS patients and increasing the choices available to them.
6. A second phase of procurement is also under way. This is expected to provide up to 250,000 elective procedures and approximately 1.5 million diagnostic assessments per year.
7. The involvement of the independent sector should not be viewed as a departure from the NHS's values. Those values remain: a health service funded by all, available to each person equally, free at the point of use, with care based on need and not ability to pay.
8. Ultimately, if independent or not-for-profit providers can help the NHS provide better services for patients and better value for taxpayers, this Government is committed that we should use them to do so.

## The Government's response to the Health Select Committee's recommendations and conclusions:

**ISTCs have not made a major direct contribution to increasing capacity, as the Department of Health has admitted. It is far from obvious that the capacity provided by the ISTCs was needed in all the areas where Phase 1 ISTCs have been built, despite claims by the Department that capacity needs were assessed locally.**

1. The ISTC programme is in its early stages with the majority of facilities opening in 2005. As of August 2006, there are 21 fixed-site ISTC facilities open and a mobile ophthalmology unit providing services for patients. A further three elective facilities and one diagnostic centre are still to open from the first wave of procurements and there are three additional fixed-site facilities which are still subject to negotiation.
2. These facilities have between them performed close to 80,000 elective procedures and provided over 38,000 diagnostic assessments to the benefit of NHS patients. Over the life of these wave 1 contracts we expect the provision of 850,000 procedures and 920,000 diagnostic assessments.
3. When the two general supplementary contracts (that provide access to existing capacity in the independent sector during 2003 to 2005) and the Magnetic Resonance Imaging (MRI) scanning contract are included, it means that well over 300,000 NHS patients have already benefited from independent sector provision of healthcare.
4. The Department conducted national capacity planning exercises through Strategic Health Authorities (SHAs) in 2002 and 2004. Through these exercises SHAs estimated the additional capacity in elective treatment and diagnostics required to meet key public service agreement waiting times targets, and identified how much of this capacity would need to be sourced from independent sector providers.
5. The outcomes of capacity planning provided the basis for taking forward national procurements of elective and diagnostic capacity from the independent sector.
6. Where Primary Care Trusts (PCTs) required changes to their requirements these were made, though when this was done after selection of preferred bidder, it made best value for money more difficult to achieve.
7. To the extent that significant changes in commissioners' requirements were identified subsequent to the launch of the procurement, the Department and the providers have been responsive to these changing requirements wherever possible within the procurement rules. This is evidenced by the reduction in the procurement size from an original circa 250,000 procedures to circa 170,000 per year now included in the first wave.
8. Utilisation of ISTCs is high at 84% and we are able to benchmark this against NHS performance.

**We are concerned that the Department has attempted to misrepresent the situation by presenting the BUPA Redwood figures as procedures performed by the mainstream ISTC programme.**

9. We disagree that the Department has misrepresented the situation. The memorandum of evidence submitted clearly stated the 44,000 procedures that ISTCs had delivered at that time. Information was also provided on the broader use of the independent sector; for example, procedures provided through the general supplementary contracts, the diagnostic scans performed through the MRI contract, and those undertaken at BUPA Redwood.
10. There has been no deliberate attempt to misrepresent the situation. However, the Department recognises that in a healthcare environment where there are many different contributions from the independent sector care needs to be taken to understand the purpose and definitions underlying questions to ensure there is no confusion.

**ISTCs have had a significant effect on the spot purchase price in the private sector and on charges in the private sector more generally.**

11. We agree that the programme has had a significant positive effect on the spot purchase market by materially reducing prices.

**ISTCs have for the present increased choice, offering more locations and earlier treatments. However, without information relating to clinical quality, patients are not offered an informed choice.**

12. The Department recognises the need to provide robust information on clinical quality which is relevant to patients, informs choice and is fair to clinicians and providers. This is a major challenge and will need to be met by working in partnership with patient groups, clinicians, provider organisations and academics.
13. The Secretary of State gave a clear commitment to develop and publish robust measures of clinical quality in the July publication *Health Reform in England – Update and Commissioning Framework*. To this end, the Department has established an Information Taskforce to develop information on measures of clinical outcomes to help patients make more informed choices about their healthcare and services. It is chaired by Professor Sir Bruce Keogh, President of the Society for Cardiothoracic Surgeons and Professor of Cardiac Surgery at University College London Hospitals NHS Foundation Trust. Sir Bruce led the development of the widely-acclaimed heart surgery website, hosted on the Healthcare Commission website. Taskforce membership includes clinicians, patient representatives, academics, NHS and independent sector managers and other interested stakeholders.
14. The Taskforce will develop and oversee a work programme to identify indicators of clinical outcomes relevant to patient choice, available either in the short term or long term. The Taskforce aims to recommend the first set of clinical indicators in spring 2007. Proposals will be discussed with appropriate Royal Colleges and patient groups.

15. A closely related piece of work funded by the Department and managed by the London School of Hygiene and Tropical Medicine (LSHTM) is piloting the feasibility of measuring and routinely collecting Patient Reported Outcome Measures (PROMS). PROMS collected in this way have the potential to be used for a variety of purposes including helping to inform patient choices of provider or treatment. The pilot focuses on elective surgery procedures (hip, knee replacements, cataracts) relevant to ISTCs. The results of this pilot, which includes NHS providers and ISTCs, will be available in 2007.
16. For the next phase of ISTCs, the contracts with providers will allow PROMS to be requested (based, where relevant, on the methodologies chosen for the LSHTM pilot trial referred to above). This includes the following measurement tools: the Oxford Hip Score, Oxford Knee Score, Visual Function Index (VF-14) and EQ5D health survey.
17. Finally, further development work is planned to standardise and improve on patient experience surveys so that more meaningful and comparable findings are available for NHS providers and ISTCs.

**ISTCs have embodied good practice and introduced innovative techniques, but good practice and innovation can also be found in NHS Treatment Centres and other parts of the NHS. ISTCs are not necessarily more efficient than NHS Treatment Centres such as Dartford.**

**The Department claims that ISTCs drive the adoption of good practice and innovation in the NHS, but we received no convincing evidence which proved that NHS facilities were adopting in any systematic way techniques pioneered in ISTCs.**

18. The Department agrees that good practice and innovation are to be found in the NHS. The introduction of ISTCs is still in its early stages; however, these facilities do offer an excellent opportunity to draw together best practice from a wide range of sources.
19. Integration between ISTCs and the NHS has not yet reached the level we should hope for. This has limited the flow of innovation and best practice from the independent sector to the NHS and vice versa.
20. The policy of 'additionality', which was introduced in order to conserve NHS clinical skills and encourage the independent sector to increase its capacity to help meet NHS access and waiting time targets, has made integration more difficult and the changes to this policy for the next phase of procurement should lead to closer links at a professional level within the local health economies. The introduction of training into the phase 2 contracts will also encourage and underpin greater local integration. The greater movement of staff will facilitate the flow of information, best practice and innovation. The Department welcomes the Committee's support for the changes being made to ensure better integration.
21. It is incumbent on both independent sector and NHS providers to research best practice in order to provide a better, more efficient service. As the body of data comparable between the NHS and ISTCs grows, institutions will be able to benchmark themselves and highlight centres that demonstrate best practice.

22. As a good example of promoting innovation, the Department organised an ISTC clinical conference at the Royal College of Surgeons to provide an opportunity for independent sector providers to present papers on their practice and results to SHAs and PCTs. The purpose of the meeting was to allow the ISTCs to present their results and ideas to a wider NHS audience. It also demonstrated how the ISTCs work within a regulatory environment and set of standards common to other parts of the NHS. Innovators influence others by introducing change, running it for a period and then demonstrating outcomes: this does not happen immediately.

**The threat of competition from the ISTCs may have had a significant effect on the NHS. This factor may be the most important contribution made by the ISTC programme. However, the evidence is largely anecdotal. Waiting lists have declined since the introduction of ISTCs, but it is unclear how far this has happened because the NHS has changed in response to the ISTCs or because of additional NHS spending and the intense focus placed on waiting list targets over this period. We are surprised that the Department has made no attempt systematically to assess and quantify the effect of competition from ISTCs on the NHS. Given its importance, the Department should have ensured that this was done from the beginning of the ISTC programme in 2003.**

23. The first wave of ISTCs was procured following a capacity planning exercise in 2002 which was co-ordinated centrally by the Department, but conducted locally by SHAs. This procurement was principally designed to introduce additional elective care capacity, in the context of the significant growth in capacity identified in SHA capacity plans as needed to meet waiting times targets. We agree that the reduction in waiting times for patients has been brought about by the additional resource this Government has made available for the development of NHS capacity, and a focus by the NHS on ensuring that patients have timely access to treatment. Nevertheless, ISTCs have made a contribution to capacity development. They have also introduced new practices, brought about an increase in the number of medical professionals working in England, and offered commissioners a better value for money alternative to the traditional spot-purchasing arrangements.
24. ISTCs are one facet of the reform programme that aims to create a service that puts the patient first, gives everyone access to high-quality care and gets best value for taxpayers' money. The Department and the NHS are committed to evaluating the impact of the reform programme so that the lessons of the current reforms can be used for policy development in the future. The programme will evaluate each of the main mechanisms of the health reform programme, as well as carrying out localised studies into how the various mechanisms of reform interact with each other across local health economies.

**There are examples of poor care in ISTCs, as there are in the NHS. However, in the absence of the necessary comparable data from both NHS Treatment Centres and ISTCs, there is not the statistical evidence to suggest that standards are different. The Department should have ensured that such data were collected from both providers and published in order accurately to assess quality of care, complication rates and other quality measures. We are concerned that currently only eight of the 26 KPIs are clinical indicators. We welcome the Healthcare Commission's review of the quality of care in ISTCs which the Chief Medical Officer has requested.**

**Given the difficulty in making comparisons, we are dismayed at the strident and alarmist tone of some criticisms of clinical standards in ISTCs on the basis of anecdotal evidence, highlighted by the BOA's questionable claim that there are revision rates of 2.3% in ISTCs.**

25. The Department notes the Committee's comment on the alarmist tone of some criticisms of the clinical standards in ISTCs.
26. Towards the beginning of the ISTC programme the Department commissioned an independent report from the National Centre for Health Outcomes Development (NCHOD) on the clinical quality, productivity and patient experience at four independent sector schemes including two early ISTCs. The two key conclusions made by NCHOD in their report, published in October 2005, were that there was a robust quality assurance system in place and that the early results of quality monitoring were encouraging.
27. There are ten clinical indicators (out of the 26 Key Performance Indicators (KPIs)) and an additional three indicators which require significant clinical input. As part of ongoing work on the next phase of the procurement, the clinical indicators are being improved to focus on patient reported outcome measures. In addition, the data for the KPIs will be patient based rather than aggregated data and will, therefore, be more useful in monitoring contract performance. At the moment the systems to support the handling of the KPI data are being specified to effect greater audit function. It was always the intention that KPIs would evolve as the new providers settled.
28. The Healthcare Commission review of the quality of care provided by ISTCs to patients will be published by March 2007. The specific terms of reference are to review:
  - the evidence on the extent to which the quality of clinical care provided by ISTCs is in line with recognised professional and regulatory standards;
  - the systems and procedures that ISTCs have in place to ensure the quality of the care that they provide;
  - the extent to which the quality of care in ISTCs can be compared with the NHS;
  - the extent to which patients offered care from an ISTC are able to gain access to information to help them make informed choices about their care;
  - patients' assessment of quality of clinical care and their overall experience of care provided by ISTCs;

- the current framework for regulating ISTCs and its impact on the assessment of the quality of care provided by ISTCs; and
- the interrelationship between the regulatory system and the systems that the Department and PCTs have in place for monitoring compliance with contracts.

**As a result of the European legislation, the regulation of foreign-trained EEA clinicians, who make up the majority of doctors in ISTCs, is not as rigorous as it should be. The GMC made it clear to us that it had reservations about the robustness of the current regulatory system for doctors who qualified outside the UK. The fact that language tests cannot be imposed on doctors from the EEA (although they can be on international medical graduates) and that the GMC has no discretion in accepting clinicians from the EEA who are registered as specialists in their home country are causes of concern. As a result, scrutiny of a foreign-trained doctor's fitness to practise in a given set of circumstances is effectively passed on to the employers. In view of the limited role of the GMC in the accreditation of EU doctors, the appointment procedures used by ISTCs must be carefully monitored. It is essential that the Department stresses to those who employ EEA qualified doctors the responsibility they have to ensure that these doctors are proficient. As a safeguard we recommend that ISTCs use the same appointment procedures as the NHS. In addition, ISTC clinical appointments for overseas doctors should incorporate a standardised, independent assessment system based on competency.**

29. Whilst it is the case that the General Medical Council (GMC) can require the International English Language Testing System only of doctors from outside the EEA, this does not stop employers from testing foreign-trained EEA clinicians' English language skills. This is what good employment practice would dictate.
30. In July, the Department published a review of the arrangements in place for medical regulation: *Good doctors, safer patients*. At the same time, it also published *The regulation of the non-medical healthcare professions*. The aim of undertaking these two reviews at the same time was to ensure the development of a coherent approach to regulation across all health professions, without diluting the tight focus necessary to address the specific deficiencies in the arrangements in place for doctors, identified by the Shipman Inquiry. *Good doctors, safer patients* recommends that:
- "A formal opinion should be sought in Europe as to the legality of the introduction of a standardised national examination as a requirement for initial registration with the General Medical Council (in addition to the clinical and other examinations necessary to obtain a university medical school degree within the European Economic Area). This examination would include assessment of both English language proficiency and clinical knowledge, and would be taken by all doctors seeking provisional or full registration, irrespective of their place of primary qualification."
31. All recommendations included within both reports are now open for public consultation, until 10 November 2006.

32. ISTCs must also comply with the standards described in *Standards for Better Health*. Core standard C10 states that healthcare organisations must “undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies”. Guidance on pre- and post-employment checks is provided in the document *Safer Recruitment: a guide for NHS employers* and these checks are the responsibility of NHS employers and ISTC providers.
33. The Department welcomes the recommendation for a standardised independent assessment based on competence. Providers in the second phase of the ISTC programme will be required to ensure that new staff, apart from those seconded from the NHS, are assessed (and are subject to ongoing assessment) for competence (including the use of appropriate competence testing tools for all clinical staff) by reference to:
- the procedures or activities that they have been or may be asked to undertake;
  - all mandatory NHS requirements and similar official requests by the Department;
  - good clinical and industry practice; and
  - any standards, benchmarks, assessments or clinical competence testing tools notified to the provider by the Department.
34. In addition, the Department has insisted that providers have a Medical Director who is the single ‘responsible person’ for ensuring the safety and quality of clinical care at their facilities. The responsibilities will include ensuring that the attributes are in place for the GMC to recognise the institution as an ‘approved practice setting’ in which there is a functioning governance system with appropriate supervision and/or mentoring along with initial and ongoing appraisal or assessments of doctors.
35. The Department is actively exploring with both independent sector providers and the Royal Colleges how to introduce external scrutiny into the appointments of consultants following the example of Foundation Trusts who have their own agreement with the Academy of Royal Colleges.

**The Department admits that some ISTCs are poorly integrated into the NHS. In our view, too many fall into this category. We were informed of notable exceptions such as the Shepton Mallet Treatment Centre, which show that with the right approach it is possible to engage NHS doctors and other staff in the work of ISTCs.**

36. Our aim is for the independent sector to work in partnership with local healthcare economies to provide solutions which reflect and cater to local requirements.

37. As recognised above, integration between ISTCs and the NHS has not yet reached the level we should hope for but changes to phase 2 should encourage greater integration. For example, local SHAs must demonstrate how ISTCs will be integrated within the local health economy before schemes can go forward. In addition, the Postgraduate Deans have requested that the Department ensures that activity is available for training purposes in the next phase of ISTCs and the contracts being negotiated with independent providers reflect this.
38. The inclusion of training in the new contracts will lead to closer integration as the ISTC will be offering modules to the trainee which will contribute to the overarching training. We also expect that some of the trainers will work across sites and bring closer professional relationships.
39. The relaxation of the additionality rules for the phase 2 ISTCs will bring about greater professional integration as all clinical staff will have the opportunity to work in both local hospitals and ISTCs during their non-contracted hours. Further engagement will occur as the changed rules also enable staff who are not in the list of shortage professions to work in the next phase of ISTCs. Good local management will lead to closer professional ties and this is one of the aims of insisting that there is clear medical leadership provided by Medical Directors and Directors of Education.
40. The Department recognises that many patients receive care across service or organisation boundaries. The planning and integration of care around their needs is important both for their experience of care and their health outcomes.
41. Health reform will help this integration of care. GP practices through practice-based commissioning will play a central role as integrators of health services for patients. PCTs, practice-based commissioners and providers will agree clinical protocols and pathways for seamless care, drawing on clinical networks, local authorities and others.
42. Forward-looking health providers of all types will begin to offer care that is better integrated. Electronic patient records will enable the planning and delivery of personal care in a way that has not been possible before.
43. ISTCs will be available as part of the Choose and Book system for both local and national menus.

**Even though Phase 1 ISTCs perform a relatively small number of procedures, there can be a significant local effect on the training of junior doctors.**

44. The Department recognises that the training of NHS staff within ISTCs is particularly important. It is intended in the longer term to develop relationships locally in order that professional development may occur seamlessly across the local health economy partners to the overall benefit of patient care.
45. As described above, Postgraduate Deans have requested that we ensure that activity is available for training purposes in phase 2. Independent providers will be expected to appoint Directors of Postgraduate Training to work with local Deaneries to oversee training provision within ISTCs across a range of clinical professions.

46. The incorporation of training into the phase 2 contracts will ensure that local training of junior doctors is not compromised as the local Deans will be able to co-ordinate the training opportunities within local health economies. Indeed, it is anticipated that the ISTCs can be used to good effect because particular modules of training will be well supported.
47. All healthcare providers have a responsibility for providing good quality learning environments and the advent of ISTCs increases the number and variety of training opportunities available.
48. 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, professional regulatory bodies such as the Nursing and Midwifery Council and the Health Professions Council, the Postgraduate Medical Education and Training Board, 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.
49. Training for doctors and nurses is already taking place at ISTCs in Brighton, York and Burton, with nurse training also taking place at ISTCs in Portsmouth and Greater Manchester. Wave 1 ISTC facilities opening later this year and in 2007 in London, Maidstone and Nottingham will also include training for clinical staff.

**The ISTC programme is intended eventually to provide about half a million procedures per year at a cost of over £5 billion in total. This is close to 10% of the total elective workload of the NHS and would clearly affect the viability of many existing NHS providers over the next five years and possibly beyond. Moreover as the quantity of ISTC activity is not evenly balanced across the country, the impact on the budgets of different local health economies is likely to vary.**

**The Phase 1 contracts, including the 'take or pay' elements, give ISTCs a significant advantage over NHS Treatment Centres and other NHS facilities. This is one of the reasons that several NHS Treatment Centres have spare capacity.**

**In the longer term, there are good reasons for thinking that ISTCs could have a more significant effect on the finances of NHS hospitals. We do not know how big that effect might be or how great the dangers might be. The Department of Health has carried out analysis of the possible effects of the ISTC programme on NHS facilities, but it has refused to disclose the analysis to us. Phase 2 ISTCs may lead to unpopular hospital closures under 'reconfiguration' schemes.**

50. The ISTC programme is being implemented during a period of elective activity growth, both to cope with underlying demand growth and to reduce waiting times. The current SHA Local Delivery Plans indicate planned total elective activity in 2007/08 of approximately 6 million procedures, of which 5.7% will be sourced from independent sector providers. On the basis of current demand projections, the wave 1 and phase 2 ISTC programmes would account for a maximum of 7.5% of elective activity by the end of the decade. ISTCs will only be introduced in health economies in which the SHA supports the case for them, and is committed to managing the capacity and financial consequences of ISTC implementation, particularly any impacts on existing NHS providers of elective care.
51. The 'take or pay' element of wave 1 contracts was included based on the need to balance risk and cost. The Department procured activity based on capacity planning exercises conducted through SHAs where they estimated the additional capacity in elective treatment and diagnostics required to meet key public service agreement waiting times targets, and identified how much of this capacity would need to be sourced from independent sector providers. Where the estimates of demand have not been met, we are working with both the NHS and providers to ensure the contracts deliver the best of value. This includes:
- **Referral management centres.** Several PCTs are developing proposals for referral management centres which would include the catchments of appropriate ISTCs. These should help improve the utilisation of ISTCs by ensuring that patients are fully aware of the choices available to them. As with all referral management centres, however, we have always made it clear that they should not and do not conflict with giving patients more choice. All patients' choices will be respected. The most recent guidance issued by the Department to the NHS made it clear that referral management centres must not be imposed on GP practices, must abide by clear protocols that provide tangible clinical benefits to patients, and should provide feedback to practices on referrals – thus enabling GPs to review the appropriateness of their referrals. These new centres would be expected to fully comply with this guidance.
  - **Re-profiling and re-basing.** The Department works co-operatively with PCTs and independent sector providers where there is underutilisation. In many cases this involves a flexible approach to moving activity to a later stage in the life of the contract.
  - **Case-mix changes.** Where underutilisation exists due to inappropriate case-mixes, PCTs and independent sector providers are working through case-mix reviews to drive up utilisation.
  - **Over referrals above contracted levels.** In several schemes the Department has negotiated with independent sector providers to allow increased flexibility around substitution between specialties, to improve overall utilisation. For example, in the Shepton Mallet ISTC, following negotiation, the provider agreed that the lost referral value could be made up during the remainder of the contract.
  - **Extensions to contracts.** Where contracts have underutilised activity that cannot be redressed under the above remedies, the Department intends that time extensions to contracts should be negotiated in order that the full number of procedures paid for in the contract are utilised.

- **Qualitative benefits.** Benefits have also been realised based on negotiation of changes to contract to more closely align with the NHS's needs as they evolve through the duration of the contract. For example, the MRI contract's time interval for booking patients was reduced from 21 to 14 days to harmonise the contract with the phase 2 diagnostic schemes and support trusts in managing the 18 week referral to treatment target.

52. The 'take or pay' element will be modified in the next phase. Although not all NHS facilities (including NHS Treatment Centres) have been running at full capacity, we have not seen evidence that this is a direct result of the introduction of ISTCs in health economies in which there are NHS Treatment Centres.
53. The detailed planning of all phase 2 ISTC schemes has been undertaken with SHAs, and in consultation with stakeholders in local health economies. Each proposed elective ISTC is subject to a due diligence process that includes a local capacity and impact analysis, carried out for the Department using standardised assumptions in the modelling of scenarios. To the extent that any ISTCs will contribute to wider reconfigurations of acute services, this will be as a result of SHA-led planning.

**The cost of Phase 1 includes a premium over the NHS Equivalent Cost which was paid to the ISTC providers, but without access to the detailed figures we do not know how big this premium was. There were other costs of Phase 1, for example the effect on NHS finances. It is hard to see that this could have been justified in terms of the need for additional capacity alone. The other major potential benefit, the galvanising effect of competition on the NHS, was not and probably could not be quantified when the decision to go ahead with Phase 1 of the ISTC programme was made. It is claimed that this decision was a leap in the dark in the hope that the 'challenge' of ISTCs would improve efficiency in the NHS. We agree.**

**Moreover, since we do not know the details of the contracts, what figure was used for the NHS Equivalent Cost or how it was arrived at, and since the benefits of ISTCs have not been quantified, it is also impossible to assess whether ISTC schemes have in practice proved good value for money.**

**In view of the high degree of uncertainty about the wider benefits and costs of the ISTC programme, we recommend that the NAO investigate them, in particular the extent to which the challenge of ISTCs has led to higher productivity in the NHS.**

54. In evidence to the Committee the Department explained that the average premium paid to the providers was 11.2% above the NHS Equivalent Cost for the wave 1 ISTC schemes.
55. The NHS has always made use of the independent sector. Historically, however, it has been conducted on an ad hoc basis at a local level. The ISTC programme has systemised much of this activity, and through bulk procurement has cut significantly the cost of doing business with the independent sector. Traditionally the NHS has paid incumbent independent sector providers a premium upwards of 40% over reference costs. By managing a national, high-volume procurement, the Department has secured substantial savings on these amounts.

56. Independent sector providers face costs that are not borne by the NHS such as staff recruitment to comply with the additionality rules, establishment costs (for example, the cost of funding new builds), the costs associated with bidding, and of direct taxation (including corporation and value added tax). These additional costs that are borne by providers are the reason why a premium above the NHS Equivalent Cost has been necessary. Phase 2 of the ISTC procurement is under way and we do not expect to pay the same premium as in wave 1. Furthermore, once centrally procured contracts have come to an end, all providers will be required to operate at tariff (or NHS Equivalent Cost) and will be compared solely on quality and access.
57. The ISTC programme aims not only to deliver extra capacity to publicly funded healthcare but also to deliver greater patient choice and contestability through improving access to elective healthcare and to different providers. This provides benefits to those patients directly using ISTC services through reducing waiting times and allowing them to select care most appropriate to their individual needs and preferences.
58. The National Audit Office's programme of work is a matter for the Comptroller and Auditor General and we understand that he is considering the Committee's recommendation.

**The Department has proposed a number of changes to ensure that Phase 2 ISTCs are better integrated into the NHS than those in Phase 1. We welcome the proposals to ensure better clinical engagement in all ISTCs. In addition, we recommend that Phase 2 ISTC facilities be sited in or near NHS hospitals.**

**The Department has recognised that the additionality principle has hindered integration and proposes to restrict its application. It proposes to allow NHS consultants to work non-contracted hours in ISTCs. We welcome this and recommend that, in addition, the Department should ensure that Phase 2 contracts encourage NHS staff to be seconded to treatment centres. We also recommend that consultants be allowed to hold sessions of NHS planned activities in ISTCs where this would be thought appropriate for local service needs and to aid integration. Consultants working non-contracted hours in ISTCs should do so at NHS contract rates.**

**If ISTCs are to be fully integrated into the NHS, the Department will need to address concerns about pay and conditions. Lower salaries and poorer pension provision in ISTCs are unlikely to assist integration.**

59. The additionality principle was introduced in order to conserve NHS clinical skills and encourage the independent sector to increase its capacity to help meet NHS access and waiting times targets. The Department has been reviewing additionality in respect of the next phase. Additionality will not apply to NHS employees except those included in the list of shortage professions and will not apply for all NHS employees in respect of their non-contracted hours. This approach will ensure that opportunities are available in ISTCs, whilst continuing to conserve skills for other providers of NHS services.

60. If NHS staff are seconded into ISTCs then their NHS terms and conditions in respect to pay and pensions will be unchanged. Rates for non-contracted hours will be a matter for individual providers; however, for consultants to consider making their non-contracted hours available to independent sector providers, those providers will need to offer rates competitive with those in the NHS. Unless providers offer competitive terms, then the best staff will seek to move to the NHS over time. It should also be remembered that competitive pay and conditions will also have to be offered within the independent sector market as a whole as well, otherwise staff will move within that sector.
61. Limiting ISTCs to NHS sites or their proximity limits their desirability to patients who want their treatments closer to home. It is not in itself a desirable goal and, though it may be a pragmatic solution, this will vary across the country.

**We support the Department's decision to include the provision of training as a contractual obligation for Phase 2 of the ISTC programme. This will greatly help to break down barriers between ISTCs and the NHS. The standard of training in ISTCs should be of the same standard as in the NHS.**

62. We welcome the Committee's support. As stated above, independent providers will be expected to appoint Directors of Postgraduate Training to work with local Deaneries to oversee training provision within ISTCs. NHS training in an ISTC setting will be directed and overseen as it is now in NHS settings.

**It is difficult at present, therefore, to assess the current state of Phase 2 of the ISTC programme, or the rationale behind it. The Department of Health and the Secretary of State have, over the course of our inquiry, given answers which have shifted in both fact and emphasis as time has gone by, and the statement of the current position by the Secretary of State leaves several important questions unanswered. The decision to maintain the commitment to spend £550 million per year despite changing circumstances has not been explained, and seems to sit uncomfortably with the Secretary of State's admission that "in other [areas] it has become clear that the level of capacity required by the local NHS does not justify new ISTC schemes". It is not clear whether this represents simply a failure coherently to articulate the situation or a more profound incoherence in terms of policy as opposed to presentation.**

**There are real concerns that the expansion of the ISTC programme will destabilise local NHS trusts, especially those with financial deficits. ISTCs should only be built where there is a local need and after consultation with the local health community.**

63. The rationale for the phase 2 procurements remains clear, within the context of the wider health reform programme. As originally set out in *The NHS Improvement Plan* (June 2004), "increased capacity will be introduced in order to reduce waiting times for elective care and facilitate choice across the system... The contribution of the independent sector will expand, particularly in relation to planned hospital care and diagnostic services".

64. The independent sector procurements facilitate patient choice by increasing capacity and bringing greater diversity of provision. In turn, greater choice and competition will promote more responsive and innovative services, higher quality care and better value for money.
65. The overall planned level of spend in the ISTC programme is intended to ensure that this expanded choice and diversity of provision is sustainable. While maintaining value for money for the taxpayer, independent sector providers have been offered levels of activity that will enable them to maintain a presence beyond their five-year contracts, if they meet patients' needs and aspirations. Without this level of spend the ISTC programme would be a short-term fix to a more permanent problem.
66. There is a robust process to ensure there is local support and a capacity need for each individual elective ISTC, and to reduce the risk that a scheme will destabilise existing service providers. The process consists of three phases:
- first, the Department carries out a capacity and impact analysis for each project, using standard assumptions to model a range of scenarios;
  - second, no preferred bidder can be appointed until the relevant SHA confirms its support for the project in the light of the Department's analysis; and
  - finally, before final business case approval (and contract signature), the analysis is updated and the SHA must reconfirm its support, following consultation with local stakeholders. The SHA must also demonstrate how the ISTC will be integrated within the local health economy, and how any impact on the activity levels and capacity of existing providers will be managed.
67. Ultimately, though, whether patients are treated by NHS or independent sector providers will depend on the choices of individual patients and commissioners.

**There are major benefits from separating elective and emergency care in treatment centres. Such centres should continue to be built where there is a need and where the decision to build the centre has been agreed with the local health community following Section 11 consultation. We are not convinced that ISTCs provide better value for money than other options such as more NHS Treatment Centres, greater use of NHS facilities out-of-hours or partnership arrangements such as those at Redwood. All these options would more readily secure integration and may be cheaper.**

68. As detailed above the Department in conjunction with SHAs has undertaken extensive work to ensure that every scheme developed in phase 2 is based on local need and is responding to a requirement for ISTC services.
69. Decisions on the scope and level of consultation with patients, the public and other key stakeholders on phase 2 schemes are for individual SHAs and PCTs to take in the light of local circumstances.

70. Early in the procurement process SHAs were reminded of the duties in the Health and Social Care Act 2001 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, and the breadth of patient and public engagement that is required both in legislation and under the Department's guidance *Strengthening Accountability – Involving Patients and the Public – Practice guidance*.
71. Through a competitive procurement, we have achieved best value available in each scheme. Many of the issues relating to integration have already been addressed in phase 2, in particular with regard to training. We further believe that in phase 2 we shall see the cost of ISTCs lowered as a result of the expansion of the market and greater competition which have resulted from the introduction of new providers. Once centrally procured contracts have come to an end, all providers will be required to operate at tariff (or NHS Equivalent Cost) and will be compared solely on quality and access.
72. The Government's aim is to reform the NHS, through policies such as payment by results and patient choice, into a self-improving healthcare system. A range of alternative providers, freely accessible by patients, is key to this aim.
73. If the private sector or voluntary organisations can help the NHS deliver even better services for patients and get better value for money for taxpayers, then of course we will use them. Ultimately it is patients who choose where they want to be treated and patients' choices which will determine where services and capacity are needed.









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