



INDEPENDENT SECTOR TREATMENT CENTRES

**A REPORT FROM KEN ANDERSON,
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TO THE SECRETARY OF STATE FOR HEALTH

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1. You asked for a report on the independent sector treatment centre (ISTC) programme covering:
 - the background to the ISTC procurement;
 - the benefits of ISTCs;
 - operational issues; and
 - the future for the use of the independent sector to treat NHS patients.

2. In summary, the key messages are:
 - i) 21 ISTC schemes are now open and a further 11 will open over the next 18 months;
 - ii) over 250,000 patients have been either been treated by or received a diagnostic service from the independent sector;
 - iii) patient satisfaction is running at over 94%;
 - iv) over 122,000 NHS patients have benefited from treatment in a range of elective surgery. This includes nearly 37,000 that have been treated through two supplementary procurements making available capacity in the incumbent private sector;
 - v) over 128,000 patients have either received MRI scans through a further contract with the independent sector for the provision of 12 mobile MRI scan units or diagnostics procedures in an ISTC;
 - vi) in 2006, ISTCs are expected to treat a further 145,000 NHS patients;
 - vii) value for money has been achieved by cutting what the NHS used to spend;
 - viii) clinical quality is driven through high standards and key performance indicators (KPI) reporting; and,
 - ix) a further wave of procurement from the independent sector will enable a further 250,000 NHS patients to be treated per year.

Background

3. In April 2002, the Government announced unprecedented investment in the NHS in England in order to refocus health services on the needs of the patient and dramatically reduce the time that patients wait for treatment.¹

4. One of the ways in which these objectives are being met is through new Treatment Centres, some run by the NHS and some by the independent sector. One treatment centre at Redhill is a joint-venture between the NHS and BUPA. This centre opened in January 2003 and predates the national procurement of treatment centres run and managed by the independent sector.

¹ *Delivering the NHS Plan: next steps on investment, next steps on reform*, DH, April 2002.

5. In October 2002, the Department 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, any anticipated gaps in their capacity needed to meet the 2005 waiting time targets.
6. The result of this exercise led to the identification of capacity gaps across the country, particularly in specialities such as cataract removal and orthopaedic procedures, where additional capacity was needed beyond the increased capacity planned by existing NHS providers. As a consequence, a procurement exercise was launched.
7. In December 2002, the Department invited expressions of interest from the independent sector to run a series of Treatment Centres, in order to enable yet more NHS patients to benefit from faster access to surgery.²
8. In September 2003, the Department announced preferred bidders for the majority of the Independent Sector Treatment Centres (ISTCs). Contracts were subsequently awarded on the basis that bidders met the core clinical standards required by the NHS, provided high standards of patient care, offered additional staffing capacity and provided good value for money to NHS commissioners. The first contracts were signed in September 2003 and the first ISTC commenced services in October 2003 at Daventry.
9. In addition to the main ISTC procurement, the Department has also run a series of additional procurements to make available to NHS commissioners the capacity and innovation that the independent sector can offer. This has included supplementary procurements to make available capacity in the incumbent independent sector to treat NHS patients and a procurement for MRI scans to ensure patients have speedier access to diagnostic facilities. More recently, a series of Commuter Walk-in Centres have opened that will provide easier access to a range of non-emergency services for commuters
10. A further, substantial procurement of additional capacity from the independent sector (known as 'phase two') was launched in March 2005. The next wave of procurements is well advanced and comprises two main areas – elective procedures and diagnostic procedures:
 - phase 2 Electives is expected to deliver up to 250,000 procedures per year and create an Extended Choice Network (ECN) of Independent Sector Providers who will deliver up to an additional 150,000 procedures per year, on an ad hoc basis. Overall, this represents an investment of approximately £3 billion over five years. The additional capacity will be provided through a variety of facilities, such as existing ISTCs, new build centres,

² *Growing Capacity: Independent Sector Diagnosis and Treatment Centres*, DH, December 2002.

refurbishments and existing NHS facilities, and will collectively contribute towards the provision of patient choice and reduced waiting times; and,

- phase 2 Diagnostics is expected to deliver approximately two million additional diagnostic procedures per year for NHS patients, and represents an investment of over £1 billion over five years. The additional capacity will help cut 'hidden waits' brought about by patients waiting for diagnostic tests ahead of any further treatment required. It will also help the NHS to meet the Government's target that by 2008 all NHS patients should be treated within 18 weeks of their GP referral.

11. When phase 2 is completed the ISTC programme will be delivering on its three principal objectives: to increase the capacity available to treat NHS patients, offer patients a choice over where they are treated, and stimulate innovation in the provision of healthcare.

Increased Capacity

12. The capacity offered by the independent sector is an important part of the 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 non-treatment centre providers in the NHS. For example:
13. The BUPA Redwood ISTC is a partnership arrangement between BUPA and the Surrey and Sussex Healthcare NHS Trust that started in early 2003 under a five year contract. This Treatment Centre was the pilot for the current ISTC programme. The centre has transformed the BUPA Redwood hospital, at Redhill in Surrey, into a fast-track surgery centre dedicated exclusively to treating NHS patients who can be treated in a single day or with a short stay in hospital. The agreement means that approximately 12,000 operations a year for NHS patients are provided. The Treatment Centre provides a range of diagnostic work, day surgery and other surgery, such as orthopaedics for NHS patients.
14. The Redwood centre is on the site of the Trust's East Surrey site in Redhill, Surrey. It has 36 beds, two fully equipped operating theatres, an endoscopy suite, x-ray, ultrasound and consultation rooms.
15. In July 2005, the new Barlborough Treatment Centre opened in Trent and it will provide 22,000 orthopaedic operations over the next five 5 years. The centre is a new, £9 million purpose built facility that has 36 ward beds, 4 critical care beds and a physiotherapy gymnasium. To date this facility has treated 5,000 patients.

16. In ophthalmology, new mobile ISTC units have created additional capacity. Nationally, the mobile units have visited 25 sites in nine Strategic Health Authorities to provide day case cataract surgery. The total amount of operations performed to the end of January 2006 is over 20,000, all by staff who are additional to those already working in the NHS.

Choice and Competition

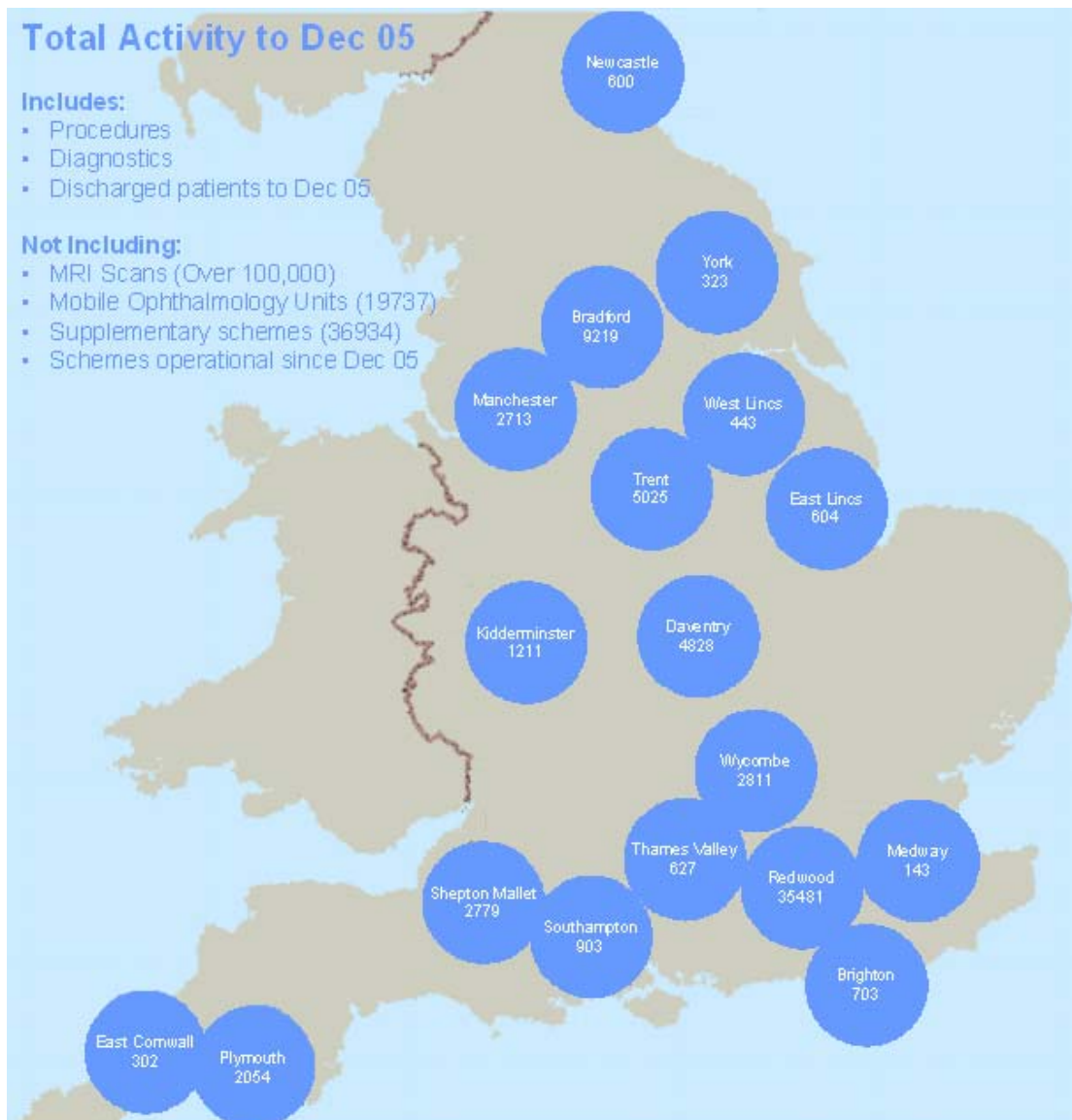
17. The programme will increase patient choice. Since 1 January 2006, patients have had a choice of at least four providers for their first consultant-led appointment. As well as NHS providers, patients are able to choose to have their treatment provided from the independent sector. Some of the PCT choice options will already include independent sector providers and this number will increase as additional capacity is made available. Choice of elective treatment will both improve the patient experience and encourage providers to develop more responsive, patient-centred services. Putting patients in charge of where they are treated means that all providers, IS or NHS have to compete for patients and this competition helps drive a patient-centred service.
18. Competition drives up productivity across a range of sectors. This is because monopolistic providers do not have anyone challenging their level of performance. Once a competitive challenge is introduced it forces the existing provider to re-examine their processes to perform as well, or better than the new provider. For example, the opening of a new ISTC at Shepton Mallet has challenged traditional providers treating NHS patients. The ISTC at Shepton Mallet has 34 in-patient beds; four operating theatres; and 18 day-case beds for pre-operative, primary and secondary recovery care.

Practices and Innovation

19. Innovations range from the physical layout of facilities to elements of administration and clinical practice, and examples include:
 - 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 designed around the clinical flow of patients, thus increasing productivity;
 - process design, to improve the patient's experience by increasing throughput without compromising patient safety or clinical quality. This is apparent in the mobile ophthalmology units capable of delivering 20-23 cases per day due to the streamlined process enabling efficient use of theatre space and surgical resource;

- taking extraneous administrative processes off-line so that surgery is not delayed and can commence at the start of the working day;
 - stocking smaller ranges of prostheses allowing theatre staff to become more proficient and productive;
 - administering local anaesthetic instead of general anaesthetic for primary joint replacements reduces the anaesthetic risk as well as the period of stay by the patient to an average of 5.3 days from 8 days experienced in the NHS;
 - the double reading of post operative x-rays for orthopaedic patients, thereby introducing a greater level of peer review and integration between the independent sector and NHS; and,
 - using effective pain management techniques to allow post-operative physiotherapy to commence earlier thus reducing the length of stay.
20. One important example of innovation is at the Peninsula Treatment Centre which is a purpose-designed surgical facility serving Devon and Cornwall. The Treatment Centre has comprehensive on-site facilities including two operating theatres, a postoperative recovery unit, a physiotherapy gymnasium, a pharmacy, laboratory services and a x-ray department. The day patient wards have one, two or four bed bays.
21. The Centre has introduced an innovative blood conservation process that is revolutionising patient outcomes at the hospital. This is the OrthoPat autologous cell saving system, which processes the patient's own blood during and after surgery by separating it using a dynamic disk, collecting the oxygen carrying red blood cells in a closed sterile environment and then re-transfusing it to the patient. The system has several key benefits. It enhances haemoglobin levels, which helps patients to recover from surgery more quickly and effectively, and assists with wound management. It also reduces the possibility of a patient reacting to donated blood and eliminates the risk of infection from donated blood.
22. The Centre's re-ablement team will also provide advice and support to patients, where appropriate, following their discharge. This includes arranging for the loan of equipment, such as walking frames, and conducting a home visit to provide advice on daily activities

ISTC Location Map and Activity levels



ISTCs are cheaper than spot purchase

23. Traditionally the NHS paid incumbent IS providers a premium of 40% to 100% over reference costs. The ISTC programme has ended this high cost approach. By bringing in new providers, it has brought competition to the private market too, meaning lower costs are sustainable. This means more operations for NHS patients at less cost. Although contract prices vary above and below equivalent cost, they remain significantly below spot purchase prices. Even where in some areas the cost is higher than within the NHS this is only short-term and reflects the costs of setting up new facilities. In the long-run providers will have to compete at tariff.
24. In 2003-04 the NHS bought 99,000 operations from private providers locally, so buying operations is nothing new. What is new is that we

use bulk buying to get value for money. In addition, based on recent years' spot-purchasing data, there appears to be a downward trend where spot purchasing continues.³

High quality of service provision

25. Patient safety is paramount in ISTCs as in the NHS, and standards in the ISTC mirror those in the NHS. All clinicians are on the appropriate specialist register of the GMC, as in the NHS. The use of overseas' clinical staff – both doctors and nurses – is not unique to the independent sector. The NHS has used, and continues to employ many overseas clinicians who come to Britain and use their skills to help our patients
26. ISTC contracts require that they collect and report on a wide range of Key Performance Indicators. These are scrutinised monthly and published annually. There will of course be individual problems in some ISTCs, as within the NHS but these will be dealt with quickly by careful monitoring.
27. ISTC providers are contractually obliged to deliver clinically safe, high quality care along agreed patient care pathways. They currently work to Healthcare Commission (HCC) standards
28. The ISTC programme selects bidders, first on clinical safety specifications, and only then commercial. It monitors provider quality carefully once treatment centres are in operation. ISTC quality is assessed around a variety of metrics, including Key Performance Indicators (KPIs), which are integral to ISTC performance management.

Training

29. In the next phase, all ISTCs will be expected to provide training. In addition, a number of ISTCs in the first wave will also offer training. This is expected to be in the following ISTCs located in Nottingham, Maidstone, north-east London, Hemel Hempstead, Stevenage, Brighton, York, Burton, Daventry, Somerset, Greater Manchester, and Portsmouth. Local training committees have been established or are about to be established with a view to developing training contracts. When fully established the contracts will include provision for junior doctor, nurse or allied health professional training. They will cover operative techniques appropriate to the case-mix, general nursing care of the surgical patient and clinical techniques for allied health professionals according to the case mix.
30. Many surgical, anaesthetic and other activities that will be provided in ISTCs are part of the core training requirements of NHS staff. Through

³ *Laing's Healthcare Market Review 2005-2006*, Laing & Buisson, September 2005.

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.

31. Administratively, ISTCs offer an ideal training environment over more traditional NHS settings since they are based around:

- regular work flow, uninterrupted by priority cases; and,
- high volume activity.

These factors offer trainees a predictable training environment in which they can concentrate on appropriate cases in a time-efficient manner.

32. 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.

Staffing

33. The IS cannot poach NHS nurses and so recruit from overseas. All staff in ISTCs are appropriately qualified to fulfil their duties.

34. All surgeons working in Treatment Centres must first be registered on the appropriate Specialist Register of the General Medical Council's Specialist Register before they can perform surgery.

Evaluation

35. Providers are required to report data on 26 Key Performance Indicators on a monthly basis. This enables the DH to closely monitor performance and ensure that problems can be caught quickly, minimising risks to patients. This information is also independently assessed annually by the National Centre for Health Outcomes Development (NCHOD) who publish their findings. Ultimately, when sufficient levels of activity are taking place this will help patients to review comparisons both between the ISTCs and NHS and between ISTCs

36. A recent report from the ISTC Performance Management Analysis Service (PMAS) / National Centre for Health Outcomes Development (NCHOD) stated that:

- *“There is a robust quality assurance system in place, more ambitious and demanding than that for National Health Service*

(NHS) organisations. The KPI data to be collected and provided by the ISTCs extends beyond that used by the NHS.”

37. The Health Care Commission visits and assesses each ISTC in order to ensure the quality of care. All ISTCs are required to survey at least 10% of their patients. Satisfaction rates across the programme consistently run at over 94%.

The next phase of procurements from the independent sector

38. In February 2005 an advertisement was placed in the Official Journal of the European Union (OJEU) seeking expressions of interest for the procurement of diagnostics estimated to be worth £1 billion over five years.
39. All Invitations to Negotiate (ITNs) have now gone out to the market following a rigorous review of expressions of interest and pre-qualified questionnaires. It is hoped that some contracts will be signed this summer and that first service delivery in some schemes will commence in 2006.
40. A second OJEU was placed in May 2005 for the procurements of up to £3 billion elective procedures. Following the review of expressions of interest and pre-qualified questionnaires ITNs are now being released in three tranches. The first two have already been released to market. We expect preferred bidders to be appointed later this year with service commencing in 2006/07.

Context of Independent Sector Treatment Centres - Reform

41. ISTCs are designed to offer NHS patients timely, high-quality care. Increasingly the independent sector will have a key part to play to offer patients choice over how and where they are treated, and to introduce innovation in the ways patients are treated. ISTCs are just one of a range of providers available to NHS commissioners.
42. We are now halfway through a ten-year programme of reform which began with the publication of the *NHS Plan* in July 2000. The plan identified the need for a programme of sustained investment in and reform of the NHS to ensure that it could deliver its core aim: providing high-quality care for every patient, responding to need, not ability to pay. It also highlighted the importance of value for money: the need to achieve consistently the best use of resources in a taxpayer-funded service.
43. For the reform programme to be successful, patients need to be fully engaged in decisions and choices about their own health and healthcare. The NHS, for its part, would need to give greater focus to the prevention of illness, by tackling inequality of access and by

empowering people to make choices that improve and protect their own health.

44. Until recently, the healthcare system has not adequately rewarded hospitals and other providers for responding to patients and improving clinical services and productivity. A combination of, on the one hand, payments based on historical budgets and, on the other, patients not having a choice meant that funding could be taken for granted rather than being linked to patients' experience or to the health outcomes achieved. As a result, while financial risk in the system was low, so too was the challenge to hospitals that performed poorly. And high-quality, well-run services lacked the incentive or support to develop further.
45. In an environment as complex and changing as that of healthcare, for the NHS to improve and innovate on a sustainable basis, the system as a whole has to better support the motivation and aspiration of staff to provide good-quality services. Targets alone, especially targets driven from the centre, cannot achieve this.
46. We are aiming therefore for an NHS that is 'self-improving', led by patients and the public in partnership with staff.
47. The reforms are not designed as a blueprint for how services should be delivered; they are a **means** to improvement and **not an end** in themselves. The reform programme seeks to embed the right balance of incentives, patient choice, plurality and transparency in the system. It will make the patient's voice and choice heard. It is also intended to give clinicians and managers the tools they need to make good use of resources, to respond flexibly to the changing needs of their patients and populations.
48. It is only by embedding a self-improving mechanism, patient power, into the NHS that we can sustain high quality delivery.
49. When fully rolled out ISTCs will account for less than 1% of the total NHS budget and only about 10% of all elective procedures. It is important therefore to note that ISTCs exist to challenge the system and supply some additional capacity but they do not represent an end to the NHS as we know it.

Ken Anderson
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