House of Commons
Health Committee

Independent Sector
Treatment Centres

Fourth Report of Session 2005–06

Volume III

Oral and written evidence

Ordered by The House of Commons
to be printed 13 July 2006
**The Health Committee**

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

**Current membership**

Rt Hon Kevin Barron MP (Labour, Rother Valley) (Chairman)
Mr David Amess MP (Conservative, Southend West)
Charlotte Atkins MP (Labour, Staffordshire Moorlands)
Mr Ronnie Campbell MP (Labour, Blyth Valley)
Jim Dowd MP (Labour, Lewisham West)
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Anne Milton MP (Conservative, Guildford)
Dr Doug Naysmith MP (Labour, Bristol North West)
Mike Penning MP (Conservative, Hemel Hempstead)
Dr Howard Stoate MP (Labour, Dartford)
Dr Richard Taylor MP (Independent, Wyre Forest)

Mr Paul Burstow MP (Liberal Democrat, Sutton & Cheam) was a Member of the Committee during the inquiry

**Powers**

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

**Publications**

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom

**Committee staff**

The current staff of the Committee are Dr David Harrison (Clerk), Eliot Wilson (Second Clerk), Christine Kirkpatrick (Committee Specialist), Ralph Coulbeck (Committee Specialist), Duma Langton (Committee Assistant) and Julie Storey (Secretary).

**Contacts**

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 6182. The Committee’s email address is healthcom@parliament.uk.
Witnesses

Thursday 9 March 2006

Mr Ken Anderson, Commercial Director, and Mr Bob Ricketts, Head of Demand Side Reform, Department of Health

Mr Bernard Ribeiro CBE, President, Royal College of Surgeons of England, Mr Simon Kelly, Bolton Hospitals NHS Trust, Royal College of Ophthalmologists, Professor Janet Husband, OBE, President, Royal College of Radiologists, Dr Peter Simpson, President, Royal College of Anaesthetists, and Mr Ian Leslie, President, British Orthopaedic Association

Thursday 16 March 2006

Dr Thomas Mann, Chief Executive of Capio Healthcare UK, Mr Mike Parish, Chief Executive of Care UK and Director Partnership Health Group, Mr Mark Adams, Chief Executive Officer of Netcare UK, Mr Peter Martin, Chief Executive of Mercury Health, Dr Ian Smith, Chief Executive of General Health Care Group, and Mr Alan Pilgrim, Chief Executive of Alliance Medical

Ms Anna Walker, Chief Executive, Healthcare Commission, Professor Sir Graeme Catto, President, General Medical Council, and Professor Peter Rubin, Chairman, Postgraduate Medical Education and Training Board (PMETB)

Professor John Appleby, Chief Economist, The King’s Fund, Mr James Johnson, Chairman, and Dr Paul Miller, Chairman of the Central Consultants and Specialist Committee, British Medical Association, Dr Sally Ruane, Senior Lecturer, Health Policy Research Unit, De Montfort University, and Mr Daniel Eayres, Public Health Information Specialist, National Centre for Health Outcomes Development

Thursday 23 March 2006

Ms Jane Hanna, Former Non-Executive Director, South West Oxfordshire Primary Care Trust and Mr Robin Smith, Chief Executive, Mendip Primary Care Trust

Ms Nicola Easey, Lead for the Modernisation & Commissioning Paired Leads Network, NHS Alliance, and Mrs Pauline Quan Arrow, Chair of Southampton City Primary Care Trust

Dr Donal Hynes, Vice Chairman of the NHS Alliance, Dr Tony Marsh, Chairman of Gedling Primary Care Trust Professional Executive Committee, Ms Valerie Smith, Independent Sector Advisor, Royal College of Nursing, Ms Gail Adams, Head of Nursing, UNISON, and Mr Barrie Brown, Health Sector Officer, Amicus
Wednesday 26 April 2006

Rt Hon Patricia Hewitt, a Member of the House, Secretary of State for Health, Sir Ian Carruthers OBE, Acting Chief Executive of the NHS, Mr Hugh Taylor CB, Acting Permanent Secretary, and Dr Bill Kirkup, Acting Deputy Chief Medical Officer

Wednesday 28 June 2006

Mr Ken Anderson, Commercial Director, Mr Bleddyn Rees, General Counsel, Commercial Directorate, Mr Geoff Searle, ISTC Programme Lead, Department of Health
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Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons Library where they may be inspected by Members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074). Hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

The Department of Health
Mercury Health Will Adams NHS Treatment Centre
Woodland NHS Treatment Centre
Capio Healthcare UK
Supplementary Information from Mercury Health
Christian Healing Workshops
Oral evidence

Taken before the Health Committee

on Thursday 9 March 2006

Members present:

Mr Kevin Barron, in the Chair
Mr David Amess  Mike Penning
Jim Dowd  Dr Howard Stoate
Anne Milton  Dr Richard Taylor

Witnesses: Mr Ken Anderson, Commercial Director, and Mr Bob Ricketts, Head of Demand Side Reform, Department of Health, gave evidence.

Q1 Chairman: Good morning, gentlemen. I wonder if I could ask you to introduce yourselves for the sake of the record and to tell us what area of expertise you bring to us this morning.

Mr Anderson: Good morning. I am Ken Anderson. I am the Commercial Director of the Department of Health.

Mr Ricketts: I am Bob Ricketts. I am with the Department of Health and I lead on policy for commissioning and choice.

Q2 Chairman: Thank you very much for coming along. This is our first sitting on our inquiry into the ISTCs. I wonder if you could start by telling the Committee how many ISTCs and National Health Service Treatment Centres there are at the moment or under development.

Mr Ricketts: There are 20 open ISTCs. My recollection is that there are approximately 45-50 NHS Treatment Centres depending on how you categorise them, but I would need to check that figure and come back to you.

Mr Anderson: I would defer to Bob on the NHS, which is not my area of expertise, but we do have 20 ISTCs with another 10 to follow.

Q3 Chairman: What are the objectives of the ISTC programmes, and how much importance do you give to the objectives? Initially the three objectives of the programme were to increase capacity, offer patients a choice of venues for treatment and to stimulate innovation. Then we also had the introduction of this word contestability which came into the frame as well. What are the objectives? Does that cover all of them?

Mr Anderson: It covers a number of them. Probably the main objective at the time was for capacity. The process that we went through was one where we would go out to the local NHS through the strategic health authorities and ask them what capacity gaps they had and what they could not accomplish or provide themselves either efficiently or at all. The primary objective was the capacity issue. There were other goals that we hoped to accomplish through the ISTC programme.

Q4 Chairman: It was the capacity issue which seemed to be the obvious one that went round in the public domain at the time. Was that because NHS Treatment Centres were not capable of filling up the capacity?

Mr Anderson: The SHAs in conjunction with the PCTs did an assessment of the capacity needs of the area and, more importantly, they determined whether or not they could fulfil those capacity needs. We received a series of submissions to the Department on the back of that and that was fairly comprehensive work that outlined in detail what the needs were in the local area. That is how we were informed at the departmental level of what the needs were, particularly around capacity.

Q5 Chairman: Was the location of the first phase to do with where the capacity was needed as it were? There is one just south of my own constituency which covers North Trent and South Yorkshire. Was that because of the need for orthopaedic surgery in that particular area?

Mr Anderson: That was a response to the waiting programmes, and how much importance do you give to the objectives? Initially the three objectives of the programme were to increase capacity, offer patients a choice of venues for treatment and to stimulate innovation. Then we also had the introduction of this word contestability which came into the frame as well. What are the objectives? Does that cover all of them?

Mr Anderson: That is exactly right. We were informed by your local health economy that they needed orthopaedic capacity in the case of Trent and therefore we procured that capacity for them.

Q6 Chairman: That was a response to the waiting times and the waiting lists.

Mr Anderson: That is correct. I cannot speak for Trent itself. There was probably a variety of issues that came up in the local economy that we are not aware of at our level that they would have put into the pot to come up with the answer that they ultimately gave us from the standpoint of their needs.

Q7 Chairman: You will be very familiar with the fact that some parts of the National Health Service felt that the location of these could destabilise local hospitals. Is that something that you took into account when the first phases were located?

Mr Anderson: Again, the capacity planning was done at a local economy level. It was not for us to try to determine at our level. We would not have had the
health economy. Research on whether there were locally specialty capability because we do not have the granularity of data to go out and make those decisions for a local health economy.

**Mr Ricketts:** It is worthwhile adding, Chairman, since I was leading on the capacity planning, that those discussions were very detailed with the health authorities and PCTs. Back in 2002 there was a very real risk of not delivering the six month waiting time target and certainly, looking at all the projections of capacity for the NHS, there was a clear need to rapidly expand the NHS Treatment Centre programme and to bring in additional independent sector capacity not just to help hit the six month target but also because in some places the non-elective targets and priorities were under pressure. A secondary aim of the programme was to take some of the pressure off so that some trusts could then reconfigure and have more physical space to handle some of their emergency pressures because at the time, as you will remember, waiting time issues and also emergency admissions were very high priorities. We were trying to address several issues when we were looking at whether we needed this amount of capacity in a given health system.

**Q8 Chairman:** Issues like choice came along at a later stage as far as the Department is concerned.

**Mr Ricketts:** Strictly speaking, no. Choice was at a very early stage of development. When Alan Milburn announced the first wave of the procurement in December 2002 he put the emphasis on cutting waiting times, but he also referred to an objective which was to increase patient choice clearly with a view that in three years’ time we would have to offer choice. We were running with two objectives then, the primary one being capacity, which was to hit the six month target and to ease some of the pressure on A&E and the non-elective work.

**Q9 Dr Stoate:** I understand why the objective was to improve capacity, particularly in areas where there was a shortage and you needed government targets to get the times down. Did you make any assessment at the time of whether increasing that capacity or bringing new capacity into the system would have any effect on existing NHS hospitals?

**Mr Ricketts:** We asked health authorities and PCTs to consider whether there was likely to be an impact. If we are talking there about Wave 1, which was the procurement launched in December 2002, particularly when taking into account the amount of elective work being done by the NHS, the overall size of that was really too small certainly nationally and in most health areas to have an impact. In terms of the ISTCs that are open now, they are doing 60,000 Finished Consultant Episodes (FCEs) a year this year and the total the NHS is doing is 5.6 million. Potentially if we had got the case mix wrong one could have had an impact at specialty level in an economy. We had one example of that in Southampton where we had to adjust the case mix and likewise in terms of cataracts, but the volumes of additional capacity we brought in from the independent sector were unlikely to destabilise local economies.

**Q10 Dr Stoate:** Certainly they would not destabilise the economy as a whole. You did not do any specific research on whether there were locally specialty difficulties, did you?

**Mr Ricketts:** Where concerns were raised, we went back and challenged SHAs and PCTs on whether these figures looked right and that led, for example, in the case of Oxfordshire, to a reduction in the activity requirements. We offered to move some of that capacity, because it is a mobile service, to those places which had got their numbers wrong in the sense of a shortfall. We were actually aware of that, but we did take the view that for the first wave, because everybody needed the capacity to get to six months, it was very unlikely that it would tip any service over. Where concerns were raised, we followed those up and we reduced the level of activity in the case of cataracts.

**Q11 Dr Stoate:** What you are saying is that, so far as you are aware, there has been no destabilisation or undermining of local hospitals because of these centres, is it not?

**Mr Ricketts:** Very much so. They are doing only 60,000 FCEs this year and next year it is going to be 117,000, but the NHS will do nearly 6 million. It is difficult to see how it can have a serious destabilising effect. I think the bigger issue which has been raised by the service is the impact on training, which is something where we recognise that if you are moving out many of the frequent but simpler procedures that junior medical staff train on then that is one of the areas where we do need to avoid inadvertently destabilising training networks. I think that feels like the bigger risk rather than causing a service to fail, which is why we have been in discussions with the Royal Colleges around how we manage the training element of ISTCs.
disposal the number of nurses and doctors that we needed to perform procedures and to bring the waiting lists down. It was a very specific part of policy that looked at ensuring bringing in that extra capacity both in terms of buildings, people and clinicians.

Q13 Dr Taylor: You are saying that it is being relaxed with the second wave.

Mr Ricketts: It has been relaxed for the second wave for those groups of staff where there are no longer significant forecast shortages. Where we know we are going to have some shortages potentially and we do not have a surplus of staff, like radiology, radiography and some of the more specialist nurses, then we have said that we intend to maintain additionality for Wave 2. We have been in six or seven months of negotiations and discussions with the key trade unions and the staff associations around what should be the list of those staff groups to whom additionality should still apply.

Mr Anderson: We also see additionality and the need to relax it as a way to start to integrate these facilities into the local health economy and so a relaxation of the additionality requirement will allow that to occur. We have had quite a bit of commentary from the Royal Colleges and others saying that that is not being allowed to occur because of the additionality issue. So we have taken that into consideration and, through ministers, we have decided to change that.

Q14 Dr Taylor: To me that is one of the most important bits because at the moment there is a divorce between the ISTCs and the local NHS economy. In places where there are, for example, NHS orthopaedic surgeons who could take on some extra work, could that now be allowed?

Mr Anderson: It could be. It would be looked at on a specific basis depending on the area but based on the things that Bob has just mentioned and whether or not there is a shortage or a deficiency because we do not want to move staff out of the NHS into an Independent Sector Treatment Centre and remove a resource that is needed in the NHS.

Q15 Dr Taylor: Unless you could be sure it was not taking away from that capability within the NHS.

Mr Anderson: That is correct.

Mr Ricketts: What we have done is introduce something called non-contracted hours so that particularly medical staff, who are maybe not using the non-contracted hours and who are not being used to the benefit of the NHS could work for a private insurer or to do something else, who are subject to strict controls around safe working, could then work in an Independent Sector Treatment Centre. That is something that we have had strong support from the medical profession for in terms of being slightly more flexible and allowing people to use their spare resources as long as it does not prejudice NHS care and it does not lead to somebody working too many hours.

Q16 Anne Milton: How do complaints about ISTCs compare with the NHS as a whole?

Mr Anderson: Currently we track through our Key Performance Indicators (KPIs) serious untoward incidents. Serious untoward incidents—and you have to understand, to date we have done 49,000 elective procedures—are of the order of one quarter of 1%. I do not know how that compares to the NHS because in many cases they do not collect that data so a comparison is not possible.

Q17 Anne Milton: What is a serious untoward event?

Mr Anderson: I could not define that for you appropriately. I could come back to you in writing on that.

Q18 Anne Milton: A serious untoward event presumably is an event that everybody knows has occurred. I was actually asking about complaints.

Mr Anderson: I do not have that figure in front of me. Again, I could write to you and give that to you. I do know that the satisfaction rates in the ISTC run at 97% in comparison to 91% in the NHS.

Q19 Anne Milton: What outcomes are measured, quality of life and morbidity et cetera?

Mr Anderson: That is a fair question. First of all, I am not a clinician so I cannot go into the detail, but what I can tell you is that we have a set of 26 Key Performance Indicators that are contained in the contractual relationship with the providers and they are clinical performance referrals and the contractual obligations just generally of the provider. Again, if you wanted specific detail on that, I could have somebody from the DCMO's office write to you and give that to you. Again, I could write to you and give that to you. I do not have those figures in front of me from a complaint standpoint, but we can get back to you on that.

Q20 Anne Milton: And if you could also let us know what a serious untoward incident is.

Mr Anderson: We will define that for you.

Q21 Anne Milton: It has to be said that theatres in the NHS throughout the night lie dormant. On the basis that you were attracting medical and nursing staff from elsewhere because of additionality, would it have been possible not to have started the ISTCs and to use the theatres overnight and to bring in staff from elsewhere if there was not capacity in the medical and nursing staff?

Mr Anderson: In some cases we did that. Depending on the contract and the availability and capability within the local economy, we did use existing NHS facilities. There is a difference between currently elective surgical throughput and it basically relates to keyhole surgery and whether or not those facilities are up to doing it because it is a completely different...
type of surgical event. What we were trying to do, along with all the other things we mentioned at the beginning, was to bring in innovation as well, new working techniques, so that we could increase throughput and, more importantly, quality for the patient and a lot of times that entailed that we had to go out and build fit for purpose facilities.

Q22 Anne Milton: Will you be doing it with the next phase, particularly on diagnostics? Will you look towards the NHS first of all and whether that can be used more effectively by using it out of hours?

Mr Anderson: Most definitely. The process with Wave 1 was non-static that we went through around the gap analysis. We had started out initially with the NHS telling us that we should procure 250,000 procedures and we actually procured 170,000 and that will continue in Wave 2. I would not wish to be flippant, but it is really too early to tell exactly what those service redesigns and configurations will look like, particularly around the diagnostic piece.

Mr Ricketts: What you are suggesting is exactly our strategy in terms of diagnostics. We have got to deliver a huge increase in diagnostic provision, particularly scanning, in the next two years to deliver 18 weeks because we need 900,000 more MRI scans and over half a million CT scans. We are getting less than half of that from the independent sector. At the same time as we procure diagnostic capacity from the independent sector we have also strongly encouraged local NHS Trusts to increase their diagnostic capacity. We will not hit 18 weeks if we solely rely on the independent sector. The strategy you are talking about where trusts are encouraged over the next two years to use their scans to best effect and so on is exactly what we are looking for, it is an investment into a growing NHS capacity or question. I do not know that I have the specific data. My area of expertise is not in the NHS, it is Outcomes Development. Is this a new arm’s length body?

Q23 Mr Anderson: I have just been passed an answer for you. I am told that one in four in the NHS itself is overseas trained and that the vast majority in the IS are overseas trained.

Q24 Dr Taylor: Is it pretty much the vast majority who are overseas trained or is that impression wrong?

Mr Anderson: I would not want to proffer an answer and be wrong. It would be my sense that that would be correct, but I would not want to mislead you. I will write to you on that.

Q25 Dr Taylor: That would be very useful. In your report to the Secretary of State, dated 16 February, you say that all clinicians are on the appropriate specialist register of the GMC as in the NHS. Is the accreditation process exactly the same for people coming from other countries as from this country?

Mr Anderson: The accreditation process is handled by the General Medical Council. Everyone is registered with the GMC.

Q26 Dr Taylor: So these are questions we should put to them. Are you not aware of differences in accreditation?

Mr Anderson: I believe that there is no difference, but if you want to ask questions around that area I suggest you talk to the GMC. Mr Ricketts: The requirements are exactly the same in terms of registration and being on the specialist register. It is a contractual requirement of the programme. We could confirm that in writing.

Q27 Dr Taylor: We will take that up with the GMC when we see them.

Mr Anderson: Dr Taylor, I have just been passed an answer for you. I am told that one in four in the NHS itself is overseas trained and that the vast majority in the IS are overseas trained.

Q28 Dr Taylor: That is very useful. You have talked a little bit about complaints. Are there any figures for complication rates between NHS Treatment Centres and ISTCs?

Mr Anderson: We collect them in the ISTCs. The problem we have is that a lot of the data we collect under our Key Performance Indicators is not routinely collected in the NHS. We find it very hard to compare complication rates. The more you get into the granularity of data the harder it is to compare apples to apples. Again, that is a clinical question. I do not know that I have the specific answer in front of me. I will put that to our clinical colleagues.

Q29 Dr Taylor: We have got this horrendous paper entitled “Preliminary Overview Report for Schemes: ISTC Performance Management Analysis Service” which is going to put anybody off after just one glance at it because it is all figures. Could either of you give us a thumbnail sketch of what it says? It is prepared by the National Centre for Health Outcomes Development. Is this a new arm’s length body?

Mr Anderson: No. They are attached to a university. It is not an arm’s length body. That is clinical in nature.

Mr Amess: They will write to you, Richard.

Dr Taylor: I will not be able to understand that either!

Q30 Anne Milton: Are you saying that complications of procedures is information that is not collected within the NHS?

Mr Anderson: In some areas they do collect that data. My area of expertise is not in the NHS, it is around these centres. From the standpoint of serious untoward incidents, that is not collected. Below that level of granularity I do not know exactly in specific areas what is collected and what is not.
Q31 Anne Milton: Mr Ricketts, maybe you can answer that.

Mr Ricketts: There is a problem for some specialties and some procedures that colleges collect through audit of complication rates, and cataracts would be a good example. Once you are outside cataracts you start to struggle in terms of having reliable published data that is statistically significant and that covers all providers. It is a problem we hit when we published the patient choice booklets in December where I had hoped that in addition to the information on waiting times and some of the other Healthcare Commission data we could provide some meaningful clinical indicators. It is an area that we recognise, as the Department, we have to work on with the professionals and patients so that we can publish meaningful clinical quality data, including complications, across all providers and at a sufficient level of detail to be sensible, which probably means at specialty level and so on. It is a great difficulty. So we hit that problem in terms of the choice booklets. I think Mr Anderson’s observation is right.

Q32 Anne Milton: Can I suggest that I do not have a choice unless I have got some clinical indicators because my choice should be informed. If it is not informed by the fact that this hospital or that hospital or this ISTC has complication rates then I am not making a choice.

Mr Ricketts: I would agree that you are not making as informed a choice.

Q33 Anne Milton: The complication rates are fairly fundamental information.

Mr Ricketts: I agree with that. In terms of the introduction of choice, we have to work from where we are. It is really important that any information which is provided to patients for choice is reliable and published by an independent body. We pushed the Healthcare Commission very hard. We used the information that was published by the Healthcare Commission so that we would not mislead a patient if they are relying on that. Clearly they also have the conversation with their GP who will steer them in terms of their perception of clinical quality, but again I recognise it is very difficult for GPs in those circumstances depending on what they know of the provider. That is why we have signaled that one of the key next developments in the choice policy is to move away from waiting times and satisfaction rates, which are important to patients, into developing some measures of clinical quality that can be published and that can be used by GPs and patients to inform choice, but we are not there yet. In terms of what is nationally published, it is very limited in terms of clinical quality. I am not trying to avoid the question, I am just stating where we are.

Anne Milton: It is very difficult if we have not got any information on complaints, we do not know what an untoward incident is and we have got no information on complications to compare.

Dr Stoate: I share your point of view on patient safety. One of the things that trusts are required to do is to report adverse patient incidents which could affect patient safety. However, the quality of reporting is fantastically variable, with some trusts returning a nil return, which means they have no adverse incidents and which beggars belief. The quality of data which is submitted by trusts is extremely poor.

Anne Milton: So patients are not going to be able to exercise an informed choice, it is as simple as that.

Q34 Chairman: Has any comparative assessment been made between independent and NHS Treatment Centres?

Mr Ricketts: Not a direct comparison, no. The National Centre for Health Outcomes Development (NCHOD) report could not do that in detail last year when it was published simply because the number of patients treated would not be meaningful statistically. When we publish in the autumn the next version of the NCHOD report, because we will have many more patients that have gone through the programme and therefore the KPIs will be more meaningful, we will be able to provide much more comprehensive information on clinical quality, but at the time they produced the report they had comparatively few cases and certainly not enough to draw meaningful comparisons.

Mr Anderson: From the standpoint of ISTCs, I do not have that granularity of data at hand. We collect data as a matter of course through the contractual environment and through the Key Performance Indicators that we ask of the firms who are doing the work. So that data is out there. I just do not have the specifics in front of me.

Q35 Chairman: You do not ask for it of NHS Treatment Centres, is that what you are saying?

Mr Anderson: NHS Treatment Centres are not within my realm of expertise.

Q36 Chairman: It seems that doing any comparison is going to be very difficult if you are not comparing like with like.

Mr Ricketts: What we are doing as part of the next phase of choice is we are working currently with the NHS Confederation, the Foundation Trust network and also the independent sector to look to develop, before the autumn patient choice booklets, meaningful measures where you can compare NHS and independent sector providers like for like. That work is being developed. It is not that information is not out there, it is that it is not pulled together in a way that would be meaningful and, crucially, some of it is quite variable, so we need to improve the quality. We are trying to do all we can to ensure that over the course of the next year, as choice rolls out, more and more information is available for patients and GPs to take those choices, but we have had to start from where we are.

Q37 Dr Stoate: One of the things we have picked up from some of the evidence we have had is that people are concerned about continuity of care, the aftercare from these Independent Sector Treatment Centres, not so much the operation itself but what happens
Mr Anderson: When we set about trying to determine what the needs of the local economies were we worked on a pathway basis and so we asked the NHS about the pathway and in some cases they could do a significant part of the pathway but maybe not the surgical part of it. So maybe they could do the pre-operative care and the post-operative care but the actual surgical intervention was not possible in their area. So it varies, to be very honest with you, among contracts. Some contracts can stipulate that the provider has to provide all of the front-end surgical and back-end care, whether that is physiotherapy or other modalities post-surgery. It can stipulate that all that they do, depending on the area, is just the surgery itself. We definitely look at that as a pathway concept. We used that as an integration tool from the NHS into the ISTCs and then back into the NHS after post-operative care.

Q42 Dr Taylor: Is there any record of the numbers of patients who have been operated on in ISTCs who have subsequently had to be admitted to NHS hospitals?

Mr Anderson: I do not know if we keep that record, the provider has to provide all of the front-end information. I cannot honestly answer that question.

Q43 Dr Taylor: How would we get at that?

Mr Anderson: We should be able to get that.

Q44 Dr Taylor: A readmission rate to you?

Mr Anderson: No, to any hospital post-surgery.

Q45 Dr Taylor: So that is available, is it?

Mr Anderson: We should be able to get that.

Q46 Dr Taylor: That would be very useful to have. One thing that alarms us is that when a commissioner contracts a service it is for a certain number of procedures over a certain time, which might be as long as five years. Have you any record of how ISTCs are keeping up with those contracts? If a contract has gone one year out of five, is there anything to say they have done a fifth of the number contracted? I am pretty concerned that some of the PCTs are going to be unable to get providers to do all the cases they have contracted for which obviously is going to put the price up.

Mr Anderson: It has no relational value to the price.

Q47 Dr Taylor: If you only do 1,000 operations they and we fix them. Specifically down at NHS instead of 2,000 effectively—local level, I do not have the detail. I do know of something is truly in its infancy. We... of that has been in place over whether it has been joined up appropriately. one year. We brokerage within contracts when throughput is not taken up and we do track it. On the figure at the end of the contractual period, it is too early to say if that loss value has occurred because they are live contracts. We do have the ability to brokerage activity again within contracts and we do that very effectively and very proactively.

Mr Anderson: It will reduce the value for money. The programme is truly in its infancy. We only have one contract that I know of that has been in place over one year. We brokerage within contracts when throughput is not taken up and we do track it. On the figure at the end of the contractual period, it is too early to say if that loss value has occurred because they are live contracts. We do have the ability to brokerage activity again within contracts and we do that very effectively and very proactively.

Q48 Dr Taylor: Are they mostly five-year contracts?

Mr Anderson: They vary throughout the piece. I could not give you an average figure, but a lot of them are for five years, yes.

Q49 Dr Taylor: So it is too early to ask you for a table showing how far down the line of completing their commitments different ISTCs have gone, is it?
**Mr Anderson:** Within the contract and the way it is written it is because that only translates into a snapshot of where we are and not a real value assessment of the contract itself because it has not been completed.

**Q50 Dr Taylor:** If we were half-way through a contract, would you then be able to give us figures?

**Mr Anderson:** Yes. I apologise to the Committee, but a lot of it is the lack of maturity in this programme. As it matures we fully anticipate, because we do collect a very rich set of Key Performance Indicators, being able to come back to you in a year and being far more specific about the effects and, more importantly, the contracts.

**Q51 Dr Taylor:** Let us go on to waiting times. We keep hearing ministers claiming that it is the ISTC's that are reducing NHS waiting times and yet Mr Ricketts has given us the figure of 60,000 as opposed to 5.5 million. When we had some of your officials before us a few weeks ago they said, in all honesty, the effect of ISTCs on waiting times was only marginal. Would you agree with that?

**Mr Ricketts:** Yes, I would. Not to be pejorative about the impact of the ISTC programme, but if you look at the timing, as these facilities open they will have more and more of an effect in terms of sustaining waiting time targets and reducing waiting times further. If you look at the straight numbers in terms of delivering the six month waiting time target, NHS facilities have largely done that. That is not to say, particularly in some areas like cataracts, the ISTC providers have not contributed directly by providing extra capacity, so there has been a contribution. They will be more important over the next couple of years in terms of sustaining that and also helping us, along with the Wave 2 programme, by hitting the 18-week target. Your observation is absolutely right in terms of delivering six months predominately NHS provision in terms of direct capacity. They have, however, helped to take some of the pressure off. That is one of the reasons, if you are looking at changing behaviours in terms of the NHS, there has been the effect of galvanising productivity. The six month waiting time was delivered by the NHS. I think the Secretary of State has said that.

**Q52 Dr Taylor:** I think we will probably hear an argument against that from our next set of witnesses because certainly if you look at cataracts, the rate of increase in the numbers done was going up long before the independent sector programme came in.

**Mr Ricketts:** I absolutely agree with that. One of the areas I led until very recently was ophthalmology and I was very much involved in the initiative to get down to a three month waiting time target for cataracts. I have been very clear that the majority of the contribution even in cataracts was from the NHS. As it happened, some of our earlier ISTC programmes were in ophthalmology so there was a bigger proportionate contribution, but I would certainly want to go on record saying that, in terms of delivering three months for cataracts, the NHS did it because at the time the majority of the facilities were NHS facilities. We had seen a big increase in cataract activity and a fall in waiting times from before the ISTC programme was announced and so I would not disagree with you.

**Q53 Dr Taylor:** I think you were responsible for NHS Treatment Centres initially.

**Mr Ricketts:** Initially, yes.

**Q54 Dr Taylor:** Is it right that organisations like NHS Elect feel they are being dumbed down by the independent sector?

**Mr Ricketts:** I do not think it would be appropriate for me to comment on that. I have not had a recent conversation with NHS Elect. NHS Elect is now in a position where their success or failure depends on attracting patients and whether GPs have a higher view of NHS Elect than other NHS hospitals or the independent sector. I think they will either have to sink or swim in terms of how attractive they are to patients and GPs.

**Q55 Dr Taylor:** Is competition between them on a level playing field?

**Mr Ricketts:** In terms of attracting the referrals, yes. Since the introduction of patient choice it is for the GP and patient to decide which hospital they go do. The NHS Elect treatment centres are in the patient choice leaflets in the same way that NHS hospitals and the open ISTCs are. It is a patient/GP decision now; it is not the PCT directing people to go that way or the other way.

**Q56 Dr Taylor:** Do you think we could have got to the 18-week target without the use of the independent sector?

**Mr Ricketts:** We have not got to it.

**Q57 Dr Taylor:** Could we get to it without that?

**Mr Ricketts:** I think it would be impossible in terms of diagnostics because of the amount of expansion. In some cases we need to double the amount of diagnostic capacity. In terms of electives, we still need very substantial growth to deliver 18 weeks. It is difficult to see the NHS delivering all of that. There is a debate in terms of what the proportion should be, but certainly we need extra capacity. We needed it at the time of six months to sustain it. I think the case for diagnostics is unanswerable given in actual fact the huge increase we have got to deliver. So I think it has a role to play in delivering 18 weeks in several years’ time.

**Q58 Chairman:** We have heard that ISTC prices are lower than the current spot-purchase prices of the independent sector. Is that the case?

**Mr Anderson:** Yes, they are. When we first started the programme probably the biggest change before any ISTC even had planning permission was the change in the incumbent private sector. BUPA reorganised completely and sold 12 hospitals; BMI streamed its business into two halves, one addressing specifically the NHS and the other taking care of their private patient base, and Capio, which is
owned by a Swedish company, did a lot of changes and became more efficient. As a result of that we gained significantly in the spot-purchase market from the efficiencies that were inbuilt in the incumbent private providers. Once we started letting contracts the price transparency also turned a light on the commercial environment that had not been there before and all of that accumulated to bringing down the spot-purchase market.

**Q59 Dr Taylor:** Do you think it is a good value for money comparator to be able to look at it that way or not?

**Mr Anderson:** If we had based our value for money calculation on that one indicator the answer would be no. There are a variety of VFM measures that we take into account that have been internally improved by our Finance Director, externally looked at by the OGC and ultimately approved by Her Majesty’s Treasury. It is actually a far more involved set of calculations than just basing it on a spot-purchase market.

**Q60 Dr Taylor:** Do you think there is going to be any further movement? Could you see a situation where we would get down to the NHS tariff rates?

**Mr Anderson:** We will have to. The intention of the Department through the policy push is to get everyone a tariff and if private sector providers cannot compete at tariff once that is instituted then they will not be providing the care to patients.

**Q61 Anne Milton:** Can you tell me how much the ISTC programme has cost to date?

**Mr Anderson:** Just in terms of the procedures that we have bought, we have done 49,000 procedures, it is £106 million.

**Q62 Anne Milton:** Do you think that is good value for money? The three things, the ISTCs, the NHS Treatment Centres and then there is what would happen in the NHS normally, how do they all compare?

**Mr Anderson:** You have to understand that if the NHS could have created this capacity and they told us they could not—There is an incremental cost to providing new treatment centres even in the NHS. You have to go out and build a building and theatres.

**Q63 Anne Milton:** Or you could use the theatres overnight.

**Mr Anderson:** Based on the evaluations that we did on the bids—and we went through a very robust procurement process and a resultant force within that was the fact that the spot-purchase market came down significantly—we did achieve value for money and we had a set of procurement tools that we utilised and then ultimately the decision was based on a value for money calculation and we achieved value for money within that environment.

**Q64 Anne Milton:** I am missing a bit of this story. You said you achieved value for money based on what? How do you measure that? What is your evidence for making that statement?

**Mr Anderson:** Our evidence for making value for money statements is that we went out with a mandate from the local NHS who said we needed to go and have capacity put in place to take care of patients and bring down waiting times. The value for money process is based on the fact that the NHS could not do that, that we had a robust procurement process in place and that we went out and procured the appropriate—as specified by the NHS—throughput at prices that we could benchmark against an NHS equivalent cost.

**Q65 Chairman:** Let us move on now to Phase 2. I realise it has not been laid out in many ways. How will the location of Phase 2 ISTCs be decided? You hinted that the first ones were decided on the basis of the need for elective surgery. Presumably surgery lists were a good indicator of where they should go in geographically. Is that going to be the case for Phase 2?

**Mr Ricketts:** Phase 2 is about additional capacity in some health economies. In some places there is still a need for significant capacity to do 18 weeks. Cumbria and Lancashire would be a good example of that, Chester and Merseyside, Greater Manchester and West Midlands South. Some of those are a combination of elective capacity and what we call ICATS, so it is like a combination of diagnostic capacity and assessment, a bit like an assessment centre for patients that then go on to electives. It is therefore not the same as schemes in the traditional Wave 1 programme, but that is very much based on local economies’ needs in terms of delivering 18 weeks or whether they need to change services. Some of it is around there being a need for capacity. There are issues around improving access. In West Midlands South we were asked to look at a mobile service to improve access. We have also had a look at that in some of the more rural areas like the south-west peninsula and so on. There is also the need in some locations to improve patient choice and in other areas we have said that we need to use the independent sector programme as one of the levers to improve NHS productivity and responsiveness in a given economy, which is what is behind some of the schemes in Avon, Gloucester and Wiltshire and Essex and so on. The exact rationale does vary from place to place. In some places it is absolutely about pure capacity to do 18 weeks; in other places it is more around creating some further competition to drive up standards in the NHS and/or it is greater financial choice. It is much more variable in terms of the reasons why we are proposing putting something somewhere than in Wave 1.

**Q66 Chairman:** On the issue of choice, I mentioned very early on this awful word contestability which I think we have now got rid of and said it is competition. Where you have got a situation where an area has effectively not had a great call on the
independent sector in the past—My area would be one of those areas. There are some independent sectors there but not on the scale that there are in other parts of the country. A cynic might turn round and say that the reason why the second wave is going in there is because they want competition and the only way that you really get it is by bolstering the independent sector by bringing in a second wave ISTC. What do you say to that?

**Mr Ricketts:** It would be inappropriate to comment on South Yorkshire—

**Q67 Chairman:** It is an area that does not have an independent hospital.

**Mr Ricketts:** There are various ways of getting competition. The point of competition—and it is not something we are pursuing in its own right—is to drive up NHS productivity and standards in those areas. In some cases you can deliver competition and those improvements through the Foundation Trusts’ programme. That is one element of getting increasing competition, to drive up standards and so on. In the independent sector we have the main ISTC procurement, we also having something called Extended Choice, which is focused around using some of the incumbent independent sector to offer patient choices at tariffs and we have the main procurements. What we have been doing is looking in each of the areas at what is the right balance. If you take somewhere like South Yorkshire then it is difficult. Yes, arguably there is a lot of patient choice in terms of Foundation Trusts, but we also have two PCTs where over 90% of their elective work comes from one provider. I think there is quite a sensitive discussion to have around that. In certain circumstances an NHS provider can so dominate a local economy, but you need to have a discussion around how you make sure that the commissioners, working on behalf of patients, have enough leverage to make sure that that big provider is responsive to patients, keeps up-to-date with clinical practice and so on. That balance of is there enough choice and is there enough contestability are the sort of factors that would be taken into account before ISTCs are issued for areas and it is one of the factors that has been fed back to us by both the Foundation Trust chairmen and clinicians in South Yorkshire and that Lord Warner is considering. I think it is right that we consider those things. You might have Foundations Trust but, equally, you might have a very big NHS provider where there is an issue around whether you need to strengthen PCTs’ ability to commission the right services to their patients.

**Q68 Chairman:** Presumably you have more than anecdotal evidence that work practices are changing inside the National Health Service primarily because of ISTCs.

**Mr Ricketts:** It is very difficult to quantify that. We have got a lot of anecdotal evidence from both the NHS and the independent sector of people saying their behaviour has been changed—not just because of the ISTC programme but the combined influence of choice and payment by results. Trying to say there has been X improvement in Y place specifically because an ISTC was proposed or it is the effect of choice, you cannot make those conclusions. Unfortunately the evidence is anecdotal.

**Q69 Chairman:** You have put the case that that may be one of the reasons you would put a second wave into an area.

**Mr Ricketts:** I think it is one of the reasons why I would explore putting it into that area. We would want to look at the implications, which is why ministers are very keen to look at the proposal in the round and at the implications before they take the decision to issue an ITN.

**Q70 Chairman:** Will additionality still continue to be a part of the ISTC programme?

**Mr Ricketts:** We have said that for Wave 2, apart from diagnostics where there are still major skill shortages, we are relaxing it for those groups of staff where we do not have a problem. For those groups like radiology, radiography and orthopaedic surgeons it is still an issue. For the time being we still think there is that need to protect the NHS and also to encourage independent sector providers to bring in additional capacity. If we have still got skill shortages in radiographers, radiologists, orthopaedic surgeons and other groups it does make sense to incentivise IS providers to try to bring them in from outside the NHS.

**Mr Anderson:** Wave 1 was blanket additionality with no exceptions. Wave 2 has been looked at on a case-by-case basis.

**Q71 Chairman:** What about first phase funding? We have all got anecdotal comments about money having to be put in even if the elective surgery did not take place. Is that going to be the same for Phase 2?

**Mr Anderson:** Again, you have a maturing market and a maturing provider base. We anticipate—and I cannot tell you categorically this will happen—that as these providers become more a part of the NHS landscape they will want to rely less on us and more on their ability to attract patients to their facilities. We have made it very clear as we have gone out for tender on the Wave 2 procurement that that is what we are looking for. We have given a very clear steer to the providers who were involved in this that we are anticipating that we have a more mature market. Underpinned volumes will become less of an issue within the contracts.

**Q72 Chairman:** Effectively the funding is not going to be guaranteed as it was in the first phase; it is something that will have to be worked for. Would that be the right expression?

**Mr Anderson:** It will be variable. It is our intention that it will be significantly less on the guaranteed side than it was on Wave 1 or at least it should be if we did our job correctly on Wave 1.
Q73 Dr Taylor: I was a bit rude about the Preliminary Overview Report. In contrast, I think your detailed report on the whole thing in our green book is very helpful. You have given us the cost of delivering an 18-week target time, which will be £1.4 billion in 2006–07 and £2.7 billion in 2007–08. This is not the right time to ask you how the NHS is going to find the money. How much of these totals will go into ISTCs? Is that something that you can answer?

Mr Ricketts: We can definitely tell you that we approximate 3% of total elective activity will be provided by ISTCs in 2006–07 and that will rise to 7% of elected activity by 2008.

Q74 Dr Taylor: 3% of elective activity, 2006–07; up to 7% to 2008.

Mr Anderson: That is correct.

Q75 Dr Taylor: We can take roughly the percentages of those figures.

Mr Anderson: That is specifically elective activity. That is not total surgical activity. That is the elective component of surgery.

Q76 Dr Taylor: Are ISTCs doing anything other than elective surgery?

Mr Ricketts: They are doing an increasing volume of assessment and diagnostics.

Q77 Dr Taylor: None is doing any sort of emergency work?

Mr Ricketts: No.

Q78 Dr Stoate: I am particularly concerned about training. Much of the evidence we have taken has concentrated on the fact that if you take cases away from trainees in NHS hospitals there is going to be a possible impact on training. How are you going to make sure that provision for training is included in Phase 2?

Mr Ricketts: I have to apologise to the Committee. Sir Nigel and I met Bernard Ribeiro and other clinical colleagues a couple of months ago and we recognised that there was a need for the Department to clarify the position of ISTCs on training. In the last day, we have sent a draft statement to the colleges, the BMA and other staff associations, spelling out that it is for consultation, a very clear statement of ISTC engagement in training. We can make a copy of that available for you but can I take one minute to take you through three or four key points? It may be helpful for your next conversation. That statement says very clearly that ISTCs will be expected to play their part in training medical and other clinical staff. The ISTCs in Wave 2 are being required contractually to provide training across the full range of the clinical services they provide for the NHS. That would be medical, nursing and AHP. They may also be required to provide some training where it is requested in non-clinical skills like outcome measurement, audit and so on. The training provided in ISTCs will be required to meet the same standards as training in NHS organisations. This was a concern from the colleges. The responsibility for setting those standards will rest with the accrediting bodies. There will be no compromise around training standards. Training will be funded through the Multiprofessional Educational Training Levy, as for the NHS, and where ISTCs provide training clearly they will be entitled to their fair share of those funds although, as you know, we have now moved to a commissioning arrangement in terms of medical training. It will be for deans locally to decide from whence they want to secure their training. Mr Anderson has required independent sector bidders, as part of the process, to submit two sets of prices, one price including training provision where it has an impact on productivity so that one can insist that IS providers, where deans and local communities want them to do the training, do so. Strategic health authorities will be responsible for ensuring that that training is delivered. They are likely to discharge that through Deans and the PMET board arrangements. There is more detail in the statement but I thought it was important that you and the Committee knew that the department has stated that as clearly as we can. It is in draft form for initial discussion with the colleges, the British Orthopaedic Association, the BMA and others. Once we have had their initial comments, we will issue something formally for consultation in April but it is an area where we recognise that we need to provide a much clearer statement to the NHS and the colleges around our ISTC responsibility for training.

Mr Anderson: The initial Wave 1 was all about going out and trying to bring waiting times down and therefore patient suffering and the other things that go along with that quickly. Towards the end of the Wave 1 procurement, we did start addressing a lot of the training issues. Nottingham is a good example of that where £4 million was included in the contractual value and it was specifically for training. The provider base that is providing services to patients absolutely wants to be involved in training as far as we can tell. We have had conversations with the providers and they are very up for doing the training. Wave 2 will be a completely different environment. Again, it goes back to the services’ and more importantly the patients’ need to integrate this into the wider NHS provider framework.

Q79 Dr Stoate: That is a very detailed answer you have both given. I have been concerned about this for some time. It still leaves one concern and that is, where an ISTC effectively takes over a large chunk of work from a local DGH—for example, all the elective hip operations—do you see that as undermining the training of the generalist surgeons in orthopaedics or ophthalmology for the future, because my worry is that even if the ISTCs are training some of these specialists for the future if the training programme for a hospital department is undermined by them, that must mean they lose accreditation as a training hospital, which may have other implications for workforces in the future.

Mr Ricketts: That is the next thing that needs to follow. The department is now in the process of clarifying exactly what the training requirements
are. Stage 2, once we have reached agreement on that—we have only just sent it to the colleges—is to ensure that locally deans and others in terms of the commissioning arrangements ensure that when they are looking at training accreditation and what they are commissioning they look across the health economy so that you get any independent sector provision included in the training network, if that is appropriate. You then move away from the debate where there is perceived to be a threat to the training accreditation of an NHS hospital. You are looking to get accreditation across the whole of the economy. That is one of the issues we have been in discussion on in Southampton, for example, where there is an ISTC. How do we ensure that accreditation is maintained? That will mean ultimately some training being undertaken in the ISTC. In terms of supervision and so on, it needs to be integrated into how training is done across the patch. I recognise that we are going to need to do some work, both locally and nationally, to make sure that all the local players, the trusts, the Deans and so on understand the proposed new arrangements. We will also need to work with the colleges more to unpick exactly how this should work. The fact that you are moving work—it is analogous to moving it into an NHS treatment centre—into another building from another organisation should not put a threat on accreditation for that health economy.

Q80 Dr Stoate: It will do because you are not employing the same people. The ISTC will be employing a very high proportion of overseas doctors, whereas the trust may not be. You are not talking about the same doctors. How are they going to get training for the next generation of orthopaedic surgeons if all the hip replacements are being carried out by South African doctors in the ISTC?

Mr Ricketts: There are two things there. One is the use of non-contracted hours and also relaxation around additionality gives us an ability certainly outside orthopaedics to do that. Non-contracted hours also apply to orthopaedics. It is not my area of expertise but in terms of the rules around additionality there are specific requirements in relation to relaxing that for supervision. We would have to come back to you in terms of how that works but that should not be an impediment. It is part of the detail we need to explore with the colleges. Once we have agreed what the roles are—and we have said very clearly we want to encourage ISTC providers to do training; they want to do it—we are going to have to work through the fine detail of how we get the NHS hospital consultants to work effectively with the independent sector provider, how they may share staffing supervision and all those sorts of things, but we are not at that level of detail yet. We are just trying to set out the principles and the funding so that at least people understand that. We are then going to have to do a lot of detailed work to avoid the situation you describe.

Q81 Dr Stoate: I would be very interested to hear what the colleges have to say and we will be speaking to them shortly. I still have concerns. I still do not see how my orthopaedic registrar working in the district hospital, if he has no hip replacements to practise on because they have all gone to the ISTC, can be trained properly.

Mr Ricketts: He will be able to undertake the hip replacements within the ISTC and that is the point in terms of moving the training across.

Mr Anderson: The example that you have illustrated would probably suggest in that instance that additionality would not apply. If you have a wholesale movement of orthopaedics to a different facility—

Q82 Dr Stoate: Additionality would be the bugbear because additionality means that the ISTC must employ overseas doctors, for example, to carry out hip replacements and effectively, if the majority of hip replacements from that area go to the ISTC, how is the NHS orthopaedic surgeon going to get any practice on hip replacements?

Mr Anderson: I understand. First of all, we do not have any instances of that.

Q83 Dr Stoate: I am looking to the future.

Mr Anderson: Given the example that you have illustrated here, additionality would not apply in that case if there is that wholesale movement. Therefore, that doctor would have the ability, because additionality did not apply, to work in the facility.

Q84 Dr Stoate: The DGH still loses its credibility as a training centre for orthopaedics because they have all moved to the ISTC. Where is my hospital going to train orthopaedic surgeons in future?

Mr Ricketts: Perhaps in ISTCs.

Q85 Mr Amess: Gentlemen, I hope you are not going to make promotional videos about these treatment centres because if that is your intention I suspect you may struggle to convince people. Indeed, in the earlier part of this session, I wondered if we had the right witnesses here because they seemed to struggle to be able to answer anything. All I can suggest is that Sir Nigel Crisp’s departure must have temporarily destabilised the department. It has been reported that the Government wants to see between 10 and 15% of patients being treated by the independent sector. If this does represent the Government’s aims the philosophy behind it is certainly obscure. The Secretary of State was reluctant to admit to such an intention and in December 2005 she told the Committee: “I do not think this is ideological. John Reid made the point that looking at what he thought was needed he did not believe—I think his phrase was—in his political lifetime that it would be more than 15%.” Can you two gentlemen clearly tell the Committee what the department’s long term aim is for these treatment centres?

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Mr. Anderson: We have not announced a Wave 3. We are procuring Wave 2. I do not know the political background for that. It is not for me to comment on. I do know that we have gone out with Wave 1. We have procured that, and on the back of the success of that, as we perceive it and calculate it, we have decided to do a Wave 2.

Q86 Mr Amess: It is a terribly weak answer. It is fair enough you cannot respond politically but for God’s sake. This is a huge thing that is happening. Surely you must be able to tell us what the department’s long term aims for these treatment centres are. What you have just said is waffle.

Mr. Anderson: The long term aim for the treatment centres as they exist is that they go out and bring waiting times down. They integrate into the NHS family of providers and provide good, high quality, reasonably priced care for patients.

Q87 Mr Amess: Let me try something else. There are fears that increasing these treatment centres’ capacities combined with payment by result will destabilise the National Health Service. How will the department ensure that this does not happen?

Mr. Ricketts: It is very difficult, given the volumes of work that will be carried out by the independent sector, to look at Wave 1 and Wave 2, quite frankly, and how they could destabilise the NHS. It is very difficult to see how they could destabilise an individual hospital. There may well be circumstances where the effect of an ISTC and choice combined places pressure on an individual service, where that service is not held in high repute by GPs and patients. That is where you are likely to have the impact on an individual service. In those circumstances, there is a responsibility particularly on the local strategic health authority to work through the consequences and make sure that local patients have access to services. If you are talking realistically, if you add together Waves 1 and 2 at something around 7 or 8% of elective care, I really cannot envisage the situation—that is only elective care which is a minority of the spending and the work carried out by the NHS—where it could destabilise the NHS. I cannot see it destabilising a hospital. There will inevitably be issues around services but choice will generate that where patients and GPs are unhappy with the quality of service.

Q88 Mr Amess: We will wait and see what the other witnesses have to say on that point. It is claimed that the existence of these centres frees up the NHS capacity for emergency work. I would like the department to offer a view on how it will manage and, if necessary, resolve tensions between the NHS and the independent sector as the provision of the latter expands. Can you say something about how you see this working out in practice?

Mr. Ricketts: Mr Anderson has made it clear that there are not plans beyond a Wave 2 so we are talking about something of the size of Wave 1 and 2 combined. There will be some tensions potentially at local level around services. That will be for PCTs in their key commissioning role to work through to ensure that patients retain access to services. It is not something that the department is in a position to direct; it is something that local commissioners will be expected to take responsibility for in the same way that they will be expected to take responsibility for a poor or failing service currently.

Q89 Mr Amess: There is also a fear that the removal of elective procedures to these independent treatment centres, combined with the introduction of payment by result, will have an adverse effect on National Health Service finances. Do you anticipate that the hospitals of the future could be purely elective and purely emergency?

Mr. Anderson: We have to return to Mr Ricketts’s work that will be carried out by the independent sector, to look at Wave 1 and Wave 2, quite frankly, answer around destabilisation from a financial standpoint. In comparison to the total spend of the NHS, this is a very small amount of money. To suggest that that would significantly undermine the finances of the NHS would not be appropriate. The second part of your question is how would we envision the reconfiguration of services as we go forward. That is a question for local health economies, based on demographics and the patients’ needs in that area. There is a move worldwide to take elective surgical care and minimally invasive surgical care and stream them separately from tertiary care, because those two, from the standpoint of throughput and quality of service, do not exist very comfortably together. What the hospital of the future will look like will vary by community. You will see, I would hope, a lot more streaming of elective and tertiary throughput from the surgical standpoint particularly.

Chairman: Could I thank you both very much indeed for coming along and answering our questions this morning? We get the professionalism we expect and we should thank you for it. We just assume that civil servants will come in. I think you have done a very good job this morning and I would like to thank you both on behalf of the Committee.
Witnesses: Mr Bernard Ribeiro, CBE, President, Royal College of Surgeons of England, Mr Simon Kelly, Bolton Hospitals NHS Trust, Royal College of Ophthalmologists, Professor Janet Husband, OBE, President, Royal College of Radiologists, Dr Peter Simpson, President, Royal College of Anaesthetists, and Mr Ian Leslie, President, British Orthopaedic Association, gave evidence.

Q90 Chairman: Good morning. Could you introduce yourselves for the record with your name, organisation and where you come from?

Mr Kelly: I am Simon Kelly. I am a consultant ophthalmic surgeon at Bolton Hospitals NHS Trust. I am representing the Royal College of Ophthalmologists here and I have been involved with the former National Implementation Team since 2004 on the Royal College heads meeting and I have also been quite involved with the ophthalmic ISTC schemes since they started.5

Dr Simpson: I am Dr Peter Simpson. I am a consultant anaesthetist at Frenchay Hospital, North Bristol. I am President of the Royal College of Anaesthetists and I am Deputy Chairman of the Postgraduate-Medical Education and Training Board (PMETB).

Mr Ribeiro: Bernard Ribeiro, general surgeon at Basildon Hospital. I am President of the Royal College of Surgeons of England.

Professor Husband: Janet Husband, President of the Royal College of Radiologists and Consultant Radiologist at the Royal Marsden Hospital.

Mr Leslie: Ian Leslie, orthopaedic surgeon from Bristol and president of the British Orthopaedic Association.

Q91 Chairman: Welcome. I am tempted to ask you all for your comments on what most of you have just heard from our previous witnesses. You may not have a collective view but let us try the individuals.

Mr Kelly:

Mr Kelly: I was here and there are a number of points. If I stick with cataracts, because that is my field, I was interested to hear Mr Ricketts say that in the early stage of the Phase 1 development the capacity planning had been decided locally and, in the question about Phase 2, that this would be decided locally again. When questioned, “Was it not the case that the cataract requirement was not necessary?” he did concede that. He conceded that the Phase 1 ophthalmic cataract scheme, the Netcare scheme, was possibly needless. That is quite a significant learning point. Just to put it in context, that is a £40 million scheme. He also said that one of the benefits of the schemes was to drive up under the name of the operating surgeon. There are significant learning points. Just to put it in context, from ISTCs, they are admitted under the care of the consultant on call if there is a complication, not under my name, so there is a continuity in the private hospital system. A surgeon who has disappeared back to Poland or Sweden is not around to deal with a complication.

Q92 Chairman: Would that be the same if people had been in the independent sector for an operation and then they had complications?

Mr Leslie: In the independent sector there is a continuity of care in private hospitals. The consultant who did the operation would be a local surgeon and if there was a complication that happened to go back to an NHS hospital, I would expect a colleague to hand that patient back to me under my name, so there is a continuity in the private hospital system.
Q93 Chairman: You see no difference in that a surgeon who has somebody as a private patient who gets complications will just take that complication over as an NHS patient?

Mr Leslie: No, sorry. I thought you meant if he was admitted as an emergency to an NHS hospital.

Q94 Chairman: With a complication from the original procedure.

Mr Leslie: He would expect, to my knowledge, to take that over again, yes, or take it back to the private hospital. I did not mean they went the other way.

Q95 Chairman: Janet Husband, have you anything to add to what you heard?

Professor Husband: I would like to make a point about additionality. Radiology and radiography were pointed out as the two specialties where additionality would be maintained. This is the major problem. We need to have an integrated service between the NHS and the independent sector so that clinical governance issues can be properly addressed, so that we can have clinical leadership. It is very different in the radiology independent sector where the reports are done overseas remotely and there is no link, so if the clinician has a lack of confidence in the reports there is no input into the multidisciplinary team meetings where major management decisions are made. If additionality were completely relaxed, this would be a major benefit. The other point in relation to that is that there are different scenarios in different parts of the country. In the south east, there are enough radiologists who could provide service to areas in the Midlands. They could do the reporting and work in that way. We have the proposal that NHS trusts could second a radiologist to the independent sector for, say, a day a week, but the independent sector would pay the trust who could then bring in more radiologists so that the whole system was integrated rather than in different silos, where all the problems have been related to this separate process.

Q96 Chairman: Do you think the first phase is changing work practices inside the National Health Service? There was a hint in the evidence we took earlier that probably your members are changing their attitude in terms of work and changing work practices which makes the NHS more efficient. Do you think that is true or not?

Mr Ribeiro: We must draw a line under the first wave ISTCs. They were brought in for a specific purpose which was to reduce waiting lists and to some extent that was achieved. The methodology that was used and the people who were brought in to do the work are another issue. In terms of change of practice, what has been demonstrated by ISTCs—and it is government policy—was the need to separate emergency from elective work. We from the college and specialist associations have for the last 10, 12, 15 years been talking about separating emergency from elective work. Currently some 64% of consultant general surgeons are on call for emergencies when they are doing elective work. The NHS has to deal with emergencies at the same time as it does its elective work. We have evidence of at least 38 NHS Diagnostic Treatment Centres (DTCs) where there has been separation of elective and emergency. I have been to Central Middlesex when it first started. I have been to Hinchinbrook. There are a whole lot of these which are very effectively run and very efficient proving the fact that if you separate elective from emergency you will get good treatment. That was there before independent sector TCs came on the ground. The fact is that there is a lack of will to follow through by having these centres in the NHS because it is government policy to contest, challenge, the NHS, put ISTCs close by and see whether the NHS hospital nearby will deliver. If it cannot deliver, it goes down. It is policy that is driving the change rather than practice and benefit. You asked are there any benefits. Last week, I went to the Greater Manchester Surgical Centre in Trafford which is an ISTC. It is a bit of a surprise for a member of our profession to do that in the private sector we are supposed to be criticising but it was a very well run centre, run by Netcare. It had a very good throughput of work. It had good facilities but there were issues over the fact that the contractual arrangements that are made there are such that if patients do not turn up they still get paid. If operations are not done they still get paid. Those issues, I am sure, have been addressed. They have surgeons from overseas, from Hungary—where a large number came through—who do three hip or prosthetic procedures and stop. The practice is well managed and well done. One thing they have to teach us however is—and this was identified in Ken Anderson’s paper—about stocktaking and the keeping of prostheses. In the Trafford centre, they only have one prosthetic part and that is by Stryker. All the instrumentation is by Stryker. The surgeons who work there have to be trained to use Stryker equipment. In the NHS, surgeons are trained in lots of different units to use lots of different bits of equipment. Therefore, what you find is a cost effective exercise with no instruments on the shelf because Stryker employ a full time employee who is there to make sure that the equipment you need is available for you at the time. These are lessons that we can learn. That is the positive side, but I would like to underpin it by saying the experiment had already been done. What we are missing is a will on behalf of government to develop DTCs within existing NHS hospitals, rather than without.

Q97 Chairman: Does anybody else have a view?

Dr Simpson: I would like to echo what Bernie Ribeiro said. The word Janet Husband used earlier was “integration”. Ours is a service specialty in anaesthesia. As such, with intensive care together, we provide a service for the surgery that goes on. If you say, “Has anaesthetic practice in the UK been changed by the introduction of treatment centres?”, no. It is the same. If you say, “Is the standard of anaesthetics likely to be any worse in treatment centres?” it is very difficult to say without auditing it and you need to be very careful about what you audit. If you audit severe morbidity and mortality, I
would be absolutely appalled if it was any different. The quality issues are the things that matter to patients. As a college, what we are concerned with are two things with treatment centres. One is the quality and safety of patient care and the other is training. For us, if we can achieve both those as an integrated part of the local health care economy, that is fine but we have a number of examples of where the introduction of a treatment centre distorts local health care and also the supervision of trainees in the base hospital, which is a significant issue that I will enlarge on if you wish.

Mr Kelly: I fully support Mr Ribeiro’s argument on the separation of elective and emergency care. That already exists in day case units and in five day wards and in NHS Treatment Centres. It makes all sorts of operational and patient safety sense. The problem is if you separate it on two different sites, if you have elective surgery done on one site and emergency surgery done on the other site. For most of the specialties in the UK, it is at this moment in time the same surgeons and the same anaesthetists providing the care. If care has to be provided over two sites, it is much more problematic. It is sensible to have it integrated on the same site so that we are all singing from the same song sheet, singing to our strengths. That also underpins training and safety. Whilst Dr Simpson has said that the two issues for the College are about training and patient safety, our College has exactly the same two issues. They are the key issues for us. We do have a third issue, interestingly. We are concerned about the impact of the ISTC procurement on local NHS facilities, on local NHS Hospital Eye Services, because the issue is that in the Hospital Eye Service we provide comprehensive, holistic care in which we are integrated with the patient groups, with the Royal National Institute for the Blind, with the Patients Association and many local organisations. We are also providing care for the chronic, blinding eye diseases and for children. What has happened is that one segment of our work—cataract surgery—has been pulled out and moved into a separate group. The effect of this is that it destabilises the manpower planning for the future generation of consultants. We have seen that the number of consultant appointments advertised in the BMJ in the last 18 months is 40% of what it should have been. This is occurring ironically at a time when our own UK graduates are coming out of the training schemes and are unable to get consultant positions and also at a time when there is going to be an increase in the medical school production. Our third reservation is the impact on the local NHS services. Finally, there is another issue which is also an impact on local services. There is an issue on the impact on the ethos of medicine as a profession as currently delivered and on the impact on the morale of doctors working in the existing NHS. The reason I say that is there has been little or no engagement between the medical profession and the Department of Health in planning these arrangements which are policy driven. I can say that having attended the National Implementation Team for the last two years. It was made clear to us that the Implementation Team, which is under the Commercial Directorate—Ken Anderson is the lead, Dr Tom Mann was the first Clinical Director. He has moved on to the independent sector himself. The current Clinical Director is Dr Bruce Websdale. NIT is there to implement policy. It is not there to consider the voice of the medical profession or of the nursing profession for that matter. They are there to implement policy that is coming right from the top. I think this cuts to the core of medicine as a profession. Professor Husband: There are two points on the effect on the NHS. One is that because a lot of the radiology reports are being done outside the UK they are different. They are not necessarily incorrect but they are much more descriptive. They tend to hedge bets. They will come back with recommendations for further investigations, perhaps two or three, so they are increasing the workload within the NHS, not with necessarily necessary tests. Also, there has to be a lot of re-reporting by the radiologists back at the base, who are trusted by the clinicians before they go and operate on a patient where they are not happy with the report. Thirdly, the simple tests are going out of the hospital. This leaves all the complex tests within the department which has an effect on stress and the morale of the radiologists who are left with all the complex work. It also has an impact for radiographers who are working with just complex cases and there is no simple work to intervene in that. Finally, there have been major problems in terms of the NOF funded equipment which has been put into a department—for example, a new MRI scanner—when the local resources are not available to run that machine so it is lying idle. The independent sector provision is then the way of working. There are about 20 MRI scanners in the country that are currently not working to full capacity, semi-mothballed.

Mr Leslie: I have not from any of our members found one group that has said that things have improved as a result of a local ISTC. There is no evidence whatsoever for the comment that it would benefit and improve things. There has been a statement by the Secretary of State that in Plymouth they innovated a blood transfusion technique and that was an innovation from the ISTC. That has been present in orthopaedics. We have a blue book two years old stating that. These concepts of innovations in ISTCs and changing NHS hospitals have been more negative than positive. They have decreased morale. Perhaps I could support Professor Husband’s comment about MRIs. We do use a lot of MRI scans in orthopaedic surgery and one reason for the increase in use is the number of people who are able now to order MRI scans, mainly the Extended Role Practitioners. That will increase your volume of requests for MRI scans. We get reports back from a radiologist maybe in Holland or somewhere else. You cannot talk to the radiologist because you cannot find him on a telephone. I like to talk to the radiologist about what he has described. Those are all negative effects. I cannot find one positive effect in what was stated.
Q98 Chairman: I ought to say that the memorandum that all your organisations have submitted, and others, is being published today. Your Association (BOA) was extremely negative in terms of ISTCs. At least it was consistent. I went on the web and I found an article written by presumably your predecessor, D H A Jones, in 2003, which was extremely negative about ISTCs. In view of some of the comments that your colleagues have made about this first wave, whilst not overwhelmingly supportive of them, do you think there are some positive things from them or not?

Mr Leslie: If we go back, first of all, orthopaedics was a big player in this as well as eyes because we have waiting lists. When this came in, we learned about it as an association some nine months after it was all taking place. To support my colleagues, there was no collaboration with the professionals who knew something about hip replacements and how they are done during the early times. It was on our approach to the Department of Health that we managed to get a hearing. In 2004, we sat down with Tom Mann and drew up an agreement about how this could go forward in a positive way. One of the things we said in that agreement was that there should be collaboration between where the ISTC is and local orthopaedic surgeons. For some reason, that collaboration statement was squashed. They said, “No, you cannot go ahead with that.” The involvement of the orthopaedic world was very scant. I can give you a list of the meetings and the correspondence we have had with the Department of Health, trying to say where we believe they are going wrong. It was not necessarily, “This is wrong”, but, “You are doing it the wrong way.” If we come onto importation, why we are negative is because so many surgeons were imported into this country to operate for a short time and then went back to their country. My colleagues were seeing the bad results. It is anecdotal, but there is now enough evidence gathering out there. There is the Portsmouth Inquiry which substantiated what we said. My colleagues see the bad results coming back. Bad results perhaps in eye surgery or hernia surgery occur rapidly. In orthopaedic surgery, they occur over five or maybe 10 years. We are seeing dislocation and high revision rates. If one is seeing that with patients it is no wonder that we are negative about the way it is being done. We could be positive about the future and I support my colleagues in that. I think we did have good grounds for being negative.

Q99 Chairman: Have any of your members changed any work practices in the last three years?

Mr Leslie: Not to my knowledge. They have improved them but not because of an ISTC.

Q100 Dr Taylor: I was so encouraged with our first lot of witnesses when they suggested that integration was going to be possible. You have mostly talked about integration on the same site. What are your views about integration at a site, say, 10, 15 or 20 miles from the acute hospital?

Mr Ribeiro: I would like to draw a line under what has passed. There is a huge potential for the future. We should come back to the financial implications of ISTCs present and future on the NHS. I think that is an important aspect within this particular financial climate that we have of funding the NHS. Coming back to your question, our college has been very clear. We are prepared to train our trainees anywhere as long as the facilities provided are up to the standard the college would accept for training. As you know, not a million miles away from where you are, there is a DTC in Kidderminster which was set up by Professor Ara Darzi in his investigations. We have evidence from Kidderminster that there is an important aspect within this particular at least it was consistent. I went on the web and I found an article written by presumably your predecessor, D H A Jones, in 2003, which was extremely negative about ISTCs. In view of some of the comments that your colleagues have made about this first wave, whilst not overwhelmingly supportive of them, do you think there are some positive things from them or not?

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specially like ours if you take the consultants from the base hospital to a remote hospital to staff your TC what are left behind are the trainees. The consultants do not only train; they supervise. If I take an orthopaedic surgeon to a remote centre, he will not leave his trainees back operating because his list will be in the remote site. The anaesthetic trainees of course work across a range of specialties and therefore are often left back at the base hospital relatively unsupervised. We have had problems with that and the training scenario in places I could tell you about.

Q101 Dr Taylor: Could not rotas of consultants be organised so that there was always somebody back at the base to cover?

Dr Simpson: Yes, rotational arrangements are possible but it depends on the degree of supervision that the junior doctors need.

Q102 Dr Taylor: Mr Kelly, I get the impression that ophthalmology is not the shortage specialty that orthopaedics and radiology are. Therefore, it was easier for you to say that you could have covered the waiting list problem without ISTCs. Is that fair?

Mr Kelly: In ophthalmology, it is one very specific procedure. It is cataract surgery only. There are problems in ophthalmology in the blinding eye diseases of macular degeneration, glaucoma, diabetic retinopathy and eye problems in children and in the care of the chronic eye disorders. What this scheme has done is to put disproportionate resources into one particular clinical area and, as a result of that, the indications for cataract surgery have dropped down greatly. We are now operating on patients at a much earlier stage than before. A second issue is, because of the direct referral from optometrists, which I support and we believe in as an organisation, because the ISTC contracts have to be met and are paid for, we are seeing patients referred directly from optometry with cataracts to the Netcare scheme and being operated on very early. Meanwhile, the next door neighbour of that patient who has really serious problems—such as diabetic retinopathy—is left to lie fallow; whereas if the funds were in the local NHS eye unit the clinicians in the unit could make the decisions how best to allocate them within their own unit. Equally, if there is going to be national guidance, for example, from NICE or somebody to say that the blind are more important to us or less important to us—which is what this scheme is saying—that people who have mild cataract, so be it, but at least an informed decision could be made with patient and public involvement. That has not happened.

Q103 Dr Taylor: Integration, if it came, would also help on that score.

Mr Kelly: We have already heard about NHS Treatment Centres based within the NHS unit in all the surgical specialties. In my own case, we are a unit in Bolton that benefited from the funds from ‘Action on Cataract’. We essentially have a cataract treatment unit within an ophthalmic treatment suite. We are doing it and there are many other examples up and down the country: eg Peterborough and Moorfields Hospital in London. That integrated model within the NHS already existed.

Q104 Dr Taylor: Do you think, in your specialty, Netcare and mobile cataract units are superfluous?

Mr Kelly: Yes.

Q105 Dr Taylor: What should happen to them?

Mr Kelly: That is an excellent question. The team working in them is efficient. The units are very clean. I visited a unit in Liverpool recently. I have colleagues in South Africa. The President of the Ophthalmological Society of South Africa, Dr Kruger, recently told me that there is a huge backlog of cataracts to be done in South Africa, particularly in the back streets of the deprived areas, and in the homelands. An idea thus may be to take those mobile units out there, because there is good ophthalmic provision in the private sector in Cape Town and Johannesburg. That might be a move for the units?

Q106 Dr Taylor: In a way, you have been almost complimentary about the service in Netcare. Are you less worried about complications than the orthopaedic people, for example?

Mr Kelly: We have seen our own bevy of complications. It was intriguing that Mr Anderson and Mr Ricketts were not able to comment on that, but they did say that they were not clinicians. Mr Anderson used the lovely words, “That is the granularity of the system”. That granularity is individual patients going blind or going lame. These have surfaced in media investigations. Channel 4 News have done some good stuff. Journalists have done some work. There is litigation going on. Clinical negligence litigation and media exposure are not the best ways to improve patient safety. It has to be a whole systems re-organisation.

Q107 Dr Taylor: In a word why was the ISTC programme dreamed up?

Mr Kelly: I do not know. It was announced on Christmas Eve 2002 and why it was announced on Christmas Eve I do not know.

Q108 Dr Taylor: Have you any comments?

Mr Ribeiro: Yes. It was to win an election. It was to reduce waiting lists. This policy is to get waiting lists down. We heard last year that in Birmingham 1,000 patients were corralled into a hall. It cost £25 million to get the answers out and the net result was waiting lists were the first priority that patients wanted dealt with. If you couch policy on reducing waiting lists, that is why you have ISTCs. The fact of the matter is the waiting list problem and the work that was done before identified cataracts or orthopaedic procedures as the ones that were most needy. General surgery, interestingly, did not have much of a problem. In my hospital we have hardly any waiting lists at all in general surgery because we keep on top of things. I will give you an anecdotal example of how things can go desperately wrong if we do not move to separation. On Monday, I had an
operating list at Basildon. I had two laparoscopic cholecystectomies and three hernias to do, ideal training operations. I now act more like an assistant to my trainees who do the operating. At two o’clock when we were about to start, a ruptured aortic aneurysm came in. Mine was the only theatre that did not have the patient asleep. My patient was moved into the recovery area where she stayed for three hours until the aneurysm was dealt with. I had to cancel the three hernias who went home. That is the day to day reality of working in the NHS. If you were to put me into an ISTC in my hospital away from that, my team could have completed a day’s operating and that is what it is all about. That happens on a regular basis in the NHS. Therefore, what the NHS is saying and what we are saying on behalf of the NHS is give us a level playing field. Do not give us a situation where ISTCs are getting 11% on costs to get started, a little bit more on top and it does not matter whether they do the work or not; they get paid. Give us a level playing field where the NHS is doing the work on exactly the same terms as the ISTCs. The government has made its point. It can get waiting lists down. Great. We are all very pleased about it but let us move on to the next stage and make some progress.

**Mr Leslie:** In terms of training outside the centre, this has been going on in orthopaedics since about 1998. The Horder Centre near Brighton is a charity which has been contracting work from the NHS and that has been approved for training for orthopaedic registrars since about that time. It is possible to do it, and it is done because the local NHS surgeons go there to do the operating. When I come back to qualifications, Bob Ricketts spoke about qualifications. Being on the specialist register of the GMC does not necessarily mean that you can go and do a safe hip replacement. What it means is that in Europe, if you reach a certain level of training in any European country—and they are all different in terms of the end point of training—you are automatically, due to European law, allowed on the Specialist Register of the GMC. There is nothing else to do except to send in a piece of paper. In Italy, you get your CCT or Certificate of Completion of Training at the end of doing a certain number of procedures. For a complex one you might get 100 points; for a simple one you get 10 and when you have built up enough points you get your CCT. How do they do that? At the end of training you then are under very strict supervision in a hospital system whereby you are still under the master for some years after that. In the UK, we train people to operate independently at a certain point in time so that they can go to the Isle of Skye and be an independent orthopaedic surgeon if necessary. We put them into independent practice. It does require whoever is training them to be up to scratch as to our standards of training and that has been built up over many years.

**Professor Husband:** I wanted to make a positive point. There has been under-investment in imaging over the years. MRI waiting times were something up to two years. They are now down to 13 weeks and that is of major importance obviously for the individual patient. I do not think we must throw that point out of the window. It is important. As a college, we have been very proactive in working with the Department of Health on quality issues. We have undertaken audits between the independent sector and the NHS. We have worked with the National Imaging lead in the Department of Health. We have an MR guardian who is a college officer, who has been reviewing the CVs of every radiologist working in this scheme. Nevertheless, my big point is integration. Get rid of additionality and we can work a good system. For example, we have to also take into account that there has been a major investment in academies for training radiologists, many millions. I will not give a precise number in case I get that wrong. We have taken an additional 20% of trainees in radiology this year and that will continue. Very soon we will have more qualified radiologists and we need to bring them in and integrate them into the service. Just a final point on whether we could work with an independent centre 10 miles away with programmes of rotas, that would work very well. One of the problems with radiographers is, if they are appointed to the independent sector, then they are just going to do simple investigations for their workload and in terms of continual professional development that is a disaster. They need to be integrated within a team so that they can have the benefits of a full career, and it is the same for radiologists. Finally, 70–80% of individuals coming out of medical school will be women. A lot of these people do not want to work full time and this would be an excellent way of them working in an integrated fashion within the NHS and the independent centre.

Q110 Dr Stoate: It has been suggested by the BMA that the ISTC programme has caused private practice incomes to fall. Is this true?

**Mr Ribeiro:** I would not know, sir, but to answer that question I think there is no question that you will find instances where people’s income has fallen but, on the other hand, if you take cardiac surgery we know there has been a natural fall of income in cardiac surgery because an awful lot of cardiac surgery has gone to intervention procedures and not the actual bypasses, so that may demonstrate a fall of income there. I think that in niche markets like London, London is a peculiar sort of place where private practice perhaps carries on without any impact from outside, but clearly there has always been this feeling that consultants keep their waiting lists deliberately long in order to encourage private practice.

Q109 Dr Taylor: We are certainly going to take that up with the GMC when we see them.

Q111 Dr Stoate: This has certainly been suggested at a previous inquiry I was involved in some time ago.
Mr Ribeiro: Absolutely. I think it is a lot of hocus-pocus. Frankly, I have always thought that. I know there has been a perpetuation for years. It is like the question of why is it that we now find a huge amount of money has gone on to consultant salaries in the last round? Because everybody thought they were doing private practices and were around the golf courses.

Q112 Dr Stoate: But do any of you, or your colleagues, offer private treatment where NHS waiting lists are longer than acceptable?

Mr Ribeiro: I can only speak for myself. I have a private practice—and still do although I probably will wind down by the end of this year because I am too busy doing other things—where I give my NHS patients exactly the same amount of time and consultation as I give my private patients, and in fact I can get an NHS patient on my list for surgery for a hernia in six weeks and I would have difficulty sometimes in getting that in private practice because I do not have the time availability to do it. So I do not think this is an issue. I think it is one that has been brought up time and time again. People do their private work in their own free time and put the effort into it.

Q113 Dr Stoate: But certainly the BMA has suggested to us that this is at least a factor. Do you think it could be part of the reason why there is so much resistance by professional—

Mr Ribeiro: No, I do not. I think the profession resisted ISTCs because we have been encouraged and asked to consider working in teams. Part of the paranoia about consultants is that they are arrogant, distant, they do their own things and they are Lancelot Sprats, etc, and there has been a big change in the profession post Bristol, post Alder Hey, post all the disasters. We have been really under the microscope as a profession, not just surgeons but everybody, and the emphasis on surgery has been working in teams more collaboratively and working within a team structure. Now, that creates a completely different culture and climate in which to work. So I do not think that is an issue, the one you are raising.

Dr Simpson: Anaesthetists do not admit patients in their own name; we only respond to the workload that comes to us. I certainly do not believe that anaesthetists do not offer the same quality of care in the two sectors; they do the same. If you use the BMA figures, if you factor into that loss of waiting list initiative money, because the waiting lists are being dealt with in ISTC treatment centres, then I think their incomes have gone down, because that was work that they did to take account of waiting lists but within their base hospital in their own time—at evenings, weekends whatever.

Q114 Dr Stoate: Professor Leslie, it is a big area where there is a lot of private practice still occurring. What is your view?

Mr Leslie: There are two criticisms of orthopaedic surgeons and their waiting lists—one they are on the golf course and two they are in private practice—which have been levelled at us constantly but there is a shortage of manpower in orthopaedics which we told the then Government about in 1995. We had a manpower document which we published and it showed the number of orthopaedic surgeons we should be heading for. So waiting lists were not created by the orthopaedic surgeons but by a chap called John Charnley, who invented a hip replacement, and all of a sudden there is a whole lot of people out there who find that life will be better with a total hip and a total knee replacement so there is a shortage of manpower. Why is it that we now find a huge amount of money which have been levelled at us constantly but there has gone on to consultant salaries in the last round? That is a shortage of manpower in orthopaedics which we told the then Government about in 1995. We had a manpower document which we published and it showed the number of orthopaedic surgeons we should be heading for. So waiting lists were not created by the orthopaedic surgeons but by a chap called John Charnley, who invented a hip replacement, and all of a sudden there is a whole lot of people out there who find that life will be better with a total hip and a total knee replacement so there is a shortage of manpower. So if there is a demand out there for something to be done in private practice then people will go and do it. In answer to your question I think private practice has gone down, perhaps manifested by the way the private health insurance companies are getting rather nervous and very worried about their future in terms of their income because I think a lot of corporate groups have stopped their private insurance, because the waiting list has come down. They used to insure them so you were not away from work that long to get private treatment. I think the corporate insurance has gone down so I think you are right, but none of my colleagues like having waiting lists. I hate having mine.

Q115 Dr Stoate: Certainly when waiting lists for hip replacements were two years plus I referred a lot more people at patients' request to the private sector. Now I can say to somebody “I can get that hip replacement within six months” I am referring very few people to the private sector so there must be a factor there. I am just asking whether you think that factor is material in some of the opposition of some of your colleagues.

Mr Leslie: I think it is material and I would hesitate to say no. I would agree with you that amongst some of my colleagues perhaps, but I think as a body of people most of my colleagues detest having to tell someone they are going to even now have to wait six months for their operation. Telling them it would be two years was terrible, but I think it is an argument which really needs to be put on the shelf. You will find the odd person but I think as a group we are destined to try and get waiting times down but in the safest manner.

Q116 Dr Stoate: I would like to now light the blue touch paper and ask all of you why it is then that private fees in Britain are so much higher than in almost any other country in the world? Why?
Mr Leslie: The fee for a total hip replacement on BUPA's rates have not changed more than 3% since 1992.

Q117 Dr Stoate: I have some figures here. For example, if we take hip replacements, which is your specialty, in Canada it is 50% cheaper, this is the consultant’s fee, and in Germany it is something like 60–70% cheaper—

Mr Leslie: But Canada does not have private practice. That is the fee paid by the Government to the surgeon.

Q118 Dr Stoate: So surgeons in Canada are charging far less per procedure than here, and the same with cataract surgery: 60% cheaper in Canada, 50–60% cheaper in Germany and Spain. Why is that?

Mr Leslie: I will answer as best I can the second part, and I have to declare an interest. First of all, I am an overseas graduate; I am qualified in Ireland but have been working in the United Kingdom since 1983. The argument you have advanced there, and it goes back to the 2002 Inquiry, that consultants are opposed to these things because it affects their private practice, the so-called "perverse incentive argument" which I think Professor Chris Ham and others advance, personally I find it abhorrent, and I think the profession does and I would hope that NHS management finds it abhorrent, because one of the beauties about working in the NHS is that you are working in a very regulated environment. We have Appraisal and Job Planning. So if there was any hint of consultants somehow manipulating patients this is a matter actually for the local employer to investigate, and also a matter for the GMC.

Q119 Dr Stoate: I am not suggesting for a moment that you treat your patients any worse or in any different way; that is not for a moment the suggestion. The suggestion purely is whether the fee structure of consultants in private practice is anything to do with opposition to the Independent Sector Treatment Centres? It is nothing to do with standards of care or quality of outcome.

Mr Kelly: You have two separate questions there and I will take these one at a time, if I may. Just going back to the so-called 'perverse incentive', colleagues have already pointed out that most doctors do not wish to have long waiting lists, and the long waiting lists have been due to the under provision of surgeons. The orthopaedic example has been given but I will give you an ophthalmic example. There are a thousand ophthalmic surgeons in NHS practice in the United Kingdom, France has a similar hope to have this up and running by the end of the year and we are working with the Department of Health to bring this in. I think that would be very valuable in raising quality and providing a uniform choice to go privately for various reasons that are best known to themselves, just like the way some people travel First Class by train or by air. We have difficulties with the patients being forced to go privately because of long waiting lists and thankfully, because of the investment in the NHS in recent years, waiting times have come down and therefore that segment of the private medical market has probably gone down. That is actually very worthwhile, so I do not think any of us have any difficulties about it. On your second question about the international comparisons, I do not have the figures in front of me but I think you are possibly referring to the Newchurch Research.


Mr Kelly: Well, there is always a danger of comparing apples with oranges and the point is that, for example, in NHS practice an NHS surgeon doing an ophthalmic list is probably going to get paid about £100 to £150 a session, and if that surgeon does 10 cases you can see that is very good value indeed; if he does five cases you can see it is still very good value indeed. So if you are comparing like with like that may well be a more fair comparison. The figures from across Europe are the figures reimbursed by the state to surgeons and anaesthetists working in the independent sector as part of social insurance. Now it is not my specialist field and I do not know, but I do know that little bit. That may be something the Committee might want to take more evidence on? Even though you have addressed this in the past.

Q121 Dr Taylor: Several of you have said we must draw a line under Phase 1 and go on to Phase 2, but generally how are the colleges involved with trying to influence the future and the way that Phase 2 ISTCs work?

Professor Husband: In terms of radiology we are developing clinical pathways through our input from the MR guardian, but of course Wave 2 is going to be CT and ultrasound as well. We have more concerns about ultrasound than CT and MR because it really needs to be interactive. You cannot give a report on an ultrasound in the same way as you can—

Q122 Dr Taylor: Unless you have actually done it?

Professor Husband: Yes. You really need to be doing it yourself so we have some concerns there. We are also developing an accreditation scheme for radiological services from our College which will be a multi professional, multi disciplinary scheme looking at quality, and this would be applicable to both the private sector and to NHS services. It would, of course, be voluntary to start with but we hope to have this up and running by the end of the year and we are working with the Department of Health to bring this in. I think that would be very valuable in raising quality and providing a uniform quality of care. So we are also providing protocols for imaging so that the imaging that is done in the private sector reaches the standards approved by the College in the different specialties.
Q123 Dr Taylor: And you have already said it is rather limiting if radiologists are working only in ISTCs.

Professor Husband: Yes. Absolutely.

Dr Simpson: In terms of Wave 2 what we would hope and what seems to be happening is that actually there is much more integration so that the ISTC, whether sited locally or remotely, is part of the local training environment. We have not spoken a lot about training but I think we should, and one of the points is that if a new ISTC on Wave 2 wants to train then it can perfectly well do so; there is a perfectly easy way in which it can be incorporated. For example, PMETB accredits training environments, and basically a person in anaesthetics for want of a better example is doing a training programme in a particular area. If there is experience to be gained in that TC then that TC will have to be accredited for training like anywhere else. It all fits in, and people can be rotated through quite happily. The other issue that goes away is that if, as the Secretary of State has announced, you can use NHS consultants in these things then NHS consultants are accredited trainers, so a lot of the issues go away from that point of view.

Q124 Dr Taylor: I think we were told by the first set of witnesses that there is a draft statement on training coming.

Mr Ribeiro: I received mine in e-mail this morning actually from the Department of Health—

Q125 Chairman: It is the influence of our sitting as a Committee!

Mr Ribeiro: Absolutely. Incredible timing, is it not! As you know, the Secretary of State in a speech on January 10 did say about the independent sector: “But I recognise that other reasons for using the independent sector to add to the innovations already happening within the NHS and to introduce an element of competition and challenge to underperforming services is a harder argument to win, so we will continue to respond to legitimate concerns, for instance to ensure that training for junior doctors is provided within the Independent Sector Treatment Centres and more generally to provide a level playing field for different providers within the NHS . . . ” That statement is what we seek, and I think in the submission given to you by the Healthcare Commission they too stress two things. One is the introduction of training and two is the removal of additionality, and I think if the Secretary of State has put a flag on the mast to say that is what they seek then that is what the Colleges would like to do in the next phase. We have already as a College during the last year had several discussions with the private sector, the independent private sector, in fact before they folded the Independent Health Forum, about the possibility of having training in their hospitals and they were very receptive. What we want as a standard is to use the consultants in the NHS whose training abilities we know and whose results we know, to do the training in the new wave ISTCs, and I think that is the positive way forward. I should say in Wrightington, which is exactly where John Charnley did all his experimental work in the early days of hip procedures, there is excellent training in that DTC and trainees are queuing up to go there because it is uninterrupted work and they get good training. The Department of Health has now said it wishes to engage in discussions on training; I wish they had done that two years ago, frankly. It is a bit late, but your Committee perhaps has helped ginger things up a bit. I hope that continues.

Q126 Dr Taylor: Would we be allowed to have a copy of your e-mail?

Mr Ribeiro: I will leave it to you to copy afterwards, certainly.

Mr Leslie: I do not think in terms of Wave 2 any of my colleagues in orthopaedic surgery will be happy until there is a quality assurance of the surgery and the surgeons that are coming into this country to operate on patients who they have seen often in NHS clinics, the patients have gone away, had their operation and they come back to the NHS clinic with their problem. The quality assurance issue of these surgeons in orthopaedics, I cannot speak for other specialties, needs to be absolute. When you are appointed to an NHS consultant job you are on the Specialist Register, but equally you go before an interview committee where there is a member of the College of Surgeons who assesses your training and your abilities, and it is not done by a manager. You might be familiar with the Foster Report from Queensland where there was a problem with Bundaberg Hospital and one of the comments of that report was that colleges were not involved with the appointment of those personnel, and unless that is sorted out you will still get the negative effect. I am afraid, from the orthopaedic community which is not self interest. From all the letters I have had it is, that these patients are suffering unnecessarily. You can say the ISTCs have been successful in waiting lists but at a price, both a monetary one and also a lot of patients out there are having problems as a result of that innovation.

Q127 Chairman: How many of your members were trained overseas, Mr Leslie?

Mr Leslie: I for one was trained overseas, but trained overseas in terms of their surgery. Probably a small number. We have a lot of overseas fellows.

Q128 Chairman: Presumably they compare well with those trained at home, in the United Kingdom?

Mr Leslie: Yes. Because they have been appointed to NHS consultant positions they have been selected by an appropriate appointment committee. For instance, I could not go to Canada, US, Australia or New Zealand and just go and practise there. I would be mentored for a year in Australia, if I wanted to
seek registration, by a senior person before I was given the chance to operate independently, yet so many people can come here from Europe. They are very good surgeons there, do not get me wrong, but if you put me in a hospital in Sweden for two weeks my complication rate would be higher than if I am operating in my home hospital all the time with my team. So the places where the surgeons have come in and the local NHS surgeons have been involved, they get on well and work with each other. It is this flying teams in and out again which our members totally object to.

**Mr Kelly:** On your point about how do we know whether these doctors are safe or not, the reality is that some of them are probably very good and some of them are probably mixed. We could probably say the same about all the doctors working in the United Kingdom and about engineers or architects or any other profession, but the key issue in medicine is that doctors work in teams and it is the team, just like driving an aeroplane, that underpins safety. Mr Leslie’s point that if he went to Copenhagen to do some surgery he would be out of his depth for the first few days—because of using different instruments and one thing and another is exactly this point. That is where we have issues. Professor Ribeiro has made the point that audit is the way to track this. At present the audit that has been done has been rather patchy in the ISTCs. We have seen the NCHOD Report which Dr Taylor has raised. I have done a critique of the NCHOD Report on behalf our College and can circulate that to members, if you wish. Our College provided it to the Department of Health’s Central Clinical Management Unit: we have had no response from them. As regards patient satisfaction, the patient satisfaction levels in some of the surveys that have been done have been high but one needs to be very careful—and Ms Milton made the point about “how do you know where to go”—about satisfaction surveys asked of patients immediately following their procedure by the doctors and nurses who were treating them. “Was it good for you? How was it?”

**Professor Husband:** I would like to make a point about training in the radiology MRI centres. Because the reports are done overseas there is one centre in Brussels, one in Barcelona, one in Cape Town and one in Scotland which have all been visited by our MR guardian and the quality is good now. One of the centres is not listed, one in Spain I think, and has been removed from the list, so the training cannot happen because these radiologists are not in the vans to do the training, so that is another reason why
additionality must go. Our second audit is going to be published in April and has shown good quality across the board.

Mr Leslie: Just coming back again to audit of the work. Two years ago the BOA went to Aidan Halligan, who was then the Deputy Chief Medical Officer and in charge of clinical governance, and we strongly recommended to him at that stage that we should conduct an audit which should include an audit of an NHS hospital and should be comparative. We pushed that very strongly, and nothing ever happened.

Dr Simpson: Just generally I think there is a belief out there that NHS doctors do not care about their patients at the level we are talking about but I think they care passionately about their patients. For example, I live in Bristol. I had an anaesthetic a few weeks ago; I did not know who was going to give me the anaesthetic in advance and I did not bother because they are all good, and the problem is the uncertainty of another group of people coming in who we just do not know about. That is why we, and patients, need the opportunity to be informed about that.

Q130 Anne Milton: Professor Husband, you said that there were 20 MRI scanners not working to full capacity. How would you, for clarification, define “full capacity”?  

Professor Husband: I do not mean extended hours; I mean working eight till five.

Q131 Anne Milton: Five days a week.

Professor Husband: There is not sufficient funding to resource the machines to work all the time. There is also a shortage of radiographers which is being addressed, and I think double the number are qualifying this year, so that will not be a problem that will be on-going so much, but radiographers are also leaving the NHS to go into private work and then into the Independent Sector Treatment Centres, or MRI vans of Wave 1 Alliance Medical, so although they cannot jump straight from NHS to Alliance they are going via another private centre and then to Alliance, so that is causing a further reduction in the number of radiographers, but also the actual finances to run the scanners is a major problem. So there are examples of MRI scanners in hospitals in the United Kingdom which are not being used at all, and some only being used half of the week.

Q132 Anne Milton: Do you know where they are?

Professor Husband: I could get that information for you.  

Q133 Mike Penning: Is there a link between the areas which are suffering under financial deficits and those scanners that are not being used?

Professor Husband: I believe so but I have not got facts and figures on that. I believe that is the case.

Q134 Anne Milton: It would be very helpful to have the list. Can I ask you all to what extent the ISTCs are cherry-picking cases?

Mr Ribeiro: In our submission we leant heavily on the orthopaedic submission, and we have good evidence in Southampton, for example, where the Capio contract has taken a significant number of cases of low co-morbidity. We use a grading, the American Society of Anaesthesiology grading, to determine how sick a patient is and we have very good evidence that a significant number of ASA 1 and 2 low grades have gone, leaving behind a lot of ASA 3 cases to be done, which clearly are more technically difficult and therefore are not good training opportunities. So we have good evidence all over the place. But touching on what Mr Penning has said there is another more critical matter which I hope we can get on to in this discussion today, which is what the effect of ISTCs are on the economy and on the health economy of the hospitals around and about. I recently went to Trafford, the Greater Manchester surgical centre, and in Trafford two of the wards have been closed as a result of the contracted work going from the PCTs to the ISTC; £2 million worth of work in the first six months has left the Trust in the PCTs to go elsewhere.  

This has to have a significant effect on the NHS and it will have an impact. In my own little area in Essex the Government has decided it is going to put in a £45 million ISTC with the intention of taking work from Southend, Basildon, Chelmsford, Colchester, and take from each of these hospitals the equivalent of 20% of their elected work. That will have, with payment by results, a significant effect on the functionality of those NHS hospitals, and that is what I would like to move on to in our discussion now. We have said a lot about personal private practice and so forth but I am more concerned about health economics and what is going to happen to the future of those NHS hospitals.

Q135 Anne Milton: Just picking up on that, the two gentlemen previously denied that.

7 Following the oral evidence session on 9 March, the Chief Executives of Trafford Healthcare NHS Trust and Oldham PCT wrote to Mr Ribeiro about his evidence to the Committee. In their letter they stated, “... your references to ward closures and loss of income are entirely untrue. We both wish to confirm to you that no wards have been closed in Trafford Healthcare NHS Trust, nor has any funding been diverted from this Acute Trust as a consequence of the Greater Manchester ISTC programme coming into operation”. Mr Ribeiro replied to apologise and say he had been mis-informed. He has asked that this be made clear to the Committee.
Mr Ribeiro: Well, I was not here and I am sorry. I hate to use the word “nonsense” but I will. I still work in the NHS and I had this discussion with my Chief Executive on Monday, and in your constituency, Dr Stoate, Darent, you know well Sue Jennings produced and opened two wards next to the treatment centre to use with the theatres, and those two wards have been shut because of the financial pressures. Now, you cannot tell me nothing is happening and there is no impact. I can cite many more examples where it is happening. The policy was right initially to find extra capacity and, again, I will give you an example why the NHS has not been able to do this. When I was appointed as a consultant surgeon in 1979 there were 14 surgeons in the whole hospital and we had 10 operating theatres between us. Today there are 34 surgeons in the hospital I work in, and we have only 12 operating theatres. Capacity was the problem. The Government gave us capacity through ISTCs but I think somewhere along the line it has lost the plot because what it is doing by throwing all this money into ISTCs is challenging the existing NHS—and it will go down. And if you listen to people like Chris Ham they say “Right, so what? What we need to do is come down and make them more effective, more efficient.” Is that what the public want? Have we gone out to consultation? Have we asked them? It may be the right way to go. After all, my College for years have said that we should have hospitals of 500,000 population and economies of scale and so forth and it may be that is where we need to move to, but I think we can get there by better networking of hospitals. But I would like this Committee to focus much more on the impact that this will have long term on existing NHS hospitals rather than nitpick over issues about private practice and those sorts of elements.

Q136 Anne Milton: To some extent one of the reasons we bring up what might feel nit-picking to you is because that is in the evidence we have received and those are the anecdotes that people say to us in our constituencies, and therefore it is important to address it even if you might feel it is not a central part of the issue. Mr Kelly?

Mr Kelly: On cherry-picking from an ophthalmic perspective there is no doubt whatsoever that there is cherry-picking in cataract surgery in the mobile units, and it would be scandalous if there was not because quite frankly they are mobile units with no facilities for general anaesthesia or for children, or for a whole host of patients with complications, so only the fittest patients can go to the mobile unit. Now, the effect of that is that the more complex cases remain at the base hospitals. For example, patients with Downs Syndrome frequently get cataracts and they require cataract surgery under general anaesthesia and can be challenging for our anaesthetic colleagues. Those patients receive the same tariff under the new Payment by Results—which actually is payment by activity. I have to say, not by results—as do the most straightforward case done in the ISTC. Professor Ribeiro is quite right to bring to the table the impacts on the local NHS services because these impacts are going to really play in when Payments by Results come in. So while cherry-picking has got safety reasons why it is done; but it has implications for the services back home on the base and for the cost. Also, I am a resident in Trafford and the local MP, Mr Lloyd, for Central Manchester, has already raised in this House concerns about the impact of the Greater Manchester Surgical Unit, which as I understood it, was the home of the NHS and is now one of the hospitals suffering. We in our hospital in Bolton are suffering the same effect. So all of this has consequences and impacts for local clinicians and residents.

Dr Simpson: On the question about cherry-picking, although it may appear to refer to the type of surgical operation, it actually refers much more to the anaesthetic state of the patient and this creates, in fact, a very unlevel playing field, because if you have people who either need a general anaesthetic when they would otherwise not or, worse still, complicated general anaesthetic cases, by inference they stay in overnight or two days, and immediately the NHS hospital is tarred with the brush that says: “Of course all your patients stay in twice as long as those down the road”, and it is not true at all. It is a different group of patients.

Professor Husband: On cherry-picking, because the service is provided in mobile vans only very simple cases are suitable to be examined on the vans and therefore it is inevitable. It is not exactly cherry picking; it is only that a certain group of suitable patients.

Q137 Anne Milton: Fit for purpose?

Professor Husband: Yes.

Mr Leslie: One of the people wrote back and said the average length of stay for their NHS patients now has gone up by two days since the introduction of ISTC. Now they are slightly damned for that because you are now in for eight days instead of six, and that is on the length of stay. I think it is difficult for constituents to understand the health economy and that is why they probably do not ask the question, and our patients do not understand the health economy and it is up to us to try and steer that and I think that is reasonable. Patients are interested in getting the safest treatment. We heard about choice this morning from the Department of Health but a patient has not got a clue really what is available because there is no information out there, and the GP who looks at his screen when you are consulting does not have much of an idea either of the important indicators for an NHS hospital. We have a patient liaison group, as many groups do now, which looked at our submission and supported
it wholeheartedly. They want to know just where it is safe because, if you have a good hospital down the road which has a high standard and has a short waiting time, why do you need choice?

**Q138 Anne Milton:** There will be conflict about people who actually choose to have their non-urgent operation beyond the Government’s targets and waiting times. “Will you be allowed to have your operation in 21 weeks?”

**Mr Leslie:** Well, you are not actually, no. Some of my patients would like to say that. They say, “I would like to stay with you but it means spilling over six months and that is not allowed”, and that is not choice.

**Anne Milton:** Precisely. Thank you.

**Mr Amess:** Chairman, I just wanted to say what a joy it is to have quality witnesses like this who know what they are talking about. You can understand what they are saying, who have come up with some positive solutions to the challenges we face. Also, what a tragedy it is that these people, and I think you mentioned nine months, were not engaged with policy makers at a very early stage. I had been intending to ask you questions about training, accreditation procedures and foreign doctors, but because you have been so articulate I think, frankly, these questions are all a waste of time. You have covered everything and I was just going to suggest, Mr Chairman, that perhaps, given that Mr Ribeiro, who is splendid, obviously wanted to say a lot more about the future of the NHS and the work force, we could have them back as witnesses for our inquiry into the work force?

**Q139 Chairman:** Another day, perhaps. Witnesses will be aware of our future timetable in terms of inquiries.

**Mr Ribeiro:** We have made a submission so we would be very happy to come back. Thank you.

**Dr Simpson:** And I am going away to write it now!

**Dr Taylor:** May I make a couple of comments? First, I would like to reassure our witnesses that health economics will be very important and we will take it up with future witnesses. Secondly, obviously one of our recommendations should be that the Royal College of Surgeons’ Clinical Effectiveness Unit is funded to start this review of all that we want to know—outcomes, complications—tomorrow, if not before.

**Q140 Chairman:** I am very grateful to you for writing the report! To say that while we are in the first witness session commendable! Just to finish this session, and I would like to go across the piece on this one with all of you, what would be the one thing that you would add to Phase 2, if that is what you were doing, and I know Phase 2 is on its way now, and what would you take away from Phase 2, or from Phase 1, as it were?

**Mr Ribeiro:** When I went to the Trafford centre, the Greater Manchester centre, I did a rather unusual thing which was I officially opened an ISTC centre and cut the ribbon, and in my opening speech I said to the CEO, Dr Eduard Lotz, that I would hope that in five years’ time this splendid hospital would be part and parcel of the NHS.

**Anne Milton:** Precisely. Thank you.

**Professor Husband:** I would take away additionality completely and add in clinical radiology leadership for the programme to be integrated.

**Mr Leslie:** I would echo that it should be incorporated in the NHS and, in the meantime, quality assurance of the work being done needs to be absolute.

**Dr Simpson:** I think we should be grateful that what we are providing with ring-fenced surgical beds, which is what it is, but they must be integrated into the NHS plan and pattern of work.

**Mr Kelly:** I would support everything that my colleagues have said, and I think it is absolutely vital that there must be clinical leadership in discussions with the Department which have been sadly lacking in the earlier phases. This is necessary and it has to be done by specialty and also by locality. It is probably also worth bearing in mind that none of the advisers at the National Implementation Team have much, if any, clinical background. Most of them are independent consultants, many from management consultancy agencies, and there is also a danger that they tell senior policy people and ministers what they want to hear. The voice of the College may sometimes tell people what they do not want to hear, but it is a voice that needs to be heard. The Colleges have been here for a long time, and will be here for a long time, and patient and public safety and training is our underlying bedrock.

**Q141 Chairman:** Could I thank you all very much indeed for this session. I am sure it is going to be very useful when we come to make our recommendations to Government in this area.

**Mr Ribeiro:** On our behalf may we thank you for your civility and kindness to us during today’s meeting.
Thursday 16 March 2006

Members present:
Mr Kevin Barron, in the Chair
Mr David Amess
Charlotte Atkins
Mr Paul Burstow
Mr Ronnie Campbell
Anne Milton
Mike Penning
Dr Doug Naysmith
Dr Howard Stoate
Dr Richard Taylor

Witnesses: Dr Thomas Mann, Chief Executive of Capio Healthcare UK, Mr Mike Parish, Chief Executive of Care UK and Director Partnership Health Group, Mr Mark Adams, Chief Executive Officer of Netcare UK, Mr Peter Martin, Chief Executive of Mercury Health, Dr Ian Smith, Chief Executive of General Health Care Group, and Mr Alan Pilgrim, Chief Executive of Alliance Medical, gave evidence.

Q142 Chairman: Good morning. I recognise the potential problem in having six witnesses and this list of questions in front of us. It could go on for ever, as it were. In view of the evidence session we had last week and the written information we have received, probably the first question is something I could tempt you all briefly to comment on, or indeed to say if you disagree with what is being said. Maybe that would be a way of doing it. Then, after that, hopefully we will try to put some specific questions to individuals. Generally you say that your appointment procedures are at least as stringent as they are in the National Health Service. Could you tell us why you believe that the colleges and other professional bodies seem so critical of the procedures in terms of your appointments?

Mr Parish: I am happy to start because we have had many telephone calls from patients in the last week or so. They have been quite anxious, having read some of the reports recently. Of course, we have invited them in again to meet the doctors and be reassured, and happily they are. Many of the comments that are made without evidence of actual reality can cause patients concern. Hopefully, in our submission we have set the record straight. I am happy to elaborate if you require it. I think the motives are mostly genuine. There is a genuine concern about change, and this is significant change. People are seeking reassurance. Most of the reassurance is sought in a professional and orderly manner. That has happened; we have had many visits from patients and we have supplied that reassurance. There is also a staked in the status quo. The reality is that we have quite a quirky system in the UK in the way that doctors in particular are remunerated. There is the old saying that the NHS is for cachet and private for cash. It is quirky with something like 30% of reward for 70% of the time and vice versa. Any perception that that may be threatened can result in some difficult reactions. We have seen quite a bit of that. There is mostly positive and genuine concern but with elements of defensiveness.

Mr Adams: In the first wave of the ISTCs it was important to introduce additionality so that you could demonstrate that you were providing a supplementary resource to the NHS to address some of the waiting list challenges that existed around the UK. In the long term, the additionality causes a challenge and a conflict with the establishment because we are not working in partnership. We are not working on issues ranging from our recruitment of British nurses and doctors through to the training of British nurses and doctors, and that puts in an artificial divide, which I guess you would not have chosen if you were starting with a completely open canvas. For speed of mobility, it was a sensible thing for the first wave but it is one of the things we need to overcome as we go forward.

Mr Martin: A lot of the issues are around education. This is a new initiative. There is still a long way to go before everyone involved in the system is aware of exactly what an independent sector treatment centre is and what happens there. We have certainly found, from our own experience, that at a local level the initial reaction from local trusts and local clinicians has been one of resistance and in some cases suspicion. We have worked very hard to bring the local clinicians along with us and, in developing our integrated patient care pathways, we have actually worked with local clinicians and got their sign-off for those pathways. As a result, we feel that we have now developed good relationships locally and those clinicians who initially were opposed to what was going on are now supportive.

Mr Pilgrim: Whilst the fast track MRI contract, which is Alliance’ Medical’s main contribution, is not actually an ISTC, it is obviously another contribution to the capacity agenda. Whilst we have seen initially the same sort of resistance, you may have detected last week at the meeting with Professor Husband that we were quite a long way down in terms of the relationship with the radiologists. It boils down to the proof of the pudding being in the eating. We have now demonstrated that the radiologists that we are using, who are covered by the additionality, are producing reports equivalent to the quality of reports produced in the NHS. We are starting to see that radiologists are accepting that in the UK. Our business across Europe has been built on working with local radiologists. This contract that we have is slightly odd compared with everything else we do. Ultimately, we would like to see it moving towards us being able to work with local radiologists, but there has been resistance and some of the comments that Mr Parish made are valid in this regard.
Q143 Chairman: I understand about the additionality and we may get on to that later. One of the things that came out was this issue that obviously, because you were not able to recruit effectively from the NHS as opposed to the rest of the sector, you have to bring in a lot of overseas doctors. There are issues about language and there is not the back-up available for these doctors that there is in the National Health Service. Has that been a problem in terms of language barriers and things like that as employers?

Mr Pilgrim: We encountered certain problems initially, partly not through language but the nature of reports that were produced. Now I think we have sorted out those problems. It really has been a question of evolving the contract and the provision of the reports to enable NHS consultants to review them.

Dr Mann: I think it is an important challenge that we have had to deal with. Obviously, if you recruit from the NHS, you are more likely to get doctors who not only speak good English but who have actually practised in our system and understand it well. If you have to recruit from outside, you have to make sure that they do. A number of efforts have been made and all this is undertaken to make sure that is the case. There are also fail-safe mechanisms so that when we find that somebody is not everything we hoped he would be, then we have to deal with that, and we have done that.

Mr Parish: It is important to note that we do not just employ people who put a hand up. There is a rigorous selection process, and that includes language skills and cultural adaptability. A lot of work is done to meld a team together because these people come from different countries typically. It has been done very successfully and I think that the expressions of concern relates to a lack of awareness of our processes and the fear factor. If we were just to take people who put their hand up, then I too would be concerned. It is about doing that professionally. Overall, I am a big supporter of additionality. That has added real capacity to the NHS and I think it has helped some of the commercial pressures that have led to a significant and positive response across the NHS.

Q144 Chairman: In the Healthcare written submission to us on this subject, they suggests the recruitment procedures for ISTCs should be brought into line with the National Health Service, including the introduction of the equivalent to the advisory appointment committee system. I have seen written evidence that suggests that something like that does take place in certain areas. The written evidence we have this week is enlightening on what was said or not said last week. Do you have any view about the Healthcare Commission saying that you should look at this type of appointment system?

Dr Mann: It is not just the Healthcare Commission; the Royal Colleges have suggested the same thing. We took the view that there were two issues here. One was whether sufficiently expert doctors, nurses and others who are practised not only in clinical skills but also in working in the NHS locally were involved in the recruitment selection process or whether, in addition to that, the people involved were representative of certain national bodies. That is the critical difference. We believe, and this is what we practise, that senior and competent specialists from those appropriate specialties are there on our selection panels. We have not sought to ensure that those people are delegates from a particular national body but that they are representative of the local specialist expertise.

Mr Martin: Speaking for my own organisation, we believe we have already gone some way to come into line with the NHS appointments procedure. Our interview panel is led by our Medical Director, who is a former medical director of an NHS foundation trust. We have also included on that panel a senior member, a former Council member, of the Royal College of Surgeons to bring a degree of independence to the selection process.

Dr Smith: In general terms, the more we can integrate with the NHS, both locally and in terms of systems and quality, the better. The more convergence we can have—I think the Healthcare Commission is trying to do this on a number of fronts—the better it is for everyone. The debate then moves from issues of incompatible systems or processes to patients, which is really what this whole programme should be about—quality care for patients and a fair deal for taxpayers.

Mr Adams: Again, there seems to be a commonality in the panel in terms of the processes of selection and the engagement and involvement of local specialists adding to our own referencing and processing criteria. From my past experience of when I used to have responsibility for the largest UK doctor locum agency, if I look at the number of international doctors that my previous business, Medacs, used to bring into the mainstream NHS and at Netcare, then Netcare at the moment is probably working with about 25 or 26 international doctors at consultant grade. That is probably about 10% of what I know is brought into the NHS from the various medical locum agencies that exist to supply the NHS as a whole. I do not think it is just about international doctors just being a component of the ISTC programme; it is just the way the NHS has historically worked in general.

Q145 Dr Naysmith: I have a quick question for Dr Mann on something he said when he was talking particularly about the language and culture of some of the people he employs. You said you took action when you came across people who did not come up to standard. What does taking action mean? Does it mean dismissing the individual or retraining them, or what does it mean?

Dr Mann: It can mean both. First of all, it means trying to find out if there is an issue, exactly what the issue is, and then trying to make sure that we can correct that and, if that is not the case, then dismissing the person, if appropriate, and, if any other actions are needed, like reporting them to the GMC or whatever, we would take that as responsible employers of a clinical service.
Q146 Dr Naysmith: How frequently does something like that happen?

Dr Mann: It has happened once for us.

Q147 Mr Burstow: One of the things that was very striking from the evidence session last week, and I am sure you have all had a chance to read it and in some cases may have been here to hear it, was the number of occasions on which particularly the Department officials were offering to write to us on items that the Committee could reasonably have expected them to have answers to, and particularly regarding the issues of what data is being collected by yourselves. One of the issues that the Committee wanted to follow up on today was the question of access to information regarding clinical outcomes and patient safety data. We noted the submission that we had from the National Centre for Health Care Outcomes and Development where they have said specifically that there is a lack of data in terms of clinical outcomes. Perhaps, starting with Mr Parish, you could tell us a bit more about the work you are doing locally to ensure that patient safety and clinical quality data is being collected and how it is then validated because both of those issues seem to be important. You seem to have supplied us with more information on that than anyone else.

Mr Parish: We have supplied you with the data that we report, which is essentially required in the contract arrangements. I presume that is consistent across all providers. That is essentially 26 key points in the data with a subset of around 98 overall indicators.

Q148 Mr Burstow: The document you have submitted, which on our list is down as ISTC 52A, which is Partnership Health Group (PHG Trent and Peninsula ISTCs . . . ”, is the data you are talking about?

Mr Parish: Yes, it is.

Q149 Mr Burstow: You say that this is the product of what you are required contractually to provide?

Mr Parish: Yes, it is. That data is generated by us and audited locally by the PCT, and obviously the Health Care Commission when they review us. It is made available within the unit to patients. We focus on continuing improvement and therefore each of those statistics is reviewed on an ongoing basis to seek improvement. Alongside are softer measures of patient satisfaction, we have a computer tablet that patients are given on a number of occasions during the day to record their satisfaction with softer measures: food, staff attitude, et cetera.

Q150 Mr Burstow: Can I come back to quality of life in a minute? That is important but I want to stay focused on patient safety and clinical outcome to date.

Mr Parish: On the statistics we have generated, our view is that they are creditable, given that we are in a start-up phase, and we know they compare favourably internationally. It is more difficult to compare them against NHS statistics because those are more difficult to get. We thought it would be useful also to include a one-off comparison that is provided to us by our PCT sponsors with Nottingham City Hospital, so that there is a direct comparison that we include there, too.

Q151 Mr Burstow: It would be your understanding that the data you supplied us for today’s hearing is data that should be obtainable from all of your colleagues in other ISTCs and should be drawn up on a comparable basis?

Mr Parish: Essentially, yes; it is always difficult comparing one case mix or patient mix to another. There needs to be a level of intelligent comparison rather than a crude direct comparison, but essentially yes.

Q152 Mr Burstow: Why is it that you think perhaps the Department did not seem to know that?

Mr Parish: I really cannot comment.

Q153 Mr Burstow: Can I ask one final matter on this particular point? How do you actually ensure that the data is externally validated? What is the mechanism for external validation, peer review, and so on? Could anyone else add to that?

Mr Pilgrim: We have had an independent audit of our results against NHS results. We have come out in line with the NHS on both occasions.

Dr Mann: The data is collected from all of us for our ISTC contract. Every month there is a review of the data and a scrutiny of the results of that data, which is jointly undertaken between the NHS and our own people in a group that has a majority from the NHS locally. They go through all the indicator data. We have the minutes of that. They go through every individual line. We would be happy to make that available to you.

Q154 Mr Burstow: That would be very helpful. The point that has been made to us in other evidence from a variety of sources is that whilst there is a dataset in terms of KPIs which are about process, there is not so much data in respect of clinical outcomes. You are saying that the data you supply and go through is clinical outcome data.

Dr Mann: The indicators are outcome indicators about various things like return to theatre and readmission; those are available. Those are the ones that are scrutinised. They are part of the 26 indicators that Mike Parish referred to. That sort of indicator set is available in many parts of the NHS. We do look for comparators there. In addition to that, we are also trying to collect some very particular research-like clinical outcome indicators, which we have not got yet, but they are not available in most facilities.

Q155 Mr Burstow: I am labouring this a bit because I think the answer we had from Mr Parish, which was passed on in the information that has been supplied
by your company, and the answer we have just had from Dr Mann do suggest there is some conclusion here in that there may be a standard set of data that is being supplied as per the contract. The advice we have been given by our advisers, Mr Parish, is that the data you have supplied today is more than is expected within the contract. That is why I want to be absolutely clear that your advice to us today is that this is solely being provided because you are being contractually required to provide it. Mr Parish: I would need to seek clarification on that. The only uncertainty I may have is where we have supplied information over and above our contractual requirement. We absolutely do not generate that information just because it is required by contracts. We generate it because we depend on it, our patients benefit from that information, and certainly the referring GPs do. There may be elements of that information that are over and above the contractual requirement, but I will clarify that.

Q156 Mr Burstow: That would be very helpful. Accepting this may well require notice as a question, it would be very helpful if the others of you who are giving evidence today could similarly set out for us what you are required by contract to provide in terms of data and whether or not it is the same data that is provided to us today by Care UK, so that we can get a clear fix as to whether you are all collecting and publishing the same information.

Mr Martin: I will add that the Committee did ask for information on one of our centres, that is Mercury Health, which we provided yesterday. You may not have had a chance to look at that. We provided you the data in exactly the form that is provided to the various authorities to which we have to report. That has 26 or 27 key performance indicators, most of which are clinically based and that we are required to provide. You also referred to the report from the National Centre for Health Outcomes Development. My reading of that report was that there were three conclusions: that the QA system now, there are funding streams available for the training of clinicians.

Development. My reading of that report was that going to provide the funding for the training. As you now, there are funding streams available for the training of clinicians.

Q157 Dr Stoate: There have been concerns from a number of quarters about the effect of the ISTC programme on the training of medical staff. I wonder if any of you can comment on what you do, if anything, to train medical staff.

Dr Mann: We, and I think all my colleagues, are in the throes of trying to set up training schemes within our facilities. For the last year and a half we have been in discussions, nationally and locally, both with the Royal Colleges, training accreditation boards and local training schemes to see how that can be realised. There is a pilot group to do that.

Q158 Dr Stoate: You are not doing it at the moment then? There is no training at all at the moment for medical staff in your programme?

Dr Mann: We have not started that but we are due to start one later this year. We hope to roll them all out in all our facilities over the next couple of years.

Q159 Dr Stoate: Do any of the others do any training at all of medical staff?

Mr Martin: We are opening our fourth centre in the summer, an elective orthopaedic centre in Hayward’s Heath. We will be offering training there from day one. We are in discussions with the local deanery and local clinicians around that. We will be offering both training for undergraduates and postgraduates. The plan is that we will have 10 registrars, 10 SHOs, from the staff who will be training in our centre. In addition, in our Portsmouth centre, we are in discussions about providing training for paramedics, ultrasonographers and nurses. We very much welcome the opportunity to become involved with training as part of our partnership with the NHS.

Q160 Dr Stoate: None of you have had training as a requirement for setting up the ISTCs before this?

Mr Martin: It was not a requirement of the Wave 1 contracts but, as I say, we have agreed to undertake training as an addition.

Q161 Dr Stoate: Presumably there will be extra costs. Who is going to pay for it?

Mr Martin: There is money available for training.

Q162 Dr Stoate: Who pays?

Mr Martin: We are still in discussions about who is going to provide the funding for the training. As you now, there are funding streams available for the training of clinicians.

Q163 Dr Stoate: So none of you thought of training at the beginning when the ISTCs were set up and now you are all coming out for training? Why was not training an integral part of the contracts in the first place?

Mr Adams: When the first ISTC programme started, it was largely around capacity and productivity, care and waiting lists. You would take on consultant grade doctors to come in to do a job of work, working with your local PCT partners. Clearly, if you got off the ground, you had to show you had postgraduates and that you had an impact on productivity in terms of the time to supervise, to coach and to allow them to have hands-on experience. You have a trade-off between productivity versus the education of a future doctor moving through their experience curve. As we become, hopefully, more of a long-term partnership with the NHS, clearly we cannot ignore the issue of training, and so all of us now, particularly in the second wave of ISTC opportunities, are asking: how
do we integrate locally; and what kind of training partnerships can we put together? Again, from our own perspective, we are starting to move at the moment into mentorship for student nurses. That is still in the first wave of the ISTCs. We will be doing a lot more in the second wave of the ISTCs.

**Dr Mann:** In the NHS there is a funding stream for service provision, a separate funding stream for research, and a separate funding stream for training. That training funding stream is subdivided into postgraduate, undergraduate and so on. When the ISTC programme was set up and we entered into contracts, those extra funding streams were not included in the contract price or in the activity, and it was purely a service delivery contract. At the time, we did not expect to have to do that, but, as soon as the Royal Colleges and others said that they felt there would be an impact on this, all the providers agreed that they would want to participate. The debate has been about two issues: how best to involve local trainers from the NHS in the process while trying to protect the contract around add-on; and how best to get the additional funding that is given in the NHS for training. I think we have made good progress. All of us expect to deliver that. It has just taken a little while to get those details agreed.

**Dr Smith:** I think it is important to realise that this was not an issue of oversight or laziness on our part. Training is commissioned by the deaneries and the NHS is paid by the deaneries to conduct that training. Certainly for my part I would have preferred that we had, as an independent sector, been able to contract with the deaneries to provide that training, because I think it would have avoided a superficial interpretation that somehow we were free-riding on this. I am keen that in Wave 2, and I think many or all of my colleagues are too, we do engage in that training and therefore we can become a more integrated part of the NHS and avoid that sort of superficial accusation that somehow this was oversight or laziness.

**Mr Parish:** Dr Stoate, initially I think the view was that the scale of the first wave of ISTCs was so small and insignificant that it would not impact on training availability. Clearly, people have identified that in local situations, because of the particular case mix, it may, and therefore it has gone up the agenda much more. Secondly, given the operational challenge of commencing a new service with a completely new team, it would probably have been inappropriate to include training in the initial phase of activity. It is far more appropriate to include it now that units are established.

**Q164 Dr Stoate:** If you do establish training, how will you guarantee that it meets the same standards, quality and external inspection that NHS facilities have to undergo?

**Dr Mann:** There are two benchmarks on this. One is that you do need to have proper accreditation to be allowed to train. There will be an independent assessment made of any facility providing training. In addition to that, we would intend, and I think my colleagues would all do so, to involve NHS trainers in that process so that not only was it of a sufficient standard but it was well in the swim of how it was done in the NHS.

**Mr Parish:** It is supervised by the Royal Colleges.

**Q165 Chairman:** Did you see the article in the *British Medical Journal* by Angus Wallace? What did you think of it when he said that even if training were to be allowed in ISTCs, supervising surgeons may not be fully competent themselves, as previously mentioned, let alone competent as trainers, and consequently the confidence of our next generation of surgeons is in jeopardy? Can I have your views on that?

**Mr Parish:** I think it was ill-informed and irresponsible.

**Dr Mann:** If I may, Chairman, he may have thought that we were going to use trainers that they would not welcome, but in fact, from all the discussions we have had, and I think it is the case for others, we would use trainers recommended and approved and currently training in the NHS.

**Q166 Dr Taylor:** I make a comment first. I think we found the lack of information from department officials last week rather staggering, particularly about outcomes, and now we are presented with exactly the sort of information we wanted. The only one I have seen so far is Care’s, which gets away from quality and external inspection that NHS facilities were doing. We have also sought in other ways to forge better links with the NHS. At our centre in Medway, which is the centre we have provided information to the Committee on, our local medical director is an NHS urologist and our deputy medical director is a consultant NHS anaesthetist. In another of our centres where we are providing diagnostic services, we are using local clinicians to
provide quality assurance procedures. It is taking time. It is still early days, but we are trying hard and we believe making good progress in creating an integrated service with the local NHS.

Q167 Dr Taylor: This is a question to Mr Parish. You transferred 23 patients to NHS trust hospitals. How easy or difficult was that?

Mr Parish: It was very easy. The transfer arrangements are set up at the outset so that they work effectively when required.

Q168 Dr Taylor: You have transfer arrangements set up in your initial contract?

Mr Parish: Yes, between ourselves and the local NHS Trusts.

Q169 Dr Taylor: Is that so for everybody?

Mr Parish: Yes, Dr Taylor, as a point of clarification on the KPIs and clinical outcomes, those are one and the same. The KPIs are the clinical outcomes.

Q170 Dr Taylor: I wish somebody had explained that to us last week. We will not go into that just at the moment. From talking to my own PCT and independent treatment centre that is just starting, there seems to be a certain amount of worry that they will actually be able to fulfill the contract and get enough work. Is that a common problem or are you all well up to schedule on fulfilling your contract?

Mr Parish: That is probably a bigger point to integration than the additionality issues that are a bit of a red herring when it comes to integration. The integration point is about integrating with the local health economy between and across facilities and particularly with primary care. That is the real point of integration. We found that once the facilities are established and those links are put in place, then we are running at our minimum take level and I anticipate exceeding it in due course. We have not been helped by some of the negative publicity, particularly in the early days. We were asked to set up an interim service for Trent and South Yorkshire whilst we were constructing a new facility. In the initial months, that did not meet its minimum take level. I think the main reason for that was some very negative campaigning from local consultants.

Q171 Dr Taylor: In Phase 2 will you be tied to the national tariff?

Mr Parish: The national tariff is a point of comparison as opposed to a point of pricing. We submit our proposals. It depends on what we think that particular case mix and service will cost us. That goes through a competitive tender process and the selection is made. In assessing value, it is compared to the tariff. One needs to be careful in making a comparison between apples and pears, frankly, because if you look at what is made up in the NHS tariff, the reference pricing, there are different features. For example, we, as independent operators have to pay in-bound VAT but cannot pass it on to our NHS customers, so that cost sticks with us. We have the full cost of pensions that is not passed through to the tariff and a number of other cost factors, as well as the cost of setting up from scratch new operations, new facilities. The biggest factor of all probably is volume and case mix because if we were to handle 10,000 major joint replacements, that would cost less per procedure than if we were handling 2,000. Each case has to be assessed on its own merits.

Dr Taylor: As far as integration goes, you would all welcome increased integration? You all agree.

Q172 Mike Penning: This is really a question for all of you. What hard evidence is there that ISTCs represent value for money within the NHS?

Mr Parish: I start by saying that there is a direct link between what is being purchased and what is being provided. If 10,000 joint replacements are requested, they are provided by contract and there is a direct link between cause and effect, which is more difficult in terms of adding funding to the great big pot called the NHS. I think that gives a more direct impact on waiting lists, et cetera.

Q173 Mike Penning: If I may stop you there, that is clearly no hard evidence of value for money. That is anecdotal. What hard evidence do you have? If you do not have any, that is fine.

Mr Parish: It is hard evidence in terms of that volume of cases that has been delivered at that cost, that investment.

Q174 Mike Penning: That could be delivered inside the NHS then?

Mr Parish: Yes, it could. What I am suggesting is that there is a much more direct linkage to that procurement, to that service delivery.

Q175 Mike Penning: I am not trying to be difficult. In other words, there is no hard evidence?

Mr Pilgrim: Perhaps I could come in on the radiology contract. If you take the reference prices as a value for money in the NHS for MRI, our particular contract price when calculated is well less than half the reference price for MRI.

Q176 Mike Penning: There is no hard evidence then. We move on to the next point. Do you know of any comparisons that have been made between ISTC programmes and NHS treatment centres? This comes back to the comparison argument about whether it could be done in the NHS. Has a comparison been done as to what is the cost-effectiveness of what your companies are doing compared with what could be done inside the NHS and their treatment centres?

Dr Smith: That is a difficult question for us to answer. We know exactly what our costs are, and I am certainly confident that we can deliver cost-effectively against the NHS. The problem is that we do not have the NHS costs to be able to compare ourselves against. In terms of value for money, we certainly do patient surveys and consistently have patient satisfaction surveys for NHS patients at the 98% level, which I believe is higher than the NHS. I am very confident that on our side we have the data
and, if the comparison was on the other side, we would be able to conclude that we are making money.

Q177 Mike Penning: No-one else is nodding, so I presume no-one is going to answer further. One of the problems we have is that this Committee has found it rather tricky to find out what value for money methodology the Department of Health has been using in issuing contracts. Would your companies be happy for that methodology to be made public?

Dr Smith: Yes.

Mr Martin: I am certainly not aware of what the VFM methodology is that is used by the Department.

Q178 Mike Penning: One of the arguments they have always used for not putting it forward is that it would be sensitive in contract terms, but if you are not unhappy with the methodology they are using, I am sure the Committee and the public would like to know that.

Mr Adams: I think, from the Department’s perspective, they are trying to build a market here. They are looking at working with potential partners who can deliver clinically and can deliver good patient satisfaction results, and ultimately can come up with innovative solutions. With more public pricing, the openness of the bidding process and what has gone before, you perhaps inhibit that open market. I think the Department probably genuinely is saying that it would rather not issue amongst ourselves some of that data, but it is a guess why it cannot share that with you.

Q179 Mike Penning: That is slightly cynical. If they do not deliver the information, we cannot compare it with the NHS. We do not know whether you are giving value for money to the public or not, and nor do you, to be frank.

Mr Martin: The process used to offer these contracts was a very competitive tender process. Therefore, the organisations that won each individual contract were clearly providing value for money within the environment in which they were competing. They were coming out on top of a large number of tenders to provide this service. I think, in terms of whether it is value for money and in terms of what you can get from the independent sector, clearly the answer must be yes. Is it value for money against the NHS? We do not have the data to give you that comparison.

Q180 Mike Penning: You do not know and we do not know.

Dr Mann: There is some information. The tariff price is a weighted average, but there is available data about the full range of prices charged across the NHS. That is available. We have certainly looked at it. That shows a 20-fold variation in the prices within the NHS for certain procedures. If you look at that range of prices, you will find that all the contracts fall well to the middle range of that. Where prices for our contracts are perhaps above that, those differences can easily be accounted for by the additional investment of building new facilities and bringing in additional doctors. We could show that. I do not know whether you would consider that evidence to be objective and robust enough. We can give it to you but would you find that satisfactory?

Q181 Mike Penning: To be fair, the question I asked you was to do with whether we would release information from the Department of Health as well as the information that you supply to the Committee being very useful. It is about trying to get the Department of Health to tell the public and this Committee what is going on. On that basis, would you be happy for the full business case that the Department has used in assessing the ISTC bids to be put in the public domain? What are your objections to that?

Dr Mann: Is that the Department’s business case or our business case?

Q182 Mike Penning: Both the full business cases that were put forward on the bids: would you have any problems about those being put into the public domain?

Mr Parish: Clearly not the Department’s business case; it is not our business to object to that. If you were suggesting that we publish our own cost assumptions and pricing assumptions, that would be commercially sensitive, yes.

Q183 Mike Penning: The Department’s would not be?

Mr Parish: One would expect the Department to justify and explain that.

Q184 Mike Penning: They cannot use the excuse by saying, “We cannot release this because it would be sensitive”? Mr Parish: It depends what it is you are suggesting they would release. If they were releasing their business case in terms of why this investment, this programme makes good sense for the NHS—

Q185 Mike Penning: It is all very secretive, is it not?

Dr Smith: Could I just add one comment to narrow the definition of value for money, and this is a very narrow definition? If you compare spot purchases from the private sector in previous years with spot purchases from the private sector now in the G sub-contract that we do or the ISTC contract, there is demonstrably more value for money; it is about half the price.

Q186 Mike Penning: What are we trying to look at is hard evidence.

Dr Smith: This is hard evidence, the price we would have charged for spot business from the NHS a year or two ago.
Mike Penning: That is not my question, to be fair.

Q187 Mr Burstow: If Mike does not mind, I want to pick up on this one step further. The business case of the Department is part of what we are interested in knowing. There is a possibility that there is some support for us having access to that. I also want to pick up on what Mr Parish was saying, however, about the business cases that you submitted to the Department as part of the bidding process and whether or not there is anything within those that you could exclude in order to release as much as possible of the business cases that you submitted so that we can actually have the open market that Mr Adams was talking about. My understanding of market theory is that a perfect market is one where there is full availability of information. We do not seem to have a perfect market here because an awful lot of the information is either buried in the Department and the officials do not seem to know what it is or it is within your businesses. I would want to know what you feel you are able to share, without of course breaching commercial confidentiality in a strictly narrow sense rather than in any other sense. Perhaps, Mr Parish, you could tell us what you think you could release to us.

Mr Parish: Certainly, what is publicly available already is the price we are paid and the commitment in terms of case volume that we take on. There are two aspects to that. One is how we get there in terms of the prices we submit and the second is how it is evaluated by the Department. I think the evaluation by the Department is for you to discuss with the Department. In terms of how we get there, there is quite a bit of intellectual capital and property and competitive confidentiality in how we get there. Frankly, I do not think any market that I know would freely make available its cost assumptions and its solution methodology because these chaps sitting next to me would take it apart and benefit from it, I am sure, and we would from them.

Q188 Dr Naysmith: There was a bit of confusion earlier and I take this chance to clear it up. I think Mr Parish’s responses to Dr Taylor rather implied that KPIs (key performance indicators) and clinical outcomes were the same thing. In fact my information is that there are 26 KPIs and only eight of them are actually clinical. How do you square that with what you were saying to Dr Taylor?

Mr Parish: Rather than risk adding to the confusion, why do we not send to the Committee the KPIs that we submit. I believe that the vast majority of those are clinical outcomes in nature. Let us clarify that in writing.

Q189 Dr Naysmith: Our understanding, and our advisers agree, is that there are 26 KPIs and only eight refer to clinical outcomes. When the Department of Health was introducing and starting off ISTCs, I understand that they said, although I was not here, in evidence last week that one of their main reasons for doing it was to stimulate innovation and changes in the way that the National Health Service works and they were looking at the practices in the NHS to try to challenge them. I wonder—and I am doing what the Chair said you should not do—if you all think there are any examples from your contracts where this has happened but, because you have been operating a service, it has been a challenge to the National Health Service practices and you have changed some of them, possibly locally?

Mr Parish: There is a tendency to look for rocket science when one says “innovation”. Generally, I think it is applied good management practice. For example, and I would claim no intellectual capital on this, in terms of our one-stop shop methodology (where patients come to see us once and all the specialists that need to see them do so and all the tests that need to be taken are done there and then rather than the patient coming back to and fro on several different occasions) that is an example of very good practice that is very much appreciated by patients. It results in faster and better treatment because we then have a very short time for them to come in for surgery, a matter of weeks, which means that the data that is collected on their condition when they come in on that one occasion is unlikely to change in a matter of weeks, whereas if you are on a waiting list for several months, it does and therefore you get this horrible cycle of patients that keep returning and operations being deferred. Something like that is what I would put forward as an example of good practice. The use of the patient’s own blood being recycled to them during surgery is a fairly recently development. It is not something we invented but we apply that because we organise ourselves effectively to apply it, and again it is significantly better for patient clinical outcomes.

Q190 Dr Naysmith: Is part of the reason for that that you are dealing with a relatively small area of clinical practice, whereas in many situations in the National Health Service you have a district general hospital or an acute hospital where there are all sorts of different specialities?

Mr Parish: There are examples of good practice across the NHS that I admire hugely.

Q191 Dr Naysmith: There are one-stop shops, for instance for cancer treatment?

Mr Parish: Yes. What we do is not unique. I am a great admirer of the NHS and in places it works brilliantly. I think in other places the sheer burden of having to deal with the full case mix and endeavouring to do it on one site with one huge-scale solution is very difficult and challenging for them.

Mr Martin: I would agree with Mike Parish. We have probably all tried to be innovative in developing our new centres. Have we produced anything that is unique? I suspect probably not. We have certainly worked hard at looking at the actual process, the patient pathway through a centre, and so we have worked very hard on things like patient education. We have looked to stagger appointments so that when the patients come in they are dealt with efficiently. In developing our facility design, we have
looked to do that in a way that ensures there is a very efficient, productive pathway for the patient. We do not have anaesthetic rooms in our centres, again to aid efficiency. None of this is unique to us. All those things are happening no doubt in parts of the NHS. We have tried to be innovative, but have we affected the way the NHS behaves? I am not sure I can answer that. All we are doing is trying to provide the best service we can.

Q92 Dr Naysmith: The interesting thing is that there has been best practice in parts of the National Health Service for ages and ages. The really difficult thing seems to be spreading it and making sure that it travels from the area where it needed.

Mr Martin: I think it goes back to this issue about integration.

Q93 Dr Naysmith: The reason I am asking this question is that it was part of the rationale for setting all of this up that you would introduce and innovate and that some of that would rub off locally. I am wondering if there are any examples anywhere of that.

Mr Adams: I think the link in terms of talking about spreading good practice was the point I was going to make. At Netcare we were asked to meet a challenge to solve the cataract waiting list, or to be part of the solution. We fully acknowledge that there are phenomenal parts of the NHS doing an excellent job in terms of cataract surgery. We were asked, in these different geographic regions all over England and Wales, what we could do perhaps to meet the challenge. Effectively, by creating a mobile solution that would literally spend a week in Carlisle and then the following week doing surgical procedures in Cornwall, in an environment that is clinically safe and where the patient feedback is fantastic, we are carrying out procedures that can run from 20 to 24 a day for six days a week. I believe in a traditional surgery doing similar cataract procedures there would be 12 to 15 procedures a day. To have that mobile solution that can go and work with PCTs with particular problems has, I think, been an innovation that has actually worked, and the Department should be rightly proud.

Mr Parish: In our case, it is about certainty of that best practice being delivered because if we do not provide that best practice in the way we set out, we will not exist. Our goal is to be a long-term player as part of the NHS. Therefore we live or fall by the implementation of our best practice.

Dr Mann: A number of examples of innovative practice have been mentioned, and I agree with all of them, and many parts of the NHS employ one or more of them. I think perhaps the greatest innovation is that to survive we have to employ all or most of them. There is a logistical pressure on us to try to maximise quality and efficiency because we are new boys in the game and we absolutely have to demonstrate all these things in a way that perhaps some parts of the NHS have not had to. It is not that the NHS does not do it but that, because we have to do it everywhere and be seen to do it, in itself that highlights the need and the ability to innovate.

Q94 Charlotte Atkins: Could you all indicate which of you are intending to bid for Phase 2 contracts? You all are. How do you see the new Phase 2 contracts developing—in the same way as the Phase 1 or do you think there will be different features?

Mr Adams: If I could start from Netcare's perspective, I think that there is a degree of soft landing in the Department's support to get the first wave of ISTCs off the ground. You will be familiar with the minimum take contracts and the support for saying that we want to encourage innovation and to get this thing going. Now that we have all had the opportunity actually to experience the ability of working in local markets and building that local PCT/SHA relationship, in the second wave of ISTCs there will be a bit of a risk transfer away from the Department of Health and to the provider where we will actually be looking at the tariff being an indicator, as Mike Parish mentioned. There will be many cases, I am sure, where the actual bids will come in beneath tariff. There will not be the guarantee and the volume of patients, and therefore there will be an assumption that the only way to make your business model work is fully to integrate with the local primary care trust and the local GPs, and to win their confidence and their support. A lot of that will be based on demonstrating your clinical excellence from the past. I think that it is maturing into something that will be more integrated and will be yet further competitive for the Department.

Mr Parish: I welcome the relaxation of additionality that has appeared in the Phase 2 contracts. I think that in Phase 2 we will move much more towards what I would call a mixed economy where our centres are staffed by both UK-trained and qualified doctors and overseas doctors. I think that will assist enormously in developing the closer partnership and closer integration with the NHS.

Q95 Charlotte Atkins: Why do you want to get rid of additionality?

Mr Martin: Because it is a pain, to be honest!

Q96 Charlotte Atkins: In what way is it a pain—for your commercial enterprise or because of good practice?

Mr Martin: I do not think it is clinically the best solution. As we have discussed already, I think it has hindered developing close partnerships locally. It has hindered integration with the local health economy. I personally believe that the best overall solution for the Department and the NHS is by providing clinically robust solutions and high quality but on a cost-effective basis in this mixed economy where we have a mix of UK doctors and overseas doctors, and Wave 1 did not allow us to do that.

Q97 Charlotte Atkins: Overseas doctors are in the press at the moment because the NHS is being accused of robbing poor countries of doctors. What is your take on that?
Mr Martin: We have only actually recruited doctors from one country outside of the UK, which is Hungary, and that is part of the EU. There is free movement of people within the EU, and so this actually has not arisen in terms of our recruitment.

Mr Parish: Even if additionality was not required, we would still look to bring doctors in internationally because, frankly, the cost-base of UK doctors is not competitive; it is too high. That is evidenced in some of the pricing solutions we have been developing for the second wave. I do not think there has been anything like sufficient impact yet to drive to a different market. That is my first point. My second point would be that a key criterion for us going forward in terms of assessing the market is whether patients will be allowed to express their choice and go to where they choose. If patients are able to exercise their choice, I am sure that both in terms of cost and attractiveness to patients, and obviously that includes clinical outcomes significantly, we would be very competitive.

Q198 Charlotte Atkins: Choice seems to be the name of the game at the moment but obviously price is also important. Do you expect your procedures to be comparable with the NHS tariff? We heard Mr Penning earlier on talking about value for money. Do you expect your tariff to be comparable?

Mr Parish: On a like for like basis I am very confident that our costs will be very comparable and competitive.

Q199 Charlotte Atkins: You also say that the reason you want overseas doctors is because they are cheaper. Is that correct?

Mr Parish: They are cheaper than the private practice in the UK but not cheaper than NHS rates for consultants.

Q200 Charlotte Atkins: Are you saying that you would not be able to meet the NHS tariff unless you had overseas doctors?

Mr Parish: I would be surprised if we could get terribly many doctors working for us at their NHS rates and so we would be needing to pay the private practice rates and that is expensive.

Q201 Charlotte Atkins: We were talking earlier about innovation. Surely if you were offering an attractive work environment then you could possibly tempt NHS doctors away from the NHS because you are hoping to innovate and provide greater freedom for doctors to break through those barriers.

Mr Parish: I may be a bit of a lone voice in saying I am a supporter of additionality. If additionality had not applied to date and if it did not apply going forwards then we would be heavily criticised for causing a supply shortage problem within the NHS, which is quite possibly what could be the case.

Dr Mann: The single greatest value of moving away from the current additionality position is that it allows us to work more effectively with NHS nurses and doctors and that will lead to debunking a lot of the myths that I think have grown up. I think there is a sense that we are separate from them and we do not use them and all of that. I am not persuaded that that additionality undermines quality or helps price although in some circumstances it will. I think we should be allowed to try and find solutions that give the NHS best value. As regards tariff and additionality and the contracts for Wave 2, my instinct is that you will find that our prices will converge to tariff very quickly. One of the advantages for having a looser arrangement around additionality is that we will begin to compete to provide services below tariff. If you put unnecessary constraints on things like additionality what you are actually doing is trying to give value for money but doing it with one hand tied behind your back. For me the real issue is why try and hinder good networking with local doctors and good value for money by something which if it is good value and good sense we would do anyway because that is in the nature of providing a good service.

Q202 Charlotte Atkins: So you would be happy to see guaranteed referrals being swept away, would you? You are not interested in those sorts of aspects of the contract, are you?

Dr Mann: I think that is going to happen anyway. I think in Wave 2 you will see that there will be a tapered commitment to commit to that particular area. By the end of the period you will find that the tariffs are fully aligned and the referral patterns will no longer be protected. We are committed to that because that is how we would be part of the NHS.

Q203 Charlotte Atkins: Are you all committed to those restrictions being taken away?

Dr Smith: Absolutely. I think you are seeing the good effects of competition here. My company will take a different strategy than Mike's and that is good and may the best man or woman win. I think that type of innovation, that type of competition or that type of trying to do things differently and offering a different service is a very good aspect of competition. The key to this is patient choice. I think for too long in this country we have had a patient population that has been too compliant, that has not been given enough choices and therefore has not been able to choose and in the process of choosing to say this is a better service and I value this more than that. Patient choice was a key tenet of Nye Bevan's principles for the NHS in 1948, and I think this process is getting us back to patient choice and a position where we will give the right to patients to be able to make their own choices without the state telling them what they can and cannot do. For me that is the longer-term aim of this programme and minimum take and guarantees will have to go under that regime. We will have to live or die by whether we can offer a high quality clinical service at a cost-effective price.

Q204 Charlotte Atkins: How many NHS doctors would agree with you that patients are too compliant?

Dr Smith: I do not know. You will have to ask the doctors.
Mr Pilgrim: In terms of Wave 2, our involvement will be on the diagnostic front. I think one of the most encouraging things about Wave 2 is that it is geared around bringing the diagnostic tools closer to the GPs. At the moment we have far less scanners than anywhere else in Western Europe and far less scans performed, that is the preserve of the Trust hospital nowadays, but in future it will be referred by GPs and they will use that diagnostic tool. I think a very important part of Wave 2 will be bringing the role of the PCTs and the purchasing skills within the PCTs up to the point where they can get best value and best care for their patients. How our organisation would respond will be at the diagnostic end of that.

Q205 Charlotte Atkins: So you have a lot of faith in the PCTs to get value for money, have you? Mr Pilgrim: I have a lot of faith in the Department of Health process as it is very robust. You are hearing from six people here who are basically saying much the same things about the topic but who are competing toe to toe with each other on all of these tenders. In fact, Ian is linked with the major other company in the diagnostic field and we are going toe to toe for the next round of contracts and I think that will produce value for money, but there is a strong emphasis on quality as well and that will produce good results for patients.

Mr Parish: Building on what Ian has been saying on the direction of travel and I agree the direction of travel should be a world without any kind of volume or revenue commitments, I have got to say that it may take some time to get there fully because it is about us being able to invest with confidence in the belief that that market opportunity will be there. I think we have got more confidence now than we had a couple of years ago when the first wave came along, but I am not sure the market will be sufficiently confident to invest £10, £20 or £30 million per facility totally at risk currently of the market being allowed to thrive. I think there needs to be a further evolution of patient choice, with patients being free to choose, PCTs being free to choose and doctors being free to refer before we invest fully at risk, which is why Tom talks about a tapered level of commitment in Wave 2.

Q206 Charlotte Atkins: Finally, do you all believe that ICCs are an opponent part of the landscape within the NHS? Dr Mann: Yes.

Dr Smith: We certainly like to think so, yes.

Q207 Anne Milton: Do you think we are moving to a mixed economy of healthcare provision where you will be an integral part of—albeit paid for by the taxpayer— a mixed economy of provision? Dr Mann: We would hope so.

Dr Smith: I think that is purely in the hands of the patients and depends on our ability to be efficient operators. The rights of the patient and the taxpayer here are predominant over the rights of the providers and it is they who should choose, and if we fail then they will not choose us and we will not be around.

Q208 Anne Milton: Do you all feel that this first phase has gone well enough to indicate that that would be a possibility? Dr Smith: Yes. I am very encouraged that patients are getting a voice, yes.

Q209 Anne Milton: Dr Mann, you are making a face as if to say you have got some reservations. Dr Mann: I think the first phase has achieved what we needed to do but, as Mike was suggesting and this Committee and all the press have suggested, there is a considerable sense both of resentment and of uncertainty amongst NHS clinicians and others. I think we will feel comfortable that we have got to a position where patients are going to choose when that sense of resentment and confusion is dispelled and the NHS truly believes that the mixed economy in provision is here. I suspect Select Committees like this can go a long way towards helping people understand that. We are not there yet but we are getting there.

Q210 Anne Milton: Is that because at the moment you are seen as a competitor to the NHS? Dr Mann: I think it is more than that. People love the NHS and the NHS is a good thing. When you start to introduce an alien concept into something that is truly and properly cherished and loved then people, understandably, think this is good, is this bad, what is this all about? Critics come at this with a far more aggressive scrutiny than they would do otherwise. It is up to us to help people understand that we are as open as a commercial organisation can be, we publish information about clinical care and we try and work with local NHS colleagues as far as we are allowed to hence the discussion about additionality. I think we are getting there but it is not there yet.

Q211 Anne Milton: I do not know if anybody else has got anything to add. Mr Parish: If we look at it from a patient’s perspective, they consider us to be part of the NHS solution and that is very much where we view ourselves as very much empathetic and committed to the principles of the NHS but also a part of the solution to the NHS service. You may have anticipated there being quite a bit of resistance from patients and nervousness et cetera but there really has not been any, in fact there has been delight. As far as they are concerned they are getting a wonderful service from us as part of the NHS.

Q212 Anne Milton: Patients want the treatment and maybe they are less fussy about where this comes from. They want high quality and effective treatment as soon as possible. Mr Parish: Yes. There will be strong opinions over how that treatment should be provided.

Q213 Anne Milton: The resentments to some extent must arise from NHS staff who see you as a threat. Mr Parish, you have said with additionality going or being relaxed that will change things somewhat because the NHS staff will then be free to come and work for you.
Dr Mann: My thesis is that that level of anxiety, concern and sometimes resentment is because they do not understand what we are about and that is made worse by additionality. I have no problem with additionality, but as an obligation it puts up barriers between us and NHS staff. Where we have worked with NHS staff closely those barriers have come down and they have worked well with us. Were we allowed to do that more often then in time a lot of these concerns would go.

Mr Parish: We are on a sensitive market migration if that is what we are on. I think one needs to be careful in terms of the law of unintended consequences, which is why I think it is prudent to ease the additionality requirement gradually rather than risk destabilising existing supply arrangements within the NHS.

Mr Pilgrim: Another contribution that this whole process has made is to get healthcare provided in the right facilities and the right facilities are not always a huge NHS Trust hospital. If you look around the rest of the world, many more of the health economies have a much wider range of different facilities and different providers than we do in the UK. There has been a tendency in the UK for us to focus all of our efforts on an NHS hospital where lots of things can be much better provided and ISTCs are a good example of that. Standalone diagnostic centres are very common throughout Europe and produce high quality of care and there is a competitive market for the services. I think those are all positive things coming out of this whole programme.

Mr Parish: A key issue we have not talked about is the whole emphasis of the White Paper in terms of migrating treatment and care out of secondary care facilities, out of hospitals and into primary care and the community is a key feature of that market restructuring. I do not think we can look at ISTCs in isolation of that general change in the way services are delivered. In primary care we have got something of a mixed economy already in the way GPs are engaged and I know that has got possibilities of going further.

Q214 Anne Milton: With regard to the White Paper, there are quite a lot of PCTs closing community hospitals at the moment because of meeting short-term budget imperatives. If you had the opportunity, would you take over some of those facilities?

Dr Smith: If it made economic sense, yes.

Q215 Anne Milton: I gather there are around 90 of them up for grabs at the moment.

Mr Parish: It would be on a case-by-case basis because they need to meet the needs of a poly-clinic type of solution.

Q216 Mr Campbell: I would like to know if you have carried out any analysis into the long-term and short-term results of the competition with a local hospital.

Mr Martin: I would echo that. We certainly did not get involved in this because we were interested in running a contract for only five years. What we were interested in was becoming a fully integrated and
sustainable part of the local health economy. We expect to be running our centres for many years to come. I would be very surprised if the contract was renewed at the end of five years in the same terms on which it was originally let, but by that point we would expect to be a fully functioning part of the local health economy and if there was local competition then we would be quite happy to compete.

Q220 Mr Campbell: Will you be working with the local hospitals?
Mr Martin: Absolutely, yes.

Q221 Dr Stoate: Mr Parish, you said earlier that private fees are much higher than the sort of fees that you are expected to pay in treatment centres and for surgeons in particular. What do you think the effect of the ISTCs is on private practice?
Mr Parish: I think it has two effects. I have no quantification for this, but I think there is a direct impact on some private practices’ demand, the waiting list element of that demand and then a general confidence in the NHS element of that demand because I think the more the public and companies feel confident in what the NHS can provide the less motivation there is to procure or provide private health insurance. Secondly, there is a direct competitive impact in terms of bringing in new providers to the marketplace because whilst there has been substantial numbers of overseas’ doctors coming to work in the NHS, they do not need to be on a specialist register to work within the NHS and because of the nature of their engagement in the NHS they are not able to establish a private practice. I think this fear is why we think the doctors have been so vocal in their assault on the initiative. I think there is a fear that the ISTCs could be an entry vehicle to doctors setting up private practice in the UK.

Q222 Dr Stoate: To quote Ken Clarke from times past, do you think some consultants are feeling nervously for their wallets in regard to ISTCs?
Mr Parish: Yes, I do.
Mr Adams: I used to run the second largest PMI company for my sins in the UK and that is a sector where if the NHS has had much published problems in terms of waiting lists for MRSA or other issues then it has helped the private funding sector to grow and prosper because people have said they want to make an alternative choice for their family. As the NHS demonstrates that the waiting list issue is fading away and the average standard of facility is averaged up and that ultimately it is an integrated sector embracing innovation then I think there is a real threat to the independent sector on the funding side.

Q223 Mr Burstow: I want to pick up on something that Mr Parish was talking about earlier on in terms of risk. You said that in a way the ultimate goal will be that the private sector is investing “fully at risk”. Presumably Phase 1 was not fully at risk to yourselves and presumably Phase 2 of this programme similarly is not fully at risk. How transparent do you think it is from the point of view of the taxpayer’s interest and how much the taxpayer is bearing in terms of risk at the moment and indeed in Phase 2?
Mr Parish: I think there are two areas of risk, there is demand risk and cost risk. We are fully at risk on costs, we put forward a price and we either achieve our objective or we do not. In the interim service that we provided we did not, there were all sorts of complications in that service and we lost money, but that is the market, that is the way it happens. There was plenty of risk being taken even in Wave 1. In terms of demand risk, it really is a question of when we would be prepared to go fully at risk and I think that is why we have got confidence that the market would be in a sense liberated, although I do not think it can ever be fully liberated because there needs to be the management of supply and capacity. At that point, in terms of value to the taxpayer, I think the Department of Health has got a job to do and I think they have done it very well in terms of professional procurement to purchase competitively. I think one needs to be very careful about some of the comparisons made when you compare the whole price you would get from an independent sector provider to the NHS tariff which is made up of a wide range of averages. That tariff does not include the cost of the VAT, which is significant, it does not include the cost of NHS pensions, which for us to match would cost us 30–40% of our labour costs, it is not a like for like comparison. I think when the evaluation is fully carried out we will see that even Wave 1 is significant value for money.

Q224 Mr Burstow: In a way the issue I was picking up on was that the aim would eventually be that you would be investing fully at risk. The implication of the way you said that was that you are not currently bearing the full risk.
Mr Parish: We are not bearing the full demand risk.

Q225 Mr Burstow: Do you think it is sufficiently transparent from the point of view of the taxpayer’s interest?
Mr Parish: Yes, I do because the taxpayer will be able to see via the NHS and the Treasury the cost of investment and the service provided for that investment very directly. There is no murkiness in there, it is very direct, ie that is what it cost and that is what I got, therefore I think there is transparency.
Dr Mann: Mike put his finger on the fact that there are two kinds of risk. We are carrying all of the cost risk and that should not be under-estimated. The cost risk for the NHS has often been most onerous in major capital investments, recruitment, retention and other factors. We carry all that risk when we go into contracts. If you look at many of the PFI schemes and other major build schemes, they have gone from £130/140 million to £300/400 million. If that happens to us after we have signed the contract we will carry that risk. I am sure all of us have suffered those sorts of risks. I do not see that risk
being mitigated in the future. It is a very important element of the risk transfer from the public purse to our businesses.

**Q226 Mr Burstow:** You mentioned earlier on the question of openness, Dr Mann. Would you be happy for the details of your contracts to go into the public domain and, if not, what information should be withheld, and on what basis do you make that judgment?

**Dr Mann:** The details we would not want released are the details that Mike identified around what are the judgments we make about how we can deliver a service more cost-effectively and around how we feel we are adding value to the business. We have a team of people who do that and that is how we think we get our competitive advantage and I would not want to lose that. What we would be willing to share is a lot of information that I think improves clinical practice across the NHS and amongst us. We have talked about innovation. I have to say that a lot of this is about diligence, it is about saying let us be very, very scrupulous about all the little things that you can do, let us do them. You will recall that the Audit Commission did a report some years ago about the ways in which hospitals in the NHS could reduce non-attendances and a range of other things and they went back some years later and reviewed that and what they found to their dismay is that only 5 or 10% of these things had been applied. We would share how we have done a lot of those things, but the commercial assessments and such like we would not be willing to share.

**Chairman:** This has been a very informative session for us. May I thank you for the evidence that we received in writing this week. Hopefully at some stage in the future you will be able to read our report and its recommendations. Thank you very much for your attendance.

**Witnesses:** Ms Anna Walker, Chief Executive, Healthcare Commission; Professor Sir Graeme Catto, President, General Medical Council; and Professor Peter Rubin, Chairman, Postgraduate Medical Education and Training Board (PMETB), gave evidence.

**Q227 Chairman:** Could I welcome our next group of witnesses and ask you each to introduce yourselves and the organisations you are from.

**Professor Rubin:** I am Peter Rubin. I am here as Chairman of the Postgraduate Medical Education and Training Board, but, for the record, I should also say that I chair the Education Committee at the GMC.

**Professor Sir Graeme Catto:** I am Graeme Catto and I am President of the General Medical Council.

**Ms Walker:** I am Anna Walker, the Chief Executive of the Healthcare Commission.

**Q228 Chairman:** Could I declare my interest, that I am a lay member of the General Medical Council and have been since 1999. You may have heard or seen some of the issues which came out of our session last week, that the Royal College and other medical bodies were suggesting to us that clinical standards in independent sector treatment centres are inadequate. Do you have a view about that, whether they are or are not?

**Ms Walker:** The first thing I would like to make clear is that the Healthcare Commission regulates all NHS and independent sector treatment centres. We do not have a view as a regulatory body on what type of organisations they should be; our job is to ensure that, when they are there, we regulate them effectively. We have a well-developed regulatory regime for the independent sector; it is more developed than that for the NHS in many ways and in that there are a series of regulations and standards which look to oversee clinical effectiveness. Ultimately, it must be for those actually running a particular organisation to be responsible for clinical effectiveness and clinical outcome and what the regulatory regime can do is to ensure that the key issues are encapsulated and overseen in regulatory terms.

**Q229 Chairman:** Is there any comparison being made between the ISTCs and the National Health Service, from your perspective, in terms of clinical indicators?

**Ms Walker:** No, not on a systematic basis. The origins of the regulatory regimes for the NHS and the independent sector are, therefore, for ISTCs are actually very different. That is one of the things that we are working on at the moment because the more a mixed economy comes into place—and we have actually had a mixed economy for a long time and the crucial issue is a mixed economy where the NHS patient is being treated in the independent sector—the more actually the patient, and it is the patient which is the focus of our activity, actually wants to know that they are being treated broadly comparably. As your previous discussion showed, in many ways there is more information available on clinical outcomes, particularly from independent treatment centres, because of contractual arrangements with the Department of Health than there is systematically available from the NHS. One point that did, however, strike me was that there is a big difference between information being available between the Department of Health as the contractor or us as the regulator and the independent treatment centres and what is available to the public and there is a gap in availability to the public, and that is perhaps an issue we can come back to.

**Q230 Chairman:** Good data collected to make meaningful comparisons would be helpful, as far as you are concerned?

**Ms Walker:** I absolutely think that is right and information which is about outcomes and in a format which is meaningful for somebody who is trying to decide, “Should I take up this offer or not?”, I think that really is very important.
Q231 Chairman: Could I go back to this issue about clinical standards and ISTCs. Do you have any views at all?

Professor Sir Graeme Catto: Yes, the General Medical Council is responsible for regulating all doctors in the United Kingdom, including of course those who work within ISTCs. As the Committee has already heard, the doctors who work within ISTCs are predominantly senior doctors who are already trained and come from outwith the United Kingdom and again predominantly from the EEA. I should make it clear that the arrangements for regulating doctors, for admitting doctors into this country are quite different for doctors that come from within the EEA from those that come from the rest of the world, the so-called international medical graduates who come from any of the other countries outwith the United Kingdom and outwith the EEA. Before a doctor can be admitted on to the medical register, he or she must meet certain criteria; first of all, they have got to have their primary medical qualifications; secondly, they must have a certificate of good standing from the country of their origin and that needs to confirm the fitness and practice details that are relevant to that doctor, whether there have been any disciplinary hearings against them in their own country and, finally, they need to make declarations to us about probity and health issues which might affect their ability to work in this country. I should make it clear at this point though that being on the medical register does not mean that a doctor is necessarily entirely competent to work in all environments or is necessarily able to work unsupervised or even able to practise all of the procedures within their given specialty. The GMC believes that there are at least four levels, four layers of regulation: first of all, there is the personal level where the doctor himself or herself must be aware of their limitations; secondly, the team in which they work need to be aware of what the doctor is required to do; thirdly, and perhaps most importantly, the employing organisation has a real responsibility both for induction and to make sure that the doctor is competent to perform the individual tasks required of him or her; and then, finally, of course the General Medical Council has got a real role in ensuring consistency and having a national overview, and we make no distinction between private sector, public sector or any of the four countries in the United Kingdom. Therefore, it is clear from what I have said already, I think, that there are some limitations to having your name on the medical register and it may be that the Committee at some point would like to explore some of our proposals for revalidation and for changes to the specialist register which would make more information available to the public.

Q232 Dr Taylor: I really want to go on on that sort of theme because it has been pointed out to us or alleged to us by various people in some of the specialist fields that accreditation on the Continent, for example, is not accreditation to work unsupervised, but accreditation to work under a particular chief, and then people have alleged that they come then to this country and are accepted by you as fully qualified to work unsupervised. Is that correct or is that not correct?

Professor Sir Graeme Catto: Well, under the European legislation, we have no option but to accept these doctors in at the speciality level, so they come to us if they have already been accredited specialists within their own country and we would have to have a reason for deciding not to take them on to the specialist register.

Q233 Dr Taylor: But you would agree that that level of accreditation is perhaps slightly lower than ours?

Professor Sir Graeme Catto: It may be different in a practical sense, but, from a legal point of view, once the agreement within Europe was signed on 1 May 2004, there was a general acceptance that doctors who had reached the speciality grade would be able to move from one country to another without hindrance, so we accept them on to the specialist register and we would have to have a reason for not doing so.

Q234 Dr Taylor: So this is a very, very important point and the professionals who have talked to us do have a point?

Professor Rubin: Perhaps it would be helpful if I explained to the Committee the three main routes on to the specialist register because it is relevant to this discussion, and the word “overseas” has been used a couple of times this morning. There are three main routes on to the specialist register. For UK graduates, they go through a rigorous and quality-assured undergraduate medical programme. They then work for a couple of years in a managed environment, showing that they can put in the practice, the knowledge and the skills required of students. Then they go through a rigorous and quality-assured postgraduate training programme and there are assessments all the way through from the first day as a student through to the end of the postgraduate programme. That is what UK doctors do to get on to the specialist register. For doctors outside the EEA, international medical graduates, they too have to go through a robust procedure for which my organisation, PMETB, is responsible in which they have to produce documentary evidence in terms of certificates and references and other things to show that their training and experience is equivalent to that of a doctor working as a consultant in the NHS, so that is IMGs. As Graeme was saying, in the case of the EEA, neither the PMETB nor the GMC has discretion in the matter, but we have to accept the equivalence of training, so at both the undergraduate and postgraduate level we have no discretion.

Q235 Dr Taylor: So is there any obvious recommendation which we should be making from that?

Professor Rubin: To repeat what Graeme said, and this is a message that I try to give whenever I have the opportunity to do so, it is for employers to look very carefully at what a doctor has done and, for the reasons that Graeme is saying, whatever the EU says
about the equivalence, there may not be equivalence in terms of the culture in which a doctor worked and all sorts of differences may exist, so it is for the employer to look very carefully at what every individual doctor has done in their country of origin.

Professor Sir Graeme Catto: The same caveat applies to language. The regulator is not able to assess language competence of doctors coming from the EEA, but they can of international medical graduates and again it would be up to employers themselves to ensure that the doctor was able to communicate with patients adequately.

Q236 Dr Taylor: Sir Graeme, you said there were four strands, the personal one, then working with the team. Are you happy that in these independent sector treatment centres there are teams that would hold the boss of the team, the chap doing the operation, to account?

Professor Sir Graeme Catto: I have no knowledge of that and it is beyond my competence to answer that question. It just seems important to the General Medical Council that there are sufficiently robust induction processes to ensure that people coming to work in this country are able actually to perform the tasks expected of them.

Q237 Dr Taylor: So we go to the Healthcare Commission.

Ms Walker: What I wanted to add, which I hope might be helpful here, is that the regulatory regime for the independent sector and, therefore, for the ISTCs as well does put emphasis on the management of a healthcare organisation to satisfy themselves of those that they are employing for clinical purposes. In other words, there is a regulatory arm to this which can help. Now, there may need to be a debate about whether we have phrased that in the right way and there is also obviously a question about then the rigorous follow-up which we try and ensure that very best practice. Now, actually our statutory role of a healthcare organisation to satisfy themselves of clinician at each site and is responsible for clinical governance and mentoring”. Would you pick up if that existed in other sites?

Professor Sir Graeme Catto: None from me, sir.

Q238 Dr Taylor: So you would be able to pick up on your visits from members of the team, for example, if they were not happy about what was going on?

Ms Walker: Yes, to some extent we could. I could not claim that we could do it in all circumstances, but procedures in place, recognising the importance of this, the very fact of that standard makes a difference and then the checking of the standard also helps.

Q239 Dr Taylor: I think you said it is a specialist team that does the ISTCs, so it is a different team that inspects NHS treatment centres and ISTCs, is it?

Ms Walker: No, we are actually increasingly integrating our staff across the piece because we feel that is the best thing going forward. What we have had is a small team in the centre because we have had to think through the regulatory issues, especially in relation to ISTCs. As they become established, the team will remain in the centre, but our regions, because we are regionalising the organisation so that we can be in touch on the ground with local organisations, will take over the regular relationship.

Q240 Dr Taylor: So you then will be in a position to compare, as it were?

Ms Walker: We will be in a position to compare, and we will have people locally, so, if we have a concern or if others have a concern, we can go and visit.

Q241 Dr Taylor: You did say also that the Commission so far has only received one complaint against an ISTC. Could you give us any rough idea how many of our NHSTCs there were?

Ms Walker: There was one formal complaint about an ISTC. We receive about 9,000 complaints a year about the NHS. Now, that is clearly not a comparative figure and I am not suggesting for a moment it is a comparative figure. The complaints process takes complaints in the first instance to the provider of care in the independent sector and, if satisfaction is not available there, actually somebody being treated in an ISTC has two routes they can go: they can actually complain under the NHS processes or the independent sector processes; and, if they are not satisfied with their independent sector provider, they can come to us.

Q242 Dr Taylor: We had a very impressive submission from Care UK which runs some of the centres and they said at one point, “An NHS-trained and experienced surgeon is appointed as a lead clinician at each site and is responsible for clinical governance and mentoring”. Would you pick up if that existed in other sites?

Ms Walker: Yes, in the sense that, when we look at things, we are actually trying to ensure that the basics are there. What you are describing looks like very best practice. Now, actually our statutory role is to encourage improvement, so we are concerned to pick up that best practice and, as far as we can, suggest or incorporate it.

Q243 Dr Taylor: Any comments?

Professor Sir Graeme Catto: None from me, sir.

Q244 Dr Stoate: This does actually raise some extremely fundamental questions. Professor Catto, you are saying effectively then that you have someone on the specialist register from a European country and you have to accept them on to the register. We have also heard from other witnesses that some of them are trained not to the same level as an independent consultant in this country, but more as a sort of consultant under supervision, as it would be in another country, and you are saying that, as far as you are concerned, you cannot differentiate between the two. The question I want to ask is: were there to be a complaint to the GMC about a consultant who perhaps had acted beyond his competence because he was trained effectively as an understudy to a consultant in the EU, how would you handle that because you would have to accept that he was a consultant, you would have to accept
that he was on the register, but he may be in fact acting beyond his actual personal competence in a particular field for which a UK consultant may have no problems?

Professor Sir Graeme Catto: He would be treated in exactly the same way as any other doctor performing a task. The words sometimes get in the way. “Consultant” may or may not be the appropriate word here. This doctor is clearly taking a leading role in treating a patient and he or she must perform that within his or her own level of competence. The situation in Europe is that all doctors who have got to a specialty level are deemed to have got this CCT arrangement, certificate of completion of training, and, therefore, they should at that stage all be equal. That does not mean that they are all equally competent at any given task and it comes back again to ensuring that the doctor is not just clinically fit as he reaches certain standards in training, but is actually fit for the purpose for which he happens to be employed at the time. There is a real onus of responsibility on the employing organisation to ensure that, I think.

Q245 Dr Stoate: So who is to blame then when a consultant perhaps does overstretch himself and is asked by his boss to do a procedure which he may not be totally qualified to do, even though he would be qualified to do the majority of procedures? Who is to blame in that situation?

Professor Sir Graeme Catto: Well, the onus of responsibility must predominantly lie with the individual consultant or the individual doctor, it seems to me. If he or she ends up working in circumstances that cause difficulties, then the first port of call is for the doctor to put that right himself or herself, but I think we should try and get away from using terms like “specialist” or “consultant”; it is simply a doctor ensuring that he or she is competent for the task in hand. That does not mean that they are all equally competent at any given task and it comes back again to ensuring that the doctor is not just clinically fit as he reaches certain standards in training, but is actually fit for the purpose for which he happens to be employed at the time. There is a real onus of responsibility on the employing organisation to ensure that, I think.

Q246 Chairman: Sir Graeme, has the General Medical Council got any adverse patterns in terms of complaints from ISTCs as opposed to other areas of NHS work?

Professor Sir Graeme Catto: I looked into that before I came to the Committee today and the answer is no. That may of course be because the ISTCs have been in business for a relatively short period of time. We have got some doctors about whom complaints have been brought to the GMC, though none has gone through our processes completely yet, and we have got no reason to think there is a disproportionate number coming our way.

Q247 Mr Amess: How should appointment procedures be improved?

Ms Walker: Graeme actually talked about the onus being on the doctor. There must be a very significant onus on the employer, the management of the ISTC, to ensure that the doctor is qualified to look after the patients going through their care. Over and above that, I think the regulatory regime can help and it can help by holding management to account in the right way. We cannot take the responsibility from them, but we can ensure that in our regulatory regime the emphasis we put on our management ensuring themselves that they have got the right doctors doing the right things has sufficient emphasis.

Professor Sir Graeme Catto: Perhaps I could just build on that because I think that is absolutely right. I myself worked in the United States for some time and it was very helpful to have a period of induction where I got used to the way in which that particular organisation worked, the facilities that were there and the equipment that was used, so, although my clinical skills were transferable, the way in which they were actually applied had to vary and had to be adapted to meet the local circumstances, so I think it is not just the interview process or the appointment process, but it is the induction process thereafter, I think, that is critically important in giving these individuals time to accommodate to a different situation.

Professor Rubin: I do not have anything to add to those two answers.

Q248 Mr Amess: Has the additionality principle which applied to Phase 1 contracts led to an over-reliance on overseas doctors and should it apply to Phase 2?

Ms Walker: Graeme actually talked about the onus on the doctor. There must be a very significant onus on the employer, the management of the ISTC, to ensure that the doctor is qualified to look after the patients going through their care. Over and above that, I think the regulatory regime can help and it can help by holding management to account in the right way. We cannot take the responsibility from them, but we can ensure that in our regulatory regime the emphasis we put on our management ensuring themselves that they have got the right doctors doing the right things has sufficient emphasis.

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Professor Rubin: I do not have anything to add to those two answers.

Q249 Mr Amess: Beautifully put!

Professor Sir Graeme Catto: I thought the Committee might just be interested in some of the numbers associated with this because, with all I can tell you about the numbers of doctors who come on to the medical register, I cannot actually tell you where they are working or even if they are working. Some people may choose to be registered and not actually come to this country for some time. It is quite interesting that, if we look at international medical graduates, that is not UK graduates nor graduates from within the EEA, then in 2004 there were 104 that got on to the specialist register and in 2005 there were 36. If you look at doctors from the EEA, then in 2004 there were 1,329 and in 2005 there were 1,788, so there is a very small number coming from countries beyond Europe on to the specialist register, but apparently substantial numbers from within Europe coming on to the specialist register, though I cannot tell you where these colleagues are currently working.
Q250 Charlotte Atkins: One of the issues which has been arising in our evidence sessions is about the follow-up treatment for patients treated in independent sector treatment centres. Have you got any evidence that it is inadequate?

Ms Walker: No, we have not got evidence that it is inadequate, but it is one of the issues that in the early stages of the ISTCs has been raised with us in a number of ways. When it has been raised, what we have done, what our normal practice is, is to go into those particular centres, try and establish what is happening and find a way forward that is positive. In each case, we have been satisfied that there are appropriate new arrangements being made to ensure that happens, so I think actually it was an issue which was not thought through clearly enough and that came back to us in terms of complaints and concerns. I think a lot of progress has been made on it.

Q251 Charlotte Atkins: So are you saying that you now think that there is not a problem with follow-up treatment?

Ms Walker: I could not say that I did not think there was in all circumstances, but I think two things have happened. Where there has clearly been a problem, then there has been a dialogue on putting it right and that has been generally taken as learning across the piece both by those of our staff who regulate and by the centres themselves and, I am sure, by the Department of Health.

Q252 Charlotte Atkins: How many times have you had to go in and have a look at the situation?

Ms Walker: Not that frequently. Again, in preparing for today, you can imagine that one of the questions which I asked was: what is the pattern of complaint or actually the thing which is reported to us, what is called in regulatory terms, a ‘serious untoward incident’? The answer is that it has been broadly of a norm.

Q253 Charlotte Atkins: So what sort of numbers are we talking about?

Ms Walker: For serious untoward incidents, about 90. Now, in terms of comparisons, I am making those comparisons across the independent sector because we do not actually receive systematic information about serious untoward incidents in the NHS because that will tend to go to the strategic health authorities, so this is one of those areas where, because of the different backgrounds of the NHS and the independent sector, it may be that some thought needs to be given to getting a database, whoever is holding it, which is actually equal across both.

Q254 Charlotte Atkins: What about across NHS treatment centres?

Ms Walker: I do not know the answer to that.

Q255 Charlotte Atkins: When you are talking about these 90 cases, was there a pattern whereby particular firms or particular companies were receiving more complaints than others?

Ms Walker: There are two of the independent treatment centres which show higher serious untoward incidents than others. In each case, those statistics are not regularly published and they are not, as I say, for the NHS either. There is actually a debate of really some quite national significance over this, this question of wanting to ensure that that incident is reported so that the right action is taken compared with whether all of that is made publicly available. Anyway, the position at the moment is that that information is not publicly available. What we do, where there is a serious untoward incident, is we go into that particular treatment centre or organisation to satisfy ourselves that the appropriate follow-up action is being taken. If we have either a pattern of concerns or the particular concern is very significant, then we will actually insist on a root-cause analysis and satisfy ourselves that it is being followed up in that fundamental way.

Q256 Charlotte Atkins: Did you do that in these cases?

Ms Walker: Yes.

Q257 Charlotte Atkins: Could you name those treatment centres?

Ms Walker: No, I cannot, for obvious reasons.

Mr Amess: What a pity!

Charlotte Atkins: Absolutely.

Q258 Mr Campbell: I just have a question on training and the ISTCs. Basically, do you foresee any problems with the training in these centres?

Professor Rubin: I think, as with any new development, there are opportunities and there are risks. The opportunities come from a new provider coming up with new ideas and I do not think we should ignore that. There could well be innovative approaches to education and training coming out of the ISTCs and, as you have heard from previous witnesses this morning, in the first phase we are not required, or expected, to get into education and training because they had a task in hand which was to get through the large numbers of procedures. With respect to the next wave of ISTCs, there is a risk with respect to education and training, and the risk is that there will be a lack of clarity about what is expected by those who are commissioning the education and training and those in the ISTCs who are going to be providing it. Going back to the reasons of the ISTC: speed has been one of the reasons, to get through a reasonable number of procedures and to cut waiting lists. Once you start to train people, you would reduce the number of procedures you can do because you are taking time to show somebody else how to do that. For example, if you are doing cataracts, as a ball-park figure you might get through eight cataract procedures or so if you have a specialist who is doing the cataracts and not training; you might get through four or five if that specialist is training somebody else to do them. That is fine, as long as everyone goes into the arrangement, with respect to what is expected of the ISTC, understanding all the issues. It is not fine if the ISTC signed up to the same throughput as before...
while agreeing to take on training, unless that was explicitly acknowledged in some way in the contract. So there is a risk to the next phase of ISTCs and how they will handle the education and training aspect.

Q259 Mr Campbell: Who would have to bear the cost? Do you have to bear the cost?
Professor Rubin: The costs for undergraduate and postgraduate medical education are handled slightly differently. In the case of undergraduate medical education, there is more flexibility, in that there is something called SIFT which reflects the additional costs of education and training. In the case of postgraduate medical education, it is the salaries of the trainees that are held by postgraduate deans who are held responsible for postgraduate training. That is not the whole answer. Paying for the trainee is fine, but the trainee is being trained and you are still reducing the throughput while the trainee is being trained, so there has to be time to work through. What does it really mean to have educational training going on in ISTC? Those negotiations have to be intelligent and informed so that everybody goes into the arrangement with their eyes wide open.

Q260 Mr Campbell: Would the Health Service have to pay that cost or IST centres?
Professor Rubin: That would have to be done by local negotiation. Someone has to pay the costs or someone has to accept that the throughput will drop. That is the other consequence; you see, and in the next phase that could be the answer to including education and training.

Q261 Mr Campbell: You are certainly saying that the training will be up to National Health standards.
Professor Rubin: We at PMETB, as with the Healthcare Commission, have the legal power to go into and inspect the ISTCs, and will do so. Any training programme or training post, wherever it is happening in the UK, has to meet our requirements.

Q262 Anne Milton: I would like to talk to you about innovation and improvement and whether you feel that the ISTCs have stimulated both in the NHS.
Ms Walker: There is a sense, I think, that there is not a long enough history to look at that systematically, nor do I think, carrying out our regulatory function, that that is what we primarily expected. The point I am about to make is not a regulatory point, but it is about having recognised that the ISTCs were there to try to help with some of the waiting lists rather than innovation and improvement for its own sake.

Q263 Anne Milton: We were told by the Department of Health that one of the aims of the ISTC programme was to stimulate innovation in fact.
Ms Walker: I am not the Department. I do not know what they had in mind, so I simply cannot answer that. I think there is a regulatory issue around improvement. If I can put it this way, this question of the standard of care being provided is very much an issue for the regulatory function, and I do hope we have shown that we have as rigorous a system as we can for looking at that.

Q264 Anne Milton: It is whether the ISTC has stimulated improvement and innovation in the NHS. Has their presence levered up or ratcheted up (or however you want to put it) standards within the NHS and innovation?
Ms Walker: I have no evidence on that one way or another.

Q265 Anne Milton: It can be your view; it does not have to be evidence based.
Ms Walker: Yes.
Professor Sir Graeme Catto: Could I look at it from a slightly different perspective. I think the discussions this morning and some of the discussions the Committee had last week have shown up some of the deficiencies in the current systems, and I think the ISTCs have highlighted some of those deficiencies and therefore I hope that will lead to improvement. I hinted, when I spoke first, that we in the General Medical Council need to move on, so that historical medical qualifications are no longer, in themselves, sufficient to guarantee quality. My name is on the Medical Register because I qualified in 1969 and I have not been caught doing anything so awful that it has yet been removed; but you could argue that I have not done anything particularly positive to ensure that it remains on the register. Thus, when we are looking at information that will become more available to patients as doctors move from one country to another, we need to be quicker in making sure that that information is more readily available. That means, I think, not having a licence for life/be on the register for life, but having a licence for a period of time, and that the doctor can justify that licence being renewed. And, back to revalidation and the additional information that patients and the public will expect of doctors in the years to come, that applies not just to revalidation but also to the specialist register of all the deficiencies that we have already discussed this morning. So I think inadvertently it will lead to changes which I think will be improvements.

Q266 Anne Milton: It has turned the light on existing practice, in some ways.
Professor Sir Graeme Catto: From our perspective, that has helped, yes.

Q267 Anne Milton: Would you like to add anything, Professor Rubin?
Professor Rubin: I think I would agree with the point Anna made, that it is a little too early to be sure, but, with respect to education and training, ISTCs can be innovative, they can bring new ideas, if they are allowed to do so under the contracts which are being negotiated at the present time. I think this is a very important point—and applying not just to ISTCs—that it is very important not just to look at the short-term imperative but the long term as well, the quality of the doctors we are going to have 10 or 15 years from now. If we are allowed to do so, I am really quite confident that the ISTCs will want to drive innovation in education and training.
Q268 Anne Milton: If I could come back to the Healthcare Commission, I understand your organisation aims to find and promote examples of good practice. Can you highlight any areas of good practice that you have found within ISTCs?

Mr Amess: Oh, dear!

Ms Walker: No, I cannot encapsulate one which would illustrate. Perhaps the best thing I can do is to say that there are areas, such as we were talking about earlier, the transfer of care, where issues did come to light about that and then the willingness with which the particular centres work with us—and with the local NHS as well—to try to put that right. The other piece of evidence which we have which I think might be helpful, particularly in the light of the previous discussions, was that we do notice that where there is greater integration between the ISTC and the local NHS, the local healthcare economy—it is to do with the local hospital and the local PCT—that where you have it working integrally as part of that local healthcare economy, it all works very much better. That is one of the reasons why in our evidence, where you asked us what did we think about what should happen under Wave 2, how the ISTC really does mesh in with the local NHS we think is extremely important.

Q269 Anne Milton: I will come back to good practice in a minute, but I was going to ask you what you feel should be different about Phase 2. If you had to give four or five things that would make Phase 2 better, what would they be?

Ms Walker: I have already talked about the transfer arrangements. The question, also, of integration one way or another in the local healthcare economy. Lifting additionalities where it makes sense to do so—and that is an issue also about the position of the local healthcare economy. There is another point I would like to make about the medical training—and that is not a regulatory point, it is a much more general healthcare point—on this question about whether ISTCs should undertake medical training. We can understand why there is that debate, because this question of medical training is very important, particularly in relation to some of the activity which is going on in the ISTCs, so finding some solution to that which we could help underpin in a regulatory way, we think would be in the interest. There is one final point I would like to make, which I referred to at the beginning of the discussion: Wave 2, information available. You had a discussion about information being available between the contractor and the Department of Health—or it could be the NHS, in the future, the local PCT—and the providers. But there is also a question about the information that is available for the patient which I do think needs some attention, because the patient going into one of these centres wants some feel for what the outcomes are like compared with the NHS. That is not an easy job. This whole question of how you get comparable information and what indicators you choose which make sense to the patient is a big issue. We have begun some of it, because we have begun to talk to the providers about information that we would like on clinical outcomes, regularly from them, with a view to publishing that information and so making it available, but I think that is actually very important from the perspective of the patient.

Q270 Anne Milton: Professor Catto, would you like to add anything?

Professor Sir Graeme Catto: Perhaps just one wish from my perspective, and that is greater clarity on the role of the employer within the induction required for staff coming to work in the ISTCs. Secondly, I think this whole question of education and training is critically important. If we are going to have groups of patients segmented and dealt with in different ways, then it is clearly critically important that we get the education and training arrangements organised. These are my two wishes, I think, for the employers and the induction and education and training side.

Professor Rubin: I would agree with all that, and particularly integration of the local health economy and joint planning with the local health economy. That is particularly relevant to education and training. It may be that, for all sorts of reasons, not all of the second wave of ISTCs would be appropriate to undertake education and training—maybe there is plenty of capacity in the local NHS—but joint planning from an early stage with the local health economy and the providers of education and training is key. If that does not happen, things will come to grief in terms of education and training.

Q271 Anne Milton: If I may finish by coming back to the Healthcare Commission and good practice. I think we were slightly talking at cross-purposes, because you were describing what needs to happen to see it working well and I was saying: Have you, in an ISTC, thought “Wow!” I mean, have you? Have there been examples of something that is really, really excellent?

Ms Walker: I am struggling a bit because I am not the one who goes in. I think the best thing I can do is to take that away and ask those who do go systematically in—and we will come back to you.

Q272 Anne Milton: That would be quite helpful, because it would be very interesting to see that.

Ms Walker: I shall ask them about those things of which they thought “Wow” at the time.

Anne Milton: Exactly, yes.

Q273 Chairman: Could I ask you about this issue of lifting additionality. What is the highest risk to the local health community of doing that?

Ms Walker: If additionality were lifted totally, there must be some local health economies where the NHS could find that they were losing staff, and that was not one of the original aims of the ISTC programme and I suspect that needs to be kept in mind. I concede there is great sensitivity around that but some local health economies are in a very different position from others. There are some where there are staff available who would like to work in the ISTCs but...
the additionality is preventing it. So I think there has to be something very sensitive about relaxing the additionality.

Q274 Chairman: Have you, as an organisation, looked at that in any way?
Ms Walker: No, we have not looked at it systematically and in depth. It is something that in carrying out our regulatory regime we come across from time to time.

Q275 Chairman: You would not be able to give us any guidance on that. Would any members of your staff be able to give us any guidance on that?
Ms Walker: Again, I will go back and ask those concerned.

Q276 Chairman: It might be quite useful.
Ms Walker: Yes.

Q277 Dr Stoate: I would like to explore very briefly with the Healthcare Commission some of these outcome data, which I think are absolutely fundamental to what we are doing. I chaired the All Party Group on Patient Safety. Professor Catto came in and we had a very interesting meeting this week about how we are going to change the culture to improve patient safety. One of the most important things is data on information.
Ms Walker: Yes.

Q278 Dr Stoate: I am appalled in some ways that you are saying to us that you have outcome data for ISTCs, you have comparable outcome data from the private sector, but you do not have access to outcome data from acute trusts and others because that disappears off to the region. My understanding is that the reporting arrangements that finally come out of trusts are, to say the least, variable—which is probably a charitable way of putting it—so how on earth does anybody like me advise a patient which centre to go to. I can say, “I have got outcome data for the ISTC and I can give you some outcome data for the local private hospital—but NHS outcome data? It all goes off to the region. It could not help you much.” It is mind boggling.
Ms Walker: It is a really complex picture. As a patient myself sometimes, looking at one organisation compared with another, I think to myself, “Where do I start?” There is of course some outcome information available for the NHS. I am not suggesting there is none, because there is some on emergency readmissions, there is some on waiting lists—which are an indicator of something. The point I really wanted to make was that the Department of Health set the ISTCs up and, as part of their contractual arrangements, there is a very significant flow of outcome information, but we do not actually automatically get all of that information, and that is one of the things which both we and the Department of Health have learnt from the ISTC process.

Q279 Dr Stoate: Why are you not shouting at them. “We demand this information”? It is no good saying, “We only get a bit of it, some of it goes off to region, the Department has other bits” because the Department made it clear last week that they really do not have any that they are likely to share with us. Whether they do or not is another question, but they are certainly not about to show us any of the information they have. Why have you not shouted from the rooftops?
Ms Walker: I think there is a principle. Particularly where the Department of Health is the contractor, the flow of outcome information should be shared with the regulatory body. We are doing something about this area. We are talking to the independent sector providers, including the ISTCs, about producing some outcome information. This is information like planned transfers, emergency readmissions, return to theatre—so they are some of those issues on which there are the greatest concerns in ISTCs—and infection control, collecting that information and then publishing it. We have already begun those discussions.

Q280 Dr Stoate: I do not want to stop you, but I am still not satisfied. The fact is that you are doing something about it, you have got some of the information, you are making some progress. It is so fundamental, I cannot believe we are having this conversation. You should have access to all the information, all of which should be available to those who need it. As a GP, I have to decide which units patients should be referred to and I have no information to go on. The fact that you are working on it does not cut it.
Ms Walker: A message to us which says: “This needs to be done and to be done as quickly as it possibly can” I entirely understand. There are two issues that make this more complex. This is not an excuse; it is an explanation. One is this question of the publication of this information in a genuinely understandable way and which takes account of differences that you may have in case mix. That is actually really important from the patient’s point of view, because you do not want to frighten a patient who does not need to be frightened, so you do have to look at whether this information is properly adjusted.

Q281 Dr Stoate: That is fair enough. I accept that.
Ms Walker: So these things do take a bit of time. We have that. We have those discussions underway. We have a programme planned for it. A message from you as a committee which says: “This is important. Get on with it,” we would understand.

Q282 Dr Stoate: Do you ask for clinical outcome data before you inspect NHS providers?
Ms Walker: No. We have a lot of information available on the NHS. It does not tend always to be systematic but, because there is a lot of information, we can put in place and have in place systematic processes for looking at it. That is different from whether it is publicly available. So we are making a lot of use of information in the NHS and we are
moving to publishing more of that. One of the big questions I know we are going to face about the publication of information in the independent sector and ISTCs is: Is it systematically available in the same way as the NHS?—and that is something else we need to move forward.

Q283 Dr Taylor: When you inspect an ISTC you obviously get a lot of data. We have been given this morning, by the partnership health group which is Care UK, an exemplary list of their readmission rates, their complications. The only thing that is missing from that, when they do a comparison with Nottingham City Hospital, is a statement of the different difficulties of the operations, because independent sector treatment centres only take the two lowest risks, I think. If you do these inspections, do you automatically have that sort of list available?—which seems to me everything you need to know about what is going on.

Ms Walker: I do not know whether those who have gone into these particular ISTCs have had this list or not, but they do have information available on which they then carry out the check in relation to the standards and the regulations. And, of course, we also have that information, which is not systematically published, for the reasons I was explaining earlier, about encouraging patient safety on serious untoward incidents. So there is outcome information which is used for the purposes of inspection.

Q284 Dr Taylor: And you have mentioned the information gap to the public and obviously the time that it takes to get the news out to the public that a particular place perhaps is not as safe as others. What can you do to minimise that?

Ms Walker: I think there are two sorts of unsafe, if I may put it like that. I think where we need to be is: a regular flow of public information, so that that is always available to those who are taking a choice. Every so often, you will have a more significant and serious problem. If it is serious enough, then that information has to go into the public domain as an emergency. On the whole, we do not get those, but there is always the possibility that we will.

Chairman: Could I thank you all very much indeed for this morning’s, now this afternoon’s, session. I am sorry we have overrun by a few minutes. I think that is the order of the day. We will have the report to you at some stage in the future with the recommendations. Thank you.

Witnesses: Professor John Appleby, Chief Economist, The King’s Fund, Mr James Johnson, Chairman, and Dr Paul Miller, Chairman of the Central Consultants and Specialist Committee, British Medical Association, Dr Sally Ruane, Senior Lecturer, Health Policy Research Unit, De Montfort University, and Mr Daniel Eayres, Public Health Information Specialist, National Centre for Health Outcomes Development, gave evidence.

Q285 Chairman: Could I welcome you to the Committee. Thank you for coming along For the record, could I ask you to introduce yourselves and the organisations which you come from.

Mr Eayres: Daniel Eayres. I work for the National Centre for Health Outcomes Development. We work under contract to the Department of Health, analysing the KPI data and the ISTCs.

Mr Johnson: I am James Johnson. I am the Chairman of the British Medical Association and I am a consultant vascular surgeon in Cheshire.

Dr Miller: I am Dr Paul Miller. I am Chairman of the British Medical Association Consultants Committee and I am a consultant psychiatrist in Sunderland.

Professor Appleby: I am John Appleby. I am the Chief Economist at the King’s Fund.

Dr Ruane: I am Sally Ruane from the Health Policy Research Unit at De Montfort University in Leicester.

Q286 Chairman: Could I ask a question of all of you: what research has been carried out into the effectiveness of ISTCs? Have there been any problems with carrying out research with this area?

Dr Miller: The Health Policy and Economic Research Unit of the British Medical Association late last year surveyed clinical directors in anaesthetics, ophthalmology and orthopaedics, the three specialities far and away most likely to be affected by treatment centres. They surveyed them on their views and the impact on NHS treatment centres and the independent sector treatment centres. I think the main conclusions or headlines would be that the perception and the experience was that NHS treatment centres were more beneficial for patients than the independent sector ones, and this was overwhelmingly to do with integration with the rest of the NHS: that the continuity of patients’ care, the availability of notes, the ability to talk to other doctors and consultants involved were much easier with the NHS treatment centres than they were with the independent sector treatment centres. Though I should say from the start that it was widely found that there were benefits to patients in terms of shortening waiting times.

Q287 Chairman: Was there any clinical indication in this research at all? Was there any thing different there?

Dr Miller: We did not go in any great depth into differences in clinical issues, though one of the outcomes that was found was that these clinical directors, in their experience, found there were more problems with readmissions post-operatively from the independent sector centres, almost certainly because they are not integrated with an NHS facility which would have the ability to deal with post-operative complications. That is not what the ISTCs are for.
**Professor Appleby:** As far as I am aware, there has been very little systematic research into, as you say, the effectiveness of ISTCs. There is, as I understand it, an official Department of Health funded study of NHS TCs but no equivalent on the independent sector side, which I think is rather remiss. In part, it depends what you mean by research into effectiveness. I suppose I would go back into research into achieving the aims and objectives of the ISTC programme, and as far as I am aware there is no research into that at all.

**Dr Ruane:** The *Health Service Journal* conducted a survey of PCT and acute trust chief executives which was published in January last year. That was not specifically on effectiveness; it was more a question of how those chief executives perceived the impact of ISTCs on them and certainly the acute trusts. I think 79% of respondents of the acute trust chief executives believed they had had a significant impact on forcing their trusts either to reduce activity or to forego growth as a result, and there seemed to be particular impact on orthopaedic work. I think some of the more qualitative material that came out of the HSJ survey is equally important though. One of the columnists commented that there had been more strength of feeling, and more, what he called, “alarmed and angry” communications to the *Health Service Journal* over this policy than over any other policy that had taken place over the last few years, and that this was perceived as a fundamental contradiction of other health service reforms.

**Mr Johnson:** The research that has been referred to, both for the BMA and what you have just heard, is essentially extremely soft research: it is asking people who may well have pre-formed opinions about the general principles involved here what they think about how it is going. Probably that is all you can do at the moment, because even some of the first wave ISTCs have not even started taking patients yet, let alone the second wave, but we believe it is absolutely essential—and in the three-quarters of an hour I have been listening to your discussions, clearly so do you—that we have outcome data published from the treatment centres and equivalent outcome data from the NHS—which largely is absent—to compare it with. If you just have one and not the other, it is meaningless. If you have complications, is that bad, is it good? Who knows? You need to know whether it is doing better or worse on average than a similar basket of NHS hospitals across the board. You heard in the last session that some outcome data is available. It is very mechanistic sort of outcome data that you can get off a computer: how many people will be collected from April. These are the types of measures, where the status of the patient is measured before the operation and the status of the patient is measured again after the operation and some sort of measure of improvement or change or impact is made. At the moment, the key performance indicators that we have are some clinical ones, such as cancellation, readmission. Some are purely process ones, such as: Did referral lead to an inpatient appointment? Some of them do not reflect the patient pathway at all. For example, there is an indicator about additionality—you know: Were any staff employed who should not have been?—and that is in no way a clinical indicator or a patient noted indicator. We have looked solely at these, and, as I have said, on what we would call outcome indicators, KPI 15, no data has so far been collected and given to us. We understand from the Department of Health that that sort of information will be collected from April. These are the types of outcome indicators in which you were particularly interested.

Q289 **Mr Burston:** That is right. Before we go on to that, I just want to see if there is anything more you can tell us about the research you have done to date on the KPIs that have been published today and what they tell us about things.

**Mr Eayres:** We have five key points about them. First, we had quibbles with some indicators, and particularly the way specification is related to the way in which they were reported, which gave us...
some problems in creating robust comparable indicators. There are a lot of issues around interpretation of the indicators by the different ISTCs. They interpreted definitions in different ways and supplied different data. There are issues around completeness and quality of the data that was returned. Although they were all supposed to be returning data on certain KPIs, there was very little guidance from Department of Health in terms of in what format it should come. There was not a standard template, so there was a lot of variation in the completeness and quality that came in. Another issue we had was the lack of a clinical outcomes data, which was KPI 15. The final point was the way the data comes into us in terms of monthly aggregated returns and there is very little could we do in terms of validation of that data. We are basically accepting what the ISTC give us. They say, “Oh, yes, we had 100 admissions, five of those led to readmissions.” They give us that; we cannot really validate it at the moment.

Q290 Mr Burstow: That brings me back to the point you were making just now about the non-availability to you of this point about the clinical outcomes data. If you were here earlier on with our first session, you would have heard the exchanges we had with the various operators of the centre at the moment. My observations on that were that there seemed to be some confusion amongst operators as to what they were supplying at this stage, and that is something our advisors need to unpick, but one of the things which was also unclear was that at least one of the providers was putting into the public domain considerably more outcome data than the others at this stage. Do you believe that all the providers are currently collecting more outcome data but they are just not supplying it to the Department. What information or knowledge do you have of what is being collected, even if you are not being supplied it?

Mr Eayres: I do not know what individual ISTCs are collecting internally or making available to patients or the public internally. All I am aware of is what Department of Health provides to us that they have collected from the ISTCs.

Q291 Mr Burstow: Apart from this point about the Department providing a clearer framework in which data is collected so that the data is more comparable, are there any other points of learning you could draw from what you have done so far about how the system could be improved to make sure the data is being collected better?

Mr Eayres: Yes. We have made a number of recommendations to the Department of Health about how the data ought to be collected. In particular, we recommended a move away from monthly aggregate returns, to a system whereby we build the indicators ourselves out of the patient level data which they are obliged to submit in the same way that NHS hospitals are obliged to submit. Some of the KPIs might require additional information outside of the standard data set, but that way we can then do all the aggregation of the data, and that would remove all the possibilities of different interpretations of definitions, etc, so we could standardise it a lot more.

Q292 Mr Burstow: Has the Department responded to that?

Mr Eayres: They have agreed in principle and they are in discussions along the lines of implementing that at some point in the near future.

Q293 Mr Burstow: KPIs, you have outlined to us in some detail now what each of them might be in terms of the categories they broadly fall into, but what was the process for choosing the KPIs? How was that arrived at?

Mr Eayres: We were not involved at that stage, when the KPIs were chosen. My understanding is that they were chosen to reflect in some way the patient pathway through the ISTC. But, for example, they start off with referral, so there is an indicator which says: How many patients were inappropriately referred? At the next stage there is an indicator saying: Of those referred, how many then led to an inpatient appointment? At the inpatient appointments, how many did not attend? How many were cancelled? And so on through the process, until we get to a stage where they have had the operation, and then: Did it lead to a transfer? Did it lead to a readmission? Did the patient then complain? If the patient complained, was that complaint dealt with within the appropriate time framework? Most KPIs are based on that sort of idea and then there are a few additional ones tagged on to the end.

Q294 Mr Burstow: Would it be possible, if you had the disaggregated data, to reconstruct the KPIs in a way that would allow you to draw more meaningful comparisons with the equivalent data collected from direct NHS providers?

Mr Eayres: Yes. That is one of the reasons why we recommend that the Department of Health do it that way. If the ISTCs are submitting the same minimum data sets that they are required to submit as the NHS do, we basically have the same data for ISTCs and NHS hospitals, and we can then write the same queries and create the same indicators for both.

Q295 Mr Burstow: You said they have been agreed in principle. When do you think they might agree in practice?

Mr Eayres: I cannot say.

Q296 Mr Burstow: Maybe we will ask the Minister that question.

Mr Eayres: It is within the philosophy of the national programme for IT within the NHS, in that we should not be creating new return systems. Wherever possible, clinical data should be collected, and then administrative/performance management data should be extracted from that clinical information. There is even a secondary user service being set up as part of the information programme to do that. Our recommendation is that, for the ISTC programme, that information flow is channelled in through that programme.
Mr Burstow: Thank you.

Q297 Dr Taylor: Going back to aims and objectives, I think it was Professor Appleby who said that there has been no research or collection of data on the achievement of aims and objectives. Have any of you any impressions of the effect on waiting lists and how much of that has been due to the independent sector treatment centres?

Dr Miller: Perhaps the one where the data is clearest is in cataract surgery. The independent sector treatment centre cataract programme so far had done 20,000 cataracts by the end of January 2006, but that needs to be put into perspective. The NHS itself is doing just over 300,000 a year, and the productivity of the NHS increased very greatly in recent years as a result of a joint project between the Department of Health and the Royal College of Ophthalmologists. They sat down a few years ago together and agreed a plan/arrangements to increase cataract operations in the NHS. That was done successfully, so that we now have a figure of 300,000 done on the NHS and the target per year is 9,000 in mobile cataract schemes. That gives you an idea of the relative contributions.

Q298 Dr Taylor: We have had that several times from several people. Professor Appleby wants to come in.

Professor Appleby: I would like to make the point, which I think partly Paul was making, that the NHS has been tremendously successful in reducing waiting times over the last three to four years. Actually, whether the ISTCs have had any added effect to that is very difficult to say. The one thing we do not know is how long patients have been waiting who have been treated by ISTCs. This is part of the information set we would like to have to which Daniel was referring earlier. ISTCs are treating NHS patients. The information about their treatment, their diagnosis, how long they have been on the list before they get treated and so on should be treated in just the same way as if they were treated in an NHS trust hospital; that is, it should become part of what is known as the hospital episodes statistics system, which we could then analyse in lots of different ways—and then we can start to make comparisons as well. The other thing I would like to mention is waiting times and waiting lists. We know they have been coming down over the last few year—in terms of waiting times, tremendously, and waiting lists have also started reducing recently quite significantly. It is not enormously clear why or how this has been happening. If you look at the numbers of patients taken off the waiting lists to be treated in NHS hospitals, it has actually been falling over the last five or six years. One would perhaps expect that if waiting lists were going down the NHS would be treating more patients. That does not seem to be the entire story, in that it also seems that not so many patients are going on to waiting lists in the first place. So the actual reasons why waiting lists and waiting times are not coming down is not solely a function of capacity. There is an issue around that which I still think needs exploring.

Mr Johnson: I think one of the biggest factors in bringing down waiting lists is the recognition that if you separate acute care from elective care, you can guarantee to do the elective care. You do not turn up, as I do not infrequently, to do an operating list and find that all the beds are full of acute medical admissions and my surgical patients have been sent home. If you do not allow that to happen—because, effectively, you deal with your elective patients in a separate institution that does not have emergency medical admissions and you know when you come in to do your operating list that you will do it—it runs more efficiently. If you separate these things, then you use the facilities far more efficiently. Probably that has had more to do with bringing waiting lists down than the independent sector ones, which, as I say, in the first phase some are not even on line yet. The impact they have had, purely because they have not been there very long, has not been very great. The sorts of figures Paul Miller gave to you about cataracts indicate that, although they have done a lot of cases, in terms of the total numbers it is quite a small proportion.

Q299 Dr Taylor: Do we have any similar figures for orthopaedics?

Mr Johnson: Not that I know of.

Professor Appleby: I think they have been made available recently in a PQ. I cannot remember the numbers offhand, though.

Q300 Chairman: Has anybody ever done a study about where they are and where the waiting lists were? I represent a seat in South Yorkshire that has high waiting lists for orthopaedic surgery, and the ISTC has done thousands of operations, not just from South Yorkshire but from a wider area—in orthopaedics. There was an issue of geographically putting these in, as opposed to putting them in and seeing how it affects national things. Has anything like that been done to anybody’s knowledge?

Dr Ruane: I have not seen any study of that, but I note that some time ago—and the Department of Health representatives made a reference to this last week—SHAs and PCTs carried out an analysis in their own locale of capacity gaps and where they needed extra capacity. That would, I should have thought, reflect waiting lists. It may be possible to obtain some of that information from there, but of course that does not mean that that is up-to-date now.

Q301 Chairman: If that treatment centre has done the thousands of operations that it has, is it not likely that that has helped to reduce the waiting lists in the area that it covers?

Dr Ruane: I think there is some anecdotal evidence that patients have particularly welcomed rapid access to independent sector treatment centres—partly because they have tended to be underutilised, and so patients have been able to get in faster, perhaps. But I have not seen that quantified and I have not seen that patterned geographically.
Q302 Dr Taylor: If the same money had been put into the NHS, would we have seen any more improvements?

Professor Appleby: Possibly. Part of the whole research question around this issue is that we do not know. We can have a guess at that, but, as I say, possibly.

Q303 Dr Taylor: What do any of you think of the financial planning of the programme? What financial planning was there?

Dr Ruane: It seems to me that, in a number of respects, the policy has not reflected joined-up thinking, and I would have thought financial management would be one area where this would be the case. I think it is partly because the issue of waiting lists is clearly only one issue that went into influencing the implementation of this policy, and, again, I think the representatives from the Department indicated this last week that other factors kicked in, including the desire to open up to diverse providers and so on, so you tended to have treatment centres plonked down in different places. But certainly I think PCTs have had an important aspect of financial flexibility and the management of their finances taken away from them, because they have been tied into contracts with ISTCs that they have not always wanted, and I think something that comes across very strongly from the evidence that has been submitted, as well as from other sources, is that there is a strong degree of imposition about this policy. It has come from the centre and it has been imposed from the centre. Not all PCTs have wanted it. Although, again, I have not seen a total set of figures at all, you do get glimpses that PCTs in different parts of the countries have lost up to what tends to be in the realm of several hundred thousand pounds, through activity which they have had to pay for but which is then not taken up by patients, either because of referral patterns, patient choice, or for whatever reason—perhaps there was not a need in that particular area. I think the information from Dennis McDonald to this Committee is quite interesting, because he sets out activity rates in the North East by PCT, and you can see very, very different variable take-up amongst the PCTs, with several hundred procedures in some PCTs down to a couple/a few dozen in other PCTs. Perhaps that is because there were different morbidity profiles, a different need in those PCTs, but they have certainly lost out economically. I think the Department has stepped in with money, has it not? Am I right on that? I understand that there is a £100 million fund. I do not know if I am getting things mixed up here, but I think the Department of Health has accepted that it will take that financial burden now. But that is still resources lost to the NHS.

Mr Johnson: Could I widen this slightly. The BMA is not in any way opposed to either treatment centres or the multi-provider NHS, so I am not trying to make points about this, but our biggest criticism is that, in setting up a multi-providing NHS effectively, a market where different firms are competing with the State to provide services), a regulatory framework—the rules of the game, if you like—was not written, and we are playing Monopoly and making the rules up as we go along. That is unsatisfactory. We would have five areas where we think we need a written set of rules before you can play the game—and you have heard all of them this morning. The first one is an integrated service. If you are going to have different providers providing different bits of care, they must talk to each other. If you are going to go home from hospital and be looked after at home, the people at home have to know what operation you have had. We do not have an integrated, seamless service and there is not a set of rules for it. You must have—and we have talked at length about this—comprehensive audit of clinical outcomes (not these non-clinical ones) and the NHS ones to compare them with. If you do not have that, people will say, “Treatment in treatment centres is rubbish” and you cannot refute it and they cannot back it up. That is unsatisfactory. You need to have a regime for what happens when a hospital fails. It might not even be just that the orthopaedics goes out of the hospital into a treatment centre; you might so destabilise the situation that all the specialist services that the private sector does not want to provide (intensive care, maternity, A&E) are going to close down because there is no more money any more. We do not have an exit strategy and the Department is quite frank in saying we do not have an exit strategy, and we need that. We need to be able to train medical staff—we have talked extensively this morning and you have about training in treatment centres. Finally, we must ultimately, after these people have entered the market, have a level playing field. They think it is stacked against them, we think it is stacked against the NHS. It has to be transparent and a level playing field. When you have a set of rules for those five issues, you have a regulatory framework and you can play at markets. I have this summarised on a bit of paper, which I would be happy to submit as supplementary evidence. To develop these as you go along seems to us to be totally wrong.

Professor Appleby: If I may just go back to your first question about the financial planning of the programme. From the Department of Health point of view, one of the aims, the vision, it seems to me, is market creation: it is to fit in with the more pluralistic providers supply side and a desire, frankly, to put pressure on, and, in a sense, destabilise the NHS—not completely, of course, but to ginger up the market, if you like, with the independent sector. I guess that to entice them into this potential market, compromises were made on both sides, in terms of finances and the nature of the contract that was on the table, and that was accepted by the private sector and the Department. We heard earlier on about who is bearing the risk. It seems to me that is a really important question. It is a bit like concerns about PFI, do we have the bearing of the risk right in terms of the rewards that are being offered. That is where some of the quibbles, or not quibbles but big questions, about value for money and so on arise. It seems to me, in a sense, that both sides made some
compromises there. The NHS offered what was, in effect, competition for the market, not competition in the market, so a five-year contract more or less guaranteed work. Okay, there was risk borne by the private sector in terms of their costs, but presumably they came to the opinion they were worth bearing, given the rewards and so on. I think that there was a negotiation and splitting of the risks and so on relative to the costs and the rewards that went on. Whether that was worth it depends on our view or my view or your view about whether it is worth achieving the objectives, which is plurality of supplies and so on. That is the tricky thing about, say, doing some research into this to try to evaluate whether the ISTC programme is meeting that particular objective. We have not got there yet, to start with, so it is difficult to evaluate.

Q304 Dr Taylor: That is very helpful.

Dr Miller: I would like to come in on your question on planning too. My understanding is that when the survey of the Strategic Health Authority was carried out sometime ago for the shortfall, the initial answer they came back with was: Half a million procedures. They were told to go and look more carefully and came back with a second answer, which was: A quarter of a million procedures. Their third iteration apparently came up with 170,000 procedures' shortfall. I think that illustrates that the degree of planning involved in this is beyond the ability of the NHS to do very well. What else? I think it would be wrong to think that the objective of this programme is just about bringing down waiting times. It was clearly stated that one of the objectives of this was, indeed, to create a sustainable competitive market in the provision of services. I think that is fairly obvious from the way some of it has gone. Some of the other bits of planning that did not go too well would influence the additionality, which was not a terribly well-thought-out answer to some of the problems that have been discussed regarding Wave 1, such that, in fact, it has been changed and relaxed considerably for Wave 2 and is abolished completely for the Independent Sector Extended Choice Network currently being tendered for. On poor planning, the other example would be the Oxford eye capacity debacle, where it was only after some senior NHS managers had resigned from the service that they felt able to talk about the bullying and the pressure they had been put under to accept capacity that they had always thought they did not need. My understanding is that that spare capacity from Oxford is currently being hawked around the country to see if anyone will buy this surplus capacity. I also want to refer to the evidence on page EV165 about the North Tyneside ISTC. The evidence refers to the six PCTs being charged £200,000 each for this treatment centre and I would like to put some local knowledge on to that. It is not surprising that North Tyneside have 434 of the 1,047 patients treated there. It is in their patch. It is also perhaps completely unsurprising that Sunderland has only sent 63, despite paying the same £200,000. Sunderland City Hospital has a three star trust. It is one, I gather of only seven in the country that has been consistently three-star in the star ratings. It does not, as I understand it, have a particular problem with waiting times. Lastly, Gateshead has only sent 14 patients there, despite spending the same £200,000. Why? Gateshead also has a reputation for good quality services, good management and—which else?—it has its own NHS treatment centre, so why would it be sending along the coast to an ISTC? I want to make that point to talk about what I would see as the poor planning of these services.

Dr Taylor: Thank you for pointing that out. That is helpful.

Q305 Dr Stoate: I have got a very simple question in a way for the BMA. One of the objectives the Department has come up with is that the ISTC programme has been designed to stimulate innovation and improve working practices. Is there any evidence that is the case and, if so, have you got any examples?

Mr Johnson: No. Paul has been talking about whether Gateshead or wherever send people but ultimately with patient choice we will be talking about where the patients want to go and not where Gateshead PCT wants to send them and, therefore, what will matter will be whether the units are supplying what matters to patients. Probably one of the things the patient can judge least is how well the operation went because they have nothing to compare it with, they have not had three before. They do know if the doctor was nice to them and the nurse was polite, whether they were kept waiting or not, whether they could park their car and get a decent cup of coffee, and all of these things are going to be what matters to the patients. If a hospital can provide these things, which in medicine we have probably regarded as rather on the fringe of what mattered before, good medical care being everything, they will attract patients. I have no doubt at all that all these treatment centres have got the message that these fringe activities, if you like, good parking and so on, are going to be very, very important in staying afloat. This is the sort of innovation, not wonderful clinical innovation, different ways of doing things that I think we will see in the first instance. They will provide a service that is very attractive to patients and patients will say to each other, “You want to go there, they don’t keep you waiting, it is really good, et cetera”.

Q306 Dr Stoate: I am slightly concerned about this because I do not think those are fringe activities. I think that treating patients in a way that makes them feel comfortable and relaxed, to have someone who takes the time to come and talk to them, someone who sits them down and gives them a cup of tea, asks after their partner, “Can I get your partner a cup of tea?”, all of these—

Mr Johnson: I was trying to put fringe in inverted commas.

Q307 Dr Stoate: Sure, but the NHS traditionally has been spectacularly poor at that.
**Mr Johnson**: Exactly so.

**Q308 Dr Stoate**: And in terms of what patients value those things come pretty high up on the list. My own view is that if the NHS is driven to provide these so-called “fringe activities” in order to compete that can only be a good thing.

**Mr Johnson**: I agree.

**Dr Stoate**: Thank you very much.

**Q309 Mr Campbell**: I have got a question on value for money. I think I know what answer I will get from the panel, but I am still going to ask it anyway. Are we getting value for money and how can it be measured? It really cannot be after what you have just said.

**Professor Appleby**: I think it can be measured, we just need to get the right data. We also need to ask ourselves what it is that we want to measure the value of: is it the cost per operation done; is it the cost in terms of creating some sort of expanded market or some sort of contestable market; is it the cost of reducing waiting times and so on? We need to pin that down and relate it back to what the objectives of this whole programme were, or are, or are emerging to be, and we need to be clear about that.

**Q310 Mr Campbell**: We have got some data. Mr Miller gave us some little hints of centres not being used, so what has happened to the money? The NHS has lost that money if it is not being used.

**Professor Appleby**: I do not want to say what the Department would say but I suppose there is a transition going on at the moment so, as I said earlier, there has been some compromise in terms of the length of the contract, the nature of the contract, what is being paid for, what is being provided, and so on. The evidence, such as it is that I have seen, suggests that the independent sector is providing operations which are at a higher average cost than the NHS. At first sight it does not look worthwhile in some sense. I suppose the argument could be, and certainly the ISTC people here earlier said, that over time they will get the costs down, in terms of costs per patient it will become cheaper than the NHS possibly and there will be value for money. We are in a bit of a gamble here as to whether that will happen or not.

**Q311 Mr Campbell**: Can you see in the foreseeable future that they can compete with the Health Service because if they cannot they are not going to be worth it, are they, at the end of the day?

**Professor Appleby**: In part it depends on something that James raised which was the rules of the game and the rules of engagement as to how the NHS market, and there is one, is going to develop in future and the extent to which we have market regulation and the nature of that. Will NHS Foundation Trusts be able to compete for these treatment centres, for example? Is there going to be competition for the market or is there competition in the market so that private centres can set up and if they take patients and patients want to go there, fair enough, if they do not they bear that risk? At the moment we are looking at a very regulated market, if you like.

**Q312 Mr Campbell**: So what you are saying is that if the contracts come along to be had then the Health Service or a local hospital can compete for them.

**Professor Appleby**: As I understand it, the contracts for Wave 1 and Wave 2 are simply within the private sector, as it were. The Department of Health do not invite bids from the existing NHS.

**Q313 Mr Campbell**: But that could be opened up?

**Professor Appleby**: Maybe that could, yes.

**Q314 Mr Campbell**: That is a good point, we will have to remember that.

**Dr Miller**: Could I address that question? There have been a number of reports of contracts for Wave 1 ISTCs where the workload contracted for has not been carried out and they still get paid because that is the nature of the contract. That has been reasonably well documented in a number of places. I wrote to the Department of Health specifically about how the contracts were structured and the response I got back, to be fair, was perhaps predictable, understandable and believable, dare I say. It was pointed out that this is a five year contract and you would perhaps not expect the business model to take off from day one and the expectation is that whilst they have not carried out 20% of the five year contract in year one there is an expectation that it will take off and be delivered in total over the five years. I think it is important to take that into account. The whole issue of value for money is more complicated still than that. Some of these contracts are at NHS tariff plus a few per cent, some are at less than NHS tariff, but what has not been mentioned today, as far as I am aware, is that some of them also have tie-ins. At the end of the five year contract there is a residual value agreed for their buildings and their equipment for which they will be paid at the end of the five years if the contract is not renewed, as I understand it. The whole question of value for money is a lot more complicated than just whether they do it at tariff plus 5% or tariff minus 10%, there is a lot more to it than that.

**Q315 Mr Campbell**: IT centres are getting paid whether they do the procedures or not.

**Professor Appleby**: Yes, they are.

**Q316 Mr Campbell**: There is set money and that is it. If they do not do them they still get the set money. That does not happen in the Health Service, does it?

**Dr Miller**: Yes, they are, but I am saying the answer I got when I raised that was that the expectation is they will catch up over the five years and that we will have to wait and see.

**Professor Appleby**: As far as I am aware that is a longer period than the NHS is being given in terms of the phasing in of the so-called payment by results. I would argue that I do not understand why the ISTCs cannot be part of that same phasing in. I heard some of the excuses, I suppose, earlier on you...
cannot compare ISTC costs with NHS costs because, I do not know, the independent sector pays VAT and so on, there is this and that, pension issues and so on. Of course there are lots of variations within the NHS and different hospitals have different rates of efficiency and so on, so there are always quibbles about whether you can compare one hospital with another, but I would have thought on balance they have got to take the rough with the smooth on that one. One of the reasons the private sector give for why they want to enter the market is they can be innovative, at least perhaps on the cost side, that they have new ways of doing things, they employ Hungarian doctors and not UK doctors because there is an issue about private pay rates, for example. I think it should be able to compare the private sector and the NHS and make some judgment about value for money.

**Mr Campbell:** It will be interesting to see what profits they make.

**Q317 Mr Amess:** Dr Ruane, you made it very clear in your written evidence to the Committee that you are not very keen on these independent treatment centres. I would not call any of your evidence libellous but if you do want to libel someone it will certainly enliven our proceedings! You spoke about Canada and America specifically and said that you were aware of schemes with public-private partnerships that were not working out at all. I wonder if you could briefly give us some examples.

**Dr Ruane:** I made a reference to Canadian and American research not because I was claiming or suggesting that the American healthcare market is analogous to ours, because it is not, but because there research has been mentioned a couple of times in very interesting Health Service journal articles and because there has been the suggestion in Canada in recent years that for-profit companies set up hospitals within their health economy, which is not identical to ours, and I thought it would be interesting to have a look at some of the evidence that has been collected. I was thinking particularly of the research by Devereaux and colleagues. Devereaux is based in McMaster's in Canada and has worked with a team of colleagues in Canada and America. What they have done is to provide a systematic review and what they call a meta-analysis of pre-existing studies comparing for-profit and not for-profit and in some cases public hospitals. These have been compared around mortality rates. I thought it was worth looking at this material because I think it is methodologically quite sophisticated and it is methodologically quite transparent, so you can see whether you think they have done enough to make sure that their results are not biased. They have gone through all sorts of hoops to try to control confounding variables. They have evaluated studies blind, in other words not knowing what the outcome of the studies were, and they have pooled data around 26,000 hospitals and something like 38 million patients in the United States. What they found was that on mortality rates, for example, there is a 2% higher adjusted mortality rate in for-profit hospitals than not for-profit hospitals. They have also done work around comparing payments for care and found that for-profit hospitals take higher payments for care than not for-profit hospitals. There has been research by Vaillancourt Rosenau & Linder around cost-effectiveness, access and quality using a different methodology comparing a large number of studies and, again, the studies came out overwhelmingly in favour of the not for-profit. I am not suggesting we can just transfer that to here because that is not what we are working with, but what that raised for me was there is evidence there that has been collected with some care and with some degree of methodological sophistication but what is the evidence base here for our policy. I am not sure what the evidence base is for this particular policy. There have not been pilots so far as I know, there has not even been a great deal of public discussion. I suppose what I was trying to flag up was I am not sure what the evidence base is and maybe we need to develop a stronger evidence base for this policy.

**Q318 Mr Amess:** You said, disappointingly, absolutely nothing that is libellous.

**Dr Ruane:** I am sorry. I will try harder next time.

**Professor Appleby:** I was not going to offer anything libellous but maybe a little counterbalance to that. The economics literature around, in a sense, ‘does it matter who owns the means of healthcare production’? is, to say the least, mixed. It depends what you look at. If you are looking at the costs of for-profit or private sector hospitals compared with public hospitals, probably ‘yes’ is the answer but, again, it depends what you are looking at within that. In terms of access and health outcomes, the literature I have seen is reasonably mixed, to be honest. I wonder whether, in fact, who owns the means of healthcare production is the right question. You have to know what the financial incentives are in a particular healthcare system, how the contracts are set up, the nature of the contracts and so on. In a sense, it seems to me those are more important issues than the ownership issue.

**Mr Johnson:** The other issue that makes it very difficult to compare with what we have just heard about the North American system is that an arbitrary decision has been made that the price is fixed, which is a very strange situation for any real market and, therefore, we compete on things other than price. Given that the price is fixed a lot of what we have heard about North America does not apply because the price is not fixed in North America and for-profit hospitals will be more expensive than not for-profit hospitals, and so on, and HMOs take different views in America about which hospitals they will pay for and which they will not. It is very difficult to draw analogies between those two systems. My personal view is that sustaining this policy of a fixed price is going to be extraordinarily difficult. If you have purchasers who are very strapped for cash three years down the line and an organisation, private or public, comes and says to them, “Look, we will do these for you below tariff because we think we can still make a profit”, I find it
very, very strange that the state would be able to say, “No, that is not allowed”. There will be just some sort of cashback deal or something like that.

Q319 Chairman: Do ISTCs destabilise the local health economy?
Mr Johnson: Potentially they can.

Q320 Chairman: Do they?
Mr Johnson: There are one or two examples, and it is only one or two so far. There was one of orthopaedics in Southampton where the NHS unit closed because the patients were being sent to an ISTC in Salisbury. The only thing that closed was the orthopaedic unit so you could argue that you simply transferred the venue from where the orthopaedic surgery was done. Potentially it could go either way, you could have a whole hospital threatened because a lot of its surgical income would be taken away.

Q321 Chairman: It is highly unlikely to have A&E taken into this process. We had people from the profession sitting there last week who said it made good sense to take elective surgery away from A&E because of the potential for A&E to disturb elective surgery because of incidents that happen on our roads and elsewhere during the day. You are not saying doing that would threaten it in that way, surely not?
Mr Johnson: I would see it destabilising it because it would remove a sufficient chunk of the hospital’s basic finance that the hospital might conceivably become unviable.

Q322 Chairman: The other thing that was said earlier on was their influence innovative on the National Health Service. Do you think any of your members have changed their work practice because they have had an ISTC in the neighbourhood?
Mr Johnson: Some of them have gone to work for them in their spare time. I have no evidence that the practice has changed as yet. I would expect the change to be more along the lines I was talking about before to Dr Sioate of providing services that make the service more attractive to patients.

Q323 Chairman: I accept that. One of the issues was about influencing what is happening inside the NHS.
Mr Johnson: There was a case in, I think it was, Yarmouth over the orthopaedic surgeon who decided to run a production line and as one patient wound up in one theatre the next was put to sleep in the next theatre and he just went from one to the other. I am quite sure that was in response to the need to be productive and efficient but whether or not you could say that is a broad trend that is happening is rather unlikely at the moment.

Q324 Chairman: I think he was trained in France, was he not? Do you think that is a good idea?
Mr Johnson: There are arguments on both sides. The most dangerous time with an anaesthetist is when you are putting the patient to sleep and when you are waking them up. If you take your eye off the ball to put another patient to sleep at the same time you potentially have two crises going on at the same time. These things are not simple, you have got to have enough staff to do it with.

Q325 Chairman: From what I read it was the surgeon who was moving. The Secretary of State has been using it quite regularly in her speeches.
Mr Johnson: She has indeed. You need to have an extra anaesthetist to allow the surgeon to do that. If you are doing it without an extra anaesthetist it is probably not safe, but if you do it is safe.

Q326 Chairman: Dr Miller, you have got something to say.
Dr Miller: You asked about innovation and destabilisation. I think one of the ISTC representatives at the first session this morning said that he did not think there was anything truly unique or innovative that was not done anywhere in the NHS that was being done in their centres. I think it is important to remember that the NHS is innovative. It is not like the NHS has never changed profession sitting there last week who said it made

Q327 Chairman: Do you think that is a threat?
Dr Miller: I think it is inevitably a threat.

Q328 Chairman: If you have got a surgeon who is running two theatres, okay he has got to have a lot more support staff and everything else, and that surgeon might be used for an hour during that four hour process and an hour in a neighbouring one as well, surely that is of more benefit to the
organisation, and particularly the patients, in as much as you are going to get into the theatre quicker if you have got surgeons delivering two forms of services at the same time.

Mr Johnson: All other things being equal, yes.

Q329 Chairman: I realise that and it may not be. That should not be perceived as a threat, it is a way that things may move in the future.

Dr Miller: What I meant by a threat was even if by patient choice only 10% of patients looking for elective surgery chose, even just out of curiosity, to go to an ISTC, first that would not be surprising, I think the evidence is a lot of ISTCs do these things well that the NHS has not done well and give an attractive offering, the loss of 10% of elective income would be hugely destabilising for the NHS unit.

Q330 Dr Taylor: We have heard a lot about the importance of integration and the value of integration between the NHS and the independent sector treatment centres. Have you any examples of useful interaction taking place already?

Mr Johnson: Not yet. I work in a hospital where there is one being built in the back yard, sort of thing. One of the two principal limiting factors in my NHS hospital that is slowing down everything is lack of radiology. We have a complement of about 50% of the number of radiologists we ought to have. People stay in bed in hospital for days waiting for their ultrasound scan or something, a total waste of NHS money and their time. This new treatment centre, which is only going to have 40 beds, is going to be orthopaedics. It has got three general radiology rooms, a CT room and an MRI room. It is going to be 100 yards across from us. It will be hugely underused from the point of view of the treatment centre firm. I cannot believe that we could not jointly use that facility so that they would get more money for using it and we would have access to radiology and become a lot more efficient as a hospital. These seem to be the sorts of examples where everybody gains from a bit of co-operation.

Q331 Dr Taylor: The crucial question was really brought up by one of the independent sector people this morning, the question of salaries. Would NHS consultants be prepared to take a session on as part of their job plan under the NHS to work in that sector? Would that be possible, would that be practicable, or would they insist on the scale of salaries in private practice?

Mr Johnson: I think in this instance it would be rather the other way around. We would be looking for their radiologists to come and work in the NHS, in which case we would presumably offer them NHS rates. I think these are negotiable. Frankly, if a surgeon or anaesthetist decides in his own time that instead of going to do some private practice on a Saturday morning he will go and work for a treatment centre it is a matter for negotiation what the deal is and if it is not satisfactory he will not do it. It will not necessarily be NHS rates.

Q332 Dr Taylor: We hear of NHS surgeons doing crosswords on the news because there are no facilities for them to work at that time. If they have got spare slots on their job plans could they move those spare slots into an independent sector treatment centre? It would seem obvious that they should.

Mr Johnson: With respect, I think the reference to crossword puzzles was due to the fact that the NHS has virtually been told to stop working for the last two months of the financial year because it has run out of money. That is a whole new ballgame but it is something I would not support or excuse for a moment. It seems a very mixed message to tell you to work and be productive and efficient for the first 10 months of the year and then stop doing everything for the last two. That is just a bad system. That is what the crossword puzzles are about. If it were part of the job plan that it would be better done at the treatment centre it would be for the employer to second the consultant and say, “Rather than work for us for this session, you work there”. That provision is available.

Dr Taylor: This is a point we will take up in our workforce inquiry.

Q333 Chairman: I am sure we will. The BMA would not have a problem with that, would they?

Mr Johnson: Providing that the consultant was not sent against his will, no.

Q334 Chairman: They would be going there on their NHS contract which could totally destabilise the private doctors who are working in there. You would not have a problem with that as an organisation, would you?

Dr Miller: More than that, specifically we have been underused from the point of view of the treatment in talks and discussions and negotiations with the Department of Health to provide a framework in which such secondments could happen avoiding various pitfalls that could occur.

Q335 Chairman: This would be effectively through local integration as opposed to national direction, is that what you are saying?

Mr Johnson: We have no problem at all with that.

Q336 Chairman: I think that is about it. Obviously you have had a taste of the first phase and the second phase is on the way. I think we have got most issues out of you. One thing I was going to ask was you do not see a problem with training people in ISTC’s from the profession’s point of view, do you, providing everything else is equal?

Mr Johnson: It will not just happen.

Q337 Chairman: It would slow down the activity, as training does, but you do not see a problem in relation to that?

Mr Johnson: The problem will be that for the first time the costs of training will become transparent. It has been regarded in the NHS rather as something that you do. If the treatment centre firm says to the
PCT or whoever is buying it. “Okay, you want us to train, this will cost you X extra”, the PCT will say, “Hang on, we have never paid for training before, what is all this about?” It will start to make it transparent but that is probably no bad thing. **Chairman:** Sorry for the overrun. It happened in the first session and we consistently overrun with the second and third as well. Thank you very much indeed for your evidence. We will at some stage be bringing out a report. Thank you.
Thursday 23 March 2006

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess
Charlotte Atkins
Mr Ronnie Campbell
Jim Dowd

Dr Doug Naysmith
Dr Howard Stoate
Dr Richard Taylor

Witnesses: Ms Jane Hanna, Former Non-Executive Director, South West Oxfordshire Primary Care Trust and Mr Robin Smith, Chief Executive, Mendip Primary Care Trust, gave evidence.

Q338 Chairman: Good morning. Can I welcome you. It looks like you are on your own, I think Mr Smith is on a train somewhere we are led to believe by his office. He may join you or he may have to sit in on our second session this morning. Can I welcome you to what is our third evidence session of our inquiry into Independent Sector Treatment Centres. I wonder if, for the record, you could introduce yourself and where you are from.

Ms Hanna: I am Jane Hanna. I am a former non-executive director of South West Oxfordshire Primary Care Trust. In my main job I am a tutor in constitutional and administrative law at Keble College Oxford and I run an epilepsy charity. I am also a Liberal Democrat district councillor in the Vale of the White Horse.

Q339 Chairman: The first question—I do not know if you have any wider views than outside of Oxfordshire on this one—is what do you believe the geographical location of the first phase of ISTCs? What was it in Oxfordshire and if you have any views wider than that we will be more than happy to hear them.

Ms Hanna: I think from our experience in Oxfordshire there was no evidence of a need in our locality and, therefore, the decision about geography was more to do with a national policy relating to the bringing in of the treatment centres rather than consideration of the locality.

Q340 Chairman: At that time, obviously, the strategic health authority was a major force in relation to that and to some extent in Phase 2. What contact did you have with the SHA? Did you have any about the geographical location?

Ms Hanna: The only contact I personally had with the strategic health authority was in a private meeting with managers from South West Oxfordshire and Cherwell Vale PCTs. As non-executive I was present along with the chair of South West Oxfordshire PCT and the chair of Cherwell Vale. At that meeting the only discussion about location was around the fact that the view was the evidence indicated there was no need for a treatment centre in our area and, therefore, we were concerned that given that the strategic health authority was looking to bring the decision forward at that time that we would be looking to vote “no” at the board meetings because the evidence would not be in place.

At that point we were threatened with a personal surcharge by managers at the strategic health authority.

Q341 Chairman: Richard Taylor is going to take up a little bit more about that issue but at this particular stage, as far as the PCT board was concerned, they felt that there was not a need for this treatment centre. Was that because you had not got waiting lists, if that was the issue, and I believe on Phase 1 it was the major issue, or was it that you could have turned things around yourself and got rid of waiting lists? What was the issue in terms of the board’s view on this?

Ms Hanna: The consensus, which as I understood was shared by the Cherwell Vale as well as South West and South East Primary Care Trusts, by all the clinicians and all the managers in July 2003, was that the Oxford Eye Hospital was on target for meeting the six month waiting target and would in fact reach that target before the proposed date for the opening of a treatment centre. That was because there were already initiatives ongoing in the local NHS for improving the service in terms of the waiting times. The evidence was that they were on track.

Q342 Chairman: That was evidence as far as your board was concerned that there was effectively no need for it on the basis that the targets would have been met by the NHS locally?

Ms Hanna: Yes, and in July in the private meeting it was clear cut that there was no need and, therefore, at that point a letter was to be written to the strategic health authority to say that we did not want to proceed with the consideration of the business case for the treatment centre.

Chairman: I am going to move on to Richard who wants to take us a step further on your journey.

Q343 Dr Taylor: Going on the geography a moment, in your first bit of evidence that you sent to us you say—and I am reading—“Subsequent to the decisions the TVSHA commissioned an independent report into eye services in Thames Valley, the Finnemore Report, and that did conclude that there was no need”. So where did this strategic health authority get the idea that there was a need beforehand? Did they, or did they just respond to pressure from above?
Ms Hanna: I have to say I am not entirely clear about that. There was a lack of transparency about how the figures were generated and where they were generated from. It was admitted in the summer of 2003 that a mistake had been made on the numbers and that led, in the September, to a reduction in numbers as part of the contract but not to the decision that the PCT could not proceed at all with the treatment centre. We believed there were not any numbers to justify any treatment centre.

Q344 Dr Taylor: You believe it was a complete gap in knowledge of what was required between the local PCTs and the strategic health authority?

Ms Hanna: And the national team. I think it is very difficult to ascertain where the work went on which generated that.

Q345 Dr Taylor: Can I explore the bullying issue because this, by anecdote, is rife in the NHS and even recently PCTs which do not want to go along with the Government merger are being pressured. Now it is only anecdote, do you have anything in writing to prove this threat of a personal surcharge? Was this just made by a midnight telephone call?

Ms Hanna: No, the threat of the personal surcharge was made in the private meeting at the strategic health authority in front of many witnesses. I made a contemporaneous record of the meeting. There was no minute taken of that meeting and that was quite usual for minutes not to be taken of these sorts of discussions. I have a written contemporaneous record which I can provide to the Committee should you want it.

Q346 Dr Taylor: Usually the claims that this has happened are met with a complete denial.

Ms Hanna: Yes, and at that meeting I responded to the threat by asking if it could be put in writing so that it could be put before the board and we could consider it as part of our decision-making process. We were then told nothing would ever be put in writing, so it would be left as something that was said verbally. That was my experience throughout the whole of my time at the PCT, that these sorts of pressures were brought about in informal and private and essentially verbal meetings rather than anything that ever went into writing.

Q347 Dr Taylor: I think this is fearful important because at this moment we are losing the Commission for Patient and Public Involvement in Health, nobody knows what we are going to get in the way of patient forums, whether they are still going to be independent. It needs to be brought out into the open that non-executive directors are not the independent representatives of the people, except very occasionally. You were brave enough to stand up against these so I think we would like any actual written evidence of what went on so we could possibly take it further. I am sorry to go on but when one is interviewed to be a non-executive director you are asked whether you would go along with a consensus if you disagreed with it. Almost the ethos of being a non-executive director is that you have to do what you are told, which is completely wrong. Is there anything else you want to say? Have you any hard evidence of bullying?

Ms Hanna: The evidence of bullying around the actual decision time was that we would often be in meetings with executive members where they would indicate that if we were to vote against the treatment centre that their jobs would be threatened. On a number of occasions one manager in particular was extremely distressed and broke into tears and would say we were placing her job on the line. After we made the decision not to vote for the treatment centre all the non-executive directors were called by the chair of the primary care trust and were told that he had been told that John Reid wanted a reversal of the decision on his desk by 12 o’clock on the Monday. The words that were used to us were that Jane Betts of the strategic health authority was on the way to the NHS Appointments Commission and the tables were turning, by which we all understood that our positions as non-executive directors were under threat. The chair had previously told us that he had been informed that two other chairs of boards had been told that they would lose their jobs if their boards voted against the treatment centres. All of this was reported during the weekend following the decision to all the local MPs. They were around at the time when it happened because essentially the non-executives were isolated within the board. We were not allowed to issue a press release about why we took the decision we did and instead were subjected to negative publicity in the press about the stance that we were taking. It was at that point that we contacted all the local MPs in Oxfordshire to tell them what was happening.

Q348 Dr Taylor: One final question: as a tutor in law what did you think about the PCT board not to consult under section 11?

Ms Hanna: I advised the board that I thought that was illegal. I said I thought the board should seek independent legal advice rather than accepting the advice from the strategic health authority. Personally I consider that the move to the private treatment centres in Oxfordshire is a significant variation in service. It does have a major impact on pressures were brought about in informal and essentially verbal meetings rather than anything that ever went into writing.

Q349 Dr Taylor: What do you think of the decision to exclude consultation about PCT mergers from section 11?

Ms Hanna: Again I think that there should be statutory consultation. I think the public should have a say on these key questions.

Q350 Charlotte Atkins: Going back to the bullying issue, are you suggesting that this bullying occurs in other PCTs and do you have any evidence of that?
**Ms Hanna:** I think the only evidence I had of other PCTs related to Cherwell Vale PCT where prior to the decision the chair of Cherwell Vale had been told that her job was on the line if her board voted against the scheme. In a subsequent discussion with her a couple of months back she confirmed to me that was the case. In relation to the bullying, I would like to refer the Committee to the evidence of Jane Betts and Martin Avis in the Changes to Primary Care Trust Report where Jane Betts said that “. . . it became clear to me that on the issue of the treatment centres my role and that of the board and the executives had been completely subsumed to the will of Richmond House. This placed my staff in great distress and made my board impotent. We became a conduit for communication rather than being able to handle the issue ourselves.” There is evidence there that the Thames Valley Strategic Health Authority was also subject to the pressures that we were under as a PCT.

**Q351 Charlotte Atkins:** You have no other evidence than your own anecdotal evidence in your area and in that PCT?
**Ms Hanna:** I think I have to reiterate again that none of the bullying ever is put in writing.

**Q352 Charlotte Atkins:** I just wonder, given what you have said and your stand, whether other PCT non-executive directors had contacted you to say, “The same thing is happening in our patch”?  
**Ms Hanna:** Only the managers of the Cherwell Vale who would come along to our board meetings. We had a close relationship with them but, no, non-executive members did not approach us from other boards.

**Q353 Dr Naysmith:** On this same area, I want to ask, you mentioned there were figures and then they were revised down with the contract. Where did the first set of figures come from and how did they get revised down?  
**Ms Hanna:** I do not know where the first set of figures came from.

**Q354 Dr Naysmith:** What I mean is were they put before you as a non-executive director at a meeting?  
**Ms Hanna:** They were presented as figures from the managers of the PCT board who were working with the strategic health authority who were working with the national team.

**Q355 Dr Naysmith:** They had been asked to provide figures for the national team?  
**Ms Hanna:** I am not sure.

**Q356 Dr Naysmith:** You may not know the answer.  
**Ms Hanna:** I am actually not sure because the process is not very transparent at all. What I did see were internal emails during the summer of 2003 which indicated that managers had realised that a mistake had been made.

**Q357 Dr Naysmith:** It was admitted that there was a mistake and they would have to provide them?  
**Ms Hanna:** In emails that I saw that were sent on to me anonymously. I have got those emails should you want to see them.

**Q358 Chairman:** I think we are going to be joined now by our second witness for this session, Mr Smith, who has now arrived.
**Mr Smith:** Thank you, Chairman. Can I apologise for my late arrival.

**Q359 Chairman:** You have probably just heard that evidence about the issues that happened in Oxfordshire.
**Mr Smith:** Yes.

**Q360 Chairman:** You are the Chief Executive of Mendip Primary Care Trust.
**Mr Smith:** Yes.

**Q361 Chairman:** I started by asking the question which led on to the issue of what happened in Oxfordshire about what determined the geographical location of Phase 1 of the ISTCs in that area. What was it that determined it in your particular area?  
**Mr Smith:** There were two drivers, particularly the services provided by the NHS trusts in the area. My own PCT abuts the Royal United Hospital area in Bath and the United Bristol Hospital area in Bristol. I do not know if Members are aware we have had particularly challenging times in meeting the waiting list targets in those areas. What do we do? We locate into treatment centres strategically to achieve best access times for patients.

**Q362 Chairman:** Was there the consultation carried out locally with yourselves and other organisations like the SHA and other bodies?  
**Mr Smith:** Initially there was a discussion amongst the chief executive community about the principles of treatment centres and then we had a joint meeting of all of the five PCT boards with the strategic health authority to discuss the concept. We explored, through that mechanism, whether or not this was an appropriate way to increase capacity. The aim in Dorset and Somerset was not to shift work from acute service providers but to give faster access to patients in our local area and get true additionality. We were looking to reduce waiting times not shift work from an acute provider per se.

**Q363 Chairman:** Was there a consensus within the PCTs about that?  
**Mr Smith:** Yes.

**Q364 Chairman:** Was there a consensus about the money? My understanding of the first phase, certainly in my area, was that our budget was effectively taken from the PCT, put into the ISTC and then we had to find out whether patients followed them.  
**Mr Smith:** I cannot speak for other areas but this was part of our local development plan as part of the growth funding provided through the NHS funding resources.
Q365 Dr Stoate: It has been claimed that some ISTC activity has been paid for but not delivered. Have you any evidence of that, Mr Smith?

Mr Smith: In our area we would expect in the first 12 months to deliver the full value of the activity commissioned.

Q366 Dr Stoate: Over a one year cycle?

Mr Smith: Yes.

Q367 Dr Stoate: We have heard from some people that it has been projected over a five year cycle and as long as they complete the five year contract that is acceptable. You have not got any evidence of that?

Mr Smith: No. Bearing in mind these are very new facilities and they start from a standing start, they have not been established anywhere at any time, in some areas it may be necessary to have what they call a ramping of activity so you get the full value over a period of time. In my view that would be a reasonable thing to do. Whether five years is a reasonable period, I cannot say. We would expect to deliver full value in year one.

Q368 Dr Stoate: As far as you are concerned all the evidence you have got is that you have always delivered the full value of what has been paid for within 12 months?

Mr Smith: We have not had 12 months’ activity yet; that will not occur until August of this year. We have agreed with the provider the activity levels over that period to achieve that full value.

Q369 Dr Stoate: As far as you are concerned that will happen?

Mr Smith: There is no reason to expect at this time that it will not happen and we have looked at it very closely.

Q370 Dr Stoate: Ms Hanna, have you any evidence to the contrary or do you have the same view as that?

Ms Hanna: There was a complete lack of transparency about this. You have to look at the contract. I did manage to get a copy of the Netcare contract under a Freedom of Information request in January this year. I think I would like to challenge the evidence of previous witnesses that the problems of the payment for non-performance can be overcome over a five year cycle of the contract. There is a take or pay and minimum delivery clause in the Netcare contract where payment must be made regardless of whether the operations are performed. The purchaser cannot require the provider to perform any number of operations in the future due to under-performance in the previous period. There is a monthly minimum take value but under that contract that amount is commercially confidential so I am not able to give you the information on what has to be paid regardless of whether operations are performed.

Q371 Dr Stoate: You have no evidence that they have been under-performing and being paid for operations they have not done?

Ms Hanna: Under the Netcare contract we do a six month review by South West Oxfordshire Primary Care Trust. At a PCT board meeting on 24 November 2005 Netcare are currently contracted to provide 800 cataract operations a year in North and South Oxfordshire from April 2005 for four years. South Oxfordshire is contracted to take on average 456 cataract operations and 593 pre-operative assessments per year. The board paper showed that in the first six months of the contract £255,000 had been paid to Netcare, although only £40,000 of work had been carried out.

Q372 Dr Stoate: Was there any evidence that would put itself right within a completed 12 month cycle or as far as you are concerned has that not happened?

Ms Hanna: I do not think I can answer the question because the information in the contract is commercially confidential about what the minimum payment is in the monthly period. It is quite clear that there is a monthly payment which is due regardless of under-performance. You cannot just catch up during the cycle of the contract.

Q373 Dr Stoate: Will you know at the end of the 12 months how many cataract operations were carried out over the 12 month cycle? Is that information available?

Ms Hanna: Can you repeat that?

Q374 Dr Stoate: You know how many cataract operations have been contracted for, is there any way you can find out how many have actually been done over a 12 month cycle?

Ms Hanna: By non-executive directors insisting on reports to the board. My understanding, certainly I did a review on the website last night of local PCT boards and the strategic health authority, is there is very little by way of any information on review of treatment centres. The six month review in South West Oxfordshire only happened because non-executives insisted board after board meeting to have this review taking place. I think the only other way is to get it through a Freedom of Information request.

Q375 Charlotte Atkins: I am assuming you do not think that ISTCs provide value for money?

Ms Hanna: I think I can say that the ISTCs that I have had experience of have certainly not provided value for money. They have been a waste of taxpayers’ money and that is clearly of significance in Oxfordshire at the moment where we are experiencing serious cuts to local services.

Q376 Charlotte Atkins: What changes would you introduce in Phase 2 to ensure that those problems are overcome and that they do provide value for money?

Ms Hanna: Personally I think there is a fundamental problem with abuse of process and the independence of the boards and they are the key bodies which are making decisions and are monitoring these contracts. Unless these issues are addressed it has fundamental implications for the objectivity of
information coming to boards and for the whole decision-making process. I personally would not want to proceed until there were fundamental changes put in place. I have thought about it long and hard and I do not know whether it is possible without taking executive members of boards or having elected health boards. I think it is a very serious question. I think the other point would be that I do not think the second phase should proceed until there is a full independent review of all the treatment centres and all the information is known.

Q377 Charlotte Atkins: You are suggesting the remedy is elected health boards?
Ms Hanna: I came to that conclusion. I had four years as a non-executive on the Radcliffe Infirmary Board before being a non-executive on South West Oxfordshire PCT. I did give a lot of years to the current system but I had to come to the conclusion given how the processes worked, how I experienced them, that the only protection would be if you had elected representatives who would have a good reason to stand up publicly and debate the arguments in the local context of whether a treatment centre was necessary or not.

Q378 Charlotte Atkins: Your experience as an elected councillor gives rise to your confidence that as an elected councillor you have a much better way of challenging decisions made than you do as a non-executive director?
Ms Hanna: I think one of the fundamental differences is that my experience as a local councillor is that the officers look to report to the local authority as their employer and are providing the information pretty much in an objective way as the council wants it. My experience on the PCT was that managers’ primary interest was in meeting political demands from above and that the board was quite often seen as a bit of a nuisance and the board was there to be managed. Certainly I have some internal emails which were shown to me which include statements by managers which relate to how one manages the board. I think you have to ensure that managers are looking to protect the local interest as much as they are looking to meet national policies.

Q379 Charlotte Atkins: I think you have perhaps a slightly rosy view of how councils work but, anyway, I will pass on to Mr Smith. What is your view about the value for money of ISTCs?
Mr Smith: I do not think you can take the ISTCs in isolation when you are considering value for money. I think you need to take account of the wider impact of the programme on the whole of the NHS family. I can only speak again from my local experience, and indeed the UK private sector, if I may say. I was spending between two and two and a half million pounds a year in the UK private sector prior to establishing the treatment centre, it is what I call the “picture on the wall” syndrome. The moment I announced that we were building a treatment centre the pricing structure of the UK private sector changed overnight. That is a significant view. If you apply that across the country you can see there are benefits which are not directly associated with the process of the treatment centre, similarly in the way practice is changing within the NHS family locally. A typical operating list for someone with cataracts is between four and six people having their cataracts done in an NHS facility locally and using the practice that the treatment centre has used that has doubled in most of the hospitals so you are getting more output for the same level of investment in the UK healthcare system.

Q380 Charlotte Atkins: Without any adverse effect on patients?
Mr Smith: None at all, in fact in some ways a better experience because a patient is not in the theatre as long and they are treated very well. I did an initiative prior to the treatment centre where I used a private sector supplier. I got a local ophthalmologist to audit the work and I said have free access to it. He came back with a very full exposition of what he thought of the treatment. His only comment was that they only dealt with the cataract and clearly if there were other presenting symptoms they had to be treated as well. Clearly what we were doing in this operation was giving people their eyesight and allowing them to live full and active lives. We could deal with the chronic illness subsequent to the giving back of sight. One hospital locally changed its whole operating procedure to do left and right eyes instead of having left and right eyes going through the same theatre. Those are just some of the spin-offs. The other thing, of course, is that we are only tied to this for five years if we want it and if we do not want it after five years we stop doing it. We have not invested hundreds of millions of pounds in a permanent facility which has a life of 60 years, which you cannot use for the purpose for which it was intended, so you get flexibility. You probably gather I am slightly less concerned about the programme because of the wider impact. Our experience working with the provider that we have been very positive, they have been very open and very anxious to work with the NHS family as well.

Q381 Charlotte Atkins: Any changes in Phase 2?
Mr Smith: I think Phase 2 is going to be harder for the ICT providers because the learning from Phase 1 is clear and, therefore, we are more able to drive a slightly harder bargain, and that is clearly the intention. We would hope with the experience of working with this in Wave 1 they will be able to operate the tariff and move forward from there.

Q382 Dr Stoate: You mentioned, just briefly in your answer, that there had been a significant change in private fee structure.
Mr Smith: Yes.

Q383 Dr Stoate: Could you expand on that a bit because that is quite interesting.
Mr Smith: A typical hip in the UK private sector prior to the treatment centre would cost me between £7,000—£10,000 depending whether you went to BMI Nuffield or one of the other BUPA hospitals and it depended how busy they were and how
desperate we were. Bearing in mind we were trying to deliver faster treatments for patients and meet the waiting list targets which were set us, with the introduction of “the picture on the wall” we reduced that price by £3,000 per procedure.

**Q384 Dr Stoate:** That is very interesting, and you think that could happen across the country?

**Mr Smith:** I do not know, I am only representing my local experience. You do have to watch very carefully because if it was a spinal procedure, I am not doing spinal procedures in the treatment centre so, therefore, negotiating on spinal procedures with the UK private sector is different from negotiating on hips if you understand.

**Q385 Dr Stoate:** You think the element of competition brought in by the ISTC has significantly impacted upon the private sector?

**Mr Smith:** Yes, absolutely.

**Dr Stoate:** That is very interesting. Thank you.

**Q386 Dr Naysmith:** As you probably know, I know quite a bit about some of the area that you are talking about and I can confirm what you are saying about cataracts, it has completely changed the waiting lists for cataracts in Bristol as well as in the area that you are talking about. I want to talk about some of the things you have said already. The analysis that was made before the treatment centre was opened, did people look to see what its effect would be on the National Health Service? Did they document and talk about it or was it seen as an additional thing in getting the waiting list and waiting times down?

**Mr Smith:** You will appreciate there was a great deal of concern expressed by local NHS providers, particularly the clinical community. What we did with them was, prior to establishing a contract, we explained what the impact would be as a result of the changes. If we were, talking again about my local area, at the two acute hospitals in Somerset, we kept investment levels at the same level and asked for more performance, in other words to reduce waiting times even further. We have one local hospital which is likely to reach 18 weeks by 2007 as a result of maintaining investment and allowing them to treat their patients and get the patients treated they could not treat in the treatment centre. With hospitals more distant, such as the Royal United Hospital in Bath and the United Bristol Hospitals Trust—

**Q387 Dr Naysmith:** The Eye Hospital.

**Mr Smith:**—the orthopaedic centre, the Bristol Royal Infirmary as far as general surgery is concerned and the eye hospital, because we do cataracts, general surgery and orthopaedic and some diagnostics in the treatment centre, we explained to them well in advance what we would expect the change in the activity to be. We agreed with them and listened to their concerns.

**Q388 Dr Naysmith:** Do you think this was widely done in the area?

**Mr Smith:** Yes.

**Q389 Charlotte Atkins:** Ms Hanna, it is obviously different from what happened in Oxfordshire because it seems to have been rather a secret.

**Mr Smith:** I am afraid I do not know about Oxfordshire.

**Q390 Dr Naysmith:** No, I am asking Ms Hanna.

**Ms Hanna:** I think in Oxfordshire the non-executives were very concerned that any views of local professionals which were expressing concerns about the treatment centre, whether it was needed and issues of quality and impact on local services, were kept away from the board. That did not just include local specialists who were providing the NHS service, it included the optometrists in the local community who wrote to the chief executive asking for information to be placed before the board expressing their concerns that by transferring activity from the eye hospital to the private provider it would seriously prejudice training and would impact negatively on quality of clinical services for the future. They were expressing concern that they were very happy with the local service and it was looking to meet target and, therefore, why was the change being made to an unknown provider. That piece of paper was simply not shown to the board. The local impact statement by the specialist at the eye hospital was not shown to the board before we made our decision, even though the non-executives were constantly asking for information about local impact. I think overall our impression was that anything that was potentially negative about the treatment centres was kept away from board members and papers were written nearly always with a positive spin so one could not trust the information that was coming to the board as independent and objective. I think that was a key concern, that we lost trust in the process.

**Q391 Dr Naysmith:** Presumably, Mr Smith, you kept your board well informed about what was going on?

**Mr Smith:** Yes. The concerns expressed by local clinicians I would imagine were very similar to those expressed in the Oxford area and there remains a debate about ensuring that junior doctors get appropriate training. I think we do need to ensure that happens and, again, in discussions locally we are monitoring that very carefully to ensure that is not an issue and we are trying to make arrangements for sharing of experience in the treatment centre with the local NHS. We are only six months on and it is work in progress but I cannot see that should be a problem. The facilities are usually first-class and if junior doctors need to be trained they could be trained at our treatment centre as well as they could be trained at an acute hospital locally.

**Q392 Dr Naysmith:** One final question. In a way, cataracts and hips, which must be the main things you are dealing with, are seen as relatively easy things to provide for. Certainly some clinicians have said to me one of their objections is you cherry-pick
and take the easy things and leave the really complicated stuff. I was going to ask a slightly different question from the one you were just about to reply to. What has the effect been of the treatment centres on the wider National Health Service and the general morale in the National Health Service? Do they feel they will be picked off next? **Mr Smith:** I think there are lots of questions in people's minds and I think it is fair to accept that there will be because this is a significant change. It would be wrong of us to ignore those anxieties and concerns and not look at them very carefully. I have no reason to believe from the work we have done so far that the process we are going through will not do that and respond to any issues that arise. You mention the impact of cherry-picking, did you want me to respond to that?

**Q393 Dr Naysmith:** I was going to say you can respond to the cherry-picking bit now because you obviously want to.

**Mr Smith:** It is interesting to try and assess what is defined as cherry-picking. We are working very carefully locally to ensure that if the morbidity of the patients in the local acute hospitals increases such that their workload is heavier, and we have asked them to tell us about that, we would look to review the tariff for that local hospital to recognise the shift in workload, if you like. At this time we have not had sufficient evidence to support that shift but we have reassured them that we would work with them if that was the case because clearly if you are dealing with people who require post-operative intensive care or the risks are greater with that particular patient then you may need to go more cautiously with the procedure and the post-discharge period may be slightly longer. Again, we have no concrete evidence to support that concern but we are not dismissing it.

**Q394 Dr Taylor:** This is mainly to Mr Smith, I think. We have learnt in our previous two sessions that there is quite a body of opinion that feels that closer integration between the independent sector treatment centres and the local NHS services would be a great advantage. Now from the very geography of your situation this would be extraordinarily difficult because you are 20 miles from Yeovil, 30 miles from Taunton, so you have not got an acute DGH anywhere near you. Integration would be very difficult. Going on from there, in the NHS as a whole in previous years there has been a move to close isolated units which do surgery. How do you convince people that you are safe? As Doug has said, do you take the people with no risk or as low risk as possible? What medical back-up do you have at night? **Mr Smith:** There are in the centre anaesthetists on call 24 hours a day, seven days a week and, as you will appreciate, the anaesthetists are the people you need if someone goes off. Those are there. We do not profess to run an ICU or high dependency unit. Some treatment centres do, they run three or four beds for high dependency. We made a deliberate decision not to do that and have proper arrangements for effective transfer of patients to the local NHS hospital in the event of them not being well. We are confident that the immediate care of the patient will be properly managed and that has been demonstrated on two or three transfers. The competencies of the staff there are equal to that of the NHS in a similar setting. We would only need the expert support in the event of sustaining life for other post-operative complications and you will appreciate once the patient has been stabilised time is not a significant issue, it is more about transferring to an appropriate centre, depending on the circumstances presenting at the time. There are qualified surgeons available 24 hours a day and they live locally so it is an elective centre with skilled surgeons and anaesthetists available to it all day every day, 365 days a year.

**Q395 Dr Taylor:** Can I just pick you up on that. They live locally? **Mr Smith:** They do, yes.

**Q396 Dr Taylor:** You are not importing surgeons and anaesthetists from abroad to work in your centre? **Mr Smith:** Most of them have come from Europe, Sweden and Iceland but they have moved their families into the local area. They live in Shepton Mallet, in the surrounding areas and they are there for five years in the main.

**Q397 Dr Taylor:** That is very interesting. Do you ever keep people as an in-patient over the weekend or is it strictly five day admissions? **Mr Smith:** Over a weekend, absolutely, yes.

**Q398 Dr Taylor:** You can keep them over the weekend? **Mr Smith:** Yes, and we operate on Saturdays.

**Q399 Dr Taylor:** Going to your paper, the referral process, because a theoretical problem would be persuading people to go from Bristol, Salisbury, Bath, 20 to 30 miles for their surgery, now your referral process seems to go perhaps a bit across a GP's desires to decide exactly where he sends a patient. Do you have any comments on that? The Somerset Referral Management Centre, does that take the decision away from the GP? **Mr Smith:** Absolutely not, the GP's decision has primacy. What we do is we feed all of GP referrals through a referral management centre to ensure that we are getting the full utilisation of all the NHS services. If a GP says “I want to refer to Dr Smith” then we would refer on to Dr Smith. If a GP says “I want an orthopaedic surgeon to see this patient” then we will send the patient to where the shortest waiting time is.

**Q400 Dr Taylor:** If he specifies the specific orthopaedic surgeon you would not argue with that? **Mr Smith:** Absolutely. I will not say it has always been that way, we have made one or two mistakes but that is generally the principle.
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Q401 Dr Taylor: That is very reassuring to hear and I hope that is nationwide. The other thing, waiting list transfer from another hospital, where you always guarantee to inform the consultant on whose waiting list that patient was that you were transferring them.

Mr Smith: We have done waiting list initiatives from several hospitals and the process operates very much within the hospital. We ask the hospital itself to identify the patients that we would want to transfer and then they would make the notes available to us and communicate with their staff. Again where time has been the essence sometimes the patient has been taken off a waiting list and transferred because we want the patient to be treated quickly and the surgeons heard retrospectively but generally we want the surgeon to be aware and advised of the change.

Q402 Dr Taylor: Please explain the “orthopaedic interface clinic”, what is that?

Mr Smith: One of the criteria we set for the treatment centre is that you do not want surgeons seeing patients they do not need to treat.

Q403 Dr Taylor: Right.

Mr Smith: Conversion rates are an interesting concept. If you imagine every patient you send to a surgeon would not necessarily be treated. The NHS conversion rate is about one in four, so one of every four patients will go on to further treatment. They will get an opinion or be told “You do not need further treatment”. In orthopaedic care it was slightly worse than that. We introduced specialist physiotherapists and general practitioners to advise patients on the level of morbidity that they were presenting with at that time. We have been able, through the interface service for orthopaedic care, to reduce the number of people going to see a surgeon for treatment to a visit immediately. So out of every four that go three get treated now, so 75% conversion rate to treatment. If you look at a lot of the presenting symptoms there are several factors, such as back pain. A lot of people get referred to an orthopaedic surgeon for back pain and there are many other systems that you can introduce such as an interface service that would manage that much more effectively. What we have provided for the patient is a pathway from the point at the GP surgery’s through to the surgeon’s knife, if you like, and we properly assess their needs all the way along that pathway.

Q404 Dr Naysmith: Does that include physiotherapy?

Mr Smith: It does, and they are specialist physios, specially trained to work with orthopaedic patients.

Q405 Dr Naysmith: In the literature there is quite a lot of evidence to suggest that if you let a patient who is on the orthopaedic surgeon’s list see a physiotherapist lots of them come off the list.

Mr Smith: Absolutely.

Q406 Dr Naysmith: You are putting that into practice?

Mr Smith: Yes. About 55–60% come off the list as a result of that intervention.

Q407 Dr Taylor: I had the impression that treatment centres were literally just factories for doing operations. Now you are saying that a GP could refer a patient to one of your orthopaedic people for an orthopaedic opinion?

Mr Smith: If they chose. We would not normally do that because the interface service is run by the PCT and we pride ourselves on only sending people to them that they need to work on.

Q408 Dr Taylor: These local resident surgeons, what follow-up do they have of the people they have operated on?

Mr Smith: They have a follow-up after six weeks post-operatively and then if further follow-ups are required they would follow them up again. It is usually just one.

Q409 Dr Taylor: A late complication would be referred back to the surgeon who did it?

Mr Smith: Yes.

Q410 Dr Taylor: Finally, how much of your time is involved? I think you are just a representative of the PCT, are you?

Mr Smith: I am the chair of what they call the contract management board so I do get quite closely involved in the treatment centre on behalf of five other PCTs. I do monitor daily the performance of the treatment centre because clearly it is a very new initiative and I want to be assured that things are going as well as we would hope in the centre. I do take a lot of time and effort to look at it.

Q411 Dr Taylor: What do you monitor daily?

Mr Smith: I monitor post-operative complications and patient complaints, concerns arising from the GPs, concerns arising from the local doctors, consultants and so on.

Q412 Dr Taylor: How do you report this to your board on the level of activity and the costs?

Mr Smith: Each PCT board has a monthly report on the activity of the treatment centre and the likely implications of it. That will cover activity levels vis-à-vis contract and it will cover the risks associated with the centre and, if necessary, if there are questions being asked, there will be the intelligence going on in the community at any one time.

Q413 Dr Taylor: Those monthly reports go to the board. Do they go beyond that to the SHA, to the Department of Health automatically?

Mr Smith: Yes.

Q414 Dr Taylor: Do you find time to do anything else, your other responsibilities?
**Mr Smith:** All the time.

**Q415 Chairman:** Mr Smith, you said that one of the areas you look at on a monthly basis is complications. Have you measured any adverse complications in treatment centres as opposed to the same level of intense clinical work in the NHS?

**Mr Smith:** We had the first six months’ review of clinical outcomes. There are 26 performance indicators that we measure. I passed that to one of our directors of public health to try and draw a comparison between the NHS and the treatment centre. Based on the information we were able to test it against, the treatment centre was doing significantly better in most areas. The area that we have modified is the time the patient is in hospital and what we are monitoring at the moment is the out of hospital experience of the patient. There is an audit going on at the moment. A patient having a hip replacement will probably be walking later that day, or the very next day, and they will be discharged home without follow-up requirements within an average of four or four and a half days. What we are able to monitor very carefully is the patient experience in the hospital, the physical capabilities of the patient in the hospital; what we are not able to monitor is how the patient felt six weeks later. I have not received many complaints from patients and the patient satisfaction survey shows 95 to 98% very satisfied or satisfied with the service. However, we want to know more about that experience. Normally the NHS would keep you in hospital for up to 10 days and the process is very different and of course patient experience needs to be properly assessed and that is what we are doing at the moment.

**Q416 Chairman:** You mentioned your Icelandic and Swedish surgeons who are additional to your health community.

**Mr Smith:** Yes.

**Q417 Chairman:** What do you think of this additionality rule that there was on Phase 1 and do you think there should be any changes on Phase 2?

**Mr Smith:** We should always try and engage the whole community in the developments of services and I am keen to work with NHS colleagues through the treatment centre programme. I would not personally move back to a contract which was wholly run by NHS staff and NHS doctors. I would always want to introduce new staff, new skills and new techniques to the centres. We were very fortunate that the New York Presbyterian Hospital Group were underwriting the competency and the quality of the doctors in this centre. If you contrast the New York Presbyterian Hospital’s approach to care with our approach to care there is learning on both sides. It brings a bit of colour and challenge to the way we take things forward. The question I have in mind is would we had the change in ophthalmology had we used our own ophthalmologists? I do not know, but it is a question that I ask myself when I think should it be fully integrated within the NHS or should it remain slightly separate.

**Q418 Chairman:** Do you think if it was to be in part integrated in Phase 2 that the local NHS health community would have problems with going in and working in a treatment centre for one or two mornings a week?

**Mr Smith:** No, I do not think the NHS consultants would have a problem at all.

**Q419 Mr Campbell:** I would like your opinion on what you see as the future for IST centres within the health service. Do you see it as a small part or do you see their future as a bigger part of a mixed economy in the health service?

**Mr Smith:** I see them as a tool to delivering fast and appropriate patient care when we need to and at the time we need it. Cataracts in our area are no longer a problem. You were waiting 15 months two years ago. I am reducing the contract for cataracts and increasing the contract for plastic surgery.

**Q420 Mr Campbell:** There is no need in this for any treatment centres?

**Mr Smith:** I am not saying that. What I am saying is that there should, in my view, always be an opportunity to test the way we work and challenge the way we work such that we are getting best value all the way through and all the time. The best way to improve performance is to introduce a degree of challenge, is it not?

**Q421 Mr Campbell:** How would that work with the patient’s choice? How would these IST centres fit in?

**Mr Smith:** It should work this way—I am not saying it will—if their quality is of a high standard, and it is a waiting list in our case of nine weeks from start to finish from the point of referral rather than nine months, patients will choose to use them, will they not? It will be self-limiting and therefore choice may be the future invigoration of the NHS, but until that is tested I would not know. Choice is clearly part of it.

**Q422 Mr Campbell:** Choice could be you are waiting 10 weeks to get in at the proper hospital and you wait two or three weeks to get into a treatment centre?

**Mr Smith:** It could be that.

**Q423 Dr Naysmith:** One of the things that people argue about treatment centres is that they do not have any accident and emergency and they do not have any cancellations of operations. Do you think that is a big factor, the idea that beds are being taken out and operations are cancelled because surgeons are busy doing something else?

**Mr Smith:** My impression is that if you manage the elective care system well that should not be a problem. The Audit Commission have done a lot of work around this. The thing that causes the biggest cancellation of waiting lists is the way they manage elective care, not the way they manage A&E. A&E performance is very often very predictable. There has been a lot of research into what causes cancellations and interestingly one of the biggest problems for the NHS is that they bring people in on a Sunday night. It is systems that you need to
operate within the NHS to ensure that you give patients appropriate and timely treatment. If you get neither of these, such as we had in London, then clearly that is not the case, but activities through the A&E department is almost as predictable as elective care.

Q424 Chairman: The last few questions have been specific about the areas of PCTs. Have you anything further to add to anything that you have heard said?

Ms Hanna: I think there has to be full disclosure of what is included in the price relates to the tariff. Having seen the Netcare contract, and seen what is not in it because of commercial confidentiality, I do not think you can have transparency about competition between the NHS and a private provider without knowing what exactly is provided in the price of both parties that are competing and that is fundamentally important. It is really important that there is a self-correcting mechanism within the health system so that when mistakes are made that centres are not necessary and may go against and may impede other local services. There has got to be some mechanism to actually protect the public in that area. Given that South West Oxfordshire was the only PCT in the country that voted against a primary care trust, that is the only place in the country where you have evidence of what happens when non-executive members seek to correct the problem. At the moment the evidence is that it does not work. That is my main contribution.

Q425 Chairman: If we were to find out in areas—we are seeking evidence—that treatment centres had brought down long-term NHS waiting times, people waiting for orthopaedic surgery some of whom have waited years in fact if there has not been an immediate threat to life. It has been a poorer quality of life than they could have had if the intervention had come quicker. Would you be against that in principle?

Ms Hanna: No, of course not. We need to have the evidence of that it would not happen under the NHS anyway. My experience on the cataract side is that is not proved. In Oxfordshire at the moment currently the waiting times in the NHS are five weeks. We have excellent waiting times in Oxfordshire, but at the same time we have cancelled hernia operations and paediatric epilepsy services being cut and mental health services being cut. The local community needs to have a say in terms of how money is spent in the NHS. It is great that you can get these waiting lists down but there is a cost to the overall system. Often a lot of chronic care—concerns about people with long-term conditions—is omitted in all of that because they are the more complex and more serious cases. I do have concerns, for example, that the current payment by results scheme in the NHS does not necessarily set the prices accurately to reflect more serious and complicated cases. That has certainly been my experience in my neurology work.

Chairman: We are not going there but I understand exactly what you are saying. Thank you both for coming along and giving evidence this morning.

Witnesses: Ms Nicola Easey, Lead for the Modernisation & Commissioning Paired Leads Network, NHS Alliance, and Mrs Pauline Quan Arrow, Chair of Southampton City Primary Care Trust, gave evidence.

Q426 Chairman: Good morning. Thank you for coming along. Could I ask you to introduce yourselves for the record and your organisations?

Mrs Quan Arrow: I am Pauline Quan Arrow, I am Chairman of the Southampton City Primary Care Trust.

Ms Easey: I am Nicola Easey, I am the NHS Alliance Modernisation and Commissioning Lead and I have recently left a PCT where I was a commissioner.

Q427 Chairman: We are quite interested in how the location and size of first wave ISTCs came about and what consultation took place in your particular areas with the size and location and whether or not this was a decision that was taken by the SHA and told that this is what must happen, or whether you were a party to these decisions of where they were to be?

Mrs Quan Arrow: In Southampton we are having the second wave, but the treatment centres have something that we had planned already for the last three or four years of the primary care trust. That is something we had recognised as being needed and wanted. Somewhere along the way, instead of us as a primary care trust running the treatment centres, it was going to be done by the independent sector, so that concept was not that big of a deal of transferring over because we are working with the independent sector.

Q428 Chairman: Were you consulted on what type, what size and so on?

Mrs Quan Arrow: Yes, we were.

Q429 Chairman: Yourself and your neighbouring PCTs presumably?

Mrs Quan Arrow: Yes, we as a patch worked together on that. We had a collective board that met on it.

Q430 Chairman: Was there a consensus that what you got was what you needed?

Mrs Quan Arrow: Very much so, yes. We were very comfortable with it.

Q431 Chairman: Was there any dispute within your ranks?

Mrs Quan Arrow: When it became the independent sector certainly that issue was raised concerning the thinking that this is not the NHS and it is the threat of the independent sector coming in, but being part of the second wave a lot of lessons have been learned so that the tariffs are the same. It is the same amount
of money being spent. In Southampton with a population of a quarter of a million it is geographically a really small area so the places where the ITCs are located are just a stone’s throw from each other. The location was great, the need was recognised and we then just got the comfort that it was not going to cost us any more and that was good value.

Q432 Chairman: Was that your experience, Ms Easley?
Ms Easley: No, not really. As a PCT commissioner I worked within North and East Yorkshire and Northern Lincolnshire SHA, which will shortly become Yorkshire and Humber, and the experience was very much top down. The SHA had identified a centralised location for an ISTC and the consultation with local PCTs was very much this is going to happen. Previously we had an NHS treatment centre in a local NHS hospital that was funded with NHS capital and NHS resources which was a good development in many ways but has proved very difficult for patients to access because of its geographical location and few patients have wanted to go there so this has been under-utilised. The experience of the ISTC that has only just opened within the independent sector—it opened at the end of January—is that for a lot of patients within what is a very large geographical SHA patch it is very difficult for many patients to get to it even though it is in York, it is fairly central. Rurality is an issue within my patch and a lot of patients do not have access to good public transport so it is a real difficulty for some commissioners to attract patients to go to this centre. In terms of consultation it felt like it was very much a foregone conclusion in that PCTs were being asked to sign up to something.

Q433 Chairman: What was the main reason for that? Was it a capacity issue?
Ms Easley: There are capacity issues within the SHA but the SHA is meeting national waiting times for NHS treatment in that six months is being met, three months wait for cataracts, et cetera, but there are capacity issues in terms of the number of patients seeking treatment and it was felt that an ISTC option would be a good option, but if patients cannot use that facility because they cannot access it then there are concerns about whether that capacity is going to be used to its full advantage.

Q434 Chairman: Could the NHS have increased its own capacity and presumably brought waiting lists down if that is what has happened at the same time?
Ms Easley: I think that has happened but unfortunately experience suggests that it is not always easy to do that because of short-term difficulties. It does drive up demand to a certain extent. As soon as waiting lists come down we tend to see them rise again because it introduces a level of latent demand that has not been sent in by GPs in the past so you do start to see waiting lists creep up again. What you tend to see is short-term waiting list initiatives being developed to try and bring down the waiting lists as opposed to putting in a longer-term solution and also PCTs do not always have the resources to be able to sustain that.

Q435 Charlotte Atkins: I would like to explore the issue of commissioning services from ISTCs. Have there been problems in your view in the actual process of providing services?
Mrs Quan Arrow: Again, we are only the second wave so we do not have actual experience—ask me in a year or so—but who is our project manager is our Head of Commissioning, someone who is very familiar with our service requirements in Southampton and she works very closely with our PEC Chair. We are a very mature PCT, we are six years on and we have a very strong infrastructure. We have the resource and experienced person who is dealing with the ISTC services, contracts, et cetera, and interfacing with our clinicians. We have a very interactive participation from our clinicians so again we are quite confident that that will be addressed.
Ms Easley: It has been a mixed response. Within the Alliance we have a network of commissioning representatives, commissioning managers and commissioning GPs from primary care trusts in the country and we have asked them for their experiences of working with independent sector treatment centres and the response was fairly mixed. They were reporting lack of consultation, lack of engagement with local GPs and local consultants about developments and local care pathways, so that in turn led to difficulties for them in commissioning services. Within the first programme, the General Supplementary Programme (known as GSUPP), there were concerns about patients being able to physically access the service and about the very limited medical access criteria and so they were cherry-picking. There were also problems in terms of once patients got into the service and due to complexities or co-morbidities being discovered after their initial outpatient appointment they were then being turned away from the independent sector programme which of course led to difficulties with patients because they felt as though they were being pushed from pillar to post. There were a number of instances like that where commissioners had to get involved with GPs and with patients to try and ensure that their care pathway was not disrupted and that they could access treatment within an NHS hospital having been referred to an independent sector provider who was then unable to treat them.

Q436 Charlotte Atkins: What about cases of where contracted activity has not been delivered, where they have underperformed within ISTCs?
Ms Easley: Yes, that has been a problem as well. There have been a number of examples of this given from our members where they have been party to contracts through their SHA. As a former
commissioner myself, I have worked hard to attract patients to get them to go to certain centres because that is where the contracts are but it is not always possible for patients to take that up if there are not the transport links to get them there. If they do not have the ability for their relatives to come and visit them. For example, somebody who is 65 and above what is more important to them is for their spouse to be able to visit them in hospital rather than the type of hospital or often, the time spent waiting and if that is not going to be possible because of poor transport then they will not go. There have been a number of examples given to us of where PCTs have been unable to fulfil the minimum take, as it is known, within these contracts which has left them (PCTs) financially out of pocket.

Q437 Charlotte Atkins: Are you saying then that the main reluctance of patients to go to a particular ISTC is largely about geographical location? Are there other reasons why patients are not willing to go there and then this leads to a shortfall of contracted activity?

Ms Easey: In my experience as a commissioner working in a rural location that has been the main problem. The specialties that you are dealing with, orthopaedics and ophthalmology, but particularly orthopaedics, you are looking at attracting patients in a very fixed number of procedures because they are procedures that the independent provider will treat within their criteria. You are talking about patients in an age group who are 65 and above who are frail, sometimes living on their own, who rely on their local friends and local neighbours for their social networks, and if you take them away from their local hospital they do not have the opportunity to have those networks maintained. They do not have the opportunity to stay with the local consultant who they have seen and are familiar and comfortable with and sometimes that is an issue for patients in that they want to be treated by the person who they have initially seen. In some cases with the first wave of the programme, patients were being taken from NHS waiting lists and transferred to independent sector treatment providers. What that meant for the patient was typically they would have already been seen within the NHS hospital locally, had met their consultant, understood that they were going to have an operation, consented to have that operation at that local NHS hospital and then being contacted a little while later and offered the chance of earlier treatment but in a hospital that perhaps they were not familiar with and with a surgeon they did not know and with concerns from their perspective about how would they get there, who would look after them, would anybody be able to visit them. Those are the sort of problems that patients are typically reporting to PCTs.

Q438 Charlotte Atkins: If the ISTCs are in an inappropriate area is that because the PCT view has not been taken on board and maybe they have been overruled by the SHA, or has it come from higher up than that?

Ms Easey: Within the feedback from our NHS Alliance members there have been some examples where the national implementation team within the Department of Health have visited certain areas. They have spent time in the proposed localities where ISTCs were being planned, they have spent time talking to GPs and consultants in the local area and done a lot of engagement work which has been really helpful. That kind of engagement is the type of engagement we would like to see because those, in our view, are where the better outcomes have been delivered. There has been good clinical working across primary and secondary care. Where that has not happened and where there has been a distinct lack of engagement, either with GPs or with secondary care, or with communities as a whole, then I think that has led to a lot more problems because people feel as though they are simply not engaged in any of the discussions, not involved in the planning and simply being delivered a product that is not locally beneficial for them and that patients locally do not want to use.

Q439 Charlotte Atkins: What happens to the NHS patient who refuses to go to the ISTC? Are they put at the end of the waiting list and have to start the process again? What happens in your experience?

Ms Easey: Not in my experience, no. The patients who were picked for the first wave were typically from NHS waiting lists so they had already been seen in their local NHS hospital. They had already been put on the waiting list and were awaiting treatment. If they were not suitable to go because they did not fall within the range of procedures being offered by the independent provider, then they would not have been offered the opportunity to go in the first place. If, however, they were awaiting a procedure that could have been treated in an ISTC, but the patient said that they did not want to go, then there was no pressure brought to bear on the patient. They were advised that they would remain on the NHS waiting list at the hospital and the hospital would contact them with a date so they could be operated on and their waiting time would be unaffected in that way at all.

Mrs Quan Arrow: Although our ISTC is not up and running yet, we do have an orthopaedic contract with the independent sector. We had very similar teething problems as well but we were able to work them out. Our independent sector for orthopaedics was 27 miles away and our independent contractor just provided transport for our patients and their families too and everyone was delighted because it was such a lovely facility so we got around that. We also have our community teams which simply had to go out and coordinate it, their release and everything like that, so everything was still waiting for them when they got home, so that was still coordinated. In the first few months it still took a while for that to happen.

Q440 Mr Campbell: We have heard a lot about the value for money of these centres. The last evidence we heard was a lot of money has not been spent. The big question is: are the taxpayers getting value for money with these centres?
Mrs Quan Arrow: I cannot say for ISTCs, but for our contracts as we have a very advanced referral management centre we have used the complete contract. We have not had any under-utilisation and have used 100% of our contract.

Ms Easey: The experience in other areas has been more mixed, certainly the first wave. There have been a number of cases reported to the NHS Alliance where PCTs have been unable to use their full quota within the contract and have suffered financially as a result. Within the first wave SHAs encouraged PCTs to try and share their quota of cases amongst other PCTs. For example, if one PCT was going to be unable to fulfil its share of the contract the unused element should be offered that to a neighbouring PCT who might be able to fulfil it. The difficulty with that was the very short timescales in being able to attract patients to take up offers of appointments within the time that the ISTC had to treat the patients in order to reach NHS waiting times, which of course is critical within the care pathway. My feeling is that these concerns are being far more widely addressed within the second wave and the tenders that are currently being let around diagnostic care, where I do feel that a great deal of learning has taken place since the first wave in that local communities are now being offered far more opportunity to discuss local care pathways to get involved in discussions and design a local fit that best suits their local needs which is far more acceptable and far more workable and will in the end see more patients using the facilities.

Q441 Mr Campbell: If there was anything you would change in the second phase regarding the value for money what would be the number one?

Ms Easey: It would be about matching local need with the contract; having a contract that would meet local needs.

Q442 Dr Naysmith: Is there written evidence of contracts being unfulfilled?

Ms Easey: We (the NHS Alliance) have provided written evidence to the Committee where people have expressed those comments.

Q443 Dr Naysmith: Is there evidence of contracts where there has been an exchange between the contractors and the commissioners saying that this contract has not been fulfilled and we want our money?

Ms Easey: We (the NHS alliance) personally do not have access to that kind of evidence but the PCTs will obviously have that detail. There have been reported cases where contracts have not been fulfilled in certain localities. We personally do not have access to that evidence.

Q444 Dr Naysmith: You have not seen that yourself?

Ms Easey: I know within my own strategic health authority area of that taking place, but in terms of the members of the NHS Alliance who have reported their experiences of ISTCs to us they have not provided that information and to be fair we have not asked for it either.

Q445 Dr Taylor: Can I explore the issue of integration with the local health economy, firstly to Ms Easey, because I know you, Mrs Quan Arrow, have not quite started yet. The evidence you gave to us I have only one criticism that it was so long it was difficult to get to grips with everything but you have done a very valuable survey of many of your members. Picking up some of the points, it looks really, if I can quote one or two things: “Integration does not exist really very well yet.” “The advent of the orthopaedic ISTC has strained relations.” “The process has disengaged primary and secondary care.” Are there any examples of integration so far?

Ms Easey: There are a couple of examples, particularly in the South West, and perhaps Mrs Quan Arrow’s experience is common to that where GPs and consultants were more engaged from the beginning of the process rather than being presented with a fait accompli once the plans had been pulled together and they were being asked to sign them off at their professional executive committees or their boards. Those experiences are far too few and in between.

Q446 Dr Taylor: Despite additionality as it exists at the moment, are there examples where NHS surgeons and anaesthetists are working ISTCs as a result of your survey?

Ms Easey: As a result of the survey there were not specific comments made in respect of that, but I do know of NHS surgeons who have been asked to work in ISTCs alongside colleagues from other centres, but again that experience has not been very widespread.

Q447 Dr Taylor: Mrs Quan Arrow, you did mention a treatment centre 27 miles away. That is one that exists already, is it, that you use?

Mrs Quan Arrow: Yes, it is.

Q448 Dr Taylor: Where will your own Phase 2 one be?

Mrs Quan Arrow: In the City Centre. It just could not be more central.

Q449 Dr Taylor: Do you see the possibility of using NHS staff in that?

Mrs Quan Arrow: It will be in the contract that NHS staff will be seconded into this treatment centre because our teaching acute hospital is only three miles away. That site is going to be transferred to us as a PCT but it is currently still under the acute hospital so you have a lot of the same people and that was the whole point of also integrating the teaching and training as well.

Q450 Dr Taylor: The same surgeons will be teaching at the University Hospital and in the treatment centre?

Mrs Quan Arrow: Yes, they will be seconded into that. We are also working very closely with the acute trust itself because they are part of that board in making that interface happen. It is learning all the
lessons from the first wave of how to do it. Our GPs are involved, the consultants are involved. We have some pretty rough meetings but we are working out those very issues.

Q451 Dr Taylor: Will the NHS consultants who will work in the independent sector treatment centres be paid NHS rates?  
*Mrs Quan Arrow*: They will be just seconded, yes.

Q452 Dr Taylor: The 27-mile away one—do you have any integration with that or is that entirely separate?  
*Mrs Quan Arrow*: No, that is separate other than our own PCT teams go in there to make sure that the transfers and release out are coordinated for community care.

Q453 Dr Taylor: Your community nurses go in and supervise discharge?  
*Mrs Quan Arrow*: Yes.

Q454 Dr Stoate: How do you see the future of ISTCs? Are they a short-term capacity fix for the NHS or are they here to stay and likely to form a more substantial part of the health economy of the future?  
*Mrs Quan Arrow*: I think they will be very much a part of our future, full stop. Our 150 GPs are very excited about it, again because we have almost complete electronic booking. The idea that these GPs can simply look online, see what their patients need and be able to book it for them, to them it is just such a godsend and will be such a big improvement for our health population. It is perhaps the writing on the wall for the acute sector that they will have to change dramatically culturally but for the patient good. It will be a much better system for us.

*Ms Easey*: I think they are very much here to stay. The experience of NHS Alliance members who responded to the survey was that they are very keen to work with the independent sector and PCTs and Primary Care Groups (PCGs) have many examples where they have worked with contracts with local private providers in providing local healthcare for a long time so people welcome it and they have nothing against private providers but what they do want to have is something that locally fits their needs and being able to have a national or a more locally sensitive ‘call off’ contract with an independent sector provider to be able to access treatment or scans as and when they need it would be something that people would very much welcome.

Q455 Dr Stoate: What you are saying is if they finally get the contract right you see no problem with it in the future?  
*Ms Easey*: No.

Q456 Jim Dowd: Ms Easey, do you have any idea what proportion of people who were offered the chance of treatment at an ISTC declined?  
*Ms Easey*: No, we did not ask our members specifically about that. From my own experience it was quite difficult to encourage people to go, mainly because of the rurality issue because where I was working patients did not have access to good public transport and there was a very low level of car ownership so the majority of patients did not have access to transport. The treatment centre that was being offered to them was 40 miles away with a bridge in between with a toll of £5. For a lot of patients the question they would ask is would we pay their transport which was an additional cost to PCTs. These are some of the teething problems PCTs had to work out but the main difficulty for patients was in being able to easily access independent providers.

Q457 Jim Dowd: It was the logistics of it more than anything else. From what you are saying it would be the majority who declined?  
*Ms Easey*: The percentage from my own commissioning experience I would say would be about 60/40. We were working with a very small group of patients in terms of the contract we were trying to fulfil. It was not particularly easy encouraging people to go.

Q458 Chairman: You are from North East Lincolnshire.  
*Ms Easey*: I was.

Q459 Chairman: That is a general problem with healthcare because it is so rural and things are so spread out it was not just ISTC-specific, was it, this problem of travel?  
*Ms Easey*: No, it is a problem in terms of patient choice certainly with one district general hospital in the PCT area and a wide number of contracts for patients across the country for specialist services, but in terms of patient choice it is certainly an issue.

Q460 Chairman: Where is the treatment centre geographically? It is over the Humber, is it?  
*Ms Easey*: Yes, the treatment centre that has just opened is in York, which is not that far away in terms of mileage but if you have not got a car and public transport is poor, and your relatives and friends cannot visit, it is very difficult.

Q461 Dr Naysmith: You have now let this second phase contract. Does it say anything about private work that goes on in the ISTC?  
*Mrs Quan Arrow*: Not that I am aware of.

Q462 Dr Naysmith: But there will be the possibility for private work to go on?  
*Mrs Quan Arrow*: That, again, I do not know.

Q463 Dr Naysmith: In ISTC’s private work will go on there as well as National Health Service patients, will it not?  
*Ms Easey*: Yes, there are some ISTCs that I know of where they do both.
Q464 Dr Naysmith: I am thinking about it in terms of the National Health Service consultant being seconded it might encourage a bit more private work. 

*Mrs Quan Arrow:* That has not come up as an issue. It is not happening.

Q465 Dr Naysmith: It will not be happening yet in yours because you are not up and running.

*Mrs Quan Arrow:* Quite, but as they are accountable to us as the PCT we would then have the say whether that could happen or not if it is going to be at the cost of our population or anything else like that, or if it helps utilise the capacity and makes it more cost-effective then that would perhaps be a good decision, but I do not know.

Chairman: Thank you both very much for coming along and giving evidence to us this morning.

Witnesses: Dr Donal Hynes, Vice Chairman of the NHS Alliance, Dr Tony Marsh, Chairman of Gedling Primary Care Trust Professional Executive Committee, Ms Valerie Smith, Independent Sector Adviser, The Royal College of Nursing, Ms Gail Adams, Head of Nursing, UNISON, and Mr Barrie Brown, Health Sector Officer, Amicus, gave evidence.

Q466 Chairman: Could I ask you to introduce yourselves for the record, please?

*Ms Smith:* I am Valerie Smith. I am a registered nurse. I have worked in senior posts within the NHS and the independent sector and I am currently the independent sector adviser at the Royal College of Nursing.

*Mr Brown:* I am Barrie Brown. I am an officer of the Amicus Union. I have responsibilities at national level for our nursing members.

*Ms Adams:* I am Gail Adams. I am head of Nursing for UNISON. My clinical background is nursing and my speciality is theatres, anaesthetics and intensive care for the last 18 years.

*Dr Marsh:* I am Tony Marsh. I am a GP and Chair of the Professional Executive Committee of Gedling PCT. Gedling is one of the boroughs around Nottingham. 

*Dr Hynes:* Donal Hynes, I am a general practitioner in Somerset and Vice Chair of the NHS Alliance as well as Medical Director of the PCT there.

Q467 Chairman: Thank you for coming along. I would like to ask a question which you may all have an opinion about. It has been claimed, and I am sure you have heard this in the last few minutes, that some ISTCs have been paid for contracted activity that was not delivered. Presumably patients were not delivered into them in time. Do you have any evidence of this and why it happened?

*Dr Marsh:* I have got evidence for an ISTC called Barlborough Links, which is an orthopaedic ISTC which serves the whole of Trent SHA and, to a degree, an area of South Yorkshire. That is based on a minimum contract which was assessed on the perceived need when the contract was set up and was based on a monthly reckoning, so you have to reconcile within one month. You cannot carry on and catch up at the end of the year. We are a small PCT. Our forecast overspend is going to be £193,000 this year. That is on a total PCT budget of £108 million, so it is quite a significant proportion of our total budget. To put it into perspective, the cost of dispensing Herceptin to people with early stage cancer, which is obviously an issue at the moment, would cost £93,000. There is £193,000 which we have committed to pay them at the ISTC and this is reflected across the rest of the Trent PCTs where, in spite of one PCT where the treatment centre is located, having £220,000 excess activity given them which they are not having to pay for. Even knocking that off for the Nottinghamshire PCTs, there is an expected overspend of £380,000.

Q468 Chairman: Why is that? Is it because patients do not want to travel up to Barlborough?

*Dr Marsh:* We have had the experience of the Barlborough Orthopaedic Centre having started off in a preliminary phase whilst they built this big purpose-built orthopaedic hospital. They started off converting some theatre suites in a local community hospital in a town called Ilkeston, which is quite close to Nottingham. We achieved our targets quite well then. Subsequently it has now moved 40 miles up the M1. Dr Taylor has suggested that the GP had the primacy about saying where patients should go. It is not the GP who has the primacy; it is the patient who says where they should go for their treatment. In spite of patients being offered the treatment in every instance when it is appropriate, they have not been choosing to go to Barlborough in sufficient numbers for us to fulfil our contract.

Q469 Chairman: That is presumably because of the geographical location of the new centre?

*Dr Marsh:* It is. I would not be able to quantify it but there has been, as I am sure you are aware, quite vocal comments from the NHS local orthopaedic community in Nottingham. If that has not had a direct effect on patients, it does have an effect directly on GPs who have traditionally built up relationships with local orthopaedic consultants. When people do go there and they go there smoothly and are accepted then the patient’s experience is very good and positive provided they go smoothly through the system and they can get there and come out.

Q470 Jim Dowd: Are you suggesting that patients are actively discouraged from going by their GPs because of the danger of fracturing their relationships?

*Dr Marsh:* In the context of the consultation where would you want to go, the question is “What do you think, Doctor?” is commonly asked. Another thing to put into the equation is that GPs do not send
people directly to the orthopaedic centre because we too have a clinical pathway which involves an assessment by a multidisciplinary team including occupational therapy and physiotherapy at which point they will emerge having scored sufficiently to require a hip replacement or knee replacement or not. It is at that point that they are then entered into the possibility of being made the offer.

Q471 Jim Dowd: What was the time advantage in the offer of the ISTC treatment compared to what they would normally expect? If it is only a week or 10 days then people would not necessarily travel very far, but if it was three months or more.

Dr Marsh: Initially highly significant, but nobody in Nottingham has waited longer than six months for inpatient treatment for the past few months and that would be a matter of perhaps two months with the uncertainty. They are yet to have built up a groundswell of experience within the population of people who have been there and have said to their neighbours it was really good. It is still very much an unknown.

Dr Hynes: As you will see from the evidence that the NHS Alliance picked up through its survey, there is wide variation in the efficacy of communities to get on with their ISTCs. You have an area like mine where it works and an area like Tony’s where it has not worked as well. A lot of it is based around this idea of matching the capacity to the demand in the community—critical and core—and the one consistent theme in the vast majority of the responses that we gleaned in the survey was the level of clinician engagement. That is local working, particularly primary care engagement with clinicians at the very outset. That is the very top right down to the first time the patient goes through. If that is avoided you are going to spend the first two years for every one of these trying to get over the hurdle that could have been in place. You have heard already this morning from Mr Robin Smith that we already had in place for example a very active referral management centre where the GP remains totally core. That was a GP innovation and something that worked. We had interface systems again formed by local primary care communities. With that level of commitment it is very easy and our first experience with the ISTCs was with cataracts. We are the first people with cataracts to hit 100% of our contract simply because we had full engagement in the local community. The one thing that seems to separate places where it has worked and where it has not worked is this whole concept of primary care clinician engagement at the earliest stage possible. That is something that is variable throughout the country and very variable in the responses, as Tony has already outlined.

Ms Adams: I would like to draw the Committee’s attention to section seven of our evidence where we have tried to provide a wealth of information that we have been able to source around the predicted deficits that are going to occur within the primary care trusts because of the commitment of the primary care trust firstly to commission independent sector treatment centres, irrespective of what they need, but also because of the financial pressures that are now starting to appear. I would like to draw your attention to paragraph 7.1 where we have cited an example of Trent in South Yorkshire which is currently a contract afforded to Partnership Healthcare. At the moment they have three sites which were interim sites at Bassetlaw, Ilkeston and there is obviously now the purpose-built site that my colleague has just mentioned at Barlborough. In the first year of the contract there is a deficit of £3.1 million that the primary care trust is going to have to pick up. My biggest fear is that some of what we are now starting to see is the tip of the iceberg. The announcements this week in relation to deficits within teaching hospitals is going to be an emerging picture because historically at this time of year primary care trusts would have perhaps some capacity to be able to assist the financial burdens that the NHS are facing or some additional capacity that they would commission an additional waiting list that is referred to in the previous evidence. I have yet to see any evidence produced by the Department of Health, or by any of the private sector companies that are currently operating, that have demonstrated to me that with some further innovative thinking in the NHS, which we historically were not renowned for, we would not have been able to have achieved a significant amount off the waiting list. I think there is a complete lack of transparency over the facts and figures. We have written to Nottingham PCT under Freedom of Information to ascertain financial statistics and there has been a lot that has been denied because of the commercial sensitivity of the contracts. If it were not for the Committee deciding to look at this piece of work we would still have been impaired in the amount of information that we have been able to access over the last year.

Mr Brown: I have nothing to add to what you have heard from Ms Adams.

Ms Smith: We do not have any information in terms of evidence about under or over activity within the treatment centres. However, we do have real concerns about the way the capacity planning was undertaken. We have been reassured on numerous occasions by the Department of Health that clinicians were involved in that capacity planning but have no evidence to demonstrate that that has happened.

Q472 Chairman: From what you were saying, Ms Adams, Barlborough Links, Bassetlaw or Ilkeston have been under-utilised and Dr Marsh was saying one of the reasons why is because the health professionals were not encouraging people to go there. It is a bit a problem, is it not? Have you felt that that has been the case?

Ms Adams: I have come straight from service so my experience of patient care certainly within surgery is that the vast majority of people, including myself, who have had surgery would choose to go to a local organisation and a local trust and, yes, we do have relationships with your GP and you do rely on an element of informed information about where it is appropriate to go to and where it is not. If the patient choice agenda is going to be firmly delivered then
there has to be more public information and that is sadly lacking. I fail to see at the moment how a patient who is seeing a GP would be able to make an informed decision about where to go and the reasons for it, both in terms of what to expect, patient outcomes and all of that information when we have tried to ascertain it under Freedom of Information and it has been denied to us. If we cannot get hold of it how an elderly patient, for example requiring a hip replacement, is going to be able to access it and understand it is beyond reason.

**Q473 Chairman:** If a GP said to somebody having advice from their GP—people do have advice from their GP—do not go there because they have an issue about this private sector treatment centre, does that concern you in view of the fact that no matter how it was contracted it was there and it was public money spent for these interventions and people were saying they should not take it up? Would that concern you if that was the case?

**Ms Adams:** If misleading information was being given it would be a concern. One of the frustrations within the medical profession and the nursing profession is that there is not the information. I would go as far as to say that had the decision to introduce independent sector treatment centres been consulted on then some of the fears and apprehensions perhaps would have been addressed. I say that quite strongly because health workers have not been engaged in this. There has been no comparison with the NHS independent treatment sectors. I worked in South London before I joined UNISON. We have an NHS treatment centre which was consulted on, we had collaborative work which included myself then as a theatre sister in terms of where it should be sited, the types of cases that should be done and how we would have the integration, how could we rotate staff so that we are not in the dogma that we are now that we separate elective and emergency surgery and we have perhaps lost the capacity to utilise skill mix effectively which is the current situation in Wave 1. That treatment centre has an excellent management team, people that I personally have worked with, patient you have got from the Department of Health and centre has an excellent management team, people that have produced so far, within the evidence is the current situation in Wave 1. That treatment centre has an excellent management team, people that have produced so far.

**Mr Brown:** I think there has to be more public information and that is sadly lacking. I fail to see at the moment how a patient who is seeing a GP would be able to make an informed decision about where to go and the reasons for it, both in terms of what to expect, patient outcomes and all of that information when we have tried to ascertain it under Freedom of Information and it has been denied to us. If we cannot get hold of it how an elderly patient, for example requiring a hip replacement, is going to be able to access it and understand it is beyond reason.

**Ms Adams:** No, it is not, but if I can draw the Committee’s attention to the audit report that was published in 2002 and 2003 which cited that there was additional capacity within operating theatres and within the NHS but perhaps there were some different ways of doing it. The example that you described is a very real one that the NHS is historically well-placed to try to juggle. No-one would ever want to cancel a surgical list but there is unpredictability with emergency cases. We are not opposed to treatment centres with the division of elective and surgical cases. There are other ways of looking at value for money in terms of looking also at value for money because we do not have sufficient information about what is happening in the ISTCs. We know about, for example, the capacity that they are supposed to produce but we have no information about what they have done or what the financial implications are in relation to that. There are other ways of looking also at value for money. If you talk to patients that are in the treatment centres, and I have visited two of the treatment centres, they believe that they are getting very good service. If you were to ask them the question are we giving value for money I am sure they would say yes.

**Mr Brown:** Looking at value for money in terms of what has been produced so far, within the evidence you have got from the Department of Health and others clearly there is the issue of work that has been paid for that was not undertaken and you and you have heard about that already. There is also the issue of the payment levels that have been set—the 11.2% over the process, but also over the allocation of resources and the appropriateness of decision-making and I think that has been articulated early this morning and in your previous sessions from the evidence that I have read.

**Q474 Chairman:** We will be moving on later with other people about what should happen in the future. That is certainly your analysis of the past. You said about the dogma of separating elective surgery. We had the Chairman of the Royal College of Surgeons sat where you are two weeks ago and he told us about when he went to work one day with seven elective surgery list in front of him and three of them later that day were sent home because there was a road accident and the A&E effectively took over his list. That cannot be a very good thing either for the health service or for the patients, can it?

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carried out within ISTCs. It is the two key elements which we think are important in making any kind of judgment about value for money.

**Ms Adams:** The only thing I would add to what I said is that Mr Brown gave the worst case scenario of cancellations a moment ago as a posed question. What we currently see are MRI units standing empty in a number of areas, surgeons not having cases to do because of the contractual arrangements with the primary care trust requirement to commission from the independent sector treatment centres. If you work within an acute teaching hospital you will find that we are funded in such a rigid way that we cannot do additional lists unless we are funded to do them. When Mr Smith took his example of the evidence that they operate on a Saturday, so would the NHS if they paid us, but that funding is not available. I have had examples where I previously used to work where we used to run a day case surgical session on a Saturday morning.

**Q476 Charlotte Atkins:** Where was that?

**Ms Adams:** St George’s in Tooting. It was for a gynaecological case and the primary care trust withdrew the funding for that. That was a session to provide terminations. We were then not able to continue to provide that session because of the cost of staffing at the weekend. I genuinely say that there is capacity within the NHS. There are always different ways that we can work but the reality of paying a company to provide surgical cases, and paying them irrespective of whether they deliver, nowhere else is it heard of. You would not build a house and pay the builders before they did the work. You book into Gordon Ramsey’s restaurant and pay for it before you walk through the door, let alone look at the menu. It is ridiculous. I genuinely on that basis fail to see how the taxpayer, and I am one, is receiving value for money. There is a complete lack of transparency and, as a result of that, there is an element of distrust about the whole process.

**Dr Hynes:** Value for money is a very difficult thing to comment on. We would say from the patient point of view that when patients go there they feel it is value for money and I support that feeling absolutely. I would say in areas where it works where there has been clinical engagement with general practitioners that I have queried, and we have just done a whole round of our practices, they think it is value for money because the patient satisfaction is very good. There is another aspect, however, in the value for money stakes that needs to be considered and that is the concept of service reform. Part of the reason that these were introduced was to put a bit of plurality into the system so that we could set commissioning targets or commissioning rules that we had real difficulty imposing for very many years under established providers. The typical thing is the cataract where the patient comes to me and says “I have got a cataract” and I send them to a see an optometrist who says they have got a cataract, who writes a letter to me because optometrists usually cannot refer to surgeons, so they come back to me and I say “You have got a cataract” and he said, “I knew that when I saw you three weeks ago.” He says, “Are you going to operate?” and I say, “No, you have to go and see the ophthalmic surgeon.” The ophthalmic surgeon says, “Guess what? You have got a cataract.” That series of steps has been difficult to break down. Although I accept Gail’s frustration in terms of the purchase, when I buy a car I accept that I buy my car and it is my responsibility to use my car so if I do not use my car it is my problem. There is something about having the capacity in the system of making it work for the patients and having clinical engagement and using it as a mechanism for service reform. It has been very effective because we have made an awful lot of progress in other areas outside the areas provided by the ISTC because it just loosens up this concept where we can now discuss in a much more equal partnership because you do not have just a single controlling monopoly of the service as you do in my area, which is a rural area, so it has helped service reform. How you add that in to value for money is a bit more difficult to put the pound signs on.

**Q477 Charlotte Atkins:** You are reasonably happy with the way it is working at the moment. How would you see changes to the Phase 2 ISTCs improving on what is happening at the moment?

**Dr Hynes:** I am reasonably happy with it but of course there are lots of difficulties. Phase 2 is much more serious because Phase 2 is particularly on diagnostics. Diagnostics is part of a pathway. There is a profound difference there. Most people know when somebody needs an arthroscopy for a knee or needs a knee replacement at some stage. That is fairly easy. You can have a look at the ISTC options list and do a whole round of your practices, they think it is value for money because the patient satisfaction is very good. There is another aspect, however, in the value for money stakes that needs to be considered and that is the concept of service reform. Part of the reason that these were introduced was to put a bit of plurality into the system so that we could set commissioning targets or commissioning rules that we had real difficulty imposing for very many years under established providers. The typical thing is the cataract where the patient comes to me and says “I have got a cataract” and I send them to a see an optometrist who says they have got a cataract, who writes a letter to me because optometrists usually cannot refer to surgeons, so they come back to me and I say “You have got a cataract” and he said, “I knew that when I saw you three weeks ago.” He says, “Are you going to operate?” and I say, “No, you have to go and see the ophthalmic surgeon.” The ophthalmic surgeon says, “Guess what? You have got a cataract.” That series of steps has been difficult to break down. Although I accept Gail’s frustration in terms of the purchase, when I buy a car I accept that I buy my car and it is my responsibility to use my car so if I do not use my car it is my problem. There is something about having the capacity in the system of making it work for the patients and having clinical engagement and using it as a mechanism for service reform. It has been very effective because we have made an awful lot of progress in other areas outside the areas provided by the ISTC because it just loosens up this concept where we can now discuss in a much more equal partnership because you do not have just a single controlling monopoly of the service as you do in my area, which is a rural area, so it has helped service reform. How you add that in to value for money is a bit more difficult to put the pound signs on.
money because of the inequities of the minimum take saying your local NHS trust lives by the sword and payment by results, but your ISTC would be given a guaranteed income whether they do the work or not. That is the single thing which means that Gedling is not getting value for money. We would get value for money out of the ISTC if we were paying for what usage was there and it is not up to the PCT or the GPs to say where patients go. Patients do have a genuine choice to do that.

**Q478 Charlotte Atkins:** No minimum take in the future?

**Dr Marsh:** As far as I am concerned we are signed up not only to Barlborough Links, but we are also signed up to the opening of a much more widely-based treatment centre, the Queen’s Medical Centre in Nottingham in December 2007, which is also going to have a minimum take. Our plea is that those contracts need to be reviewed. Another aspect of value for money is that the tariff, even if it was the same as the tariff that the hospital are being paid, and we know that there is a top-up to that, is being paid for the cases with very little co-morbidity and the cases with co-morbidity, which quite rightly are not going to the TC because they do not have a kidney, diabetic or respiratory specialist for example on tap if things go wrong, quite rightly people who go the TC are ones who have straightforward osteoarthritis and not a lot else, which automatically reduces the numbers in this very elderly population by definition. The fact that those patients going to the TC are being paid the same tariff as the ones which are going to the local NHS trust where they are staying twice as long, not only because they are not as efficient or have different systems, but mostly because they are more medically complex. There is a value for money issue about paying the same tariff for the easy cases in terms of lack of co-morbidity as you are paying your local providers and that puts stresses on them which of course stresses the whole health community system.

**Q479 Charlotte Atkins:** Ms Adams, I want to ask you the same sort of question about changes in Phase 2, but I would also like to ask you whether you accept what the NHS Alliance says which is basically that ISTCs were important in trying to shake up the NHS, make it a bit more responsive. I would be interested in your views on that.

**Ms Adams:** There is no doubt that there are lessons to learn in terms of the separation of elective and emergency or more critically ill patients undergoing surgery. I have genuinely yet to be convinced that we needed private sector provision to the scale that we are currently facing to achieve that. I will explain my reasons why. Firstly, although we hear from both the Department of Health and some of the SHAs that there was consultation around the facts and figures of what was needed, that information has never been published so it is very difficult to make an informed decision as to whether the numbers were correct in the first place and whether the locations were correct in the first place. The second point that I would make is that I have become quite frustrated when individuals, including the media, are critical of the NHS and the reduction in the waiting list is acclaimed as a success for the independent treatment centres because I genuinely do not think that that is true. I think that staff in the NHS work incredibly hard, and I mean the whole healthcare team, and they have been integral in reducing the waiting list. Much of the innovation that is cited in the ISTCs already exists in the NHS so I do not necessarily think that we needed the private sector involvement to learn lessons. I think we could teach them a few things and I think we can learn together but much of the practice is there. I have an opposition to the private sector being involved. I make no bones about that, but that is basically because I do not necessarily think that they are needed and they are certainly not needed to the extent that they were commissioned to provide. Can you repeat the second part of the question, please?

**Q480 Charlotte Atkins:** What I was interested in was the Phase 2 and what changes should there be to make it more cost-effective?

**Ms Adams:** The first thing is I fail to see how we can make an informed decision on Wave 2 when we have not formally examined Wave 1. There has been no research of Wave 1. There have been no comparators with the NHS treatment centres. There has been no review of statistics. We had the introduction of the 18-week wait which I can see as an issue in terms of achievement, but I do not see as an impossible pass to overcome. The first thing that I personally would like to see on behalf of UNISON is Wave 2 delayed to allow that research to take place and to allow that evaluation to take place. I think that is unlikely to happen because they are already so far down the commissioning process. However, in terms of public protection, in terms of value for money, it is, I believe, a duty of care that we owe to the taxpayer in order to make a full assessment of it. I would like to see complete transparency of the process. I would like to see greater trade union and health worker involvement in making the decisions about what, where, when and who throughout the process. We have that with other contracts. With the cleaning contracts, for example, it is not uncommon for trade unions to be involved in that process and have access to highly sensitive information but we take that on board. As a nurse I am required to maintain confidence of my patients and all health workers understand the need for that. There are ways that we can involve experienced health workers and trade unions who have information and accessibility to be able to inform the process. We need to learn the lessons and I do not think we are in a position to do that. I certainly do not think we are in a position to say that Wave 1 has been an absolute success and to give the whole process a clean bill of health. I would be alarmed if we did. I think there have been some grave errors in Wave 1 and I would want to be assured that we had learnt lessons from Wave 1.

**Q481 Charlotte Atkins:** Mr Brown and Ms Smith, do you have anything to add to that?
Mr Brown: The issue of the ISTCs providing innovation is something that is identified by the Department as one of the benefits of having the ISTC programme. We would question that. In terms of innovation, perhaps a production line process for cataracts and hips can be seen as innovation, but if you look at some evidence that has been provided by the private sector it does not seem to us that you are talking about anything that is significant in terms of innovation. Some of the processes surrounding how someone actually gets to their surgery and how they leave might provide ideas that the NHS could adopt, but that raises the very real issue that if these practices exist and they exist in other countries and in other health services, why is it that we cannot import that innovation without importing the ISTC project itself?

Ms Smith: I have one thing to add about what they are actually delivering for tariff. Within the NHS staff are paid on Agenda for Change. Our concerns are that the treatment centre providers will produce activity for tariff at the expense of the staff that work for them so there will be very different terms and conditions for staff. What we would want to see in Phase 2 is recognition of the need to incorporate at least comparable terms and conditions as there are in the health service for Agenda for Change. Some of the other UK independent providers are already doing that. We have been working with a number of them looking at putting Agenda for Change into the independent sector. There is some evidence there to say that it can be done but we would like to see it incorporated into Phase 2.

Q482 Chairman: Dr Marsh, you were alluding to Queen’s Medical Centre Phase 2. What consultation is taking place between yourselves as one of the PCTs and the SHAs and others?

Dr Marsh: It is a local health community development as opposed to a SHA development. As a consequence it is starting in a much better condition. Secondly, in terms of local clinician engagement it is not going to take account of the rules of additionality and the clinicians who are going to deliver the services in the Queen’s Medical Centre are indeed going to be currently Queen’s. You may or may not know, but the two massive teaching hospitals in Nottingham are going to merge into an even more massive one next week, so the people working there will be current NHS people working there in the services and the building will be provided by the independent sector. However, the contractual arrangements are the same. In terms of how the PCTs are engaged in that, there is a partnership board which is between nations which is the independent sector provider. It includes the Commercial Contract Management Unit, the governmental body that is supervising the project and the PCTs and it is chaired by the PCT chief executive. I am a member of that and also as a knock-on to that I chair a Clinical Steering Group which is predominantly of the consultants involved who are engaging in discussions now about how they are going to design their services in the new building. There is high local engagement. One of the things we have discussed before today has been the ability to offer training. We are a teaching hospital which, by definition, does that and one of the discussions we have been having at the clinical steering group is the nature of the rooms in order to carry on delivering training and teaching. In terms of engagement it is considerably better. The worry I had with it is that it takes no cognisance whatsoever of what has happened over the last two or three years when the case mix was decided. What has happened has been we have had a White Paper and a number of other pressures which have suggested we do things far more out of hospital than we do in hospital. This is a day case and outpatient unit, not a hips and knees place. It is going to have dermatologists and gynaecologists and all sorts of outpatient people there, much of which we would regard as being more sensibly done more local to where people live than even the Queen’s treatment centre. In Nottingham we are in the process of building some very large buildings through the LIFT programme which accommodates day case theatres and outpatient suites in order to provide just that. Our dilemma with that is not clinical engagement. Our dilemma is that we have now got potentially two lots of capacity to achieve those sorts of ends. We have to rack up the capacity in the community quite dramatically in order to reach the 18 week target early in 2008. The Queen’s TC opens late 2007. We will have had to incorporate a whole load of new ways of working in capacity in the community only to find that yet again with a minimum take we are committed to somehow, double pay that by paying it into the Queen’s. That is the dilemma that we face.

Q483 Dr Naysmith: This is a question for Dr Hynes specifically. We have been struggling with it for the last half-an-hour but this relates particularly to the written evidence that you have sent in which has said that waiting times for ISTCs are generally shorter. The question is are they even shorter for ISTCs than they are for other NHS providers, bearing in mind, as Ms Adams was suggesting, if we could have a level playing field with the units like ISTC staffed by NHS people given enough money to do the job properly, is there something intrinsic about ISTCs that means they are going to be shorter waiting lists?

Dr Hynes: The way they are set up at the moment they do not have the difficulties with the complexity of caseload and in particular emergency and unscheduled care admissions that acute trusts do. That is a very significant change in the way we commission. We commission them for what they can give as opposed to a whole multiplicity of services and therefore that is good. It protects them from that point of view. I do think that they have come with a different view. Hospitals providing just this type of scheduled surgery have not been around for a long time. They had a bad name in the past and I remember being involved in one with a special interest in the elderly quite significantly who was in an orthopaedic case in hospital who was in a very bad state. That was when orthopaedic hospitals alone were doing hugely complex cases with the elderly run purely by orthopaedic surgeons, so quite
rightly they got a bad reputation. What is going on here with the ISTCs is a completely different beast. It is a provider of the community’s needs for scheduled care for a relatively uncomplicated and predictable surgery and therefore I think it works and I do not think it would have worked without them coming in from the outside.

Q484 Dr Naysmith: The one kind of implication of all this is that if the waiting lists come down, as they have been coming down, and there is no doubt about it in some areas—certainly in the Bristol area I can vouch for that for orthopaedics and for cataracts—the time will come when waiting times get imbalance between the National Health Service providers and the ISTC providers. There will have to be some spare capacity in both to enable there to be choice in the new choice agenda that is coming in. What would be the advantage of having ISTCs?

Dr Hynes: Simply to achieve what you say happens, in other words, that there is no wait. I think it was necessary to bring in the ISTCs. I do not think we would have got it any other way. I challenge you slightly by the idea that you must always have overcapacity to meet demand. We need to move on to a more dynamic phase and that is why referral management centres are springing up all over the country although they are not actually a Department-led initiative, but they are starting up. We started ours three or four years ago. The concept here is to match the patient into the capacity rather than have this massive capacity and then fit the patient into it. It is a much more dynamic and a much more interesting mechanism but an awful lot less wasteful. I think you will need areas where you have cold capacity that is scheduled and if you understand exactly what it can provide you can match the patient into it as opposed to having over-capacitised the whole place.

Q485 Dr Naysmith: As I think you heard in the previous sessions, I was saying that the evidence has been around for quite a long time, that you have managed some of these lists for orthopaedic surgery, but other lists as well, instead of just letting people wait on a list until they get to the top of it and bring in physiotherapy and all sorts of things, then you can reduce the waiting list tremendously. That idea has been around for such a long time. It was not beginning to get through the health service to any extent until these happened. Is that a reasonable comment?

Dr Hynes: I would challenge that insofar as we set up a musculoskeletal interface system that takes 100% of orthopaedic referrals, subject of course to patient choice.

Q486 Dr Naysmith: How long have you been doing that?

Dr Hynes: About three years. All the patients go into this and then you say where is patient choice? The GP can choose to send them directly to the orthopaedic surgeon but they choose not to because the benefit of going to a multidisciplinary assessment where the patient is seen, has a multidisciplinary assessment and a much wider set of choices rather than I am a cutter, I will offer you a cut. Here is a multidisciplinary set of choices where the patient is given a set of choices. If they wish to have an operation then they have the option of being direct listed from that clinic.

Q487 Dr Naysmith: My point is that a lot of the evidence suggesting that this is a good thing has been around for 10 years; longer even. Why has it taken so long to permeate the National Health Service?

Dr Hynes: The very simple thing in our case was to make it work very well you need direct listing. Direct listing is not the easiest thing to negotiate with many of our hospital-based colleagues who still have the concept that they need to see the patient at the early stages of the disease and work with the patient through the disease up to the time of the operation and then for a long time afterwards. As Dr Marsh has already mentioned, the idea now is that the patient should be seen and managed in their own community and should only go into the hospital when they need a hospital service. This is what I was saying about service reform. This is a change of thinking in terms of many of our hospital colleagues and I feel it was necessary and will continue to be necessary to have these scheduled care operation services available to continue that process.

Q488 Dr Taylor: Dr Marsh, can I clarify that the new ISTC in Nottingham is only going to be for day cases?

Dr Marsh: I think they call it a 23-hour facility—day cases and outpatients— it fulfils those two main groups.

Q489 Dr Taylor: For hips and knees, for example, the only way you will be separating elective from emergency with things like that is at the Barlborough Centre.

Dr Marsh: Because two campuses are being merged into one trust there are discussions at the moment about how that should be configured. One of the solutions arising out of that is a separation of an emergency hospital at the Queen’s where the current accident and emergency department is and a more electively-driven hospital at the City Hospital campus. We have a luxury having two campuses where it is possible to separate elective and emergency. I am quite convinced that that separation can be a useful thing to do.

Q490 Dr Taylor: You could effectively have an NHS treatment centre at one of the sites.

Dr Marsh: I am not really sure what a “treatment centre” means in that context but, yes, it is possible within the NHS to separate elective and emergency.

Q491 Dr Taylor: We have heard quite a bit about integration. From the nursing point of view how possible is it to integrate, not in Phase 1, but when Phase 2 comes how possible will it be to integrate nursing staff?
Ms. Smith: It will be reasonably possible to do it if we get the ISTCs and the NHS working together. There are also the professional networks that nurses can start integrating with. For example, we run professional forums for nurses and we will have those independent sector nurses and NHS nurses working side by side in those forums.

Q492 Dr Taylor: Would you be recommending a rotation from NHS to independent sector or would they always be entirely separate?

Ms Smith: It is possible to have that rotation and there are places where that happens now within the UK independent sector where certainly they will provide training and some experience for staff from the NHS. There are already models there and it would be a question of building on them.

Ms Adams: One of the points that I would add is it is a lot easier for both the interface and the integration to work where you are working with two NHS institutes because the terms and conditions are comparable and the service is comparable. When you introduce the private sector and with the possible weakening of the additionality clause that was applicable to Wave 1 in Phase 2, it is going to be challenging. Where staff perhaps are seconded again that is a lot easier to manage, but where they are directly employed on different terms and conditions I think you introduce a negative element of competition. There is an inherent sense of fairness within NHS staff where they want to see people recognised for what they do. Certainly the lack of training in Wave 1 has been alarming. My experience of working in South London is that there is rotation with the orthopaedic site, which is at Epsom, and with the five main hospitals who surround that where physiotherapists can work in both, OTs can work in both, nurses can work in both and surgeons can work in both, but I genuinely think that that element is a lot more complex when you are dealing with a different employer. The other area that I am slightly uncertain on is the element of risk in terms of litigation. It is quite scary how sometimes that becomes a real quirk to overcoming problems.

In terms of if you worked, for example, in the NHS for a week and then you went to work in the ISTC for a week if there were an adverse incident, for example, you would need to perhaps look at the hours the person had worked and whether they had been excessive and whether there was any risk element there. Those processes become more complex when you are working with a different employer.

Q493 Dr Taylor: You have been very forceful in saying that you think there was enough spare capacity in the NHS and if the money had been put that way the NHS could have done virtually everything the independent sector treatment centres are doing. Certainly there is evidence for that as far as MRI scans go because we know that there were NHS MRI scanners idle while work was being done in the independent sector. Is there any hard evidence that the NHS could have taken on this extra work if the money had been put into it?

Ms Adams: Again, I draw your attention back to the audit report. That clearly cited that there was additional capacity. Sometimes with the NHS—again I speak with some 18 years experience of it—you almost get frustrated. You are just through one change and something else arises and it is almost like you are drowning in a sense of change. Sometimes there is an element of frustration amongst health service staff where they do not feel they can pause for breath to think of some of these things through. It is only when you on occasions put the brakes on and think about things that you are able to do that. For example, when we opened our day unit at St Georges that had been a disused laundry service where the service had been contracted out. It had lain dormant for years but we were able to secure additional funding for the SHA and then we put together a multidisciplinary team to plan how that could be opened and, because it is separate from the unit, if something had gone wrong and we needed an intensive care facility how do we get them? It is within the same geographical area but there is a road in between—how do you get the patient from DSU to theatres? There is a link corridor now but in the mean time we always made sure that there was a consultant anaesthetist physically present until the patients were awake and stable and there was sufficient staff with advanced life support skills, including defibrillation skills, to be able to manage that situation. There are different ways of doing things but the NHS needs to be given a lot more credit for what it does. Its staff and its managers need to be given a lot more credit for what they have achieved.

Q494 Dr Taylor: You will be pleased to know that we have had witnesses sitting in your seat saying that the effect of the independent sector treatment centres on cataract surgery has only been marginal. Can I go to Dr Marsh and Dr Hynes: we have heard conflicting comments about the effect that treatment centres have had on GPs and certainly in the NHS Alliance there are different opinions. Can you summarise the effect it has had on GPs?

Dr Marsh: Preparatory to coming here I emailed all the GPs and asked them to give me any experiences one way or another and in all honesty one of my partners described a horror story and then we realised that it had happened in an NHS trust, so it then put into perspective anything you heard from things happening in the treatment centre. By and large there were one or two people who obviously had a deep-seated dislike of the concept and there were people describing frustrations at the interface, by which I mean immediately post-operative complications are quite hard to get back to the treatment centre. I sit on the clinical governance committee for the treatment centre and that is something that I am trying to address. As yet, the feeling is relatively agnostic.

Q495 Dr Taylor: Are you yet getting any feeling that the complication rate from the independent sector treatment centres is different from that within the NHS?
Dr Marsh: The complication rate is undoubtedly, I would say, currently higher in the NHS trust because the case mix is such which carries a complication rate with it. I certainly do not have a feeling that there is an increased complication rate. However, I must give a word of warning that complication rates in terms of a hip replacement is whether you need to have your hip replacement replaced at five years instead of 10 years renewed and we will not know that until five or 10 years time. In terms of the day-to-day management whether it is because of the pressures which a busy NHS unit have things tend to go more smoothly at the ISTC but it is cherries and apples as opposed to apples and pears.

Q496 Dr Taylor: Long-term follow-up is essential for comparison.

Dr Marsh: If we are to know whether it is a success, yes, but they are taking part in the national joint register.

Q497 Dr Taylor: Again, any comparisons have got to be matched to case mix.

Dr Marsh: Yes.

Dr Hynes: Nationally, in terms of the survey, there is very little opposition to the concept and when it works well it is very strongly supported and the difficulties tend to be in the process and in the consultation stages; in other words, the referral pathway was not agreed locally, patients came a cropper and were put at the back end of a list somewhere or other because of some sort of management problem. Again, it is the difficulty that there seems to be among GPs no moral objection to it; it seems to work very well from the patient’s point of view. When it works very well it is highly supported; when it causes problems then it does colour the picture, but that is perfectly acceptable, again the recommendation being not management-led but partnership with clinicians to deliver it and we will have a success that is replicated around the country.

Q498 Chairman: A couple of questions on the concerns that Ms Smith at the RCN sent in: one is that you expressed concerns about continued professional development for both seconded and NHS and also substantive ISTC and how could those concerns be addressed. The other one is on key performance indicators. You believe that the ISTC lacked it in areas of human resources and in nursing KPIs as well. What would the RCN like to see in relation to those areas?

Ms Smith: In relation to training we would like to see a commitment from the ISTCs both to professional development but also to clinical placements for student nurses. As the Committee is probably aware, student nurses have a period of time that they have to do within a clinical facility where they are supernumerary. We have difficulties at the moment in the NHS in providing enough clinical placements for student nurses and also for mentors to support them. We would want to see in Phase 2 a commitment to that training and an acknowledgement that it was needed. In terms of professional development, we have no information about what is included in the tariff, what post-registration education. Equally, going back to Agenda for Change, Agenda for Change has a number of elements to it: one is around pay banding, but one is about a knowledge and skills framework which allows you to look at the competency of staff and to look at the development needs of staff. Again, seeing that incorporated into Phase 2 would enable nurses and other professionals to have a very clear framework about professional development and what was needed.

Q499 Chairman: The other one was key performance indicators both in terms of human resources but the nursing KPIs you said that they lack as well.

Ms Smith: There was very little consultation about KPIs. We have input to the treatment centre project in two ways: one is in relation to the HR group and the second way is that there is a liaison group with the national implementation team and the Royal Colleges. What happened in terms of KPIs was that we were presented with them. We were told that if we had some views about them we could express that and that we would be given information on exactly what those KPIs were. The information did not come until after the closing date for us to comment. There are indicators in there that could be attributed to nursing but there are no nursing indicators so we would want to work with the national implementation team about what the KPIs for nursing would be. In terms of HR, there is the Improving Working Lives that the NHS have to report against. There are no KPIs like that for the treatment centres.

Q500 Chairman: Does the RCN have any current dialogue with the implementation team on those areas?

Ms Smith: We continually raise it.

Q501 Chairman: That is not quite the same though, is it?

Ms Smith: That is right. Basically the groups that we belong to or where they consult with us, yes, we can raise it but that does not mean they are going to take any notice of what is said. Certainly the Royal Colleges’ liaison is not a consultation forum; it is more an information-exchange forum.

Q502 Mr Campbell: This is a question for the unions. It has been suggested by some people that it is a two-tier system within the centres themselves and the Agenda for Change, as you have mentioned before, was not there, including pensions. Have you any evidence of this that you can give to the Committee?

Mr Brown: The staff who are employed directly by the ISTC providers are employed on whatever terms are decided by the private providers. Where you have staff who have been seconded from the NHS because of the transfer of services into the ISTC then that transfer is based on retention of employment so their NHS terms remain intact. That is the position at the moment, but if we looking at the enlargement
of the definition of “additionality” then you do have the prospect of staff either being able to be recruited directly by the ISTC providers from the NHS, or being able to work outside of their non-contracted NHS hours, additional hours for the ISTC providers. At that point that will raise the issue of the terms of service under which they are going to be employed.

**Q503 Mr Campbell:** It is a two-tier system as we have pointed out, especially with wages because obviously they must be getting less than the health service. A nurse working in there must be getting less money working in a treatment centre surely?

**Mr Brown:** Are you implying that nurses are very highly paid in the NHS?

**Q504 Mr Campbell:** I am trying to make the comparison between the NHS and the treatment centres. What I am trying to get from you is there a drop in wages for anybody being employed in that centre?

**Ms Smith:** We do not have evidence to say that that is the case and the way that salaries are negotiated within independent providers is very different to the way that they are actually put together with the NHS. That is why we feel that if this is truly NHS patients being treated in an ISTC then the terms and conditions of employment should be the same.

**Ms Adams:** One example we can give is from staff who are working within the Bassetlaw and Barlborough area. I cannot anticipate that a sensible company would offer adverse terms and conditions in terms of salary, so that is not what we are saying. What we are saying is that without a commitment to on-duty at the minimum Agenda for Change there is the potential for there to be a two-tier workforce. With the NHS we have removed that potential because we have reached a separate agreement with the Government and with the Cabinet Office for private contractors, so for staff working for example with private contractors doing domestic work or portering service, but it is not just the pay terms and conditions. If you have staff that are seconded into an ISTC and staff that are directly employed they will have to be managed in a different way. Say, for example, something went wrong and it needed to be investigated. An NHS employee would be subject to the NHS disciplinary procedure, somebody directly employed by the ISTC would be subject to a different procedure. The example that I would give you from staff that we had spoken to at Bassetlaw, and there are not NHS staff employed there to the best of my knowledge, but they described a situation where, because they have to cover all of the sites, they could be up at four o’clock in the morning to go to a site almost 60 miles away and be working all day and getting home late but they were not being paid travel. If that were within the NHS and it was an NHS employee, for example, I used to do an on-call, I might finish in theatres at nine o’clock and technically be on-call until eight o’clock the following morning, if something had gone wrong and we needed to open up two theatres I would be paid for that call. If I was called in, which did happen on numerous occasions, then I would be paid from the time I received the call until the time I got home and you would be paid a minimum call-out of two hours. The lack of transparency means that it is quite difficult to judge that and we have to draw comparators from previous examples. The previous examples that we have had of working with private contractors is through the privatisation of the ancillary service. We know that until the introduction of the minimum wage they were paid a lot less than that and their terms and conditions were less favourable than other ancillary employees working within the NHS. We also know that within the NHS we are accountable to the public and private sector provision with the domestic services have been accountable to their shareholders. We know from the bitter experience of domestic and portering staff that often their terms and conditions have been subjected to change negativity in order to ensure that there was profit margin. I am not saying that all private sector employers do that but they play to a different tune and that uncertainty cannot be eradicated. There is a genuine fear from the unions and from the staff that we have members in that without a commitment to a pay Agenda for Change at the minimum that there is a very real risk that very real risk could lead to instability of the local health economy. To give you an example, if you worked in an acute teaching hospital for example, a paediatric intensive care unit, under Agenda for Change you might get X figure. If that was a difficult area to recruit to your unit or your organisation could consider giving you an additional sum of money—it is called an RRP—in order for them to do that they would have to have discussions with their local health economy because there could be another paediatric intensive care unit down the road and if they pay £10 more an hour in site A and site B pays £10 less, then people are going to possibly leave one organisation to go to the other. The whole process about Agenda for Change was not just about equal pay for equal value, although that was the driving force, it was also to give long-term commitment to a whole equality agenda and stability to the health service. It is not fully implemented yet but certainly we are starting to see some results. That is a commitment that both the Trade Union movement and the Department of Health made together. It is just a shame that the Department of Health have not made that commitment to staff through the independent sector treatment centres. They were purposely excluded from that deal and that was raised in the discussions.

**Q505 Mr Campbell:** Are you allowed to recruit?

**Ms Adams:** Within the private sector. The bulk of our membership is in the public sector but, yes, we do have members in the independent sector treatment centres, both those that are employed directly and those who are seconded.

**Q506 Mr Campbell:** You have not heard any evidence where they are trying to keep the trade unions out?
**Ms Adams:** We have, yes. I am afraid. Sadly it is Partnership Health Group, but we have had a number of staff who work for that organisation who have raised very grave concerns about practices and clinical standards. We have tried since September of last year to meet with PHG and it culminated with us having to raise the issue with Lord Warner. It is only as a result of raising that issue with Lord Warner that Partnership Health Group are now scheduled to meet with us on 13 or 16 April. We have sought, because of the concerns that the staff raised, to request recognition with them so that we could work together to try to address the issues that the staff were raising. The concerns that they have raised to us as a nurse gravely alarmed me. We have shared that information with the regulators and with the Department of Health.

**Q507 Dr Naysmith:** Slightly related to what we have just been talking about is the idea that the additionality principle which applies to Phase 1 will probably not apply to Phase 2. That raises the possibility and some people have suggested it to us that that could lead to the poaching of National Health staff by the independent sector. Do any of you have any evidence that that is happening and, if it is happening, is it a bad thing?

**Mr Brown:** It cannot happen at the moment because we have still got the six-month rule in place for NHS staff who work in England. There is nothing at the moment to prevent an ISTC provider from recruiting a member of staff in the Scottish Health Service or the Northern Irish Service or in Wales, but the enlargement of the definition of additionality is based on two things: first of all, identifying those staff working in so-called shortage specialties and those staff would be debarred from recruitment directly into ISTCs without the six-month rule still applying. The other part of additionality is the opportunity for staff who have worked their NHS hours to work additional hours in the ISTC providers. Those are two parts of the additionality. Our concern about the first part on the shortage specialties is identifying shortage specialties. We have been working on that since last summer and the difficulty is you have got to establish quite clearly that you can find a group of staff where we have so many in the NHS that they do not constitute a shortage specialty and therefore can happily move off into ISTC providers. Our belief on the inside is that there are no shortage specialties. That is a view which has accompanied the discussions that we have had since last summer. That is why we have no agreed list on shortage specialties at the moment.

**Q508 Dr Naysmith:** You think there are no shortage specialties?

**Mr Brown:** Our shortage specialty list is everyone who works in the NHS. **Ms Adams:** It is quite difficult to comment on this issue because the discussions are ongoing with the Department of Health. I am delighted that they have taken the chance to discuss it with us. I have a fear that we are perhaps not going to reach an agreement. If it would help the Committee we can outline where we are with the discussions, but there is a real risk because there are shortages. I know that in the last week we have had almost 2,000 redundancies identified, so clearly there will hopefully be the opportunity for 2,000 staff to be redeployed rather than be made redundant.

**Q509 Dr Naysmith:** Are they redundancies or posts?

**Ms Adams:** There is likely to be a mix match of both. The organisations to the best of my knowledge have not published the full figures but there will definitely be redundancies. There are not 2,000 vacancies in one geographical area that I know of despite the high vacancy turnover. Our fear is that, with the weakening of the additionality clause, there is the potential to recruit and that increases the risk of the two-tier workforce because of the lack of commitment of honouring Agenda for Change as it currently stands. The gaps we have at the moment, for example, we have identified that staff working in operating theatres need to be protected but there does not seem to be the same level of understanding about pre-operative care and post-operative care. For example, it is possible that staff from theatres will be protected, but if you worked on an ophthalmic ward or worked in an orthopaedic ward you could possibly be recruited. Those discussions have not been concluded yet but it strikes me that with the majority of the ISTCs providing ophthalmic and orthopaedic and general surgical care it is those people that we need to secure for the NHS, because the NHS, irrespective of what happens, is going to continue to perform a vast amount of surgical procedures and need the staff that we have invested in their training, their understanding and their ability to respond to changing situations rather than hand them to the private sector which could potentially happen.

**Q510 Dr Naysmith:** We were saying a few minutes ago that the conditions of service in the National Health Service and pay are much better than they possibly are in the private sector, so why should people move?

**Ms Adams:** There are occasions where organisations incentivise things and obviously the NHS does not do that in the same way as other organisations. We have a system that is based on equal pay for work of equal value and it is taken us seven years to achieve that—a feat in itself—but there are people who would want to work within the ISTC. With all due respect, there is a great difference between somebody actively deciding that for their professional development they would wish to work in a different environment, whether it is in the voluntary sector, in a charity or overseas, and there is a big difference between that and an organisation coming in and actively recruiting. I personally would not prevent anyone choosing to go and develop their skills and expertise but I would have concerns about any organisation or any recruitment agency coming in and recruiting. The way that the contracts are currently written, or so we have been advised by the Department of Health, is that there is not anything that legally ties any of the independent sector
treatment centres other than good will to not adversely recruit staff. The comparator that we have seen with overseas nurse recruitment—by no means do I think that any UK organisation would act in this way—we have seen overseas recruitment agencies go wholesale into intensive care units in other countries and recruit the whole unit and bring them over to the UK. I am not saying that that is going to happen but without a level of protection, without a level of commitment, without some level of regulation, it is incredibly difficult to prevent that because you are acting on good will and good faith.

Q511 Dr Naysmith: Playing devil’s advocate for a minute, these are people treating National Health Service patients, some of whom have been on waiting lists for a long time.

Ms Adams: Yes.

Q512 Dr Naysmith: What is the real objection if the conditions of service might be just as good? Why should they not move freely between the two?

Ms Adams: If it is an individual that chooses to do that, that is fine, but for example if you had four nurse specialist in orthopaedics, who do pre-operative assessment, who had the ability to do post-operative care, including pain management, and you recruited two of those but you were still having orthopaedic patients needing that service, then that could have an impact on the service that NHS patients receive. Unless you have an additionality list that is sufficiently comprehensive not to expose the NHS to risk you cannot preclude that there would not be a risk to either patient care or services by possibly active recruitment. That is what we are saying. We are not saying that people should not have the opportunity to do it—they already have that through secondment—but there is a big difference with the weakening of the additionality statement and it would be fair to say that all of the trade unions have concerns surrounding that issue.

Mr Brown: To make the point about additionality, it is part of the increasing of the capacity. If you are increasing capacity one thing we do not want to see is the risk that Ms Adams has just mentioned of losing highly experienced qualified staff from the NHS to work in the ISTC where we are increasing capacity but losing part of the NHS at the same time.

Q513 Dr Naysmith: I heard the Secretary of State for Health, Patricia Hewitt, say the other day that she had had consultants and other clinical staff telling her that they would rather work in ISTCs than work in the private sector, meaning BUPA or Nuffield Hospitals.

Dr Hynes: If we are talking about the integration of services, for my patients they do not actually care who employs the person that provides the service. We have said that the most important thing is the integration of the services. Additionality is a bar to integration because it brings in people from the outside who are not involved, so there is a negative side to additionality as well that we need to consider.

Ms Smith: A couple of points about additionality: one is that there is lots of data for manpower figures for medical staff, there is very little data about shortages in nursing. The statistics that the Department of Health have is the vacancies that were advertised in the last three months, so each trust is asked to identify those, not to identify their vacancy or shortage factor, but which posts they advertise. We are not being asked to make decisions about additionality. We are making those decisions blind. The other point is the longer term and if staff are going to go to the independent treatment centres how are those treatment centres going to feed in to workforce planning for the future? What we are being told is that the ISTCs will be told not to look at the local market in a sensible way, but again no indication of how they might get information about the local labour market.

Ms Smith: You are right in what you say but we also have some history about this. If you look at what happened when day surgery was introduced in the NHS lots of staff wanted to work in day surgery units for all sorts of reasons: the fact that they work from Monday to Friday and had weekends off and those sort of things, so that is going to attract people to work in ISTCs.

Ms Smith: Workforce planning is our next inquiry.

Dr Marsh: I take the points on the rationale for additionality, but for the clinical staff losing it does stand the chance of mitigating some of the training problems we are having and if indeed there are myths to be busted, or if there are myths to be confirmed, it is an advantage in terms of getting clinical governance right that staff from one sector who are working in the other. A major anxiety that all clinicians have, both from primary and secondary care, is future training. If the training-type cases are going on in the ISTCs so must the surgeons follow on.

Mr Brown: To make the point about additionality, it is a part of the increasing of the capacity. If you are increasing capacity one thing we do not want to see is the risk that Ms Adams has just mentioned of losing highly experienced qualified staff from the NHS to work in the ISTC where we are increasing capacity but losing part of the NHS at the same time.

Q514 Dr Naysmith: Workforce planning is our next inquiry.

Dr Taylor: Going on to risks to the NHS, because treatment centres only cope with elected work and the whole atmosphere will be calm and peaceful as opposed to an ordinary proper hospital, is there a risk of people wanting to get out of the stress of the emergency situation and move into independent sector treatment centres for that reason?

Ms Smith: You are right in what you say but we also have some history about this. If you look at what happened when day surgery was introduced in the NHS lots of staff wanted to work in day surgery units for all sorts of reasons: the fact that they work from Monday to Friday and had weekends off and those sort of things, so that is going to attract people to work in ISTCs.

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presumably we can ask for that sort of thing. It would be very helpful because we want concrete evidence about that.

Dr Hynes: On this point about people working in casualty departments and the high stress area, you know that people going off work with stress is one of the difficulties of the NHS and certainly confining somebody to work in that area because there is no option means that we might lose them permanently to the health service rather than to offer them a more peaceful existence where they can apply their skills. I am not sure how you can measure the risk. When we finally see a soap not named Casuality but actually named ISTC I expect we will know!

Dr Taylor: I was not suggesting that we should compel people not to go.

Q518 Charlotte Atkins: Have you had complaints about professional standards in ISTCs? I know that Ms Adams has raised the issue of other sorts of complaints but were they about professional standards?

Ms Adams: I believe they were.

Q519 Charlotte Atkins: Was that the only area that you have had professional complaints or have there been other ISTCs that professional complaints have arisen from?

Ms Adams: There have been concerns from some other ISTCs but it was this one that raised the hairs on the back of my neck, so to speak. That is where we have the most evidence. Other elements are slightly anecdotal so I do not think that would be appropriate. Dr Taylor raised that in terms of evidence.

Q520 Charlotte Atkins: What about the RCN?

Ms Smith: We have no information about professional complaints or complaints about those particular providers.

Q521 Charlotte Atkins: What about the NHS Alliance? You have not come across anything?

Dr Hynes: No, and again it is based on anecdote, but you have heightened awareness for everybody. I noticed a dislocated hip, number one, and number two is severe nerve pain, and because I had a heightened awareness I had better track down those patients and both of them, as in Dr Taylor’s case, were done in the traditional NHS system, but that is anecdotal.

Q522 Charlotte Atkins: In that case it would be very useful to see the UNISON evidence.

Ms Adams: Could I make one comment on what Dr Taylor said in regard to the evidence that they had submitted last week? It is quite interesting because we have probably asked for about 30 things under the Freedom of Information from the primary care trust and we have been declined that, including the statistical information that you are referring to under commercial sensitivity. I am delighted that there has been some kind of change in the approach and some information is now being provided.

Q523 Chairman: That information is from the independent sector. We asked for it and it came within a week.

Ms Adams: I am delighted. When we have requested information the commercial sensitivity has been a real hindrance, including from the Department of Health in the preliminary questionnaire that organisations fill in to express an interest we were not even allowed a blank copy of it until very recently because of the commercial sensitivity of it. I am delighted that the picture seems to be changing and things are becoming more open. I hope that that can increase.

Q524 Dr Taylor: It is a comparison with Nottingham City Hospital although not balanced for case mix.

Ms Adams: To be truthful I would have assumed that Nottingham City would have discussed it with the company because it was their information. I am not sure, but I imagine that would have taken place.

Dr Taylor: They must have got it from Nottingham City Hospital certainly.

Q525 Mr Campbell: How do you see the independent sector working within the health service? In a small way like it is now, or do you see it integrating with a mixed economy in the health service in the future?

Ms Adams: What we have seen recently with the White Paper and with the independent sector treatment centres is the tip of the iceberg as far as privatisation goes. I have worked in the NHS for 18 years and I am very passionate about it—that may have come across today—but I am gravely concerned about the future of the NHS. I am increasingly concerned about the lack of consultation. It is all very well to establish policy. Policy can only be effective if it is jointly developed, if it is based on research and if outcomes are reviewed to ensure it is the best direction of travel. The independent sector treatment centres have contributed, not delivered, towards the delivery of the reduction in waiting lists, but the Committee made the interesting point—I believe it was Dr Naysmith—of what happens when there is not a waiting list. I think that will be achieved. It would have been achieved by the NHS but it will be achieved and when we get to that stage we will see more hospital closures and we will see greater numbers of redundancies because it is clear that with five-year contracts, and I believe when the private companies gave evidence at your last session they indicated that they had an anticipation their contracts would be extended at the end of the five years, I fail to see how the NHS will be able to compete in that context. There is always going to be a place for it. I think there is a clear agenda and it alarms me.

Q526 Chairman: They did say that they thought that their costs will come down to tariff levels. I know what you said earlier about tariffs not being an exact science.
Ms Adams: Even in Wave 2 the issue is that they are still going to receive some level of protection. The point that my colleague made earlier on around the tariffs not being comparable because ISTCs are doing perhaps less complicated cases, I do not have a problem with that approach because the same argument is applied to day surgery. A patient has to be fit and medically well enough to be able to undergo a day procedure, but there has to be a correlation of the funding and if they continue to receive this almost safety-net of their risk I fail to see how the NHS is going to be able to compete.

Ms Adams: It is the tariffs, it is the transparency, it is the process, but it is also the future provision. What we are seeing is the establishment of the longer term provision for the private sector through the independent sector treatment centres and it will have an impact on the NHS there is no doubt in my mind.

Dr Marsh: If we were to look in five years' time at the involvement of the independent sector and the NHS, the major growth area will have turned out to have been in primary care and in provision of community services. That is just starting to edge into things. That is going to be a massive step change which is going to be occurring.

Chairman: Thank you all very much for coming along this morning. I am sorry we have overrun. Hopefully we will be putting a report out within the next few months in terms of this area.

Q527 Chairman: There are tariffs and tariffs is basically what you are saying.
Wednesday 26 April 2006

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess, Dr Doug Naysmith
Charlotte Atkins, Mike Penning
Jim Dowd, Dr Howard Stoate
Sandra Gidley, Dr Richard Taylor
Anne Milton

Witnesses: Rt Hon Patricia Hewitt, a Member of the House, Secretary of State for Health, Sir Ian Carruthers OBE, Acting Chief Executive of the NHS, Mr Hugh Taylor CB, Acting Permanent Secretary, and Dr Bill Kirkup, Acting Deputy Chief Medical Officer, gave evidence.

Q528 Chairman: Good morning, Secretary of State. Could I just, for the sake of the record, ask if you could introduce yourselves and what role you are playing?

Ms Hewitt: Of course, Chairman. Let me introduce Mr Taylor, who is Acting Permanent Secretary of the Department of Health, Sir Ian Carruthers, the Acting Chief Executive of the NHS and Dr Bill Kirkup, who is the Deputy Chief Medical Officer. I am Patricia Hewitt, the Secretary of State for Health.

Q529 Chairman: Thanks very much indeed for coming along to help us with this inquiry. I suppose this is a question to all of you, really: one of our main tasks in this inquiry is to discover whether the ISTC programme provides value for money. I wonder if you could explain why, as you have said in your supplementary memorandum (which I believe that you are about to publish today), it is you are unwilling to make available the details of the value for money methodology the Department of Health used in assessing ISTC bids?

Ms Hewitt: I will come to Sir Ian in a moment on that specific point, but if I can just make a general point about value for money, the ISTC programme has enabled us to do four things that I believe give us value for money: first of all, they have delivered additional capacity which the NHS, at the time, said it could not do within the timescale needed to get the waiting times down, as we had promised. Secondly, the ISTC procurement produced a sharp fall in pricing within the independent sector in which, historically, Britain has had the highest prices in the world, and that of course meant a very sharp reduction in the spot prices that traditionally the NHS had paid in order to reduce waiting lists. Thirdly, it has brought additional innovation and a consistent application of best practice, and, fourthly, it has provided an element—modest but an element—of competition for under-performing parts of the NHS, therefore helping us in our constant quest to drive up productivity and get value for money across the entire NHS budget. On the specific point of the methodology, Sir Ian, do you want to come in?

Sir Ian Carruthers: On the methodology used in the work on procurements we were adopting a very similar approach. It was actually based on running an open and competitive procurement, selecting the best value offered and rejecting any schemes that failed to significantly deliver better than the prevailing spot purchases. So through those processes and that methodology, in a contestable way, we are content that we have got good value for money from the process.

Q530 Chairman: But us not being able to see the detail of the methodology hinders us a little bit in terms of our role that we play here, and that is to have this oversight role in terms of how things are assessed. Also, of course, we have got the Public Accounts Committee. How can we expect to make a proper assessment, both of these Committees, of the probity of the decision to spend public money on ISTCs if we are denied the methodology of how this is being done? We understand that the business cases and the 2004 review of the value for money methodology are still in confidence. Is this necessary?

Ms Hewitt: Chairman, I am very happy to take this away and look at it again, but having looked at this, in a sense, afresh as a new Health Secretary, I am absolutely satisfied that the procurement we did was carried out absolutely rigorously in line not only with national but also, of course, with European standards. As Sir Ian has said, it was absolutely open, the criteria for selection was clear and I do not really think there is any criticism of that general procurement process to be made. As both my own officials and, indeed, some of the independent sector providers, I think, said to the Committee when they gave evidence, there are aspects of the procurement that are commercial confidential and which we undertook at the time not to publish; not to share either with the public or, indeed, with other providers—either providers who won contracts or those who failed to win contracts. It seems to me that is inherent in any process of competitive tendering whether it is by the Department of Health or any other part of government. If in some way we are being more restrictive in what we are giving to this Select Committee compared with other departments engaged in other commercial procurements then, of course, I will have a look at whether that is something we may change.
Q531 Chairman: Could I ask you particularly about the 2004 review that was done? We do often take evidence in confidence that only we will see and which will not be published in any way, so could I ask you to look at that because we may be able to learn things from the review and, indeed, the department may learn things from that review as well.

Ms Hewitt: I will certainly look at the 2004 review, Chairman. I think perhaps what would be helpful is if through your Clerk you could indicate a little bit more of the specifics that are you looking for and if, again perhaps through your Clerk, there could be some indication of what other Select Committees have been able to obtain in terms of information about other procurements (?). However, I would just make the point that in looking at this I am obviously going to have to honour commitments that were given as part of the procurement to guarantee commercial confidentiality to companies that in good faith took part in that procurement.

Q532 Chairman: I think this Committee would accept that; it is a question of learning lessons from the whole process. Another area in relation to the issue of value for money is you say that the methodology had to be designed from scratch as there was an “absence of an accepted public sector comparator for providing these clinical services”. Why was it not possible to use NHS treatment centre programmes as a comparator?

Ms Hewitt: There were very few of those at the time we embarked on this, I think I am right in saying.

Sir Ian Carruthers: That is correct.

Q533 Chairman: But there were some.

Ms Hewitt: We are talking about a period before my time and I am afraid I have not got all that detail with me.

Q534 Chairman: I realise that. It is possibly not directly a question to you, Secretary of State, but there were some. We would just like to know why it was not the case that they were used.

Sir Ian Carruthers: In essence, NHS treatment centres were very often part of individual hospitals and their costing structures actually were very similar to the NHS main hospital provision. So I think that very often they were additions to the facilities that ran in an ordinary way. I think we can look at that but the reality is that that will be consumed in most of the costs of normal hospital provision because I think treatment centres were quite often in many instances just extensions of the local hospital.

Q535 Chairman: Are you looking at them differently now? We were actually in one last week. It may be on the same site as a hospital and adjoined to the building but it is run differently from the hospital. Ms Hewitt: I think, if I may say so, that reflects part of the change that is happening within the NHS. One of the problems that arose in the old, if you like, more monolithic NHS, is that actually there was not great transparency about costs and the NHS did not, in the old days, have a very good understanding of the costs of doing different kinds of procedures in different kinds of places. That is changing and, of course, one of the main reasons it is changing is because with patient choice and money following the patients, the introduction of foundation trusts and the expectation that each hospital will take responsibility for its own success and for responding to patients’ needs, so it becomes necessary to underpin the operation of the NHS with proper transparency on costs and a real commitment to driving through better value for money in order to ensure that we are giving all patients the best possible care and releasing resources for all the other things that we still need to do. So I think although we are still not where we need to be in terms of every part of the NHS really understanding costs and value for money, we are significantly further ahead this year than we were four or five years ago.

Chairman: We may want to ask you if that is influencing the potential of what is happening in the Phase 2 round.

Q536 Dr Taylor: Secretary of State, I think we understand that your memory cannot be as long as some of ours. At the time that the independent sector treatment centre programme was instituted there were at least five NHS treatment centres in the organisation NHS Elect which was set up by one of your predecessors to foster the development of independent sector treatment centres separate from acute hospitals specifically to sort out the separation of elective and emergency work. These at the time were working at, from memory, something like merely 50% of capacity and had a vast amount of spare capacity that could have been taken up. The crucial question is why ever was money not put up and made available for these NHS centres and the expansion of this programme rather than the sudden switch to the independent sector?

Ms Hewitt: My colleagues may well be able to give more detail on what was happening five years ago, but otherwise I will see whether I can supplement this.

Q537 Dr Taylor: If I can be very rude, you said right at the beginning that additional capacity was not available in the NHS and you said that the NHS said it could not do the extra work. I wonder actually if the NHS was ever asked if it could do the extra work.

Ms Hewitt: On that latter point, my understanding of the first wave of ISTCs was that the Department went out to each area of the NHS and asked what additional capacity was needed in order to achieve the waiting time targets and whether that capacity could, in fact, be developed rapidly enough within the NHS. The answer was, in some cases, no, it could not be—not least because of workforce constraints. This was, of course, at a point when we had started expanding the number of doctors and nurses being trained but we had not yet got them through the system. So we needed very rapidly to bring new capacity into the NHS, and my predecessors, I think quite rightly, made the decision to do that, first of all, by expanding capacity within the NHS itself,
secondly to expand capacity through the ISTC programme. Of course, in July 2000 in the NHS plan, where we said that we would develop a new generation of separate diagnostic and treatment centres, we said we would do that in partnership with the private sector as well as on the free-standing basis. Of course, the third element of increasing the capacity was that through patient choice, initially in six months. We mobilised spare capacity that was sitting around in the private sector of the kind that was made visible to patients when they were told, as they so often were: “Well, of course, if you have it done on the NHS you will have to wait 12, 15 or 18 months [whatever it was] but if you would like to go private we can do it for you next week”. We said, quite rightly: “If they can do it next week they can do it on the NHS”. However, it was by centrally procuring this, in particular through the ISTC programme, that we challenged the exceptionally high prices of the private sector in the United Kingdom, got those prices down, brought the prices down for the spot purchasing (thus increasing value for money), brought in new providers to the independent sector, challenging the incumbents (uncomfortably for them, perhaps) within the UK private sector and introduced a new element of dynamism into the NHS but, more broadly, into the health care system. So I do think it is very important in all of this that we think in terms of a dynamic and not a static model. We recognise that by committing ourselves as we did, and we started out again in June 2002, to greater plurality and diversity in the delivery of elective surgery services we introduced into the old monolithic NHS a significant element of competition and dynamism. It came from the ISTCs, it came from choice at six months and it came from the creation of foundation trusts, and it is that system of what John Kay would call disciplined pluralism that will actually give us the big prize which is much higher productivity across the NHS as a whole. Forgive me for a long answer but I think it is important to have the full picture.

Dr Taylor: I think we will come back to dynamism later.

Q538 Mike Penning: Briefly, Secretary of State, if I can bring you back to when you were referring to commercially sensitive information that would be revealed if you were to reveal the methodology that was used, I am sure you are very busy but, hopefully, your officers and officials have managed to look at the evidence given to this Committee previously. The independent providers, giving evidence to this Committee recently, when I asked them the question did they have a problem if the methodology was revealed, said no. So they are happy and you are not. Why?

Ms Hewitt: I, of course, had a look at that exchange and the transcript of the previous evidence. They drew a very clear distinction between information that they would be happy to have released and the commercially confidential information which they would not be at all happy to release.

Q539 Mike Penning: That is not what they said to the Committee.

Ms Hewitt: The procurement rules that we operate under, which are both national and European, impose certain confidentiality requirements. The commercial agreements with the bidders themselves impose confidentiality requirements, which we are not going to break and they certainly do not want us to break, and then obviously there is a confidentiality requirement that simply relates to individual patient records, which I think is not a matter between us. I have said, obviously, Mr Penning, in response to a request from the Committee, that I will look again at whether there is additional information that we can release that does not infringe any of those constraints.

Q540 Dr Naysmith: Good morning, Secretary of State. The questions I am going to ask are partly, really, historical and it is interesting that since the last time we were going in detail into this subject on this Committee there has been a total change of personnel sitting at the top table—and it is nice to see Sir Ian Carruthers who comes from my part of the world there, too. Welcome, Sir Ian. The reason I introduced it in that way is because the first question I am going to ask you is a historical question. Since none of you were really involved in it would you agree that there has been a lack of transparency in the value for money methodology previously? That is really what we are all circling around.

Ms Hewitt: First of all, I know you had an extensive session with Ken Anderson and Bob Ricketts who have been involved in this programme from the outset, and I believe that Ken Anderson and his team have brought exceptionally high quality and tough commercial negotiating skills to the Department of Health, which I think have benefited the Department and benefited patients, both through the ISTC contract but, also, through the pharmaceutical contract negotiation. What we were doing with Phase 1 of the ISTCs was new, so of course we have all been learning through that—and I am sure we will come on to other things like training where we have also learnt to change policy—

Q541 Dr Naysmith: You are not really answering my question: whether you think that in the early days things were perhaps kept too secret and not really revealed to people who might have had an interest in what was going on.

Ms Hewitt: I do not actually think that that was the case. I have not seen anything to suggest that we were hiding information that should have been made public. I am very impressed by the scrupulous adherence to absolutely best practice procurement and confidentiality where that is required. Part of the purpose of the ISTCs was to bring in new providers and if there had been any question of looseness around commercially sensitive data we would never have got them in.
Q542 Dr Naysmith: One of your criteria for assuring value for money in is “selecting the best value offer received”. Under what circumstances could that not be a necessary criterion? Does it actually mean anything? In any procurement you are going to have that.

Ms Hewitt: It most certainly does. I was not involved in the Wave 1 procurement but I have been involved in other departments in major procurements and public/private partnership deals, one of which, for instance, was an enormous outsourcing agreement for National Savings. One of the high level criteria was best value from the different bids received. Underneath that was a huge amount of detail about what were the criteria that then enabled you to judge best value.

Q543 Dr Naysmith: Again, in the same submission, one of your criteria seems to have been rejecting any scheme “which was not significantly better” than prevailing spot purchase rates. Spot purchase rates almost by definition are always much higher, or tend to be higher, so is it an appropriate comparator?

Ms Hewitt: It was not being used as the benchmark, it was being explicitly excluded, and I think it is very important when you do procurements that you make these things explicit, and that is what that criteria was doing.

Q544 Dr Naysmith: Sir Ian obviously wants to come in, but it is not offering the benefits of scale, or economies of scale, which you would really hope to be getting if you make that comparison. Is it?

Ms Hewitt: On economies of scale, the first wave—and indeed the second wave is still fairly small scale—I agree you would expect to get significant differences on spot prices—

Q545 Dr Naysmith: If you get spot rates, then you do not get as much as you can get (?). That is what I am talking about.

Ms Hewitt: Spot pricing is massively inefficient. So, in a sense, what the criteria were doing was saying because spot pricing is massively inefficient anything that is near the spot price is not good value for money. That may be common sense but I think it is extremely important that that was put out there at the outset and the private sector will—

Q546 Dr Naysmith: So the important thing is it is significantly better?

Ms Hewitt: I believe so, yes.

Sir Ian Carruthers: I think it is important, as Dr Naysmith has mentioned. I was not in this role but I can give you an account from how it looked from the NHS.

Q547 Dr Naysmith: So could I, actually, from the Bristol experience.

Sir Ian Carruthers: I do not think there was a lack of transparency but what there was was a process of evolution. Where we started from was, in actual fact, that there was a lot of extra capacity needed. We quite often had to utilise the private sector in varying local circumstances and quite often there were spot purchases which actually are more expensive, as a general feature. What then happened—and this comes back to Dr Taylor’s question—is NHS Elect was established but NHS Elect was only in a defined number of areas. What then occurred is many people could not or would not travel quite the distances so that it was limited. Part of the use was about how those organisations engaged with the NHS and how referrals were made. In parallel to that, to set this in context, we then began, in the NHS, a separate development which is the NHS treatment centre. In fact, if you look at some parts of the country they are much more weighted to NHS treatment centres than they are independent sector treatment centres. Quite often the cost basis for treatment centres was based on a hospital base. So what we had was an issue around value for money where we still had spot purchases because there was antipathy to using some of this, and we had an evolving situation where as facilities grew and as people were more willing to exercise choice and move, there became a greater need, really, to tackle the value for money issue. I think it is for that reason we then moved away from localised procurement to more nationalised procurement. It is about, really, getting value for money for the NHS. I think we did that through utilising things like the G-supp and other methodologies which were about better value for money for the NHS. The ISTC problem is slightly different because we were creating completely new capability and the importance of the new capability was that we quite often had new situations—and I can speak of a place which is just over the border in Shepton Mallet, where I know you have taken evidence from—and there is no doubt that the NHS, even in an area with very low waiting times, could not have got to the levels that some of them have. So the real issue was that you need to see this as an evolution, and the aim was to get value for money for the NHS. That has overall been achieved because, actually, the pricing structures of the private sector during this period of national procurement have equalised in a significant way and, overall, we are now moving to a position where we are using our own capacity plus, if I can, use ISTCs as NHS branded capacity much more effectively. I think the spot purchase has been eradicated and so on. One of the questions, if I may comment, has been around commercial-in-confidence and the methodology. I think the real issue is what is commercially confident? I think the Secretary of State has indicated that we will look at that, but I think we need to distinguish the detail because it was in most instances just a straight procurement exercise which had to balance the price, the comparator with the NHS and, of course, the other important factor was about creating more diversity of provision that would give more local access. In fact, the national procurements with their local centre are overcoming some of the difficulties faced in NHS Elect, because people were more willing to be referred 10 miles from home than they were much bigger distances.

Q548 Dr Naysmith: Thank you for that. I know, obviously, Secretary of State, you will indicate who you want to answer the question, but there has been
a lot of talk about spot purchasing rates. You have presumably been measuring those and you say they are coming down as a result of the activities that you have been involved in. Is there any way you can give us an indication of how much these spot purchase rates have come down and how useful that has been, if it has been?

**Ms Hewitt:** The premium on spot purchasing when we started on the ISTC programme was about 40%. The average premium on the ISTCs is about 11%—and I was just checking that that was indeed included in the supplementary memorandum we have given you. There is no real need now for the NHS to use spot purchasing at all. There has been a transformation in the structure of the independent sector health care market in the United Kingdom as a result of what we are doing.

**Q549 Dr Naysmith:** Did I hear you to say you were not using spot purchasing at all? There is no need for the NHS—

**Ms Hewitt:** There will, no doubt, be the odd occasion when somebody has got to do it but there is no real reason why spot purchasing should be featuring in any significant way within the NHS at the moment. What we have got is not just the ISTCs, we have also got the G-sup (the supplementary provision). In my own city, for instance, Leicester, where there is a Nuffield hospital, through not the ISTC programme but through the supplementary contract the local NHS uses the Nuffield hospital for orthopaedic patients who are in danger of breaching the six month maximum time. They work in a very sensible, collaborative way; patients are very happy and certainly the consultant I met at the Nuffield is using his overtime hours in the Nuffield with the agreement, obviously, of the NHS trust, and it is an arrangement that works extremely satisfactorily. It has got waiting times down to a maximum of six months, and for most people, of course, much less; patient satisfaction is very high and as far as I know, in that particular health community, there is not any spot purchasing. What we will do is check what figures we have on current levels of spot purchasing—

**Q550 Dr Naysmith:** I have got one last question in this area and it has already been touched on. It is this question about the value for money methodology. It has been reviewed in 2004 and I know the response you have given is that some of it is confidential, but can you give us any idea of the sorts of things you are looking for in these changes, because you have been talking about an evolutionary process and things changing as we get experience of what was going on. What is it that you want to get in future that you have not got in the VFM methodology that we are using up until now?

**Ms Hewitt:** The outcome we want, obviously, is high and consistent standards of clinical and non-clinical quality of care for patients in the NHS and independent sector providers. We want to get all our providers as close to or below the NHS tariff prices. So a level playing field here, both in terms of quality and in terms of cost. That is the goal. We will get their gradually.

**Sir Ian Carruthers:** Can I just add to that? I think also there are other issues we will be looking to as part of this learning curve. We want future ISTCs to be much more engaged in training—

**Dr Naysmith:** I think we are going to come on to talk about that later. What I was just going to say is that I hope all this is being monitored and recorded so that we can actually see the difference in two years’ time. Thank you very much, Secretary of State.

**Q551 Anne Milton:** Good morning, Secretary of State. I promise to be very brief. Thank you for coming, particularly as, clearly, you have a very bad cold.

**Ms Hewitt:** I am waiting for the pharmaceutical companies and a brilliant R&D programme to produce a pill for the common cold!

**Q552 Anne Milton:** Did I hear you to say you were produce a pill for the common cold! What is it that you want to get in future that you you are going to have hospitals, particularly with patients might also be coming out of the NHS. So a result of what we are doing.

**Q553 Anne Milton:** Can I just add to that? I think have been involved in. Is there any way you can give us an indication of how much these spot purchase rates have come down and how useful that has been, if it has been?

**Sir Ian Carruthers:** Can I just add to that? I think have been involved in. Is there any way you can give us an indication of how much these spot purchase rates have come down and how useful that has been, if it has been?
from a patient point of view: where patient choice is limited (or, in some cases, non-existent) to a system where patients will have far more choice, in the context of electives (which is obviously what we are talking about), and they will have completely free choice by the end of 2008 of any provider in England that can deliver to the quality that we want and within the time. On top of that, each of the hospitals, each of the providers and each of our NHS hospitals will be expected to take responsibility for understanding the needs of their patients; making sure they are responding to those in the best possible way, addressing causes of patient dissatisfaction if those exist, and where capacity needs to be adjusted either because patients are saying they prefer one thing and not another or because new medical practice makes it possible to do things in better ways, then one of the challenges we face is the NHS becoming more nimble in responding to those changes in capacity which, as I say, are driven very often by medical technology as well as by growing patient choice.

Anne Milton: Thank you very much.

Q554 Mike Penning: This massive effect that ISTCs have had on the NHS. The policy, as I understand it, was that ISTCs were brought in to increase the capacity to deal with waiting lists, and yet your officials have indicated to us that they are effectively very marginal. I wonder if you can confirm the figures that there have only been 60,000 procedures by ISTCs and of the NHS procedures 6 million. My mathematics is surely not as good as yours, Secretary of State, but that does not seem to be such a massive effect. Is that correct? Why is this the BUPA Redwood centre is nothing to do with ISTCs and of the NHS. The policy, as I understand it, both the independent sector and not capacity to deal with waiting lists, and yet your purely the ISTCs. Ms Hewitt: Indeed, but let me just respond to the question. I do not think I actually used the word “massive”. The ISTC programme is a small pebble in a very large pool. You are absolutely right, if you combine the diagnostics and the electives, we are talking about 250,000 patients so far who have benefited—that is diagnostics as well as electives—and as you rightly say 6 million elective operations a year. So it is a very small proportion. However, even a small pebble in a very large pool can create a lot of ripples. If you like, that is what I am describing: the additional capacity which made an important—not the majority difference—difference, for instance, in getting cataract waiting times down; the fall in spot prices that we have been talking about and the additional innovation, for instance, in mobile diagnostic centres, which in the case of MRI scans helped bring those waiting times down really quite dramatically.

Q555 Mike Penning: Can we see then just how small this pebble is and whether or not there is an interpretation that is trying to make this pebble even slightly bigger than it perhaps is? What significant part of the 60,000 or the 250,000 you were referring to does the BUPA treatment centre at Redwood, in those figures, contribute?

Ms Hewitt: I am not sure. About 35,000 elective patients treated so far.

Q556 Mike Penning: The Committee has a figure of 38,000 so we are pretty close, but that is not within the ISTC programme. Why were those figures used to boost the way that the ISTCs have been working where they were there as contracts with BUPA before the ISTCs started? Surely, they should not be inside those figures.

Ms Hewitt: I am not sure I follow your question.

Q557 Mike Penning: You are saying that a certain amount of work has been done by the ISTCs because of the excellent work they have done, yet you are using figures from a contract which is not inside the ISTC programme. It is pretty simple, really.

Ms Hewitt: There are a number of different ways in which we use the independent sector. You are quite right that there is an ISTC programme, specifically Wave 1 and now Wave 2, there is also the joint venture represented by BUPA Redwood (there may well be other joint ventures in future) and there is the G-sup contract. I noticed, as I was going through the transcript of earlier evidence sessions, that actually both the questions and the responses dealt with a variety of uses of the independent sector and not purely the ISTCs.

Q558 Mike Penning: That is not the question I asked you, Secretary of State. I am asking you why the figures are within the ISTC programme (in other words, how successful the ISTCs have been) when the BUPA Redwood centre is nothing to do with ISTCs; the contract was there before. Why are those figures inside those successful figures?

Sir Ian Carruthers: The BUPA arrangement was established before the national procurement, but it is viewed as a prototype ISTC and, actually, it is therefore different. It was one of the initial things; almost a pilot to establish how we went forward. I think you have got to see it in that context, so to leave the figures out would give a slightly distorted picture because it is not, if you like, a totally private sector organisation as some of the other groups would be—the Nuffield, and so on.

Q559 Mike Penning: I think it is distorting the figures by saying they are inside an ISTC programme when they are clearly not.

Ms Hewitt: We can give you both sets of figures. On the total Wave 1 activity, excluding Redwood and excluding the supplementary procurement, we are looking at about 855,000 procedures over five years, and around 11% average premium is calculated on Wave 1 ISTCs, again without Redwood and the supplementary catalogue.

Q560 Mike Penning: We have already heard, earlier on, that the use of the ISTCs is at something around 40% or 50%. Surely, then, the argument that they were so desperately needed and the NHS could not cope without them is, perhaps, flawed.
**Ms Hewitt:** These judgments about capacity were made at the time by the local NHS, and I think it is fair to say that capacity planning is quite a difficult thing to do. I think it is also true to say that once we had announced patient choice at six months and we had announced the first wave of the ISTC programme, actually the NHS responded, in some cases, by changing the way that hospitals worked and got those waiting times down. I would be very happy to give the Committee a copy of the slide\(^1\) which I was showing Cabinet colleagues last week which shows very clearly that between March 2000 and September 2002 the number of patients waiting more than six months barely changed at all, despite the fact there was more money going into the system. When we announced choice at six months and the beginning of the ISTC programme, those waiting times absolutely plummeted, and it comes back to the point about the dynamic effect of even quite a small number of new providers changing practice, improving the use of resources and therefore improving productivity.

**Q561 Mike Penning:** I do not want to dwell because there are lots of other Members that would like to ask questions and the answers are very long. Can I ask you, Secretary of State, how many NHS facilities you are happy to see closed—that have been closed or will continue to close—for the ISTCs to go forward? In some hospitals you are going to demolish hospitals and build ISTC centres. How many of these hospitals are you happy to see closed?

**Ms Hewitt:** I do not regard that as, if I may say so, a right measure.

**Q562 Mike Penning:** It is a question though, is it not? I have asked a question on behalf of the Committee and I would like you to answer it.

**Ms Hewitt:** My answer is that what we are doing is building new NHS hospitals, including of course the proposed PFI in Bedfordshire and Hertfordshire. We are also commissioning ISTCs—a small number and a very small proportion of the total budget—but in many cases because the local NHS believes that is a better way of delivering faster and better patient care—

**Q563 Mike Penning:** Are you not willing to answer the question?

**Ms Hewitt:** My criterion for success is simply: are we giving patients the best possible care with the best possible value for money?

**Q564 Mike Penning:** So the answer to the very simple question of how many NHS departments and hospitals you are happy to see closed so that the ISTC project can go forward is that you are not going to answer the question?

**Ms Hewitt:** It is not a question of closing NHS facilities in order that—

**Q565 Mike Penning:** It is a question from this Committee to you, Secretary of State.

**Ms Hewitt:** It is not a question that I am—

**Q566 Mike Penning:**—willing to answer?

**Ms Hewitt:**—willing to answer in that form because that is not how the system works. When patients have free choice of where they have their elective operations (which I would have hoped, Mr Penning, is a goal that you would support) it will be the patients who decide which facilities flourish and which facilities are to change.

**Mike Penning:** There is no choice if you close hospitals, Secretary of State. It is simple.

**Chairman:** Secretary of State, I want to move on to Charlotte but can I just say that the thing you shared with the Cabinet last week we would be more than happy if you shared it with the Committee. If there is anything in terms of numbers of patient alongside that it would be very useful to us.

**Q567 Charlotte Atkins:** Good morning. In the statements you have kindly provided to us it says that ISTCs have played a major role in increasing capacity to NHS patients but it also says that you have to get this into perspective, that ISTCs have only treated 3\% of those NHS patients having routine elective surgery. That appears, on the face of it, to be somewhat contradictory. Are you saying that the dynamic you were talking about closes that particular gap?

**Ms Hewitt:** Yes, I think the effect of the ISTC, in terms of capacity, has been two-fold: there has been the direct contribution (modest but significant) and there has been the indirect contribution that together with choice (this greater plurality of providers) has encouraged other parts of the NHS to make more effective use of their own capacity.

**Q568 Charlotte Atkins:** So, basically, then, it is not the ISTCs that have been responsible per se for the reduction in waiting lists and waiting times, it is, in fact, the NHS providers who should actually get their just desserts, in the sense that they are the ones who have actually reduced waiting times down to less than six months.

**Ms Hewitt:** It is actually both. I take the example of cataracts, which I know is controversial with some of our NHS colleagues, and if you look at that there is no doubt at all that the majority of cataract operations are done, and always have been, within the NHS. I have no doubt that will continue to be the case. If you look at the number of additional operations that had to be done to get those waiting times down to a maximum of just three months, around a third, I think, of those additional operations were done by the ISTCs—not the majority but, nonetheless a significant contribution. On top of that you have this really exciting example of innovation which was the mobile surgical units going around to those parts of the country that have the greatest waiting lists and really helping to get them down. So a significant contribution. I have never said that the ISTCs were purely responsible for the really extraordinary fall in cataract waiting times (we have hit the three-month target four years earlier than we said we would) but they have made an

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important contribution and both should be recognised. The other example I would give you is MRI scanning. That was really very important because under the contract that we had with Alliance Medical about 113,000 NHS patients directly got faster scans—that is by February of this year—as a result of that service. Again, what Alliance did was to bring in a mobile operation which saw a very, very dramatic fall in waits for MRI scans in some parts of the country, from the order of six months or more to the order of six, eight or 10 weeks—that sort of area. So very big reductions there in waiting times for some patients in some areas, and as we move towards the 18 week target at the end of 2006 we need both a massive expansion in diagnostics in the NHS but we will also need a significant contribution from the independent sector just to hit that contract.

Q569 Charlotte Atkins: If NHS facilities were given the same resources why would they not be capable of doing exactly the same thing in terms of bringing down waiting times to the 18 week target? Is there any particular reason, given now that you have introduced this new dynamic?

Ms Hewitt: This really goes to the whole question of innovation and best practice and how you get a dynamic system that incentivises both innovation and best practice. I think most people would agree that the NHS is superb in places at innovation and creating best practice, and on almost any aspect of patient care you care to name you will find best practice somewhere in the NHS; it is there, particularly, but not only, of course, in our brilliant teaching hospitals. However, what the system, taken as a whole, has been very poor at doing is incentivising best practice—not as the occasional result of superb clinicians and entrepreneurs and so on but as the norm. By putting more diversity and more competition into the NHS as a whole we are incentivising best practice and innovation throughout the entire service. This is really important, because what we are finding with the ISTCs is that, partly because they are set up on Greenfield sites but also because they come from a different culture, they are institutionalising as best practice a whole series of things about how you treat patients. For instance, the idea that every patient is seen for a proper assessment before they are admitted; that every patient is telephoned before they are admitted to make sure they still need the surgery, the date is convenient and all of that. I can send you a very detailed note because I am not going to give you a long answer—I could go on for ages on this—but a whole series of aspects of best practice, each of which taken on its own represents common sense but which are not the norm throughout the NHS. I know this can be difficult for NHS colleagues and all of us who love the NHS to admit, but I will give you just one example that I picked up the other day: two orthopaedic surgeons working side-by-side in the same hospital. One of them has his secretary ringing every patient the previous week to check that they know they are coming in, they know what the procedure involves, they know what they have to do to prepare and they know what will follow after the operation. Not surprisingly, most of his patients turn up for the operation. The next orthopaedic surgeon, working in exactly the same hospital, does not do that. His secretary looks at the list on the Friday, starts ‘phoning them and says: “Pack your bag; you are coming in on Monday”. Now, which consultant has the better rates of attendance at the surgery? It is blindingly obvious. But, actually, there should not be that kind of variation; best practice says you know what the best way is and you do it like that for everybody. It is that kind of attention to detail and building in best practice to the design of the building, the design of the processes as well as the clinical quality that the ISTCs actually exemplify. Parts of the NHS equally exemplify it, but to get it generalised across the NHS as a whole, which is what we have to do to get best value for money across the NHS, we need diversity, we need choice and we need an element of challenge and competition.

Q570 Charlotte Atkins: Given how much we are now paying NHS consultants, I would have hoped that that increase in productivity would have been, effectively, part of their contract. It seems to me that if we are paying them more they should be delivering more and, perhaps, they are not always doing that.

Ms Hewitt: I think consultants are often let down by the systems within which they work. A very senior consultant surgeon whom I was talking to just last week said that when he arrives at his hospital for, let us say, a Friday session, there are occasions when there are too many patients and too few beds, there are occasions when there are too few patients because they have not been checked in advance and they have not turned up, so there are occasions when he is overworked and there are occasions when he is sitting around doing nothing. That is because the system within that hospital is inefficient and there is not the collaboration between the managers, the nursing and the clinical staff required to deliver the best possible use of your most expensive resource, which undoubtedly is the consultant—he or she is your most skilled resource.

Q571 Charlotte Atkins: You have just given us a perfect example yourself of two surgeons who behave totally differently. It seems to me that the NHS should be ensuring not that we necessarily incentivise surgeons to do that but that we require it of them. I want to go on to an issue because I know that we are short of time—

Ms Hewitt: You can require, but actually incentivising best practice is quite a good way of getting it.

Q572 Charlotte Atkins: Absolutely, but it should just be part of the normal process; they should not expect more money to do what we would expect them to do in a normal situation. We visited, as a Committee, the Woodland NHS Treatment Centre in Dartford. That facility, which is obviously an NHS facility, is delivering excellent results next door to the hospital delivering fantastic elective care. It seems to me, certainly, having seen that, that I do not see why the
rest of the NHS treatment centres should not be delivering the same as ISTCs. To all intents and purposes it was operating just the same as an ISTC and why should we not expect those treatment centres to multiply within the NHS? Why do we have to rely on the private sector to provide them?

**Ms Hewitt:** I think we need both.

**Sir Ian Carruthers:** If I can just come in there, we are in danger of saying one is good and one is bad. The fact is we are not saying that; we are actually saying that NHS hospitals—just to give you some context—in some places do fantastically well but, as you would expect across a big range of organisations, there is variability. Exactly the same can be said of NHS treatment centres: there are some that function very well; there are some that are less productive than others. I think what we really need to look at is what can be achieved in terms of the integrated impact of treatment centres and NHS hospitals in proving their effectiveness and efficiency, and indeed ISTCs. Actually, it is the integrated part and the impact of that which is really important. If I could just refer back to a comment which has been made to illustrate this, ISTCs have made an impact on reducing waiting lists but, overwhelmingly (and the cataract is a great example of where they have made that impact) we should be saying very well done to NHS hospitals, because actually over time they have done that. The real question is how do we move to the next phase on 18 weeks? What will we need? There is little doubt that, as the Secretary of State has said—and I can give some local examples of this—when you introduce an ISTC you are not working from the same practices that have grown up in some of the other organisations over many years. We need to look at two things, two impacts. One is the impact in terms of capacity, ie, doing more operations, and they do that, but the most important impact is the impact they often have on the local NHS which is about how they improve their practice, and the Secretary of State has mentioned some of those. Also we should not forget the impact it has on local clinicians because quite often they will go and adjust their practice and I am sure that there are examples where lengths of stay and other things have occurred as a result of that injection. I think that it is really important that we see this as part of an integrated development of more provision where each can play its part, but actually we need all components to make a success if success is better outcome, more up-to-date practice, capacity to reduce waits and the driver for value for money because I am sure we will not drive value for money without some of these processes. I would not like to say where, but I think if we asked for the same quantum, and in fact I could ask for the same quantum, of treatment that we are getting from some ISTCs from the normal planning processes of hospitals, the results would be greater because of the way it is done. I think we have got to see this in the round rather than saying that one is good and one is bad. The fact is that it is the interaction of both that is going to transform the healthcare system and that is why it is crucial to reform.

**Q573 Charlotte Atkins:** But the Woodland NHS Centre seems to be achieving the same as ISTCs delivering the same as ISTCs. To all intents and without the advantages that you seem to be piling on to the private sector. Now, the Secretary of State has said that they could create a dynamic. Is, therefore, this support for the private sector driven by ideology rather than by looking at what places like Woodland actually produce and would actually create?

**Ms Hewitt:** Well, as I said a few moments ago, there are superb examples of best practice and innovation on every aspect of care you care to name within the NHS itself and there are indeed some excellent treatment centres, but the point Sir Ian has just made is a very important one, that it is actually much easier not just to innovate, but to embed every aspect of best practice in a total system if you are starting on a greenfield site and you do not have established ways of working or an established culture of, “This is how we’ve always done it”. I think that is probably one of the main reasons why in 2002 in the very early stages of this the NHS Modernisation Agency reported that the good practices that they identified at the time in the NHS treatment centres were not widespread, nor did any treatment centre embody more than a few of them, whereas actually a lot of the gains are to be found if you have every aspect of best practice in every aspect of care and you try and get the whole lot together. Now, by no means are all the independent sector treatment centres doing the best on absolutely everything, but the advantage of a new provider on a greenfield site is that you can design the whole thing from scratch and you can then leap ahead not of best practice, but of most existing practice and show people what can be done. That is a very powerful dynamic for change, so our commitment to greater diversity of provision, which is foundation trusts as well as the independent sector, is not driven by ideology, it is driven by the experience of virtually every sector not just in our country, but across the world, that actually you need an element of diversity and pluralism in order to get an entire system operating on the basis of best practice, best clinical outcomes and best value for money.

**Q574 Charlotte Atkins:** Ultimately then why are we not giving NHS treatment centres exactly the same advantages as the ISTCs in terms of the take or pay contracts? Ultimately our objective is to improve the NHS, improve its productivity and improve its dynamism, so why are we not doing that with the NHS treatment centres that we have ongoing at the moment?

**Ms Hewitt:** Well, we do not have contracts with NHS hospitals, except for foundation trust hospitals which are now in a rather different category because they are freestanding and responsible for their own futures and taking the risk associated with it. The reason we had to have take or pay contracts for Wave 1 was because the judgment was made at the time that we simply would not have been able to get new providers into the system if we had not been willing to share that or to take that degree of risk.
away from them. The Wave 2 contracts are likely to be done on a rather different basis, but of course that is something we are exploring at the moment in the procurement process.

Q575 Jim Dowd: The ISTC and the treatment centre programme really cannot be anything more than a temporary, and I was going to say “expedient”, but I do not think that is the right word, a temporary device because we have received evidence that at the outset when there was a great differential in waiting times between going to a treatment centre and going to a closer local unit, there was a much higher take-up rate. As the effect of the existence of the treatment centre drove down improved practices locally and drove down the waiting times and the differential became much narrower, the use of the treatment centres dropped off quite sharply. Surely how are you going to sustain it as an incentivising component of the organisation if the work and demand, as the rest of the organisation improves, takes away much of the work it has got to do?

Ms Hewitt: Well, I do not look at this from the point of view of the providers. I do not stay awake at night worrying about whether this centre or that centre is going to have enough patients. What I worry about is the patients and I think increasingly what will drive the system is not our contracts or our targets or our top-down performance management systems, it will be patient choice and stronger commissioning both by primary care practices and the primary care contracts, so it does build in that adjustment in a way that we have to handle in the intermediate term has more of the work it has got to do?

Q576 Jim Dowd: The point I was making is that the more effective it becomes, the more expensive at the margin it also becomes and, therefore, unsustainable over the long term to provide a permanent pressure, a permanent incentive, if you like, on the NHS sector not just to improve its performance to get rid of it, but actually to sustain it over time.

Ms Hewitt: I think what we will see is a growing impact from foundation trusts and of course we will over time have significantly more foundation trusts, so we will have NHS hospitals themselves with far more freedom to innovate and respond to what patients need and improve their services in order to attract those patients and that is going to be a new element of dynamism in the system. However, the NHS has always used the private sector and we should not pretend otherwise, and I believe that the independent sector for diagnostics and electives as well as other aspects of care will be a permanent part of the NHS family.

Sir Ian Carruthers: I just wanted to add to that because there is an assumption behind the question in fact that we have this one list of patients waiting on a common threshold and, therefore, somehow when we get through them all with the capacity it will become poor value for money. The plain truth is that if you compare our healthcare with other areas of Europe and the world, they all operate at different thresholds for accessing care. In fact if you look at

Hewitt: I am very happy to send you a more detailed note because it really would take too long to go through it, but it comes back to the point I was making earlier, that if you are starting on a greenfield site and if success or failure on the contract you have entered into absolutely depends upon reaching your clinical quality standards, but
doing that with best value, you are going to organise things in a way that absolutely maximises efficient use of time.

Q578 Dr Stoate: I entirely appreciate that.

Ms Hewitt: The result of that is, for instance, that the best, it is not all of them, but the best ISTCs are doing six to seven arthroscopies a day compared with three or four typically in the NHS and that is because they have gone through the process in grinding detail and something, for instance, like going through the consent process for the operation, they do all that in advance at the outpatient appointment instead of doing it when the patient comes in at the beginning. Now, I am sure that happens in some places in the NHS, but what I am saying is that with the ISTCs, they are routinising best practice.

Q579 Dr Stoate: But the question is: are they giving the necessary kick up the backside to those parts of the NHS that are not doing best practice to make sure that they do? That is my question. Are the other parts of the NHS that are not currently delivering best practice looking on and actually being given this necessary kick?

Ms Hewitt: We have sought for many years to spread best practice more effectively in the NHS. That was why the Modernisation Agency was set up and now the NHS Institute. It is why over many years we have trained well over 100,000 staff in all the techniques, if you like, of modernisation and service transformation, but there is no doubt at all that if you build these incentives into the system, you get results, well, I think you get them on a different scale. Now, I would offer you the two pieces of evidence. One is the graph that we will send you about the waiting times that were pretty static and then came down when we made some structural changes and injected some dynamism into the system. The other is anecdotal and is simply to do with the number of hospital chief executives who have said, and it is a bit unpopular to say it, or it was when they were able to say, for instance, to some of their consultants, “Well, if we don’t get our waiting times down, patients will go somewhere else after six months or there’ll be an ISTC down the road”, and actually they got the change in practice that they wanted. Now, that probably makes it sound too adversarial and I suspect it is not as adversarial as that, but there is evidence of that happening and of course as the reforms we are making take effect, and we can see it happening at the moment, many of those hospitals that have got deficits have got deficits because they have not been institutionalising best practice and they are now having to do so.

Q580 Mr Amess: Secretary of State, I rejoice with you that this is the best year ever for the National Health Service since its inception, but there are a number of points about these independent treatment centres and the rationale behind them that frankly have concerned me. To summarise everything, you have just said we have got 100,000 staff being trained in part of the modernisation service, but overall the reason for these independent treatment centres is that there has been a failure of National Health Service management. Now, you, Secretary of State, have realised, and you have been very honest about it, that there has been a failure in your Department because we have got before us this morning the Acting Chief Executive of the NHS, the Acting Permanent Secretary and the Acting Deputy Chief Medical Officer, so everyone seems to be acting for all sorts of reasons, so at least, Secretary of State, you have put your own house in order. I am very, very concerned about your overall rationale behind these centres, that you seem to be saying there is a failure of management. Now, is it the fault of the doctors and nurses? Given that this is the best year ever of the National Health Service, who is actually to blame for the failure of management because I understand that you are going to try and incentivise the NHS to do better, but who is to blame?

Ms Hewitt: First of all, I am not saying, and I do not believe, that there has been a failure of management on the scale that you are talking about and, secondly, I think trying to rush around the place saying is that with the ISTCs, they are routinising management because I was talking about earlier, and what we are doing, is moving the NHS from a monolithic system to a new kind of system and the NHS has operated in one kind of way for nearly 60 years. It was set up in the way that they set up organisations after the Second World War because that was at the time the best practice in organisational structure. You had command and control organisations, you had public services that were monolithic, that were, if you like, a provider monopoly and because the NHS at the time was a transformation for patients, it was the most enormous step forward for people, but we are nearly 60 years later. Patient expectations have changed, they are rising very fast, the demands on the NHS are rising very fast, particularly because of demographics, and medical technology and practice is changing faster than I think most of us ever imagined possible. Now we know, and we can see this in public service reform all around the world, that we will achieve the next stage of improvements in public services by giving people greater choice, by having greater plurality and diversity of providers, by giving those providers more freedom and more incentive to respond to what people need and to adopt best practice and to innovate and underpinning that of course with money following the patient and so on. Those are the reforms that we are making, but that does not mean that the old NHS was a failure of management; it was nothing of the kind. It was, as Nye Bevan said, the most civilised thing in the world and the changes that we are making are absolutely designed to safeguard the founding principle of the NHS, that care should be given to people on the basis of their clinical need, not their ability to pay, that it should be funded by all of us through our taxation contributions and that it should be free at the point of need. By changing the NHS in the way we are, by meeting rising
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Q581 Mr Amess: The only thing I would say, Secretary of State, is that you do not have to explain the principles and the motive of the independent sector, as I think we have said on a number of occasions. You accept, don’t you, given that the general public and the staff of the National Health Service have a certain view of what the NHS is and what are the values of the NHS? And I think we have agreed that the NHS is the place where we provide for the sick, and there are those values that are important to the public. I think we would all agree that the NHS is a public service, and it is the public who are entitled to expect that the NHS will provide for them.

Ms Hewitt: Well, I think the decisive moment was as the NHS Plan in 2000. That was the beginning of a ten-year programme of investment, improvement and reform in the NHS to move from the old NHS to the new NHS. Now, obviously I have not had your experience of the Select Committee, but I have read a number of evidence sessions with both Alan Milburn and John Reid and I believe that what I am saying and doing is absolutely consistent with what Alan Milburn and John Reid said to this Committee, that the NHS is a public service, and it is the public who are entitled to expect that the NHS will provide for them.

Ms Hewitt: No. I think the mobile centres, yes, it is Select Committee, but I have read a number of would have been lovely if they had been introduced, particularly, as with MRI scans, the private sector programme was introduced at a time when some NHS MRI scanners were idle because the PCTs did not have the money to pay for those extra sessions, so if the money had been channelled to PCTs to buy them for the NHS sector wherever possible, would that not have been preferable?

Q582 Dr Taylor: First, I am afraid I have got to try and lay to rest the myth once and for all about cataract operations because we have been told absolutely clearly on this Committee before that waiting times for cataract operations were coming down very fast before the independent sector came in to work. We have also been told that in a given year the independent sector provided between 17,000 and 20,000 cataract operations, whereas the NHS did 400,000. People sitting before us, high-ranking officials, have said that the effect on cataract operations has only been marginal, so I do think that we should get that absolutely stated. Secondly, I am delighted Sir Ian talked about integration. When we went to Redwood and when we went to Darent Valley, although one is run by the private sector and one is run by the NHS, the theme that made success was that in both of them the services were being provided by NHS staff, the consultants were working on Redwood as a part of their NHS job plan and integration worked. When you have competition between independent sector treatment centres located near NHS centres where they are not in any way integrated, then there is the wrong sort of competition between the two places and the system does not work. Now, coming back to the script, you have mentioned dynamism and you have acknowledged that innovation does exist within the NHS. You have mentioned mobile cataracts and mobile MRI scans as innovation in the private sector. I feel that, with money given to the NHS, that could have been done just the same. Could you give us any other examples of innovation which is absolutely unique to the ISTC programme?

Q583 Dr Taylor: Yes, thank you. I am absolutely convinced the same innovations and more could have been introduced, particularly, as with MRI scans, the private sector programme was introduced at a time when some NHS MRI scanners were idle because the PCTs did not have the money to pay for those extra sessions, so if the money had been channelled to PCTs to buy them for the NHS sector wherever possible, would that not have been preferable?

Ms Hewitt: Well, this business of scanners and the use of equipment is a very interesting one because, as this Committee knows, there is equipment, very expensive capital equipment, that is seriously under-utilised. Now, we are putting enormous sums of
money into the NHS and we are encouraging hospitals, particularly through Agenda for Change, to use their staff in much more flexible ways. I have seen examples, for instance, in Huntingdon of superb practice in the NHS where radiologists are now doing what only they need to do, radiographers are taking on more of their work and then assistant radiographers and radiography assistants are being trained up to do more of the work and, through that kind of changing role, they are making far better use of the equipment, they have slashed the reporting times from anything up to 24 days to less than 24 hours, so that is happening. However, it is not happening everywhere and last year we had some shocking cases, headline cases, of patients, and one patient in particular I remember who was told by the NHS, “You will have to wait six or 12 months for an MRI scan”, and then scribbled on the letter she was sent was, “If you want to go private, ring this number”. Now, that is unacceptable and, as a result of that, last November we introduced choice for scans at six months, MRI and CT scans, and from April, from this month, we have introduced choice at five months for all scans. Now, we have not yet got the detailed monitoring data and we will obviously have to see what impact it has, but for a very small number of hospitals, and this is not yet statistically significant, we have seen a massive reduction in waiting times since we introduced choice of scan at six months. Since that is exactly what happened when we introduced choice of operations, starting with heart operations at six months, I would not be surprised if the effect we have seen in a few hospitals actually was replicated in other places. You need structural changes to get best practice as well as exhortation and education.

**Q584 Chairman:** We did have a couple of questions on local autonomy, but I think, in view of the time, Secretary of State, we will skip over them and move on to the issue of Phase 2 of the ISTC programme which is certainly more relevant to our inquiry, I think. What stage is Phase 2 at now, how many bids has the Department received and when will the contracts be agreed?

**Ms Hewitt:** We have for tranche one now had the expressions of interest in, we have issued the invitations to negotiate and we are now working our way through that process.

**Q585 Chairman:** Do you know how many ISTCs you have commissioned?

**Ms Hewitt:** Yes, on the electives there are 12 schemes which are in tranche one and tranche two. The Invitations to Negotiate (ITNs) have gone out. We have had responses on five schemes and bidders are assembling their responses on the remaining seven, so we are currently evaluating the bids for—shall I give you the detail? Anyway, we are evaluating the bids for five schemes and we are waiting for the responses on the remaining seven.

**Q586 Chairman:** Are there discussions taking place with the local and wider health communities about these or have there been in the recent past?

**Ms Hewitt:** There has been on each of them before the invitations.

**Q587 Chairman:** I understand that is taking place. Will take or pay contracts be a feature of Phase 2? We have heard this thing about ISTCs developed without this financial safety net, but can they do that given the strong hostility towards that part of the system as far as the NHS professionals are concerned? What is your view on that?

**Ms Hewitt:** Well, as I said earlier, take or pay contracts were needed to bring the new providers into Wave 1. I would expect them to be a much less significant feature of Wave 2, but it is too early to say whether we will need them at all.

**Q588 Chairman:** We have heard this issue about tapered take or pay. Is that something that you are looking at?

**Ms Hewitt:** Yes, that is one of the possibilities we are looking at.

**Q589 Chairman:** Does that relate to the amount of referrals that you get from the rest of the health community? We have had anecdotal evidence and we have discussed with the health professionals about in some instances the reluctance of the wider health communities to send or to refer people to the current ISTCs.

**Ms Hewitt:** As we move to a system of patient choice, it will be the patient who decides where they actually go. The real issue here, I think, is risk. Do we ask new providers or independent sector providers to invest in facilities and simply do that on the basis that if they get the patients, they get paid and if they do not get the patients, they do not? Now, that will mean transferring the entire risk to those providers and that is likely to cost more than if we share some of that risk. Obviously with the take or pay contracts, really we carry the whole of the risk and that is why you can look at variations between all of the risk being held by the Department, all of the risk being held by the contractor or the risk actually being shared, so we have asked providers to bid on the basis of tapering guarantees for contracts because we think that will be much more appropriate in Wave 2 than these 100% take or pay contracts that were in Phase 1. What we want to get to is by the end of the initial guaranteed contract period all independent sector providers should be providing services obviously of NHS quality, but also at the equivalent of NHS tariff with patients having free choice and a level playing field.

**Q590 Anne Milton:** Can I ask you about training. I do not know what your plans are for Phase 2, but will the inclusion of training provision affect the rates which ISTCs can offer?

**Ms Hewitt:** Yes, we are intending to include training requirements in Phase 2 and I think that was one of the very important lessons, if you like, learned from Phase 1. It really was not possible to build training in from the outset. They were starting to do it in some of the Wave 1 centres, but training not only for doctors, but also for nurses and allied health professionals.
professionals will be part of Wave 2, but what we are asking the bidders to do is to look at the impact of providing training on their own levels of productivity, if you like, and then costs and, therefore, to give us prices.

Q591 Anne Milton: Will all the Phase 2 ISTCs have training potential?  
Ms Hewitt: That is our intention, yes. We are going to require ISTCs in Wave 2 to provide training across the full range of clinical services. They will have to provide it across clinical services and we may also ask them to provide training in clinical management skills, the kind of thing we were talking about earlier in relation to best practice.

Q592 Anne Milton: Would you at the same time allow Phase 1 ISTCs to provide training because there is some concern that they are not doing so?  
Ms Hewitt: Yes, indeed there is and we have already been working with the providers and with the Royal Colleges and the deaneries to get training into some of the Phase 1 providers.

Q593 Anne Milton: Some or all?  
Ms Hewitt: At the moment it is some, but there are discussions going on on this with in fact most of them.

Q594 Anne Milton: Will anybody training within an ISTC be trained by an NHS consultant or a recognised trainer?  
Ms Hewitt: An NHS trainer.

Q595 Anne Milton: So all of them will be trained by NHS consultants or recognised trainers?  
Ms Hewitt: There will be a recognised NHS trainer delivering the training to clinicians in Wave 2.

Q596 Chairman: The issue of additionality as far as Phase 2 is concerned, I would like to believe that that is now going to be relaxed, the additionality of workforce which in the vast majority of Phase 1 we understand that the majority of the workforce, certainly the surgeons, most of them came from outside this country actually.  
Ms Hewitt: Yes.

Q597 Chairman: That is going to be relaxed, so there are a number of questions, but I would just like your wider view on it, and could I also couple with it the issue of BUPA Redwood that we saw where there was actually this joint venture where NHS staff and BUPA staff were working alongside one another in a treatment centre, no matter how it is described elsewhere. Is that the type of thing you see for the future, particularly of Phase 2, in view of the relaxation of additionality if that is going to go ahead?  
Ms Hewitt: I will turn to Ian in a moment on that point, but on additionality, I think it was absolutely right to have very strict additionality rules for Wave 1 because we were desperately short of staff at that point and the priority was to build that extra capacity as quickly as possible, so we had a ‘no poaching from the NHS’ rule because, otherwise, we could have ended up simply moving staff from the NHS to the independent sector with no overall gain to patients, hence the additionality rules. Last year the Royal College of Surgeons, in particular, and others talked to me and said, “Look, this is becoming too restrictive and it is hampering the kind of integration of services”, which both Sir Ian and Dr Taylor were rightly talking about, so we looked again at additionality and of course we looked at it in the light of the fact that we have now got so many more staff than we have ever had before and the new training places for doctors and nurses are now delivering more graduates than ever before, so we were able to relax the additionality criteria. I think the Royal College of Surgeons and possibly the Royal College of Radiologists would like us to go a little bit further and I think there is still a balance to be struck here. For the shortage occupations, and there is a worldwide shortage of radiologists, if we relax the additionality requirements there, there is still a real danger and all we do is shift or all we do is allow the independent sector to poach very scarce staff from NHS providers and that does not add to the capacity which is what we are trying to do.

Q598 Chairman: Are we likely to see this sort of BUPA Redwood joint venture?  
Ms Hewitt: There is no reason why there should not be more joint ventures in the future.

Q599 Chairman: In a sense, if you wanted to, you could effectively stipulate that as part of Phase 2 or some parts of Phase 2, could you not?  
Ms Hewitt: It is an issue that we are keeping under review. A lot of foundation trusts, I think, are interested in developing joint ventures, but there is also an issue which I mentioned before about diversity and an element of competition and challenge. We are not trying to create a private market here, but we do want an element and, therefore, we do not simply want foundation trusts and the independent sector taking over everything together.

Sir Ian Carruthers: This has to be seen in the overall development of the NHS and the reform programme. Effectively what we want is diversity of provision and what we want is provision that is actually integrated where arrangements can be the most appropriate at the local level, so there is no reason why that would be precluded. Indeed, in many hospitals now and ISTCs, they have arrangements where not quite the same thing occurs, but through the secondment scheme and other things, people do work in the different centres. I go back to the point that we made earlier, that we need to see this as an integrated whole and how the various components can improve the NHS, and I think that is the stance that needs to be pursued.

Q600 Anne Milton: Sir Ian, you said earlier in the session that BUPA Redwood was always a pilot for the ISTCs.  
Sir Ian Carruthers: I think BUPA Redwood was the first of its type and we did a lot of learning there.
Q601 Anne Milton: But you used the word “pilot” and I am curious as to why—
Sir Ian Carruthers: I do not think you should attach too much significance to the use of the word “pilot”. It was actually something that occurred and was developed and in many ways the ISTCs have taken the learning from that as they have developed.

Q602 Anne Milton: I am surprised, therefore, that you did not develop that idea and recreate it because we were terribly impressed when we saw it. The thing is that it had in place safeguards against the issues which have been raised about training, et cetera, so, as you have accepted it as a pilot, I am amazed you dismissed this model.
Sir Ian Carruthers: I was not here at the time, but I give you my view of why the approach taken is probably the appropriate one. I think we have got to remember that ISTCs are, on the one hand, creating capability and, on the other hand, trying to break the monopoly so that consumers can actually have choice. I think, and this goes back to the point Dr Taylor made, sometimes you have to go through this difficult phase of creating the infrastructure before you can then reintegrate because if you start from the point of integrating, you quite often end up with replicas of the same organisations, and that is part of the argument about treatment centres as well. Once you have got an infrastructure in place, you can reposition how you do some of that for the common good.

Q603 Anne Milton: I would suggest that although you have said that it was the introduction of the ISTCs, ie, the introduction of the marketplace, the introduction of competition, the fact that it was the only way, in your words, that you could kick-start the NHS into operating at the sort of levels you wanted to see, I would suggest that the separation between elective and non-elective work was the crucial factor and, therefore, not necessarily down to the ISTCs, and I would urge you not to come to the wrong conclusions in the second wave. That separation, I think, is the thing which has driven a lot of the innovation, not the presence of the ISTCs and, therefore, I would suggest that the ISTCs were never necessary and what was necessary was to separate elective and non-elective work.
Ms Hewitt: I completely agree that the separation of elective from emergency is central to improving the quality of care for patients and is a very important feature of these changes. I do not agree that the ISTC programme was unnecessary and I think that the Modernisation Agency Report that I referred to earlier confirms my view that a bit more diversity, a bit more competition and patient choice were very important drivers of these changes.

Q604 Sandra Gidley: I would like to pick up on the patient choice aspect because it seems to me that patients at the moment cannot compare like with like because different data is collected in the ISTC sector compared to the NHS and it is even difficult to compare rates of adverse incidents. What is going to be done to address this problem? Why is there this reluctance to ensure that there is a level playing field and an equality of information to patients?
Ms Hewitt: I completely agree that we need a level playing field and we need equivalent information across all providers so that patients can make an informed choice, but also of course so that clinicians, the providers themselves and the regulators can make sure that we keep improving standards. That is why the Chief Medical Officer has now asked the Healthcare Commission to conduct an audit of the ISTC programme. The Healthcare Commission will formulate the terms of reference for that. The process will be completed by the end of the year, although the Healthcare Commission has undertaken to give us an interim report, and that is part of what we need to do to make sure that we are getting equivalent data on the same issues right across NHS hospitals and independent sector treatment centres. At the moment we are in the position where in some cases there is more detailed information coming from the independent sector treatment centres because of their contracts. In other cases we are getting more information from NHS hospitals. Therefore, as you rightly say, the patients are not given equivalent information.

Q605 Sandra Gidley: Will the audit include comparisons with the NHS independent treatment centres? They are another part of the equation and it would be useful to be able to compare directly.
Ms Hewitt: I believe they will. The Healthcare Commission is looking at the detailed terms of reference but I am confident that I can say yes.

Q606 Sandra Gidley: Is this not an admission that the system was set up wrongly in the first place that only way, in your words, that you could kick-start the NHS into operating at the sort of levels you wanted to see? I think strange to me because you have a 97% satisfaction rate and a 3.4% complaint rate and I do not think the two are quite compatible somehow—cannot compare.
Ms Hewitt: We do of course do patient surveys. The ISTCs do them and the NHS does them. Satisfaction in the NHS is 91% and for ISTCs I believe that the average is about 94%. What we want to make sure is that we have got comparability of information and as much transparency as possible for patients and others across all of the NHS family. I do not think it is about saying it was all done wrong in the first place. What we did was a very important piece of innovation in the way that the NHS works. It has had some very beneficial effects. There have been some problems. We have talked about training. We are now talking about clinical and broader audit and we are learning lessons and making further change. I think that is the way you go on improving things.

Q607 Sandra Gidley: You talk about comparability but we had some evidence in this Committee that, in effect, the independent sector treatment centres are cherry-picking, they are doing the easy operations, and when we introduce payment by results, on which
Q608 Sandra Gidley: You disagree then with Mr Kelly from the Royal College of Ophthalmologists who added that the inevitable cherry-picking of relatively simple elective procedures by ISTCs would have a very damaging effect on local NHS services once payment by results is introduced?

Sir Ian Carruthers: It is important to recognise that ISTCs do not decide what specialties they house themselves. These are determined after discussions with the local NHS and they are in fact specified so that any discussions that have come, the specialties included, have usually emanated from difficulties in the local NHS. So I think if anything we can reflect on that within the NHS but that is not the fault of the ISTCs. We ask them to do a given amount of work and a given range of specialties. In many contracts as well there is the opportunity, over time with suitable notice, to change the range of operations and the types of specialties so that they can be flexible to local circumstances. I know the one I have been involved in is. The notion that they determine the patients is quite inaccurate.

Ms Hewitt: Can I just add that I think this issue of patient information is terribly important. We are building up ways of giving patients much more information about clinical quality in the NHS hospitals as well as in the ISTCs. You no doubt have seen, it has just been launched today, the website that has been launched by the Royal Society of Cardiologists, working with the Department of Health and the Healthcare Commission, which gives detailed information on clinical outcomes, adjusted for case mix for individual cardiac surgeons. Generally at the moment we have only got clinical quality information for an entire hospital, and of course what the patient needs is information on clinical outcomes for a particular team and specialty or even a particular consultant, which is what the cardiologists are now providing. So we are making real advances in terms of making that sort of information transparent and we will do it not just across the ISTCs but right across the NHS family.

Q609 Sandra Gidley: A final question, it was not really answered earlier but from a slightly different angle. As we are moving more work to the ISTCs, you would not answer the question on hospitals closing, but I would hope that some analysis has been done to quantify the effect on the NHS providers and on the workforce. Has any such analysis taken place and how many NHS jobs would you expect to be lost as a result?

Sir Ian Carruthers: Firstly, yes, analysis has taken place and part of the putting together of the detail and capacity that will be required against which applicant ISTC providers will be judged will include an assessment of what the transfer of work might be from some hospitals, what the transfer of the workforce might be from some hospitals. Obviously the aim is not to lose jobs; the aim is about getting this integrated balance. If I can give an example of Southampton which has one of the biggest ISTCs, that has been a key component of that local discussion. There has been an arrangement about what the hospital thinks it needs to change because many surgeons are very happy to see ISTC develop. What they want is a more integrated approach.

Ms Hewitt: Can I just reinforce the point that in all of this discussion about ISTCs, which are a very small proportion of the total investment we are making in the NHS, we have to have this discussion in the context of more patients being treated, more operations being done, far more diagnostics being done (because we do not get to 18 weeks without it) so more staff, more patients, more treatment, more diagnostics than ever before. Some of these accusations that the ISTCs are going to cripple the NHS imply that there is some small and dwindling number of patients to be treated, whereas actually we are growing the whole system here and ISTCs are just one aspect of that growth. The other point that I would make is that on a few occasions I have heard the chief executive of an NHS hospital say that some part of his hospital is going to be put out of business by an ISTC that does not yet exist in some cases and in some cases by an ISTC for which we have not yet decided whether we are going to go out to tender. We are only a few years away from the end of 2008 when patients will choose where they have this kind of operation. What I would hope is that the chief executive who is currently saying one department is going to be put out of business instead would say, “How are we going to make ourselves a foundation trust? What do we need to do to improve the quality of care? What do we need to do to improve patient satisfaction? What do we need to do to improve best value for money and make sure that if an ISTC comes along we will be better and the patients will come to us instead of to them?” instead of saying, “This is terrible and we are going to lose our patients.” There is no reason why they should at all.

Sir Ian Carruthers: If I could add to that because I think it goes back to some of the points before. If you see this as totally competitive then you end up with a wrong conclusion. If I can give a local example. Let us take a large teaching hospital, generally they are brilliant at the leading edge work that they do. However, they may not be able to undertake the routine DGH-type services in elective provision. What this is a chance to do is to rebalance this to enable the local population by using an integrated approach to get the access to the DGH services that they need, quick access to GPs, quick access for all the more routine conditions whilst the institution itself repositions itself to do what it does best. I think contestability is an important notion because it drives change, but what we have to achieve is a level
of complementarity because at the end of the day we want the Health Service to meet all its needs in every locality, therefore that is why it is not a choice of either/or; it is about how we make it all work together. Some ISTCs are good news for local hospitals because it will enable them to address some problems that they would not ordinarily address in some cases.

Chairman: It might be quite useful if we could have some of that analysis that has been done about the potential effect on the wider health community by ISTCs, or all of that if it is feasible. I would greatly appreciate that. It is a voice that we do hear even from foundation hospitals, as you are aware. I want to move on very quickly now to Charlotte.

Q610 Charlotte Atkins: Have you got any evidence to support the claim that the quality of care in ISTCs is higher than in the NHS?

Ms Hewitt: There have been various studies done on the MRI scans. The clinical guardian has just completed an audit which shows that the quality there is directly comparable in the independent sector with the NHS. The clinical audit which we have just asked the Healthcare Commission to do will answer the broader question very fully but we do need to remember that in every healthcare system untoward incidents happen in around 10%, sometimes more, of all cases. I think it is a frustrating feature of medical practice. Everyone tries to get it as low as possible but I doubt it can be completely obliterated.

Q611 Charlotte Atkins: So you are saying they are broadly comparable and one is not better than the other?

Ms Hewitt: Yes.

Q612 Chairman: On the issue of contestability of patient choice in the idea of having informed patient choice are we going to have both the NHS and independent providers monitored in exactly the same way so that we are able to say that is a choice that I want to take? Will we get to that, do you think?

Ms Hewitt: Yes, we already have the Healthcare Commission inspecting all providers, everyone as part of the NHS family, and to have informed patient choice we need better information and the same information across the whole NHS family.

Q613 Chairman: And will that be a feature of Phase 2?

Ms Hewitt: We are developing the information requirements for the whole of the NHS as I indicated earlier but, yes, we will building in more information requirements where we need them.

Chairman: I will hand over briefly to Anne.

Q614 Anne Milton: Just briefly on the basis that you feel these have been a success, we are not attacking, we are voicing the concerns that have been voiced to us and it is our job to do so. Cherry-picking—they do choose patients, rightly so, on clinical grounds. They do not operate on people whom they think it would be unsafe to operate on. So they do choose who they operate on, as I say, rightly so. Just going back to the success of ISTCs, do you think there are any limits? Why not A&E, why not oncology?

Ms Hewitt: We use the independent sector where they can do a good job for NHS patients. I have not seen any suggestion or evidence that the independent sector could provide the quality of A&E care that the NHS provides. I do not think any of them do it at the moment.

Q615 Anne Milton: You are not bringing in the ISTCs on the basis of quality; you did it on waiting times. Maybe where waiting times are very long or in areas where there are long waits for radiotherapy would you see the independent sector coming in there?

Ms Hewitt: You look at what patients need but actually emergency care, obstetrics and gynaecology, these are areas where I do not think we would want to make use of the independent sector and they are not asking to be made use of.

Sir Ian Carruthers: Could I just add—and I will deal with that question and I will come back to the first one—and at the present time if you look at it worldwide, the way that other countries practise you could make a case for saying there is an awful lot more that could be done in free-standing elective services and things are going to move on. In other parts of the world they would do other things and some of the providers have asked about that and the answer has been no we want to stick to the specification which is really about the sorts of things that are in there.

Q616 Chairman: Could I thank you all very much indeed for this morning’s session. I wonder whether we will be taking any more evidence either on paper or directly from you but hopefully in the next few months we are going to be looking at making our report on this issue of independent sector treatment centres.

Ms Hewitt: Chairman, thank you, and we look forward very much indeed to the report and responding to it and learning lessons from your conclusions.
Wednesday 28 June 2006

Members present:

Mr Kevin Barron, in the Chair
Mr David Amess
Charlotte Atkins
Jim Dowd
Dr Doug Naysmith
Mike Penning
Dr Richard Taylor

Witnesses: Mr Ken Anderson, Commercial Director, Mr Bleddyn Rees, General Counsel, Commercial Directorate, and Mr Geoff Searle, ISTC Programme Lead, Department of Health, gave evidence

Q617 Chairman: Could I thank you, once again, for coming along to give evidence to this inquiry. Perhaps I could start by asking you if you can tell us how many Phase 2 schemes the ISTC programme will include. At what stage of development is each of the schemes at the moment?

Mr Anderson: The easiest ones to describe are the ones that came out in tranche 1. I think the Secretary of State stated there were 12. I cannot give you a precise number of schemes that will be completed at the end of the process. We sit down and we talk to each health economy and we come up with a value-for-money quotient. If they do not stack up, we never take them to ITN. The ones that we can definitively tell you are in the pipeline right now which are being processed through a procurement phasing are 12. We are continuing to work on other schemes with health economies, but that tends to change, depending on whether or not the health economy decides within the context of a value-for-money envelope if they stack up and it meets affordability constraints within that locality.

Q618 Chairman: You said there are 12. The Secretary of State told us in a written submission that Phase 2 will now consist of 17 schemes. In a written answer by Ivan Lewis he stated that Phase 2 would be made up of 12 schemes—which you have just repeated to us—for elective procedures and seven regional diagnostic schemes. Are we talking of 19 and not 12 here?

Mr Anderson: The Secretary of State’s answer was correct. We have 12 that have ITNs and we have a further five that we are discussing, which were the five she told you about. They are not at ITN state. We are expecting responses back on those five. We have, underneath, a diagnostics’ procurement: a further seven schemes that are not yet there, have been identified, have been quantified and are part of an ITN process. I guess you get the 19 plus five. I think the discrepancy is that we do not count a specific scheme as one until we have an ITN identified next to it. We go out with an indicative number of schemes, based on the local delivery plans that have come back from the National Health Service and based on their preliminary sets of means, and then next to that we map across what we feel the private sector component would look like and then we have to match a lot of affordability constraints to those. If they do not stack up then I think the issues that you are starting to touch upon were the ones that were reported in HSJ that have been withdrawn. We do not take them to market and therefore they are not real in our mind until those have gone to ITN and we have private sector entities out spending money on the bid process. Until that time, it is an internal issue between ourselves at the Department and the local health economy.

Q619 Chairman: The Health Service Journal saying of State stated there were 12. I cannot give you a that seven were not going to go is about right at this precise ... will be completed at stage. It is 12 plus five, so it is about right.

Mr Anderson: That is correct, but they were not included in the number that the Secretary of State answered in question 585 in the official transcript. Those were seven schemes that we had not taken out to the market place. They were seven schemes about which we were in discussions internally with other health economies and so they were not a part of the package that the Secretary of State described to you in May.

Chairman: I think we may want to go into some further detail about some of those schemes.

Q620 Mike Penning: What lessons did the Department learn from Phase 1 of the ISTC programme? How have these been applied in phase 2?

Mr Anderson: We learned and we are applying them now. It is actually reference to the schemes we have looked at and decided not to go forward with. We need to firm up local delivery plans with the local health economies before we go out and start talking to private sector partners. We are now in the process of having detailed discussions with the folks on the ground. We are applying, I think, the lessons learned very well indeed around that process. The result of that were the seven schemes that you saw listed in the Health Service Journal.

Q621 Mike Penning: The Secretary of State referred to the seven schemes being cancelled but the strategic health authorities affected in their own area have been told to provide more independent sector services to NHS patients. Can you explain how that is going to work if the ISTCs have been cancelled?

Mr Anderson: I think it is an unfortunate misnomer, quite frankly. When we say cancelled, we should say cancelled in their present form.

Q622 Mike Penning: The word “cancelled” means it is not going to happen: you have started and you have stopped.
Mr Anderson: In their present form, I guess it would be applied to the present form, so we go back to the health economy and then we continue the conversation around what their needs are. But they have gone out and they have identified a gap or a necessity for extra throughput within that economy that would be provided by the private sector, and so, once you get down to nuts and bolts and you start talking about case mixes and the number of patients, and very honestly how maybe some of that will impact other local providers economically, then, until you can delve into the detail, it is very hard to get a true picture in that economy. The LDPs are a very macro look at what a health economy needs over the next given year, so, when you sit down and you start having discussions with the health economy, the package may not stack up in the same way that it was originally envisaged. We had the same issues, if you want to call it that—and I think it is a good discussion to have with the local economy—around how they stacked up, and we cancelled schemes in wave 1 which came back to health economy but in a different guise with a different case mix. Maybe, instead of being a stand-alone scheme, it then became something that we did on a JV basis with another National Health Service trust, or maybe it was a completely different package, where it was attached to a more community-based provision package. Until you can sit down and describe specifically what the private sector components are in their capabilities and have a detailed discussion, we cannot take it forward around the constraints of value for money—which we are going to talk about after this.

Q623 Mike Penning: I think I will stop you at that point because I think you have used so much jargon I do not believe you have answered the question in the first place. We will come back to that.

Mr Anderson: Okay.

Q624 Dr Naysmith: The Secretary of State also wrote in her submission “we remain committed to investing £550 million on the procurement in the independent sector: this includes £50 million from the first wave of ISTCs.” Is this £550 million per annum over a five-year programme, which represents a total of £2.75 billion?

Mr Anderson: Yes, that is £550 million annually.

Q625 Dr Naysmith: If so, can you explain how this relates to PEQ (public expenditure questionnaire) from 2005, which suggests expenditure of up to £5.8 billion over Phases 1 and 2 of the ISTC programme.

Mr Anderson: I am sorry, I do not have that in front of me. I could go back and look at that. I am not familiar with that figure.

Q626 Dr Naysmith: Which one are you not familiar with, the £2.75 billion or the £5.8 billion?

Mr Anderson: I think I would recognise £5.8 billion as a total between the Phase 1 and the Phase 2 combined procurements but I would not recognise that figure attached to the Phase 2 alone.

Q627 Dr Naysmith: Phase 1 of 2.

Mr Anderson: That is correct.

Q628 Dr Naysmith: £5.8 billion is an accurate estimate, is it?

Mr Anderson: I would imagine, roughly, with Phase 1 and 2 combined, you would probably get fairly close to that.

Q629 Dr Naysmith: We were told that ISTC programmes were “consultative and pragmatic” and that schemes had been cancelled if it was clear that the local NHS had adequate capacity and also that the Government is “committed to investing £550 million on the procurement in the independent sector”. How can you be sure that you meet that target and at the same time be committed to a number that is flexible and pragmatic.

Mr Anderson: I think the flexible and pragmatic piece is being realised through the fact that we have dialogue with the local health economy and, in some cases, if the health economy has come to the conclusion, based on some of the assumptions they had made in the local delivery plan exercise, that that amount of activity is no longer needed then we talk to other health economies. Across England I do not think there is a lack of need for extra capacity, particularly around some of the elective procedural pieces that we are doing.

Q630 Dr Naysmith: Will new ISTCs go ahead in any areas where it is clearly demonstrated there is no need for additional capacity? Is that what you are saying—although we have this figure of £550 million—if the demonstration is that ISTCs are not needed?

Mr Anderson: If they demonstrate not a need for ISTCs, then that is a conversation they will have to have with ministers. As far as I know, we are not forcing ISTCs down anybody’s throat, to add extra capacity in an area where they say specifically and categorically they do not need it.

Q631 Mike Penning: We had evidence on Thursday’s session from the Chief Executive of West Herts Hospital Trust, who clearly said to this Committee that they do not want the ISTC. It will have a major effect on them. They will physically have to knock down a hospital which is perfectly okay: five theatres working very well. Are you saying that, if that trust does not want the ISTC, they go to the Minister and the Minister would listen?

Mr Anderson: We have a conversation with the trust initially. We are still having conversations with Hertfordshire as we speak. That scheme was one that started in the Phase 1 portion of the schemes, and one of the reasons it has not gone forward to date is because we are still talking to that health economy about their needs.

Q632 Mike Penning: That you have not progressed because there is an argument over the need.

Mr Anderson: No. I would not characterise it as an argument. I would characterise it as a discussion. The flip side of that is that health economies used the
Q633 Mike Penning: If West Herts Hospital Trust want to reconfigure, and you are aware of the situation . . . Reconfigure, by the way, means knocking down a general hospital because that is what is going to happen.

Mr Anderson: Not necessarily. I would not accept that.

Q634 Mike Penning: The only way that can go ahead is if the ISTC comes in. It is a tool.

Mr Anderson: It is not the only way. There are a lot of health economies who are reconfiguring without ISTCs or independent sector involvement. It depends on what tool that health economy needs.

Q635 Mike Penning: I am interested in your comment that if they are not happy they go to the Minister—and the Minister says, “It is nothing to do with me,” and passes it down the line.

Mr Anderson: No, that was not what I meant at all. Mike Penning: That is what happens in real life.

Q636 Dr Naysmith: Following on that line, the Minister also said, when we were discussing the decision not to go ahead with seven of the Phase 2 schemes, that “in other [areas] it has become clear that the level of capacity required by the local NHS does not justify new ISTCs schemes”—which is really what we are discussing now. You ought to be able to provide us with a list of those areas where you have been looking at the possibility of going ahead.

Mr Anderson: I think we can give you a note on that. I do not have that detailed information in front of me.¹

Q637 Chairman: Presumably it would not be much different from the seven that are highlighted in the Health Service Journal.

Mr Anderson: I think it might reflect the Health Service Journal article.

Q638 Chairman: You think it is pretty accurate, do you?

Mr Anderson: I think they had reasonable information, and they tend to . . . I do not know the complete content of the Health Service Journal. I do know the seven schemes that they were talking about. The article was accurate to the point of the seven schemes that we have decided to look at differently, or to go some place else and try to draw that value out of a different area.

Q639 Mike Penning: There are clearly other schemes that you are looking at on top of that seven.

Mr Anderson: If there are not in ITN, yes.

Q640 Mike Penning: There are more than seven. How many?

Mr Anderson: I do not have a number in front of me. Any scheme that has not made it to ITN typically is not in ITN because we are having discussions with the local health economy and we are trying to figure out what the case mix is.

Q641 Mike Penning: Could you supply the Committee with a list of the ones that have not made it to the ITN.

Mr Anderson: I believe we should be able to do that, yes.²

Q642 Chairman: It would be very helpful if you could also give us the reasons why.

Mr Anderson: Certainly.

Q643 Mr Amess: Mr Anderson, as you will recall, when you came before the Committee to give evidence before some of us were a little bit disappointed with what we perceived to be your lack of robustness and you seemed to be a little vague on issues. As you know, the whole purpose of these sessions is to call witnesses and gather information which we determine as evidence to produce a report. You have turned up today with an army of minders behind you. We are now on to, I will tell you, question 7, and you still seem to be vague about things. Anyway, here we go, let us see if we can get an answer. If Phase 2 is all about extending patient choice, will the establishment of independent sector treatment centres in areas with no capacity shortage be a problem but NHS bodies with funding issues such as West Hertfordshire or South-West London?

Mr Anderson: I will return to the way I answered the question earlier. We have discussions with the local health economy to determine what their needs are. We do not go in and impose a needs package on a local health economy. It is not something that you can very detailed conversations around an extremely sensitive and extremely involved strategic issue for health economies. It is not something that you can resolve in a matter of days or weeks even and it takes a detailed conversation with the health economy around what does reconfiguration look like and what does 21st century healthcare look like.

Q638 Dr Taylor: Can I take you back to the March 6 meeting again, when we talked about additionality and integration particularly, because so many of the people we have been to see felt that integration is really absolutely vital between the NHS and the ISTC. At that time Mr Ricketts told us that

¹ See Ev 218 Volume III

² See Ev 218 Volume III
additionality was being relaxed for the second wave. In the last three months, has there been any change in that idea? Or are you still relaxing additionality?

Mr Anderson: No, additionality will be relaxed for Wave 2.

Q645 Dr Taylor: Are there any groups of staff for which it is going to be more difficult to relax it?

Mr Anderson: I cannot specifically answer that.

Q646 Dr Taylor: You told us last time radiology, radiography and some of the specialist nurses.

Mr Anderson: I am sorry. I do not have that data in front of me. I can write you a note about it.3 As far as I am concerned, I think Mr Ricketts gave you that answer. I do not think any of those providers have changed from the standpoint of where it is difficult to start to relax additionality.

Q647 Dr Taylor: We have also had some comments from witnesses, and letters, that, when ISTCs were rather foisted on areas that did not need them, additionality was bringing in extra capacity that was not needed. Do you have any comment on that or has that been expressed to you at all?

Mr Anderson: There has been press around that. There have been health economies that have expressed concerns around that, but ultimately—and I am honestly not trying to be abrupt on record here—it is up to the local health economy to determine what the needs are for that health economy, and then the ISTC programme was placed in those localities because they stated they wanted that throughput or that capacity to cure—

Q648 Dr Taylor: We have had letters to the contrary of that, to say that they were forced on them, but that is probably nothing to do with you. Do you think additionality being relaxed will lead to a migration of staff to ISTCs? Or do you think integration will then be so easy that we will see a real coming together of them without detriment to the NHS?

Mr Anderson: I think the initial positive that will come from the relaxation on additionality will be a crossover from a training perspective. There is a lot both sides can learn from each other and probably one of the big frustrations that has been expressed to me personally has been the fact that doctors or consultants would like to learn in ISTCs and vice versa. The relaxation in additionality will allow that two-way traffic to start occurring—and I think appropriately so, and then, hopefully, as they become integrated into the health economy—and they are—that will allow an exchange of ideas. The only way I think you get an exchange of ideas is with an exchange of people.

Q649 Dr Taylor: You would agree it will reduce the resistance in the NHS to the independent sector treatment centre if they are working as one with shared staff.

Mr Anderson: That is correct.

Q650 Chairman: What implications does that have on things like pay differentials between the independent sector and the NHS? Have you thought this through?

Mr Anderson: First of all, we do not get involved in pay between whoever is involved in the ISTC and the employer. I cannot answer that question.

Q651 Chairman: Has your team looked at the issues around people working alongside one another on different pay or, indeed, on different pensions in terms of the second phase?

Mr Anderson: I cannot answer that. It may well have been looked at, and I am not aware if it has been, but I could get a note back to you.

Q652 Chairman: Do any of your colleagues know.

Mr Anderson: It has been looked at.

Mike Penning: Your colleagues had better come and sit up here and tell us what is going on.

Mr Amess: We are wasting our time, chaps.

Mike Penning: If there are people here who know this information, surely we should have it.

Mr Amess: What is the point of this? It is farcical.

Q653 Chairman: If you feel that you do not know and somebody is sitting behind you might know, could you ask them to proffer the words.

Mr Anderson: If I might ask Bleddyn Rees, our General Counsel, and Geoff Searle who takes care of procurement.

Mr Rees: Good afternoon. The answer to the pay grade question is that about 18 months ago the Government issued guidance about the two-tier workforce. At that time, there was some extensive correspondence inter Department around the application of the two-tier work code to the ISTC programme. The ISTC programme benefits from a specific exemption, which does not apply the two-tier work code to the programme. Strictly speaking, the Department’s position is: No, there is no requirement to impose obligations on the private sector to engage any medical workforce on identical terms to the NHS, so Agenda for Change does not apply. The Department is simply testing its value for money on procedures by reference to the procedure prices. We have no visibility of the terms and conditions on which any staff engaged by the IS sector are employed, so we are not able to answer the question as to whether there are two workforces operating and doing the same things with different prices. We do not know. Neither do we know that that is the case either.

Q654 Chairman: Richard has just asked about the issue of additionality. If restrictions are lifted, what is the likely effect that that would have on the local health economy in the immediate area of the ISTC? Has any work been done on that?

Mr Rees: I am sorry, could you ask me the question again.
Q655 Chairman: Correct me if I am wrong on this, because this is something the Committee has only been looking at in recent months, but our understanding is that the additionality rule was tight so that ISTCs would not recruit from within the National Health Service and potentially weaken the National Health Service in terms of its ability to deliver. If we say there is going to be relaxation of the additionality rule for Phase 2, then has anybody looked the implications of that on Phase 2? That potentially could happen. There could be recruiting from the NHS which, as a consequence, would affect the ability of the NHS to do the work we expect of it.

Mr Rees: Yes, there has. The workforce directorate at the Department of Health has analysed the availability of NHS staff. The Secretary of State previously said you have to place things in context. The number of procedures that are being bought by the ISTC programme is a small fraction, therefore, following through, we are only talking about a relatively small proportion of the total workforce who could be recruited. The point to understand is that the relaxation of additionality relates to non-contracted hours. First of all, we are not talking about the recruitment of NHS, full stop; we are only talking about their non-contracted hours, if you like, their overtime hours. Those overtime hours and the use of those overtime hours is controlled by virtue of the consent process involving the NHS employer, so there is a safety procedure to ensure that the use of the staff does not detract from services that are provided in NHS hospitals and facilities.

Chairman: Thank you for that indication.

Q656 Dr Taylor: You said that the ISTC work is really a small proportion of the total amount that is done. Does that not make that graph on the back of the Department of Health paper extremely misleading, because, with the rapid fall, the only points above are: first ISTC operational, 10 ISTC’s operational, 18 ISTC’s operational. That gives the impression to somebody who does not know that the total improvements in the waiting times are due to the ISTCs rather than to the increased work the NHS are doing.

Mr Rees: I sat in the hearing when the Secretary of State answered that question, when she made the point, I believe, that the ISTC programme was a small proportion of capacity but it was having a significant effect on the NHS services. The contribution overall to the waiting time reductions, whilst in terms of pure numbers might be relatively small, she believed had a more major effect as a change agent. I still believe that to be true.

Mr Amess: That graph is misleading.

Q657 Dr Taylor: I wonder if the graph has been circulated, because it at least ought to have “NB” on it or a caveat.

Mr Rees: I am not familiar with that graph, I have not seen that graph, it is difficult for me to—

Dr Taylor: It is a Department of Health graph. We will follow that up.

Q658 Mike Penning: Would you accept that in areas where elective surgery units are closed to facilitate an ISTC will have a very large effect on the National Health Service? Secondly, if an ISTC was in Phase 1 but has not gone ahead yet, can you confirm, if it does go ahead, that they will not be drawing staff from the NHS?

Mr Rees: In effect, the relaxed additionality policy only allows non-contracted hours to be used. The IS providers are not free to recruit those members of staff. That part of the additionality still applies. “No poaching”, if you like, simplistically, is still there. That protection is still there.

Q659 Mike Penning: If a chief executive of a trust has said his staff will go, under a Phase 2 regulation, into the ISTC, that is not correct.

Mr Rees: That is not correct. No contract in Wave 1 has involved the TUPE transfer of staff. The deployment of the Retention of Employment secondment model is designed to ensure that no NHS staff TUPE transfer.

Q660 Mike Penning: What will happen to the staff who lose their jobs when a treatment centre comes— which is what will happen in West Herts Hospital Trust, for instance, where three theatres will close at Hemel and five theatres at St Albans. Those staff will have no jobs. Which is why 750 job losses were announced at this Committee last week. Those staff will not be transferred to the ISTC if and when it is built.

Mr Anderson: First of all, I do not think we are familiar with those numbers. Secondly, I have not seen an announcement from Hertfordshire, so it would be hard to comment on something.

Mike Penning: You have lots of civil servants who would have read what went on in the Committee last week who would know.

Mr Amess: You are a good stonewaller, Mr Anderson.

Q661 Chairman: If he does not know.

Mr Anderson: May I say, Mr Chairman, that this was called quite quickly. This portion of it was handed to us, I think, just last week, and the amount of preparation in between our day job that we could put forward towards this has been minimal. We were told it was around a specific area and issue, so if we are not answering questions to the fullest extent that we can, I apologise. I think the short timeframes have not helped with that.

Mike Penning: Was that the same last time, then?

Chairman: Let me say that I do understand that very well, and what is happening in West Herts is a moving picture. None of us is going to be able to second-guess what is happening.

Q662 Charlotte Atkins: Mr Anderson, are you aware that the first phase of ISTCs was criticised heavily because of the lack of training grant.

Mr Anderson: We are very aware of that.
In Phase 2, therefore, will it be a contractual requirement for training to be provided?

_Lord Anderson:_ I think it will be on a scheme by scheme basis. Having said that, because of the amount of criticism—and understandably so—in wave 1—and that was a result of expediency through the procurement process and less about not wanting to do it, and we have learned quite a bit—that goes back to some of the questions that we were asked earlier from a learning standpoint and we have learned quite a bit from that process. I think Mr Rees could answer specifically on a contractual basis how that is being handled.

_Q663 Charlotte Atkins:_ It surprises me that you say it is not going to be contractual.

_Lord Anderson:_ I would say I did not say that.

_Lord Rees:_ Perhaps I could help you in answering the question. In Wave 1, in a number of contracts, it is contractual. There are pilot training programmes designed to ensure that we understand how best to buy training services from ISTC providers. They are signed and they will start training when full service commencement starts on the particular schemes.

_Q664 Charlotte Atkins:_ Specifically, Nottingham—which was one of the last ones that we signed—had £4 million worth of training contractually bound to it.

_Lord Rees:_ We have worked with the deans around exactly what training they wish to see in ISTCs. For Phase 2, the contract volumes and case mix has been given to the deans to establish what training they would like to purchase in future from ISTCs. I am not sure whether you are familiar, but with the reforms it will be the deans who decide where they commission training from. Bidders on Phase 2 schemes are required in the ITNs to submit bid prices with training and without training, and we have given them as much information as we could about the types of training that would be required at the time the ITNs went out. We are now developing a generic training schedule to incorporate in the contracts. Essentially, it will be a form of call-off contract, where the provider will agree contractually to provide the training specified in the schedule. That will be worked in more detail with the local NHS to ensure that it meets their requirements and needs. They will have bid a price for that training. All that will have to happen for training to be undertaken in the ISTC is for the deans to decide that they wish to buy training and to commission it. It will effectively be a call-off arrangement.

_Q665 Charlotte Atkins:_ On top of the increased price for operations at the ISTC, there will be an extra levy for training.

_Lord Rees:_ No. There will be a training price which is a component of the total price that is signed off on the contract.

_Q666 Charlotte Atkins:_ That will be over and above the tariff which was determined for the first phase. Already ISTCs we are paying over the top of the NHS price.

_Lord Rees:_ It is not new money. It will be training money allocated from elsewhere in the system. The tariff only has a proportion of contribution to the total training costs. There are specific grants given to trusts that would cover training costs. In the future, it is intended that the deans will have the full training budget, so the price that they pay will be for all training requirements. It is giving effect to the new rule and the reforms that are coming.

_Q667 Charlotte Atkins:_ I am a bit confused. You are saying that only some Phase 2 ISTCs will be training.

_Lord Rees:_ I did not say that.

_Q668 Charlotte Atkins:_ Can you answer whether all of them will be doing training.

_Lord Rees:_ That depends whether the deans wish to commission it. In theory, if the deans choose to have training in every ISTC, they can have training in every ISTC. It will not be a decision for the providers, it will not be a decision for the commissioners, it will be a decision for the deans.

_Q669 Charlotte Atkins:_ I am talking about Phase 2.

_Lord Rees:_ I am talking about Phase 2.

_Q670 Charlotte Atkins:_ The British Medical Association have said that they were very concerned that the procedures most suitable for training purposes are being transferred. They are worried about the bread-and-butter training. Given that the ISTCs do the more straightforward operations, it is absolutely crucial, for training our future medics—

_Lord Rees:_ That is why it is a contractual requirement to provide training if the system wants the training.

_Q671 Charlotte Atkins:_ UNISON gave evidence in another inquiry a few sessions ago that they were very concerned about the way that training within the NHS was not being ring-fenced and was likely to be the subject of an easy target for sorting out deficits. We have a situation where the NHS may cutting back on training and we have a situation within the ISTCs where it is not going to be a contractual requirement for all ISTCs but it will be determined by commissioners.

_Lord Rees:_ Our programme is to put in place ISTCs. We do not control training. The individuals here do not have responsibility for training. We are required to ensure that training can occur in an ISTC if those responsible for training wish it to do so, and that contractual commitment is there.

_Q672 Charlotte Atkins:_ If training does take place—and there appears to be a big “if”—how would we ensure that it is of the same standard as training within the NHS?

_Lord Rees:_ All I can give you as an answer to that is that the training specification is effectively approved by the deans, so it is to the NHS requirements and standards. The licencing requirements for operating the ISTCs are still there, so all law has to be complied with, and there is consultation with the Royal Colleges occurring around the quality of the training.
training. I believe those are the safeguards that ensure that the training will be of the appropriate standard.

Q673 Charlotte Atkins: You mentioned earlier that in the price for operations there is an element of cost for training. Where you have ISTCs that are not commissioned for training, will they still be paid an allowance for training?

Mr Rees: No, because they are not paid tariff. It is not a same comparison.

Q674 Charlotte Atkins: In Phase 1, ISTCs have been paid for work on operations that they have not done. Because they are guaranteed a certain volume of operations, they have been paid for operations that they have not performed. In the same way, it would be logical, therefore, for ISTCs to be paid for training that they do not necessarily do. Or is that a completely separate contract?

Mr Rees: I do not understand the question. I am afraid. The debate in training in the NHS is, as far as we are concerned, a commercial question. Our understanding is that the debate is really about lost productivity. When you are looking at remunerating training in terms of the ISTC programmes, you are looking at a concern that you will have less procedures performed because training is taking place. The cost position, we understand, is likely to be claimed for lost productivity from providers. That is why we have pilots to establish whether as a matter of fact there is lost productivity there. There are some commentators who believe there is no lost productivity; there are others who believe it is substantial.

Q675 Charlotte Atkins: My concern is that our workforce should be properly trained. If the ISTCs are taking some of the bread-and-butter operations from the NHS, which the BMA consider to be very important in terms of training our future medics, I would have hoped the ISTCs would take their fair share of training.

Mr Rees: I do not believe there is any suggestion that they will not. The point is that the contracts have arrangements in Phase 2 for the delivery of training provided the deans, as the people who are responsible for training, wish training to be undertaken in that facility.

Mr Anderson: It is the same people who have responsibility for ensuring that training takes place in the NHS. Therefore, if there is a disparity it will lay with them and not with the ISTC provider.

Q676 Charlotte Atkins: There are concerns from some of the staff organisations that perhaps training is being targeted for cuts. We are concerned about training overall in the NHS, but, particularly, if the ISTCs are going to be expanding their level of commitment in terms of doing operations, then obviously they should also be committed to doing training across the board.

Mr Anderson: As providers they are. But Mr Rees is trying to explain that they do not really have control over whether or not they are going to be allowed to do training. The deans are the people who sit down and decide where training will occur. A lot of the independent sector providers would dearly love to do training. Just from my travels in the NHS, quite a few of the NHS consultants would like to do training in the ISTCs. It goes back to Dr Taylor’s questions. From the standpoint of, maybe, consultants not wanting to be engaged in it, I do not think there is an issue. I think the issue will lie with the deans and whether or not they allocate training funds, as they do to the NHS, to independent sector treatment centres to do that training.

Q677 Chairman: Mr Rees, you mentioned pilots. Do you have any information readily available on these pilots?

Mr Rees: Do you mean has the pilot started? No, because the time between the contract being signed and the treatment centre opening can be up to 18 months, and the shortest pilot is six months and the longest is 12 months, it will be some time before we have the results of the pilot— which, to some extent, makes it a little bit harder to do Phase 2, which is why we have separate arrangements.

Q678 Mr Amess: Mr Searle, Mr Anderson and Mr Rees—I will show no favouritism—who would like to answer this one? The Department told us that the general principles for ensuring value for money included “selecting the best value... offer received.” Are there any circumstances under which that would be a consideration? It seemed to us that it was an absolutely meaningless statement.

Mr Anderson: We are constrained and bound—

Q679 Mr Amess: Mr Searle was nearly going to answer.

Mr Anderson: Go ahead, Mr Searle.

Mr Searle: Sorry, just to clarify, was your question are there any circumstances in which we would not take the lowest price?

Q680 Mr Amess: Yes. Shall I read it again?

Mr Searle: If you could, please.

Q681 Mr Amess: The Department told us that the general principles for ensuring value for money included “selecting the best value... offer received.”

Mr Searle: That is what we do.

Q682 Mr Amess: Are there any circumstances in which you would not do that?

Mr Searle: No.

Q683 Mr Amess: Brilliant. You see, I knew Mr Searle had been brought here for a reason. We got a straight answer. An Australian or New Zealander?

Mr Searle: New Zealander. I have been here six years.

Q684 Mr Amess: The Department also said that another consideration was whether bids were significantly better than spot purchase rates. Given that spot purchasing is done "ad hoc", while the ISTC
programme is systematic and relatively high volume, would you not expect all bids to be significantly better than spot purchase rates?

Mr Searle: Yes.

Mr Amess: We can move on now to the last question.

Q685 Charlotte Atkins: We are told that the ISTCs operate at around 11% above the NHS tariff. That seems to be the going rate for Phase 1. Do you expect that to be the case for Phase 2 as well?

Mr Rees: I cannot answer that question right now. We have got bids in place. We are talking to the bidding population and I do not think we have established any fair market rates.

Mr Searle: The only thing I would say is that it is early days in terms of Phase 2 procurement, so we are only just starting to get bids back now. We certainly do not have anything close to final prices, but I would say that the general feeling from the market is that there is an increasing level of comfort in terms of operating this environment, so that may result in lower prices. It remains to be seen.

Q686 Charlotte Atkins: It seems to me that if the NHS increasingly has to compete for patients—and after all that is how they get their money, by the money following the patient. It seems to me that the NHS is getting a pretty bad deal if they have to compete with organisations that, firstly, do the more straightforward operations but, secondly, get paid up to 11% if the price is going to be less in Phase 2. Is this fair competition?

Mr Searle: It might be best if we deal with that in terms of the detailed value for money discussion that I understand is going to follow on after this, when it will probably easier to give you more clarity around that.

Q687 Charlotte Atkins: Do you reckon payment by results is going to make this competition more difficult? You could probably add in there patient choice as well, because when we have been going around we have certainly found that patients are sometimes resistant to going to ISTCs.

Mr Anderson: Hypothetically it is extremely difficult for us to answer a question like that.

Q688 Mr Amess: Come on, take a risk and answer it!

Mr Anderson: First of all, it is anecdotal. It has not happened yet.

Q689 Charlotte Atkins: Phase 1 has happened. Mr Rees: I do not think you are comparing apples and apples. You are comparing an apple and a pear. For instance, the NHS costs do not include pension costs. You are making a false comparison and we do not have the data to be able to say to you that you can compare prices in that way. You cannot. At the end of the day, NHS providers benefit from state aid: the building capital is provided at no cost; staff pension costs; the provision of free services from PASA and other areas. There is a multitude of benefits effectively that subsidise tariff prices, so your premise, I am afraid, is incorrect.

Q690 Charlotte Atkins: The ISTCs do not provide training, they do the less complicated operations, market is that there is an increasing level of comfort in terms of operating this environment, so that may result in lower prices. It remains to be seen.

Q691 Charlotte Atkins: In Phase 2 we are already told that perhaps it will not be 11%. We are trying to get an idea of how much the ISTCs will cost above the NHS tariff.

Mr Rees: The point is, to give value for money for procedures by aggregating volumes and producing competitive prices.

Dr Taylor: He has given us one of the most important bits of information that I did not know: the obvious difference between pension costs, which I had not gathered.

Chairman: On that positive note, we will close this public session.
Follow-up Questions from 9 March Evidence Session

Question 1: How many NHS treatment centres are open?

1.1 44 NHS treatment centres are open and a further two are expected to open later this year.

Question 2: What is the proportion of overseas doctors practicing in ISTCs compared to home-grown doctors

2.1 In operational Wave 1 ISTCs, 96% of additionality compliant doctors are sourced from overseas and 4% are “home-grown” (4.5 WTE are home-grown from a total of 114.5 WTE). This figure excludes the contracts for the provision of MRI and the supplementary procurements for activity from existing incumbent independent sector providers.

2.2 Home-grown refers to those individuals who have been recruited from within the UK who are additionality compliant as they have not been involved in the delivery of NHS services in the last six months. Overseas is interpreted as those countries outside of the UK.

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<tr>
<th>DOCTORS CURRENTLY WORKING IN ISTCs</th>
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<td>Total number of doctors currently working in ISTCs</td>
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<td>Of which—number currently seconded from the NHS</td>
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<td>Balance who are additionality compliant</td>
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Breakdown of Overseas Doctors by Country of Origin (WTE)

| European Union | 91.0 |
| Rest of World: | 2.0 |
| Lebanon | 2.0 |
| South Africa | 17.0 |
| Total: | 19.0 |
| Total | 110.0 |

Question 3: What is the total number of complaints in the ISTC Programme?

3.1 In Wave 1 ISTCS, there have been 407 reported complaints out of 120,080 patients referred for treatment (this numbers includes both outpatient treatment and day-case/inpatient procedures to the end of January 2006 rather than just the number of discharged procedures). This represents a complaints rate of 0.34%. This figure excludes the contracts for the provision of MRI and the first year of supplementary procurement for activity from existing incumbent independent sector providers as these schemes are not covered by the same KPI reporting requirements.

3.2 ISTCs, like NHS facilities, are required to have complaints processes in place in compliance with the Healthcare Commission’s National Standards for Better Health.

3.3 The patient complaint process for the independent sector is identical to that of the NHS. Patients are required to first report a complaint to the provider, after which, if they are dissatisfied, they may submit their complaint to the Healthcare Commission (HC). The HC processes these complaints in the same way they do those received against NHS providers.

3.4 ISTC complaint frequency and resolution is reported to the Department’s Central Contract Management Unit (CCMU); complaints against NHS providers are not recorded centrally. The reported KPIs are:

— rate of patient complaints; and
— percent of complaints handled outside the acceptable time frame.

3.5 In wave 1, the patient complaints process differs slightly from how the NHS tracks patient complaints, and requires more frequent and comprehensive reporting. Given the low levels of complaints in wave 1 and the desire for NHS-comparable data, for the next phase of procurements the metrics have been modified to replicate NHS tracking.
**Metric** | **ISTC Wave 1** | **NHS**
---|---|---
Rate of patient complaints | Report monthly the number of “logged” complaints received as a percent of patients referred for (1) outpatient treatment (2) inpatients and (3) day cases. A “logged” patient complaint is defined as a written complaint or an oral complaint that requires follow-up by the provider. (KPI 19) | Report quarterly the numbers of written complaints received. Oral complaints not reported. |
Percent of complaints handled outside the appropriate time frame | Report monthly the number of patient complaints not handled within the acceptable time frame as defined in the contract (KPI 20). | NHS trusts report to the Healthcare Commission the number of written complaints received which were not locally resolved within 20 working days. |

**Question 4:** What is the definition of a “serious untoward incident”?

4.1 For the purposes of reporting incidents into the CCMU and Department of Health, the following definition will be used: a reportable event includes an accident or incident when a patient, staff or a member of the public suffers serious injury, major permanent harm or unexpected death while on hospital or other healthcare premises or in other premises where care is provided. It may also include incidents where the actions of healthcare staff or the provider are likely to cause significant public concern.

4.2 The providers consider incidents under a number of categories; near misses, minor, moderate and serious. Only serious incidents and more minor incidents which may be forming a trend are reported through to CCMU.

4.3 The ISTC programme has contractual obligations for addressing adverse incidents and serious untoward incidents. This procedure has been written to:

- promote and maintain patient safety by avoiding risks and learning lessons from the past;
- outline expectations for the timely transmission of information and communications for providers, the CCMU and the Department of Health;
- provide guidance to providers, the CCMU and the Department of Health on the management of untoward incidents; and
- promote consistency in the way incidents are managed across all stakeholders.

**Contract References**

4.4 An adverse patient incident is defined in the contract as “any event or circumstances that could have or did lead to unintended injury (physical or psychological), disease, suffering, disability, death, loss or damage to a patient.”

4.5 According to the contract, a serious untoward incident is “an accident or incident when a patient, member of staff (employed or engaged either by the provider or the authority or another Health Service body) or a member of the public suffers serious injury, major permanent harm or unexpected death in the facilities and where the actions of staff involved (whether employed or engaged by the provider or the authority or another Health Service body) are likely to cause significant public concern.”

**Examples of Reportable Serious Untoward Incidents**

4.6 This list is not exhaustive, but gives direction as to the types of incidents that must be reported to CCMU:

- all patient deaths whether in the provider facility or in another healthcare facility;
- wrong site surgery/wrong patient/wrong treatment;
- serious drug error involving patient harm requiring further treatment;
- admission/transfer to an NHS or other facility where the patient requires extensive supportive care, urgent revision surgery or critical care and where the admission is directly or indirectly linked to the procedure undertaken in the ISTC;
- multiple incidents indicating a possible trend where there is an adverse surgical outcome involving the same member of the surgical tea million, procedure and/or equipment. Examples may include multiple infections or similar complications;
—— suicide or homicide committed by a person with mental health problems;
—— major health risk, outbreak of infection or radiation incidents;
—— suspension of a health professional because of concerns about professional practice;
—— any incident where the reputation of the provider and/or the ISTC programme is likely to be adversely affected or that has already attracted media attention;
—— serious damage to ISTC property, eg through fire, flood or criminal activity that may affect the ability to care for patients;
—— large scale theft, fraud or litigation valued at more than £50,000; and
—— serious injury or unexpected death involving a member of staff, visitor, contractor or another person to whom the organisation owes a duty of care.

4.7 In the event that the provider is unsure whether to instigate the escalation procedure, advice should be sought from the Head of CCMU and the CCMU Clinical Risk Advisor.

4.8 As of January 2006, there have been 254 SUIs reported across the whole of the IS programme: including ISTCs, the supplementary contracts for additional capacity in the incumbent sector and the MRI contract. Of this number, 94 have been reported from Wave 1 ISTCs (out of a total of nearly 49,000 procedures and over 13,000 diagnostics); 4 relating to the MRI contract (out of a total of over 100,000 scans), and 156 relate to the supplementary procurements (out of a total of nearly 37,000 procedures).

Question 5: Please check the 97% patient satisfaction claim

5.1 The reported patient satisfaction level in January 2006 was 97%. This figure is an average of the satisfaction ratings as reported in KPI 19 from each of the schemes and includes all Wave 1 ISTCs, the supplementary contracts for additional capacity in the incumbent sector and the MRI contract.

Question 6: Do the NHS collect complication data?

6.1 There is no single measure of complication rate in either ISTCs or the NHS. Complications will be picked up through a variety of different measures but there is no aggregate figure. Further information is provided under question 7.

Question 7: How are complications managed and what provisions are there for the management of post-operative care?

7.1 ISTCs, like NHS facilities, are required to comply with NPSA reporting requirements, NICE procedural guidelines and the complaints processes outlined by the Healthcare Commission. To supplement this with additional oversight, CCMU monitors ISTC complication management through four key metrics. These are:
—— return to theatre (KPI 4);
—— unforeseen inpatient admissions (KPI 7);
—— unplanned transfers (KPI 8); and
—— emergency readmissions (KPI 9).

A full list of all the KPIs is annexed.

7.3 For post-operative care, the specifics of the ISTC role in delivering post-operative patient care is clearly laid out in each contract in accordance with requirements of local NHS commissioners. This enables the requirements to:
—— be appropriately tailored to the specific types of care delivered by the ISTC; and,
—— align with local procedures and availability of the required after care.

<table>
<thead>
<tr>
<th>Metric</th>
<th>ISTC Wave 1</th>
<th>NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission of day cases</td>
<td>For day cases, inpatient admission to the facility or to other providers' facilities (including NHS providers) which was unforeseen at the time of admission. For the purposes of the performance, threshold is measured as a percentage of all day cases in the facility.</td>
<td>The NHS does not report this metric. The NHS captures admission data for every patient in the Hospital Episode Statistics (HES) database. HES could potentially track this but coding quality may be questionable.</td>
</tr>
<tr>
<td>Metric</td>
<td>ISTC Wave 1</td>
<td>NHS</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Return to theatre</td>
<td>Patient returning to operating theatre for procedure which was unforeseen at the time the patient’s previous procedure was completed as a percentage of all patients admitted in the facility.</td>
<td>NHS does not report return to theatre data.</td>
</tr>
<tr>
<td>Emergency readmissions</td>
<td>Emergency admissions/readmissions of patients who have received inpatient treatment and have been discharged within 28 days of such discharge where such admission or readmission is related to or arising from the relevant inpatient treatment, for the purposes of the performance threshold measured by HRG as a percentage of all patients discharged.</td>
<td>Percentage of all admitted patients who returned to the same hospital as an emergency case, regardless of specialty, within 28 days of initial discharge.</td>
</tr>
<tr>
<td></td>
<td>The ISTC report on any known readmissions (this could include readmission of a patient to another hospital). Also, readmissions are only reported if they are related to the original treatment. Not all readmissions in the NHS are reported to the ISTC Provider.</td>
<td>Similar measures but a direct comparison is not possible. The NHS report on all readmissions to the same hospital regardless of whether they relate to the original treatment. They also only report on the total number of patients readmitted (not by HRG as in the ISTCs).</td>
</tr>
<tr>
<td>Unplanned transfers</td>
<td>Transfers of any patient for treatment which was not in the management plan for that patient upon admission to the facility. For the purposes of the performance, threshold is a percentage of all inpatients in the facility by HRG.</td>
<td>The NHS measure this for all patients (daycase and inpatient) and do not break it down by HRG. As such a direct comparison is not possible without further analysis by HES.</td>
</tr>
<tr>
<td>Surgical site infections</td>
<td>Surgical site infections through the SUI process. This will be a specific indicator in Phase 2.</td>
<td>Trusts submit forms to HPA. HPA run a SSI surveillance service</td>
</tr>
<tr>
<td>MRSA/MSSA bacteraemia</td>
<td>Reported through SUI process.</td>
<td>Acute trusts are required to report levels of Staphylococcus aureus bacteraemias (including MRSA) to Health Protection Agency (HPA) on a monthly basis</td>
</tr>
<tr>
<td>Mortality</td>
<td>Reported to a number of bodies (Coroner, NCEPOD and SUI Process).</td>
<td>Reported to a number of bodies (HCC, Coroner, through SUI process and NCEPOD)</td>
</tr>
</tbody>
</table>

**Question 8:** What are the readmission rates in ISTCs and how do these compare to NHS?

8.1 The definition for Emergency Readmissions in wave 1 of the ISTC Programme is:

“Emergency admissions/readmissions of patients who have received inpatient treatment and have been discharged within 28 days of such discharge where such admission or readmission is related to or arising from the relevant inpatient treatment. The performance threshold is measured by HRG as a percentage of all patients discharged.”
8.2 To be included in this KPI, the readmission must be related to or arising from the relevant inpatient treatment. This is measured by the original HRG. This data is captured for all patients treated by ISTCs, regardless of age. The information is reported on a monthly basis.

8.3 The Emergency Readmission rate for the ISTC Programme (excluding GSup) up to the end of January 2006 is 0.4%. The NHS Definition for Percentage Readmissions (source: Performance Investigator User Guide version 1.1 September 2005) is:

“Percentage of all admitted patients who returned to the same hospital as an emergency case, regardless of specialty, within 28 days of initial discharge.”

8.4 This information is reported via HES on a quarterly basis. The HES reports are usually published a number of months after the last data has been submitted (for example, for 2005 Quarter 3 results (Oct–Dec), data was collected until February 2006 with a report likely to be published in April 2006).

8.5 The measures between the NHS and ISTCs are similar. However a direct comparison is not possible for the following reasons:

— the NHS report on all (day case and inpatient) readmissions to the same hospital. They also only report on the total number of patients readmitted (not by HRG as in the ISTCs);
— the ISTCs report on any known inpatient readmissions (this could include readmission of a patient to another hospital). Also, readmissions are only reported if they are related the original treatment (the NHS could pick up other readmissions not related to the original treatment); and
— HES can carry out an extraction/analysis (by specific request) to show the number of patients treated more than once within 28 days in all facilities (including ISTCs). This comparison would have to be by HRG and is not picked up in standard NHS reporting.

Department of Health
March 2006

Annex

DESCRIPTION OF KPIs ON ISTC WAVE 1 SCHEMES

KPI 1 Incidence of inpatient and/or day case activities not commenced because of DNAs as percentage of all activities.

KPI 2 Procedures cancelled by the provider for non-clinical reasons on or after day of admission. For the purposes of the performance threshold, it is measured as a percentage of all patients admitted to the facility.

KPI 3 Procedures cancelled by provider for clinical reasons on or after day of admission. For the performance threshold, this is measured as a percentage of all patients admitted in the facility.

KPI 4 Patient returning to operating theatre for procedure which was unforeseen at the time the patient’s previous procedure was completed as a percentage of all patients admitted in the facility.

KPI 5 In relation to each (HRG), the conversion rate ie the percentage of patients who go on to be given a patient appointment for a procedure following an outpatient assessment.

KPI 6 In respect of [the][each] facility, the rate of rejection by the provider in respect of patients referred within the referral protocol (schedule 3) as a percentage of all patients who are referred in the contracted month.

KPI 7 For day cases, inpatient admission to the facility or to other providers facilities (including NHS providers) which was unforeseen at the time of admission. For the purposes of the performance, threshold is measured as a percentage of all day cases in the facility.

KPI 8 Transfers of any patient for treatment which was not in the management plan for that patient upon admission to the facility. For the purposes of the performance, threshold is a percentage of all inpatients in the facility by HRG.

KPI 9 Emergency admissions/readmissions of patients who have received inpatient treatment and have been discharged within 28 days of such discharge where such admission or readmission is related to or arising from the relevant inpatient treatment for the purposes of the performance threshold measured by HRG as a percentage of all patients discharged.

KPI 10 Average length of stay in hours and minutes for day cases by HRG, measured from the time of admission to the time of discharge.

KPI 11 Average length of stay by HRG measured in inpatient whole days measured from the time of admission to the time of discharge.
KPI 12  Average procedure time, collected in minutes, by HRG, and specifying surgery where Local Anaesthetic surgery is used and where General Anaesthetic surgery is used, broken down by:
  — induction
  — time on operating table
  — recovery measured from [ ] to [ ]

KPI 13  Patient receives or is listed or recommended for a further procedure to put right any aspect of the original activity less than 5 years from the date of discharge. For the purposes of performance threshold, measured as a percentage of all procedures carried out at the facility.

KPI 14  Numbers of procedures carried out under local anaesthetic and general anaesthetic by HRG as a percentage of all procedures.

KPI 15  Clinical outcomes specified by procedure, by reference to the Patient Care Pathways.

KPI 16  Timeliness, completeness and accuracy of provider performance data provided to the joint service review and/or to sponsor, recorded as the number of complaints in any reporting period.

KPI 17  Timeliness, completeness and accuracy of provider clinician reporting to referring health body’s clinician recorded as the number of complaints in any reporting month.

KPI 18  Patient/customer satisfaction (by survey) based on a survey of 10% of all patients at each facility in each [contract month].

KPI 19  Rate of patient complaints ie number of complaints received as a percentage of all patients referred for:
  (i) outpatient treatment
  (ii) day case treatment
  (iii) inpatient treatment

KPI 20  Patient complaints handling: complaints not handled within relevant timescales set out in the contract.

KPI 21  Incidents which are reportable to the NPSA, or other statutory body.

KPI 22  Additionality: NHS staff recruited in breach of Clause 9 of the agreement.

KPI 23  Condition of facility, measured by inspection by a sponsor and/or the provider and assessed against the requirements of the facility manual and operational procedures.

KPI 24  Breach of security related to the services where there is an identifiable risk of harm, million, loss or damage to people or property.

KPI 25  Breach by the provider of confidentiality and/or data protection requirements in the agreement.

KPI 26  Failure to meet treat-by date.

Supplementary memoranda submitted by the Department of Health (ISTC 1D)

CAPACITY PLANNING OVERVIEW BY STRATEGIC HEALTH AUTHORITY

1. INTRODUCTION

1.1 This note draws some key data from Capacity Plans, including:
  — Forecast total elective growth.
  — Forecast elective inpatient growth.
  — Forecast day case growth and overall day case rate.
  — Forecast elective growth and day case rate for orthopaedics, general surgery, ophthalmology and ENT along with current +6 month waits as a percentage of elective admissions (2000–01 admissions, 2002 waits: not from Capacity Plans).
  — Benchmarks the day case rates for the same group of specialties.

1.2 In all cases the growth rates by SHA can be compared to the national model assumptions contained in the Capacity templates. These are shown below.
Table 1 National Cumulative Assumptions on Activity Growth

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>24.6</td>
<td>17.9</td>
</tr>
<tr>
<td>Daycases</td>
<td>42.2</td>
<td>30.2</td>
</tr>
<tr>
<td>Inpatients</td>
<td>–5.5</td>
<td>–4.1</td>
</tr>
<tr>
<td>Non-electives</td>
<td>7.0</td>
<td>5.2</td>
</tr>
</tbody>
</table>

(All specialties)

1.3 Cumulative growth is shown taking both 2001–02 and 2002–03 as the baseline. This is because there are a number of SHA’s presenting very sharp growth between 2001–02 and 2002–03 and it is not clear if this was intended or is a problem in the definition of the 2001–02 out-turn.

2. National Summary

2.1 Table 2 presents overall national growth rates from Capacity Plans which can be compared to Table I. We have not presented numbers of FFCEs as there are still significant gaps in the templates (this also implies that Table 2 and SHA specific data needs to be treated with caution). Looking by SHA a number of common features are apparent.

(i) Overall elective growth is below that forecast from the national assumptions, with very few SHAs expecting to equal or exceed the national rates;

(ii) Inpatient electives do not fall. Very few SHA’s actually forecast any reduction in inpatient electives, and a significant group are forecasting rapid growth (at the limit, exceeding the growth for day cases);

(iii) As a result of (i) and (ii), while day cases account for the majority of increased elective activity, this still represents a very significant shortfall in expected day case growth. Overall, the 75% target for day cases is not met.

Table 2 National Cumulative Activity Growth Contained in Capacity Plans

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>19.2</td>
<td>13.8</td>
</tr>
<tr>
<td>Daycases</td>
<td>23.0</td>
<td>18.1</td>
</tr>
<tr>
<td>Inpatients</td>
<td>10.9</td>
<td>4.7</td>
</tr>
<tr>
<td>Non-electives</td>
<td>8.8</td>
<td>6.7</td>
</tr>
</tbody>
</table>

(All specialties)

Table 3 Differences in Cumulative Percentage Growth: National Assumptions and Capacity plans

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>–5.4</td>
<td>–4.1</td>
</tr>
<tr>
<td>Daycases</td>
<td>–19.2</td>
<td>–12.1</td>
</tr>
<tr>
<td>Inpatients</td>
<td>16.4</td>
<td>8.8</td>
</tr>
<tr>
<td>Non-electives</td>
<td>1.8</td>
<td>1.5</td>
</tr>
</tbody>
</table>

(All specialties). Note: negatives imply national assumptions are higher than Capacity Plans.

3. Caveats and Explanation of Table 3

3.1 The capacity templates for several SHAs are not yet complete in terms of speciality data. This should not affect the four specialties highlighted. However, for information based on all specialties (Table 1) missing speciality data (particularly in the large categories such as “other G&A”) may affect the calculations in a minor number of cases. In one case we know of missing trust/PCT data which will affect the speciality data in Tables 2 and 3.
3.2 Table 3 particularly deserves explanation. It is a distilled assessment of day case performance but also tells us something about the quality of capacity plan data.

— Row 1 indicates whether the capacity plan day case rates for 2001–02 differ by less than $+/-5\%$ from HES data for 2000–01. This is an indication of the “quality” of the plans in terms of day case rates, and in general. We assume that a $+/-5\%$ range of tolerance is acceptable, given an extra year’s data.

— The next two rows indicate whether day case rates in 2001–02 and 2005–06 are in the top decile of HES data for 2001–01. A good performer would be marked YY, and an “improver” NY.

(iii) The final row cross references with data from the NHSIA. This assesses whether, given the age-sex profile of the SHA population, it is performing more day case rates than expected based on national data.

3.3 It is therefore possible to have several day case rate profiles lying between two extremes,

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>YYYY</td>
<td>Good data, good current and projected performance and doing more day case rates than expected given population characteristics.</td>
</tr>
<tr>
<td>NNNN</td>
<td>Questionable data, non top decile current and projected performance and day case rates lower than expected given population characteristics.</td>
</tr>
</tbody>
</table>

CAPACITY PLANNING EXERCISE 2002

1. Guidance on capacity planning was issued by the Director of Access & Choice to DHSC Directors on 16 May 2002, for sharing with SHAs and PCTs. Capacity planning was to be DHSC-led, and to be a developing process rather than a “tick a box” exercise. The focus was on securing the capacity to deliver the NHS Plan waiting time and emergency care targets, taking into account the cohorts of patients waiting, and likely trends in demand.

2. This was in the context of “Delivering the NHS Plan”, which highlighted the importance of robust strategic planning to ensure that capacity-enhancing interventions (including Diagnostic and Treatment Centres) are focussed where they will be most effective. Capacity planning was intended to encompass the whole secondary care access agenda, engage all appropriate stakeholders within the health community. Capacity plans were to contribute to increasing patient choice and plurality of provision.

3. Capacity planning was recognised to be an iterative process. It was to aid the development and prioritisation of programmes for DTCs, day surgery, and other programmes to increase NHS capacity, including testing innovative partnerships with UK independent sector and overseas providers, particularly for acute elective care.

4. SHAS were required to agree an appropriate format for their capacity plans, in line with principles and requirements set out in the guidance. As well as quantitative material on such things as GP referral growth, elective and non-elective activity growth, length of stay and day case rates, SHAs were asked to set out provisional proposals as to which interventions were likely to be most appropriate to secure the necessary capacity.

5. DHSCs were asked to ensure that all SHAs had set up appropriate planning processes by October 2002, so that they could produce specialty level capacity plans for 2003–04 to 2005–06, adopting a common method for modelling demand and supply. SHAs were required to submit definitive capacity plans to DHSCs, copied to the Access Directorate, by 31 October 2002.

6. The capacity planning figures submitted by SHAs in October 2002 were analysed by DH analysts. An overview analysis and a summary for each SHA are attached. These analyses, and the other material provided by SHAs to DHSCs, provided the basis for continuing work by DHSCs with SHAs, including work to finalise investment intentions for NHS and independent Sector DTCs.

7. Capacity planning took place in the context of the already established DTC Programme, which had the overall aim of improving access to acute elective care by contributing capacity for an additional 250,000 FFCEs by 2005. This programme was particularly geared to achieving the activity growth needed to achieve maximum 6 month waits by 2005, through providing safe, fast, pre-booked surgery and diagnostic tests, and separating scheduled treatment from emergency pressures in specialties with high waiting times. The capacity to be added through the DTC programme (NHS and IS) would contribute to achieving the 19.2% growth in elective activity and capacity, which SHA capacity plans identified as necessary to achieve maximum 6 month waits by 2005.
8. In December 2002 a procurement process was launched for 11 IS DTC projects, to create capacity for 39,500 FFCEs a year by 2005. IS providers were also invited to propose innovative options for a series of “chains” of DTCs for cataracts, simple day-case surgery and orthopaedics procedures. The detailed planning of the requirements for these schemes, which became known as the “ISTC Wave 1 programme”, was taken forward by DHSCs with SHAs and PCTS. DH centrally did not engage further in the capacity planning for IS and NHS DTCs in the DTC programme.

29 March 2006

LONDON CAPACITY PLAN SUMMARIES: 22 November 2002

NORTH-CENTRAL LONDON SHA (Q05): CAPACITY PLAN DATA SUMMARY

Main points

— 62% day case rate in 2005–06.
— Very high in-patient elective and orthopaedic growth in 2001–02 to 2002–03.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>21%</td>
</tr>
<tr>
<td>Daycases</td>
<td>27%</td>
</tr>
<tr>
<td>In-patients</td>
<td>13%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>5%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>51%</td>
<td>21%</td>
<td>13.7%</td>
<td>39%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>31%</td>
<td>13%</td>
<td>9.1%</td>
<td>78%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>20%</td>
<td>12%</td>
<td>3.8%</td>
<td>59%</td>
</tr>
<tr>
<td>ENT</td>
<td>29%</td>
<td>24%</td>
<td>10.6%</td>
<td>37%</td>
</tr>
</tbody>
</table>

Table 3 Specialities—Daycase Rates

<table>
<thead>
<tr>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>
NORTH-EAST LONDON SHA (Q06): CAPACITY PLAN DATA SUMMARY

Main points
— 75% day case rate in 2005–06.
— Exceptionally high in-patient growth in 2001–02 to 2002–03.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>20%</td>
<td>9%</td>
</tr>
<tr>
<td>Daycases</td>
<td>21%</td>
<td>12%</td>
</tr>
<tr>
<td>In-patients</td>
<td>19%</td>
<td>2%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>7%</td>
<td>5%</td>
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</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>30%</td>
<td>0%</td>
<td>16.6%</td>
<td>42%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>20%</td>
<td>−3%</td>
<td>16.1%</td>
<td>91%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>10%</td>
<td>3%</td>
<td>6.2%</td>
<td>62%</td>
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<tr>
<td>ENT</td>
<td>22%</td>
<td>0%</td>
<td>16.6%</td>
<td>33%</td>
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</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
**NORTH-WEST LONDON SHA (Q04): CAPACITY PLAN DATA SUMMARY**

*Main points*
- 65% day case rate 2005–06.
- High non-elective growth.
- Growth by specialty appears to match current waiting problems.

**Table 1 Activity Growth**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Daycases</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td>In-patients</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>12%</td>
<td>10%</td>
</tr>
</tbody>
</table>

(All specialties)

**Table 2 Specialties—Summary**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>20%</td>
<td>12%</td>
<td>11.2%</td>
<td>44%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>14%</td>
<td>9%</td>
<td>3.6%</td>
<td>81%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>12%</td>
<td>9%</td>
<td>4.6%</td>
<td>50%</td>
</tr>
<tr>
<td>ENT</td>
<td>28%</td>
<td>15%</td>
<td>13.5%</td>
<td>44%</td>
</tr>
</tbody>
</table>

**Table 3 Specialties—Daycase Rates**

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>
SOUTH-EAST LONDON SHA (Q07): CAPACITY PLAN DATA SUMMARY

Main points
— 71% day case rate in 2005–06.
— Low elective growth, again heavily loaded into 2001–02 to 2002–03 for some specialties—ENT in particular.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>15%</td>
</tr>
<tr>
<td>Daycases</td>
<td>17%</td>
</tr>
<tr>
<td>In-patients</td>
<td>10%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>7%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th>Total elective growth</th>
<th>Current six-month waits as a proportion of admissions</th>
<th>Daycase rate 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>36%</td>
<td>13%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>20%</td>
<td>15%</td>
<td>12.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>12%</td>
<td>11%</td>
<td>3.4%</td>
</tr>
<tr>
<td>ENT</td>
<td>16%</td>
<td>–6%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
SOUTH-WEST LONDON SHA (Q08): CAPACITY PLAN DATA SUMMARY

Main points

— 67% day case rate in 2005–06.
— Very high in-patient elective growth combined with high non-elective growth.
— High activity growth in the four specialties.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>24%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Daycases</td>
<td>22%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>In-patients</td>
<td>29%</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Non-electives</td>
<td>12%</td>
<td>9%</td>
<td></td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th>Total elective growth</th>
<th>Current six-month waits as a proportion of admissions</th>
<th>Daycase rate 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>38%</td>
<td>23%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>33%</td>
<td>29%</td>
<td>4.4%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>16%</td>
<td>7%</td>
<td>4.3%</td>
</tr>
<tr>
<td>ENT</td>
<td>26%</td>
<td>13%</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
CAPACITY PLAN SUMMARIES: MIDLANDS AND EAST 22 November 2002

BEDFORDSHIRE AND HERTFORDSHIRE SHA (Q02): CAPACITY PLAN DATA SUMMARY

Main points

— All specialty day case rate forecast to be 75% by 2005–06.
— In-patient growth expected to reverse.
— Major waiting list areas are ENT and trauma and orthopaedics where day case rates are already top decile. Given this, elective growth in ENT seems relatively low.

<table>
<thead>
<tr>
<th>Table 1 Activity Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Total electives</td>
</tr>
<tr>
<td>Daycases</td>
</tr>
<tr>
<td>In-patients</td>
</tr>
<tr>
<td>Non-electives</td>
</tr>
</tbody>
</table>

(All specialties)

<table>
<thead>
<tr>
<th>Table 2 Specialties—Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total elective growth</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Trauma and Orthopaedics</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>General Surgery</td>
</tr>
<tr>
<td>ENT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3 Specialties—Daycase Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total elective growth</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>&lt; 5% difference between HES 2000–01 and Plan 2001–02</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
</tr>
</tbody>
</table>
BIRMINGHAM AND THE BLACK COUNTRY SHA (Q27): CAPACITY PLAN DATA SUMMARY

Main points
— 64% day case rate in 2005–06.
— There are very low waits in the specialties focussed on here.
— Day case growth is projected to greatly outpace elective growth.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>24%</td>
</tr>
<tr>
<td>Daycases</td>
<td>34%</td>
</tr>
<tr>
<td>In-patients</td>
<td>9%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>9%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>28%</td>
<td>23%</td>
<td>4.1%</td>
<td>55%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>24%</td>
<td>25%</td>
<td>1.3%</td>
<td>84%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>25%</td>
<td>19%</td>
<td>1.0%</td>
<td>66%</td>
</tr>
<tr>
<td>ENT</td>
<td>16%</td>
<td>13%</td>
<td>1.7%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th>&lt;5% difference between HES 2000–01 and Plan 2001–02</th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top decile 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
ESSEX SHA (Q03): CAPACITY PLAN DATA SUMMARY

Main points

— All specialty day case rate forecast to be 72% in 2005–06.
— Major problem with exceptionally high waits for ophthalmology, coupled with very high existing day case rates but relatively low planned elective growth.
— Other problem is trauma and orthopaedics, again with reasonably high day case rates.
— High non-elective growth.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>25%</td>
<td>16%</td>
</tr>
<tr>
<td>Daycases</td>
<td>28%</td>
<td>18%</td>
</tr>
<tr>
<td>In-patients</td>
<td>12%</td>
<td>4%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>11%</td>
<td>8%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Total elective growth</th>
<th>Current six-month waits as a proportion of admissions</th>
<th>Daycase rate 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>42%</td>
<td>20%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>23%</td>
<td>12%</td>
<td>25.1%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>28%</td>
<td>15%</td>
<td>4.9%</td>
</tr>
<tr>
<td>ENT</td>
<td>21%</td>
<td>19%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
LEICESTERSHIRE, NORTHAMPTONSHIRE AND RUTLAND SHA (Q25): CAPACITY PLAN DATA SUMMARY

Main points
— 71% day case rate in 2005–06.
— Current day case rate performance is poor across the board and very high in-patient elective growth 2001–02 to 2002–03.
— Ophthalmology is a big problem with high waits and a low day case rate. T& O is also an issue with low day case rates but large elective growth is forecast to 2005–06.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>22%</td>
</tr>
<tr>
<td>Daycases</td>
<td>25%</td>
</tr>
<tr>
<td>In-patients</td>
<td>16%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>10%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

Total elective growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>55%</td>
<td>42%</td>
<td>9.2%</td>
<td>40%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>34%</td>
<td>23%</td>
<td>12.3%</td>
<td>82%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>11%</td>
<td>13%</td>
<td>2.6%</td>
<td>52%</td>
</tr>
<tr>
<td>ENT</td>
<td>11%</td>
<td>7%</td>
<td>3.7%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>~5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
NORFOLK, SUFFOLK AND CAMBRIDEGSHIRE SHA (Q01): CAPACITY PLAN DATA SUMMARY

Main points
— All specialty day case rate predicted to be 74% in 2005–06.
— In-patient growth expected to reverse by 2005–06.
— Major waiting problems in trauma and orthopaedics and ophthalmology. In the former day case rates are low.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001–02 to</td>
<td>2002–03 to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2005–06</td>
<td>2005–06</td>
<td></td>
</tr>
<tr>
<td>Total electives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daycases</td>
<td>20%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>In-patients</td>
<td>25%</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Non-electives</td>
<td>8%</td>
<td>-5%</td>
<td></td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

Total elective growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>30%</td>
<td>8%</td>
<td>11.7%</td>
<td>46%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>29%</td>
<td>15%</td>
<td>11.3%</td>
<td>92%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>27%</td>
<td>15%</td>
<td>4.1%</td>
<td>57%</td>
</tr>
<tr>
<td>ENT</td>
<td>24%</td>
<td>8%</td>
<td>7.6%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
SHROPSHIRE AND STAFFORDSHIRE SHA (Q26): CAPACITY PLAN DATA SUMMARY

**Main points**

— 68% day case rate in 2005–06.
— Trauma and orthopaedics is a problem with high waits, low day case rates and relatively low elective growth forecast.
— High non-elective growth and in-patient elective forecasts.

**Table 1 Activity Growth**

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001–02 to</td>
<td>2002–03 to</td>
<td>2005–06</td>
</tr>
<tr>
<td></td>
<td>2005–06</td>
<td>2005–06</td>
<td></td>
</tr>
<tr>
<td>Total electives</td>
<td>23%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Daycases</td>
<td>27%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>In-patients</td>
<td>16%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Non-electives</td>
<td>17%</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

(All specialties)

**Table 2 Specialties—Summary**

<table>
<thead>
<tr>
<th></th>
<th>2001–02 to</th>
<th>2002–03 to</th>
<th>Current six-month waits as a proportion of admissions</th>
<th>Daycase rate 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2005–06</td>
<td>2005–06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma and Orthopaedics</td>
<td>19%</td>
<td>17%</td>
<td>10.6%</td>
<td>41%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>62%</td>
<td>24%</td>
<td>4.0%</td>
<td>89%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>13%</td>
<td>10%</td>
<td>2.8%</td>
<td>57%</td>
</tr>
<tr>
<td>ENT</td>
<td>16%</td>
<td>11%</td>
<td>4.5%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Table 3 Specialties—Daycase Rates**

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
**TRENT SHA (Q24): CAPACITY PLAN DATA SUMMARY**

**Main points**
- 74% day case rate in 2005–06.
- The SHA envisages an increasing day case growth rate twinned with a fall in in-patient electives by 2005–06.
- Main area of concern is trauma and orthopaedics.

**Table 1 Activity Growth**

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001–02 to</td>
<td>2002–03 to</td>
<td>2005–06</td>
</tr>
<tr>
<td>Total electives</td>
<td>20%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Daycases</td>
<td>28%</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>In-patients</td>
<td>2%</td>
<td>–4%</td>
<td></td>
</tr>
<tr>
<td>Non-electives</td>
<td>11%</td>
<td>8%</td>
<td></td>
</tr>
</tbody>
</table>

(All specialties)

**Table 2 Specialties—Summary**

**Total elective growth**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>30%</td>
<td>22%</td>
<td>9.6%</td>
<td>54%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>37%</td>
<td>24%</td>
<td>7.3%</td>
<td>91%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>16%</td>
<td>10%</td>
<td>2.6%</td>
<td>59%</td>
</tr>
<tr>
<td>ENT</td>
<td>23%</td>
<td>9%</td>
<td>5.6%</td>
<td>47%</td>
</tr>
</tbody>
</table>

**Table 3 Specialties—Daycase Rates**

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
WEST MIDLANDS SOUTH SHA (Q28): CAPACITY PLAN DATA SUMMARY

Main points

— 72% day case rate in 2005–06.
— Day case rates are improving. Orthopaedics shows substantial elective growth, day case rates are quite good and are expected to improve.
— In-patient elective growth is forecast to reverse—the decline is actually faster than national assumptions.

### Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>18%</td>
<td>12%</td>
</tr>
<tr>
<td>Daycases</td>
<td>28%</td>
<td>23%</td>
</tr>
<tr>
<td>In-patients</td>
<td>−1%</td>
<td>−7%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>7%</td>
<td>5%</td>
</tr>
</tbody>
</table>

(All specialties)

### Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>39%</td>
<td>28%</td>
<td>9.8%</td>
<td>61%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>38%</td>
<td>28%</td>
<td>2.8%</td>
<td>88%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>13%</td>
<td>9%</td>
<td>3.3%</td>
<td>64%</td>
</tr>
<tr>
<td>ENT</td>
<td>49%</td>
<td>38%</td>
<td>4.6%</td>
<td>60%</td>
</tr>
</tbody>
</table>

### Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>
CAPACITY PLAN SUMMARIES: NORTH 22 November 2002

CHESHIRE AND MERSEYSIDE SHA (Q15): CAPACITY PLAN DATA SUMMARY

Main points

— 69\% day case rate in 2005–06.
— Relatively low in-patient elective growth (compared to adjacent SHAs) and many other growth rates close to national assumptions.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>22%</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Daycases</td>
<td>31%</td>
<td>27%</td>
<td></td>
</tr>
<tr>
<td>In-patients</td>
<td>7%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Non-electives</td>
<td>8%</td>
<td>6%</td>
<td></td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>35%</td>
<td>26%</td>
<td>10.8%</td>
<td>55%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>21%</td>
<td>17%</td>
<td>11.3%</td>
<td>88%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>23%</td>
<td>19%</td>
<td>3.8%</td>
<td>65%</td>
</tr>
<tr>
<td>ENT</td>
<td>26%</td>
<td>19%</td>
<td>9.0%</td>
<td>51%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
Main points

— 72% day case rate in 2005–06.
— Plans imply declining activity 2001–02 to 2002–03 in some specialties and flat overall.
— Very high in-patient elective growth.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>16%</td>
</tr>
<tr>
<td>Daycases</td>
<td>15%</td>
</tr>
<tr>
<td>In-patients</td>
<td>21%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>2%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th>Total elective growth</th>
<th>Current six-month waits as a proportion of admissions</th>
<th>Daycase rate 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>22%</td>
<td>12%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>13%</td>
<td>15%</td>
<td>7.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>14%</td>
<td>15%</td>
<td>2.8%</td>
</tr>
<tr>
<td>ENT</td>
<td>13%</td>
<td>16%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
CUMBRIA AND LANCASHIRE SHA (Q13): CAPACITY PLAN DATA SUMMARY

Main points

— 69% day case rate in 2005–06.
— Rapid overall activity growth 2001–02 to 2002–03.
— Very high in-patient elective growth.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th>Type</th>
<th>Growth (%)</th>
<th>2001–02 to 2005–06</th>
<th>2002–03 to 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>17%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Daycases</td>
<td>17%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>In-patients</td>
<td>17%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Non-electives</td>
<td>8%</td>
<td>6%</td>
<td></td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total elective growth</th>
<th>Current six-month waits as a proportion of admissions</th>
<th>Daycase rate 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>19%</td>
<td>7%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>14%</td>
<td>9%</td>
<td>8.3%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>15%</td>
<td>7%</td>
<td>3.2%</td>
</tr>
<tr>
<td>ENT</td>
<td>31%</td>
<td>18%</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th>Category</th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>
GREATER MANCHESTER SHA (Q14): CAPACITY PLAN DATA SUMMARY

Main points
— 65% day case rate in 2005–06.
— Very high in-patient elective growth.
— Growth by speciality appears to match waiting problems.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001–02 to</td>
</tr>
<tr>
<td></td>
<td>2005–06</td>
</tr>
<tr>
<td>Total electives</td>
<td>21%</td>
</tr>
<tr>
<td>Daycases</td>
<td>20%</td>
</tr>
<tr>
<td>In-patients</td>
<td>24%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>9%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th>Total elective growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>33%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>30%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>25%</td>
</tr>
<tr>
<td>ENT</td>
<td>22%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
**NORTH AND EAST YORKSHIRE AND NORTH LINCOLNSHIRE SHA (Q11): CAPACITY PLAN DATA SUMMARY**

**Main points**
- 67% day case rate in 2005–06.
- Very high in-patient elective growth.
- High activity growth in orthopaedics 2001–02 to 2002–03.

**Table 1 Activity Growth**

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001–02 to</td>
<td>2002–03 to</td>
</tr>
<tr>
<td></td>
<td>2005–06</td>
<td>2005–06</td>
</tr>
<tr>
<td>Total electives</td>
<td>19%</td>
<td>14%</td>
</tr>
<tr>
<td>Daycases</td>
<td>20%</td>
<td>15%</td>
</tr>
<tr>
<td>In-patients</td>
<td>18%</td>
<td>13%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>7%</td>
<td>5%</td>
</tr>
</tbody>
</table>

(All specialties)

**Table 2 Specialties—Summary**

|                      | Current six-month | Daycase rate |
|                      | waits as a proportion of admissions | 2005–06 |
| Trauma and Orthopaedics | 7.8%                 | 45%     |
| Ophthalmology          | 11.4%                | 84%     |
| General Surgery        | 3.2%                 | 57%     |
| ENT                    | 8.8%                 | 33%     |

**Table 3 Specialties—Daycase Rates**

|                      | Trauma and Orthopaedics | Ophthalmology | General Surgery | ENT |
|                      | <5% difference between HES 2000–01 and Plan 2001–02 | <5% difference between HES 2000–01 and Plan 2001–02 | <5% difference between HES 2000–01 and Plan 2001–02 | <5% difference between HES 2000–01 and Plan 2001–02 |
| Top decile 2001–02   | N                     | N            | N               | N   |
| Top decile 2005–06   | N                     | N            | N               | N   |
| NHSIA > expected daycase rate | N         | N            | N               | N   |
**NORTHUMBERLAND, TYNE AND WEAR SHA (Q09): CAPACITY PLAN DATA SUMMARY**

**Main points**
- 71% day case rate in 2005–06.
- Low elective activity growth, particularly from 2002–03.
- High in-patient elective growth.

**Table 1 Activity Growth**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>15%</td>
<td>9%</td>
</tr>
<tr>
<td>Daycases</td>
<td>17%</td>
<td>11%</td>
</tr>
<tr>
<td>In-patients</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>6%</td>
<td>4%</td>
</tr>
</tbody>
</table>

(All specialties)

**Table 2 Specialties—Summary**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>22%</td>
<td>6%</td>
<td>7.8%</td>
<td>48%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>30%</td>
<td>10%</td>
<td>1.9%</td>
<td>90%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>15%</td>
<td>9%</td>
<td>2.1%</td>
<td>69%</td>
</tr>
<tr>
<td>ENT</td>
<td>10%</td>
<td>8%</td>
<td>10.0%</td>
<td>62%</td>
</tr>
</tbody>
</table>

**Table 3 Specialties—Daycase Rates**

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
SOUTH YORKSHIRE SHA (Q23): CAPACITY PLAN DATA SUMMARY

Main points

— 70% day case rate in 2005–06.
— All growth rates except in-patient electives somewhat low by national assumptions, but no outstanding outliers.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>18%</td>
</tr>
<tr>
<td>Daycases</td>
<td>24%</td>
</tr>
<tr>
<td>In-patients</td>
<td>8%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>6%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

Total elective growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>27%</td>
<td>17%</td>
<td>7.2%</td>
<td>44%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>20%</td>
<td>17%</td>
<td>4.4%</td>
<td>91%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>18%</td>
<td>10%</td>
<td>1.5%</td>
<td>60%</td>
</tr>
<tr>
<td>ENT</td>
<td>17%</td>
<td>6%</td>
<td>2.4%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>
WEST YORKSHIRE SHA (Q12): CAPACITY PLAN DATA SUMMARY

Main points
— 69% day case rate in 2005–06.
— High in-patient elective growth.
— High activity growth in orthopaedics 2001–02 to 2002–03.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>Daycases</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>In-patients</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th>Specialties</th>
<th>Total elective growth</th>
<th>Current six-month waits as a proportion of admissions</th>
<th>Daycase rate 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>40% 26%</td>
<td>6.4%</td>
<td>50%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>25% 23%</td>
<td>4.4%</td>
<td>89%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>25% 18%</td>
<td>3.0%</td>
<td>60%</td>
</tr>
<tr>
<td>ENT</td>
<td>26% 22%</td>
<td>3.9%</td>
<td>44%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>between HES 2000–01 and Plan 2001–02</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
CAPACITY PLAN SUMMARIES: SOUTH 22 November 2002


Main points

— 71% day case rate in 2005–06.
— High in-patient elective growth and low day case growth.

**Table 1 Activity Growth**

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>18%</td>
</tr>
<tr>
<td>Daycases</td>
<td>13%</td>
</tr>
<tr>
<td>In-patients</td>
<td>14%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>10%</td>
</tr>
</tbody>
</table>

(All specialties)

**Table 2 Specialties—Summary**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>42%</td>
<td>29%</td>
<td>12.9%</td>
<td>42%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>28%</td>
<td>22%</td>
<td>6.9%</td>
<td>91%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>15%</td>
<td>11%</td>
<td>3.6%</td>
<td>67%</td>
</tr>
<tr>
<td>ENT</td>
<td>31%</td>
<td>29%</td>
<td>10.8%</td>
<td>41%</td>
</tr>
</tbody>
</table>

**Table 3 Specialties—Daycase Rates**

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
Hampshire and Isle of Wight SHA (Q17): Capacity Plan Data Summary

Main points

— 67% day case rate in 2005–06.
— Electives growth close to national assumptions particularly after 2002–03 except for high non-elective growth.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>22%</td>
<td>17%</td>
</tr>
<tr>
<td>Daycases</td>
<td>37%</td>
<td>30%</td>
</tr>
<tr>
<td>In-patients</td>
<td>1%</td>
<td>−4%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>13%</td>
<td>13%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>40%</td>
<td>21%</td>
<td>13.7%</td>
<td>52%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>31%</td>
<td>13%</td>
<td>12.0%</td>
<td>94%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>19%</td>
<td>14%</td>
<td>2.5%</td>
<td>62%</td>
</tr>
<tr>
<td>ENT</td>
<td>27%</td>
<td>16%</td>
<td>6.5%</td>
<td>61%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
Kent and Medway SHA (Q18): Capacity Plan Data Summary

Main points

— 70% day case rate in 2005–06.
— Overall growth below national assumptions, and may be low compared to current waiting challenge by speciality and in total.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001–02 to</td>
<td>2002–03 to</td>
<td>2005–06</td>
</tr>
<tr>
<td>Total electives</td>
<td>18%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Daycases</td>
<td>23%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>In-patients</td>
<td>8%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Non-electives</td>
<td>7%</td>
<td>6%</td>
<td></td>
</tr>
</tbody>
</table>

(All specialities)

Table 2 Specialties—Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>28%</td>
<td>18%</td>
<td>14.8%</td>
<td>56%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>27%</td>
<td>18%</td>
<td>18.0%</td>
<td>93%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>18%</td>
<td>15%</td>
<td>6.3%</td>
<td>70%</td>
</tr>
<tr>
<td>ENT</td>
<td>14%</td>
<td>7%</td>
<td>16.0%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Table 3 Specialties—Daycase Rates

<table>
<thead>
<tr>
<th>&lt;5% difference between HES 2000–01 and Plan 2001–02</th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top decile 2001–02</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
SOMERSET AND DORSET SHA (Q22): CAPACITY PLAN DATA SUMMARY

Main points
— 74% day case rate in 2005–06.
— Total electives growth close to national assumptions, but in-patient elective growth very high.
— Non elective growth 2001–02 to 2002–03 high.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>22%</td>
<td>18%</td>
</tr>
<tr>
<td>Daycases</td>
<td>24%</td>
<td>20%</td>
</tr>
<tr>
<td>In-patients</td>
<td>16%</td>
<td>13%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>12%</td>
<td>6%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialities—Summary

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>50%</td>
<td>42%</td>
<td>5.3%</td>
<td>53%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>27%</td>
<td>26%</td>
<td>3.8%</td>
<td>90%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>22%</td>
<td>17%</td>
<td>1.0%</td>
<td>66%</td>
</tr>
<tr>
<td>ENT</td>
<td>28%</td>
<td>17%</td>
<td>5.8%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Table 3 Specialities—Daycase Rates

<table>
<thead>
<tr>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
**South West Peninsula SHA (Q21): Capacity Plan Data Summary**

**Main points**
- 68% day case rate in 2005–06.
- Plan shows declining activity 2001–02 to 2002–03, particularly in day cases.
- Declining in-patient electives moves close to national assumptions over 2002–03–2005–06, which is unusual at SHA level.

**Table 1** Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>12%</td>
</tr>
<tr>
<td>Daycases</td>
<td>19%</td>
</tr>
<tr>
<td>In-patients</td>
<td>–1%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>10%</td>
</tr>
</tbody>
</table>

(All specialties)

**Table 2** Specialities—Summary

<table>
<thead>
<tr>
<th></th>
<th>Total elective growth</th>
<th>Current six-month waits as a proportion of admissions</th>
<th>Daycase rate 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>33%</td>
<td>22%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>28%</td>
<td>25%</td>
<td>10.7%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>14%</td>
<td>10%</td>
<td>3.7%</td>
</tr>
<tr>
<td>ENT</td>
<td>23%</td>
<td>11%</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

**Table 3** Specialities—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
SURREY AND SUSSEX SHA (Q19): CAPACITY PLAN DATA SUMMARY

Main points
— 67% day case rate 2005–06.
— High in-patient elective growth and high non-elective growth.
— Growth rates other than orthopaedics may be low given current waiting issues.

Table 1 Activity Growth

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001–02 to</td>
</tr>
<tr>
<td></td>
<td>2005–06</td>
</tr>
<tr>
<td>Total electives</td>
<td>18%</td>
</tr>
<tr>
<td>Daycases</td>
<td>22%</td>
</tr>
<tr>
<td>In-patients</td>
<td>11%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>12%</td>
</tr>
</tbody>
</table>

(All specialties)

Table 2 Specialities—Summary

<table>
<thead>
<tr>
<th></th>
<th>Total elective growth</th>
<th>Current six-month waits as a proportion of admissions</th>
<th>Daycase rate 2005–06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>44%</td>
<td>31%</td>
<td>15.7%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>23%</td>
<td>19%</td>
<td>14.8%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>16%</td>
<td>10%</td>
<td>5.5%</td>
</tr>
<tr>
<td>ENT</td>
<td>26%</td>
<td>22%</td>
<td>13.8%</td>
</tr>
</tbody>
</table>

Table 3 Specialities—Daycase Rates

<table>
<thead>
<tr>
<th></th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5% difference between HES 2000–01 and Plan 2001–02</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>
THAMES VALLEY SHA (Q16): CAPACITY PLAN DATA SUMMARY

Main points

— 64% day case rate in 2005–06.
— High growth 2001–02 to 2002–03, particularly in in-patient electives and orthopaedics.

**Table 1 Activity Growth**

<table>
<thead>
<tr>
<th></th>
<th>Growth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total electives</td>
<td>17%</td>
</tr>
<tr>
<td>Daycases</td>
<td>22%</td>
</tr>
<tr>
<td>In-patients</td>
<td>10%</td>
</tr>
<tr>
<td>Non-electives</td>
<td>9%</td>
</tr>
</tbody>
</table>

(All specialties)

**Table 2 Specialities—Summary**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma and Orthopaedics</td>
<td>40%</td>
<td>15%</td>
<td>10.9%</td>
<td>40%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>21%</td>
<td>15%</td>
<td>6.2%</td>
<td>82%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>14%</td>
<td>4%</td>
<td>4.0%</td>
<td>61%</td>
</tr>
<tr>
<td>ENT</td>
<td>16%</td>
<td>10%</td>
<td>7.9%</td>
<td>46%</td>
</tr>
</tbody>
</table>

**Table 3 Specialities—Daycase Rates**

<table>
<thead>
<tr>
<th>&lt;5% difference between HES 2000–01 and Plan 2001–02</th>
<th>Trauma and Orthopaedics</th>
<th>Ophthalmology</th>
<th>General Surgery</th>
<th>ENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top decile 2001–02</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Top decile 2005–06</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>NHSIA &gt; expected daycase rate</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

Further supplementary memorandum submitted by the Department of Health (ISTC 1E)

SUPPLEMENTARY QUESTIONS TO THE DEPARTMENT OF HEALTH

1. What was the methodology for determining Value for Money with regard to ISTCs?

1.1 The value for money methodology used in Wave 1 of the procurement is very similar to the approach adopted for Phase 2. The independent sector market know that a benchmarking exercise involving NHS tariff is carried out but do not know the detailed process. To release information on the detailed process would jeopardise the ability of the Department and the NHS to secure the best value for money in the next phase of procurement.

1.2 What follows is a high-level description of the process adopted and its origins, and the steps taken to ensure that the process is robust.

1.3 Wave 1 was the first time that a national procurement of clinical services on this scale had been undertaken. As a consequence, a methodology had to be developed whereby the value for money for each scheme could be determined. In the absence of an accepted public sector comparator for providing these clinical services, value for money was assured by:
— running an open and competitive procurement;
— selecting the best value (compliant) offer received; and
— rejecting any scheme that failed to significantly better the prevailing “spot-purchase” rates.

1.4 It should be noted that value for money is the optimum combination of price and qualitative factors. For the remainder of this answer we focus on the financial aspects of value for money, however approval of any of the Wave 1 schemes involves an assessment of all relevant factors.

1.5 In order to ensure that each scheme offered better value than the prevailing spot market, a benchmarking process was devised. An NHS Equivalent Cost (explained in more detail below) is calculated for each scheme and compared against the bid price. The percentage variance between the two is known as the VfM of the scheme.

1.6 Independent sector providers face costs which 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.

1.7 A VfM threshold above the NHS Equivalent Cost was set at a level substantially lower than the prevailing spot rates—with no schemes progressing that showed VfM above that level. The average achieved for Wave 1 is 11.2% in comparison with the historical “spot-purchasing” rates of in excess of 40% above NHS Tari.

1.8 NHS Equivalent Cost is a calculation of the amount that would be paid to an NHS provider for delivering the same activity in the same location as the provider with the same care pathway. It is necessary to provide a baseline against which bids from the independent sector can be compared.

1.9 NHS Equivalent Cost is derived from NHS National Tari (which is based on average costs within the NHS for providing clinical procedures), with specified adjustments to reflect the IS provider’s delivery model (including restrictions on the type of patients that can be admitted), the cost of out-patient appointments etc, anticipated inflation rates and the Market Forces Factor (“MFF”) that would apply for NHS Providers in that (geographic) health economy.

1.10 The following seeks to clarify a statement made in the Department’s reply to the Committee’s supplementary questions issued on 7 March (point 3.11 (d) concerning residual values). Where a Wave 1 scheme necessitates a new build, and where this new build may revert to Secretary of State at the end of the contract, a “residual value” payment may be made to the provider. The residual value payment was subject to competitive tender, and so varies as a proportion of the total build cost from one scheme to another.

1.11 To ensure that the VfM methodology takes into account the residual value payment, the anticipated value of the property to the NHS at the end of the contract is calculated and the difference between this and the residual value payment (known as the residual value adjustment) is included in the VfM calculation. If the residual value payment is greater than the calculated value to the NHS the residual value adjustment is positive and worsens the VfM position.

1.12 The difference between the original capital cost of the scheme and the residual value payment will be borne by the provider through the annual depreciation charge, which will be recovered through the provider’s price.

1.13 In practice the VfM calculation entails detailed spread sheets for each part of each scheme showing the NHS Tariffs including outpatient appointments etc; and agreed adjustments to derive NHS Equivalent Costs—including taxation, MFF etc. The results of the VfM calculation for each scheme are then consolidated to give the total position for the whole of Wave 1.

1.14 The same model (ie the spreadsheets and consolidation referred to above) is used for each scheme, tailored only to take account of differing casemixes and delivery models, to ensure that the calculation is applied consistently across all schemes in the procurement. This approach to assuring Value for Money has been agreed with HM Treasury.

1.15 An independent review of the application of the VfM Methodology was commissioned in October 2004. The purpose of the review was to establish whether the agreed methodology was being correctly and consistently applied in practice. This review did not raise any material issues. Some of the recommendations from this review are being adopted for Phase 2 of the programme.
2. *Will you provide copies of the Full Business Cases which successful Phase 1 bidders submitted?*

2.1 Full Business Cases (FBCs) were prepared by the Department and were not submitted by the bidders. Bidders submitted responses to the Invitations to Negotiate (ITNs) that the Department issued. We have not published full FBCs or responses to ITNs for schemes as:

- they contain commercially sensitive information;
- if we released commercially sensitive information, we think that would be likely to reduce the bidder pool. We think that would be contrary to the public interest as reduction in competition would affect our ability to obtain best value for money; and
- unlike one-off procurements (eg PFI projects), we are undertaking a programme of related procurements. Thus, (i) information may remain sensitive after a scheme reaches financial close because its release could affect value for money on further schemes; and, (ii) disclosure could lead to unequal treatment of bidders and breach procurement rules.

2.2 Provision of a redacted version of each of the FBCs and responses to the ITNs would require line-by-line review of each of them. This would require a significant investment of time and money, including external legal costs.

2.3 In relation to the responses to the ITNs, we believe the cost of reviewing and extracting the information requested is likely to be very large indeed and lead to a requirement for significant extra resource in the Department. Our estimate is that the ITN responses of successful bidders amount to four 800-page volumes per ITN response, so a total of approximately 45,000 pages for the successful Wave 1 responses. In addition, we consider it likely that detailed liaison with each Wave 1 provider is likely to be required as part of the process.

2.4 The Committee might wish to clarify what information within these documents it wishes to receive. We could then establish whether the provision of a redacted version of each of the documents (or the documents in either category) would be sufficient, or whether the information desired would in any event be withheld in accordance with an exemption under the Freedom of Information Act.

3. *For each Phase 1 ISTC, how many bids were received?*

3.1 The Wave 1 ISTC Programme was advertised in December 2002, from which a total 147 companies expressed interest in the schemes. In response to this the Department issued Pre-Qualification Questionnaires (PQQ) and Memorandum of Information (MOI) documents to all those showing interest.

3.2 The PQQ documents were received back from bidders on 14 February 2003. Pre-qualification for the ITN stage of the procurement was decided by assessing bidders’ technical and financial capability (experience) and capacity (resources) in order to evaluate whether they are likely to be able to deliver an effective scheme. Those bids that were successful were short-listed to proceed to the ITN stage of the procurement.

3.3 The ITN documents were issued to short-listed bidders in April 2003 and were received back during May to June of that year. Each bid was subject to evaluation on the following criteria:

- Clinical.
- Infrastructure.
- IM&T.
- Human Resources.
- Legal.
- Financial.

3.4 The six stages of the Bid Evaluation Phase included:

- Stage 1: Bid Receipt.
- Stage 2: Evaluation.
- Stage 3: Clarification.
- Stage 4: Bidder Convergence.
- Stage 5: Final Evaluation.
- Stage 6: Preferred Bidder Selection.

3.5 The aim of this phase is to evaluate and compare all ITN submissions from qualified bidders in order to select a Preferred Bidder (PB) for each scheme after which negotiations take place to close contracts with the Preferred Bidder.
3.6 The following table shows the number of bids for each scheme.

<table>
<thead>
<tr>
<th>Scheme location</th>
<th>Number of PQQ Bids received</th>
<th>Number of ITN documents issued</th>
<th>Number of ITN bids received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradford</td>
<td>11</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Burton</td>
<td>10</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Trent</td>
<td>10</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Daventry</td>
<td>8</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Somerset</td>
<td>12</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Manchester</td>
<td>8</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Plymouth</td>
<td>14</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Chain Schemes</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spine Chain</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>North West Chain</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Maidstone</td>
<td></td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>London</td>
<td>12</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>South East Chain</td>
<td></td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Ophthalmic Chain</td>
<td>31</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

Notes

1 To ensure a competitive procurement it is important to have more than 1 potential provider involved in the procurement process. For each of the Wave 1 schemes a minimum of 3 bidders received ITNs. This struck the balance between ensuring a robust competition on each scheme and that each bidder had a reasonable probability of winning the bid (as each bidder will incur significant bidding costs).

2 The general scheme advertised in the OJEU notice was split in to chain schemes once the PQQ responses had been received back and prior to issue of the ITN documents.

3 An ITN bid was issued for the GC5 North West scheme but once bids had been received back the scheme split in to two schemes based in the region—GC5E Nottingham QMC and GC5W comprised of two sites each based in Worcestershire and Cheshire and Merseyside.

4 GC7 London was re-advertised in summer 2004 in which 19 expressions of interest were received.

4. Will you provide copies of the contracts which were signed with Phase 1 ISTCs?

4.1 We have previously provided in relation to individual FOI requests a redacted version of each of the following:

— the Project Agreement dated 27 September 2003 for the provision of clinical services on behalf of Daventry and South Northamptonshire Primary Care Trust made between Daventry and South Northamptonshire Primary Care Trust and The Birkdale Clinical (Rotherham) Limited; and

— the Project Agreement dated 23 December 2003 for the provision of clinical services to the Ophthalmology Chain made between the Secretary of State for Health, Netcare Healthcare UK Limited and various NHS Trusts.

4.2 A copy of each of those documents is annexed to this response. Information that is commercially sensitive or otherwise subject to an exemption to disclosure under the Freedom of Information Act has been struck out of the document in the redaction process, but this should provide a useful indication of the level of information likely to be available from redacted Wave 1 contracts.

4.3 Provision of a redacted version of each of the contracts would require line-by-line review of each of the contracts. This would require a significant investment of time and money, including external legal costs.

4.4 We are therefore keen to ensure that, if the Committee wishes this work to be undertaken, the redacted documents would significantly assist it. If the Committee could identify what information within the contracts it wishes to receive, we could establish whether provision of a redacted each of the Wave 1 contracts would satisfy those requirements or whether the information sought would in any event be withheld in accordance with an exemption under the Freedom of Information Act.

Department of Health

March 2006
Thank you for your letter dated 3 May regarding your Committee’s enquiry into the Independent Sector Treatment Centre (ISTC) programme.

**Phase 2 Procurement**

You raised the issue of the article in the HSJ on 27 April which stated that seven of the 24 schemes that we proposed for the Phase 2 ISTC procurement have been scrapped and the remaining 17 schemes and Extended Choice programme would be delayed by up to a year.

Let me reassure you that I did not deliberately mislead the committee. While it is true that seven of the schemes that were originally proposed for the procurement will no longer go forward, I can assure you that all of the SHAs affected are being required to make available more Independent Sector services for NHS patients in their areas either through:

- local procurements;
- extended choice arrangements; or
- as in the case of NEYNL SHA, through a revised centrally procured scheme.

There is no truth in the assertion that the 17 remaining schemes or indeed the Extended Choice programme will be delayed for up to a year.

In making decisions about which schemes should be procured we have responded to the needs of some Strategic Health Authorities following detailed consideration of whether the rationale for their schemes remained sensible. In some of the areas a national procurement could not provide, in time, the additional services required for delivering the 18 week target in 2008 and in others it has become clear that the level of capacity required by the local NHS does not justify new ISTC schemes.

These decisions highlight the consultative and pragmatic approach that the Department is taking to ensuring the needs of the health economies are met, with the overriding principle of ensuring that patient needs are met. I also want to make it clear that we remain committed to investing £550 million on the procurement in the independent sector: this includes £50 million from the first wave of ISTCs.

I have also attached copies of the letters that were sent by Commercial Directorate to bidders involved in the programme on the 10 April. The first is a generic letter that was sent to bidders who had not expressed interest in any of the schemes affected. The second letter was sent was to those who had expressed interest in those schemes, and was annotated as per scheme descriptions, also attached.\(^1\)

**Value for Money Methodology and Business Cases**

Unlike the PFI deals that you mentioned in your letter, the ISTCs programme is part of a rolling procurement. This means that at certain stages of the programme the release of commercially sensitive information will jeopardise the ability of the Department and the NHS to secure the best value for money (VfM). It is not surprising that bidders would like the Department to release its VfM methodology (as was put to me at the hearing) because it would reveal how much the NHS is willing to pay. It is vital that we run a competitive procurement to ensure that we are able to achieve the best VfM.

In earlier written evidence, we have explained the overall methodology but the additional review that you mentioned was undertaken by a third party on behalf of the Department and we do not have permission to release their report. However, I would suggest that representatives of the Commercial Directorate meet with yours or, a small number of your members in private to explain in more detail the methodology that has been applied. If you would like to take up this offer, could your Committee Clerk please contact Ken Anderson to agree the terms of reference for this meeting.

With regard to Full Business Cases, the Department holds 15 FBCs each of approximately 200 pages in length that include information that is commercially sensitive to both the Department and to the independent sector providers (for example, information on failed bids, details of bidder negotiations and final prices from bidders).

We have not released the FBCs because:

- they contain commercially sensitive information;
- their release would be likely to reduce the bidder pool and thereby reduce competition affecting our ability to obtain best value for money; and
- unlike one-off procurements (eg PFI projects), we are undertaking a programme of related procurements. Thus, (i) information may remain sensitive after a scheme reaches financial close because its release could affect value for money on further schemes; and (ii) disclosure could lead to unequal treatment of bidders and breach procurement rules.

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\(^1\) Not printed here.
If it were possible to establish what information within these documents you wish to receive my officials could establish whether provision of a redacted version of each of the documents would meet your information needs or whether the information desired would in any event be withheld in accordance with an exemption under the Freedom of Information Act. Redaction of each of the FBCs would require significant amount of time and resource on behalf of the Department so we would seek reassurance that the cost and time spent would not be adversely disproportionate to the benefit to your Committee from that information.

**IMPACT ON THE NHS**

Analysis on the impact of Phase 2 on the NHS forms part of the advice that has been prepared for Ministers. These procurements are still at an early stage and key decisions have yet to be made: it is for this reason that I'm not able to release this analysis.

**INNOVATION AND BEST PRACTICE IN ISTCs**

Attached is the fuller document that I promised the Committee on the innovation and best practice that the ISTCs have introduced (Annex 1).

**IMPACT ON WAITING TIMES**

Attached is a copy of the slide that I presented recently to the Cabinet: it includes some additional text boxes that show when the ISTC programme was introduced (Annex 2).

**IMPACT ON SPOT PURCHASING**

In addition, I also said I would provide information on spot purchasing. Spot purchase data is collated only on an annual basis, and it is not possible to conduct a statistical study of the effect of ISTCs on local spot procurement. However, the body of evidence concerning the impact on the provision of spot services is growing. For example, I would like to point the Committee towards the recent Laing & Buisson Annual Report, which provides independent analysis of the UK healthcare sector. In their 2005–06 report they noted:

> The emergence of a new raft of ISTC providers able to quote at, or fairly close to, NHS reference costs made it clear that the days of NHS spot purchasing from the “incumbents” at 30–40% over reference costs were over, and that they would have to reduce costs and prices if they wished to be involved in any significant way in the servicing the NHS market. (Laing & Buisson, *Laing’s Healthcare Market Review 2005–2006*, p 105).

A specific example at a local level is the Shepton Mallet ISTC where the contestability introduced has led to a reduction in local private provider prices with providers now offering to undertake NHS work at NHS tariff prices—a reduction of between 20 and 30%.

Further examples of independent sector companies responding to the introduction of ISTCs include:

- Nuffield announced that it has lowered prices to win more work from the NHS. It has also announced the development of low cost pre-fabricated office and ward accommodation called “health ports” to offer treatment more cheaply and flexibly than in traditional fixed, infrastructure.
- Caplo announced that it has lowered prices to provide NHS services.
- BUPA closed 10 small hospital/niche sites and announced plans to invest.
- £100 million over three years in its 25 remaining hospitals to produce greater consistency in the way they operate and drive down costs. It also planned to install IT systems compatible with NHS patient records.
- BMI Healthcare created Amicus Healthcare to provide services to the NHS—this operation will be lower cost and designed to provide a more limited range of care that better fits the NHS model.

I hope that you find this information of use and I look forward to responding to your findings in due course.

*Patricia Hewitt*
Secretary of State for Health

*May 2006*
INTRODUCTION

1. Although innovation and best-practice exist within the NHS, ISTCs have demonstrated a propensity for combining a wide range of such practices in one place to generate improvements in efficiency and patient care. Staff are drawn from a wide range of sources and introduce best practices from their own countries. Although the good practices (eg swab counting) remain the inquisitorial process allows all preconceptions to be challenged in an non-accusatory environment that welcomes changes that improve patient care. As such, ISTCs do not conduct ground-breaking research nor do they introduce changes that cannot be found elsewhere.

2. It should be noted that ISTCs are not expected to be performing cutting edge research, but are expected to be consistently incorporating tried and tested world class best practice, whether clinical or management focused, in order to deliver high quality and patient centric solutions within an efficient operation. Some go on to act as focal points for the spread of innovation and best practice.

3. A significant element of the “innovation” related to ISTCs is in reality about diligence, being scrupulous about all the little things that can improve productivity and applying them rigorously across the board.

EXAMPLES

4. Some of the innovations and best practices that have been adopted in ISTCs (eg the use of mobile units, or blood conservancy measures) are well publicised, however they do not represent the full extent of the practices adopted by ISTCs. The following examples are taken from a recent survey of three ISTCs (Shepton Mallet Treatment Centre referred to as LP7, the Greater Manchester Surgical Centre referred to as LP8 and the Peninsula NHS TC referred to as LP9).

5. They highlight how ISTCs adopt innovative or best practices and ways of working across all areas of their operations, from physical layouts to administration and culture. Attributing practices here to certain ISTCs is not intended to suggest that they do not occur in other TCs.

ADMINISTRATION AND WAYS OF WORKING—THE ISTC ETHOS

6. The administration and ways of working are centred on patient care rather than support services. The aim is to get the maximum use from the physical facilities while minimising service disruptions.

   — No admin time: It is expected that surgeons will deliver 46–48 weeks operating time per year. There is no “admin time” in their contract and they share high quality admin support. They are expected to deliver pre-picked lists and to maximise the conversion from outpatient to surgery. Primary care screening is an important element that has been seen to facilitate this process.

   — Efficient process design: (LP7) ISTCs that have designed their clinical and physical pathways from scratch, learning from NHS custom and practice have been able to make improvements. For instance some ISTCs can conduct six to seven arthroscopies per day compared with three to four in the NHS, because they work to take out extraneous processes or take them off line (eg they acquire consent at outpatient appointments and so do not delay the operation. Surgery can therefore commence at the start of the working day).

   — Increased day surgery: Operational Productivity has been improved through the widespread adoption of day surgery and operating on a six day working basis as the norm with a 12 hour theatre day.

   — Reminder calls: (LP9) Contacting patients two to three days before a planned operation, reduce Did Not Attend rates. Whilst this also occurs in some instances in the NHS, within ISTCs it is a widespread and routine practice.

   — Workload management: (LP8 and LP9) Theatre manager/lead consultants oversee distribution of workload—Consultants’ workload is monitored by a manager who ensures equitable distribution of work and minimises over- or under-work by consultants. Advance visibility into consultant leave schedules eliminates cancellation of planned procedures due to visibility into consultant availability.

   — “One stop” pre-screening: (LP9) Every patient undergoes a comprehensive pre-screening appointment(s) in which they see a consultant, nurse, and anaesthetist. Candidates not fit for treatment are therefore quickly eliminated.
— Sharing best practice: (LP7, LP8 and LP9) As part of patient pathway design and surgical practice alignment process, staff are encouraged to discuss systems and practices which they have employed elsewhere or otherwise have heard about in order to identify improvements to the efficiency of the current system. In this way practices evolve in keeping with national and global best practice.

— Short notice cancellation list: Patients seeking accelerated care are put on a “to be notified” list and are called if cancellations occur. This saves vacated theatre slots from being “lost”.

— Interchangeably scheduled consultants: (LP8) Patients do not have to be operated on by the same consultant who saw them in outpatient, increasing ability to schedule patients in earliest available slots.

**Theatre Utilisation—Getting the Most from the Assets**

7. Best practices surrounding theatre utilisation permit more efficient and predictable use of one of a key asset. This maximises throughput and decreases costs.

— “In place, on time” culture: (LP7, LP8 and LP9) All staff and equipment are in place and performing their required tasks on time. This minimises delays to operation starts, patient transfers, etc.

— Admission/recovery area close to theatre: (LP8 and LP9) Patients await operations in a space adjoining theatre area, minimising patient transfer delays and removing pre-operative bottlenecks caused by lack of bed availability, which can cascade to delay operations.

— Use of specialist nurses: Anaesthetic nurses working in support of anaesthetic consultants can increase the anaesthetic consultant’s ability to attend to numerous patients quickly.

— Minimising bed transfers: (LP7) Patients walk into anaesthetic area for day case procedures, rather than being wheeled in, eliminating delays caused by need for four assembled staff to transfer a patient from a pre-operative to operative trolley.

**Theatre Time—Minimising the Time under the Knife**

8. Minimising the time an individual patient spends in theatre allows ISTCs to increase their overall productivity. In making the staff more efficient, several working practices also increase their expertise and increase the quality and safety of their work.

— Spinal anaesthetic: (LP7, LP8 and LP9) Appropriate administration of spinal anaesthetic instead of general, for some procedures, shortens preparation and recovery time.

— Limiting prosthesis ranges: All ISTCs limit the range of prostheses they stock. Not only does this introduce economies of scale in purchasing, but it allows staff, in particular the nursing teams, to develop slicker, more effective theatre processes, increasing the quality and decreasing the time spent in surgery.

— Repeat exposure of operating teams: (LP7, LP8 and LP9) Surgical consultants work repeatedly with small teams on the same types of procedures. Some centres have also decided not to use temporary fill-ins to ensure staff familiarity and quick execution of in-theatre duties. This staff familiarity breeds clarity of roles and the ability to anticipate needed tasks (eg, tools required by surgeon at different stages of the operation), resulting in streamlined execution.

— Varying schedules based on consultant operating times: (LP7, LP8 and LP9) A scheduler knows typical consultant operating time variability and schedules theatre lists accordingly. This results in fewer deviations from the theatre schedule, increasing the hospital’s ability to effectively deploy resources where they are needed at the right times. Maximum number of theatre sessions used within scheduled staff time—Additional procedures are added to theatre lists as productivity improves. This maximises throughput and minimises idle staffed theatre time, eg, between operations.

— Physical Design: Optimising layouts in the design of facilities, incorporating a great attention to detail on minimising staff and patient movement distances, the use of ceiling mounted utilities and accessible, efficient storage has resulted in many “small time savings”.

— Responsiveness: The relatively small scale of some ISTCs promotes efficiency in patient care. An example of this is that on completion of a procedure, porters are ready to move the patient, they do not need to be called.

— Staff expectations and awareness of timelines: (LP8 and LP9) Internal publication of or blinded sharing of consultant surgery durations drives awareness of performance, accountability to timelines, and elimination of unnecessary mid-operative delays.
9. ISTCs have adopted a range of practices that increase recovery rates. Not only do these reduce bed time and increase the productivity of the centre, they also improve the patient’s experience.

- Setting patient expectations: (LP7) Patients attend a class two weeks prior to their operation through which their expectations are set around their recovery trajectory (eg, mobilisation on day one, discharge on day four or five), and in which they are trained in exercises and the use of specialised equipment. This prepares the patient for speedy recovery and discharge.

- Early initiation of discharge requirements: (LP8 and LP9) “Rehab teams” (external or internally-employed therapists) are activated in advance of patient operations to ensure post-operative readiness, eg, installation of handrails in the home. This eliminates discharge bottlenecks of lack of home preparedness or unavailability of step-down care.

- Admission of patients day of procedure: (LP7) Admission of fit patients for major surgery (eg, hip or knee replacement) the day of the procedure, eliminating resource utilisation for unnecessary pre-operative overnight care.

- Chair-based post-operative recovery: (LP9) Rather than being moved to a bed for post-operative recovery, for some cases, patients recover in a special chair and are mobilised quickly after the operation (eg, within two hours). This expedites patient recovery and reduces bed blocking.

- Post-operative monitoring: After operations, such as joint replacements, patients are monitored very closely for 24 hours to ensure that any issues are captured and dealt with. This has allowed inpatient stays to decrease to 4.4 days for hip replacements. An NHS Trust has adopted similar protocols and is achieving similar improvements in bed times down from 12 days.

- Discharge lounge: (LP9) A separate discharge is available for patients who are clinically fit to leave but must wait for pick up. This reduces frequent non-clinical delays to patient discharge.

10. Quality and safety are key to the successful operation of the ISTCs. Through incentives, increased accountability and the propagation of best practice ISTCs seek to guarantee high quality services and improve the patient’s experience.

- Review of complications: (LP8 and LP9) Consultants participate in a weekly review of all major procedures that week and any minor procedures in which there was a complication. Slides are reviewed and issues discussed. Differences in clinical practice among doctors are quickly identified and best practices are shared. Poor performance/outcome trends either clinic-wide or tied to a single clinician are immediately surfaced, discussed and resolved.

- Infection pre-testing of all inpatients: (LP7, LP8 and LP9) All patients are tested for MRSA (and in some cases, specialty-appropriate other high risk infections), before being admitted. Infected patients are treated for any infections prior to admission and are required to test clean one to three times (depending on provider) before being cleared for admission.

- Isolation of infected patients: (LP7, LP8 and LP9) Any admitted patient identified to have one of several specified infections, including MRSA, is isolated from other patients and given a dedicated “contamination” nurse. The infection is therefore far less likely to be passed on to other patients.

- Tight infection monitoring and root cause analysis: (LP8) All detected infections such as MRSA are rigorously identified and root causes identified. Data on what type of infection and its likely source is tracked and investigated. The quality team discusses any occurrences of infection and possible additional preventative measures required, and may also raise these at JSR meetings. As a result, trends are identified, causalties uncovered, and additional preventive measures can be put in place, as needed.

- Patient surveys: (LP9) Patients are offered a patient survey across up to six dimensions of care, and are repeatedly surveyed throughout their stay using an easy to use electronic tool. Patients can register satisfaction and dissatisfaction easily at multiple points in their visit.

- Post discharge check-up: (LP7) Patients are called 24 hours after discharge for a mini phone-based checkup and so that any questions may be answered.

- Fringe activities: It has been submitted that the NHS has traditionally been very poor at providing “fringe activities” that whilst not directly linked to quality of clinical care are valued by patients. It is recognised that it is ISTCs that have succeeded in providing such benefits as polite staff, easy car parking, refreshments, little or no waiting, etc.

2 Oral Evidence taken before the Health Committee on 16 March 2006, HC 934–ii, Qq 305–308 [Mr Johnson].
INNOVATION IN THE NHS

11. As previously stated these practices are not unique to the ISTC community, they are also not universal throughout the IS, however they are representative of philosophy demonstrated by IS providers in maximising their efficiencies while maintaining high standards. It is likely that each of the practices outlined here can be found somewhere in the NHS, however, in 2002, the NHS Modernisation Agency Elective Care Team reported that good practices it had identified in NHS TCs were not widespread, nor did any TC embody more than a small fraction of them.

Annex 2: Number of Patients Waiting more than 6 months

Target: 15 month maximum wait
Target: 12 month maximum wait
Target: 9 month maximum wait

Choice at 6 months announced
1st ISTC operational
Mobile ophthalmology unit
10 ISTCs operational
18 ISTCs operational

Mar 00 Jan 00 Sep 00 Dec 00 Mar 01 Jun 01 Sep 01 Dec 01 Mar 02 Jun 02 Sep 02 Dec 02 Mar 03 Jun 03 Sep 03 Dec 03 Mar 04 Jun 04 Sep 04 Dec 04 Mar 05 Jun 05 Sep 05 Oct 05 Dec 05
## Supplementary evidence submitted by Mercury Health (ISTC 06A)

<table>
<thead>
<tr>
<th>KPI</th>
<th>Description of KPI data collected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KPI 01</strong></td>
<td>Total # of Inpatient DNAs&lt;br&gt;Total # of Daycase DNAs&lt;br&gt;Total Inpatient Activity&lt;br&gt;Total Daycase Activity Incidence of inpatient and/or daycase activities not commenced because of DNAS. Will be calculated as a percentage of all activities.</td>
</tr>
<tr>
<td><strong>KPI 02</strong></td>
<td>Total # Cancellations After Admission (non-clinical)&lt;br&gt;Total # Inpatient Daycase Admissions Procedures cancelled by the provider for non-clinical reasons on or after day of admission; for the purposes of the performance threshold measured as a percentage of all patients admitted to the facility.</td>
</tr>
<tr>
<td><strong>KPI 03</strong></td>
<td>Total # Cancellations After Admission (clinical)&lt;br&gt;Total # Inpatient Daycase Admissions Procedures cancelled by the provider for non-clinical reasons on or after day of admission; for the purposes of the performance threshold measured as a percentage of all patients admitted to the facility.</td>
</tr>
<tr>
<td><strong>KPI 04</strong></td>
<td>Total # Patients Returning to Theatre&lt;br&gt;Total # Admissions (to the Facility) Patient returning to operating theatre for procedure which was unforeseen at the time the patient’s previous procedure was completed as a percentage of all patients admitted in the facility.</td>
</tr>
<tr>
<td><strong>KPI 06</strong></td>
<td>Total # Patients Rejected at Referral&lt;br&gt;Total # Referrals to the Facility In respect of the/each facility, the rate of rejection by the provider in respect of patients referred within the referral protocol (schedule 3) as a percentage of all patients who are referred.</td>
</tr>
<tr>
<td><strong>KPI 07</strong></td>
<td>Total # Unforeseen Inpatient Admissions&lt;br&gt;Total # Daycase Admissions For daycases, inpatient admission to the facility or to other providers' facilities (including NHS providers) which was unforeseen at the time of admission; for the purposes of the performance threshold as a percentage of all daycases in the facility.</td>
</tr>
<tr>
<td><strong>KPI 08</strong></td>
<td>Total # Ophthalmic Daycase Inpatient Transfers&lt;br&gt;Total # Orthopaedic Daycase Inpatient Transfers&lt;br&gt;Total # Other Daycase Inpatient Transfers&lt;br&gt;Total # Ophthalmic Daycase Inpatient Transfers&lt;br&gt;Total # Orthopaedic Daycase Inpatient Transfers&lt;br&gt;Total # Other Daycase Inpatient Transfers Transfers of patients to another provider of inpatient treatment which was not in the management plan for that patient upon admission to the facility, for the purposes of the performance threshold as a percentage of all inpatients in the facility for: (i) Ophthalmology and mini surgery (ii) Orthopaedics (iii) Other procedures</td>
</tr>
<tr>
<td><strong>KPI 09</strong></td>
<td>Total # Emergency and Readmissions within previous 29 Days&lt;br&gt;Total # Patients Discharged from this Facility Emergency admissions/readmissions of patients who have received inpatient treatment and have been discharged within 29 days of such discharge where such admission or readmission is related to or arising from the relevant inpatient treatment. For the purposes of the performance threshold measured by HRG as a percentage of all patients discharged.</td>
</tr>
<tr>
<td><strong>KPI 14</strong></td>
<td>Total # Completed Daycare Inpatient procedures Percentage of procedures carried out under local anaesthetic by HRG as a percentage of all procedures.</td>
</tr>
<tr>
<td><strong>KPI 15</strong></td>
<td>To Be Advised Clinical outcomes specified, by procedure, by reference to the PCPS.</td>
</tr>
<tr>
<td><strong>KPI 16</strong></td>
<td>Provider Performance Data Timelines, completeness and accuracy of provider performance data provided to the joint service review and/or to sponsor.</td>
</tr>
<tr>
<td><strong>KPI 17</strong></td>
<td>Clinician Performance Data Timelines, completeness and accuracy of provider clinician reporting to referring health body's clinician.</td>
</tr>
<tr>
<td><strong>KPI 18</strong></td>
<td>Outpatient Satisfaction Level&lt;br&gt;Daycase and Inpatient Satisfaction Level Patient/customer satisfaction (by survey) based on a survey of 10% of all patients at each facility in each (contract month).</td>
</tr>
</tbody>
</table>
### KPI 19
**Total # Outpatient Complaints**
Rate of patient complaints i.e. number of complaints received as a percentage of all patients referred for:
- (i) Outpatient treatment
- (ii) Inpatient/daycase treatment

### KPI 20
**Total Complaints Not Handled Within Contract Timescales**
Patient complaints handung—complaints not handled within relevant timescales (set out in this agreement).

### KPI 21
**Total # Incidents Reported to NPSA or Other Body Handled Within Contract Timescales**
Incidents which are reportable to the NPSA or other statutory body.

### KPI 22
**Total # NHS Staff Recruited in Breach of Clause 9**
Additionality—NHS staff recruited in breach of clause 9 of this agreement.

### KPI 23
**Condition of the Facility**
Condition of facility, measured by inspection by a sponsor and/or the provider and assessed against the requirements of the facility manual and operational procedures.

### KPI 24
**Total # Security Breaches Related to Services Handled Within Contract Timescales**
Breach of security related to the services where there is an identifiable risk of harm, loss or damage to people or property.

### KPI 25
**Total Breaches by Provider of Confidentiality or Data Protection Handled Within Contract Timescales**
Breach by the provider of confidentiality and/or data protection requirements in the agreement.

### KPI 26
**Total Treatments After Agreed Treat By Date**
Failure to meet treat by date
## WILL ADAMS TREATMENT CENTRE—PATIENT SATISFACTION SURVEY RESULTS—DAY CASE SURGERY

<table>
<thead>
<tr>
<th>Period</th>
<th>3 October 2005 to 2 January 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of first form</td>
<td>01/11/2005</td>
</tr>
<tr>
<td>Date of last form</td>
<td>22/12/2005</td>
</tr>
<tr>
<td>Total Number of Day Case patients treated</td>
<td>131</td>
</tr>
<tr>
<td>Total Number of Day Case patients returning a questionnaire</td>
<td>58 (44.3% of patients treated)</td>
</tr>
</tbody>
</table>

### Responses to Questions

<table>
<thead>
<tr>
<th>Question Analysis</th>
<th>Valid responses</th>
<th>Not Satisfied</th>
<th>Partially Satisfied</th>
<th>Very Satisfied</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you satisfied with your appointment time and date of attendance at the Centre?</td>
<td>58</td>
<td>0 (0%)</td>
<td>1 (1.7%)</td>
<td>57 (98.3%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel that you had to wait too long for your procedure after arriving at the Centre?</td>
<td>58</td>
<td>4 (6.9%)</td>
<td>54 (93.1%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you satisfied with the care and attention you received from staff?</td>
<td>58</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>58 (100%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you satisfied with the information you received?</td>
<td>57</td>
<td>0 (0%)</td>
<td>2 (3.5%)</td>
<td>55 (96.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you satisfied with cleanliness and appearance of the Centre?</td>
<td>58</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>58 (100%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you satisfied that your privacy was sufficiently protected whilst at the Centre?</td>
<td>58</td>
<td>0 (0%)</td>
<td>2 (3.4%)</td>
<td>56 (96.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, were you satisfied with your experience at the Centre?</td>
<td>57</td>
<td>0 (0%)</td>
<td>1 (1.8%)</td>
<td>56 (98.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you recommend the Centre to your family and friends?</td>
<td>57</td>
<td>57 (100%)</td>
<td>0 (0%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Comments Analysis

#### TOTAL NUMBER OF QUESTIONNAIRES WITH WRITTEN COMMENTS

- ALL POSITIVE: 30 (81.1%)
- MOSTLY POSITIVE: 2 (5.4%)
- MOSTLY NEGATIVE: 5 (13.5%)
- ALL NEGATIVE: 0 (0.0%)

<table>
<thead>
<tr>
<th>PSS ID</th>
<th>Date of attendance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>01/11/2005</td>
<td>Surgeon and staff made me feel totally at ease and took the worry out of me having an operation</td>
</tr>
<tr>
<td>62</td>
<td>01/11/2005</td>
<td>Very impressed with calm efficient atmosphere of Centre. The staff were extremely friendly and helpful removing any stress from the situation.</td>
</tr>
<tr>
<td>87</td>
<td>01/11/2005</td>
<td>Very good care and atmosphere</td>
</tr>
<tr>
<td>79</td>
<td>03/11/2005</td>
<td>They even looked after my mate who took me. Special thanks to Tina—a lovely nurse who made me a cup of tea and an old man very happy.</td>
</tr>
<tr>
<td>41</td>
<td>03/11/2005</td>
<td>Very satisfied with treatment—excellent</td>
</tr>
<tr>
<td>48</td>
<td>08/11/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>47</td>
<td>09/11/2005</td>
<td>Very helpful staff and extremely pleasant and friendly. Excellent facilities.</td>
</tr>
<tr>
<td>71</td>
<td>10/11/2005</td>
<td>First Class Standard—could not be bettered. Lydia and Dr Bosner pleasant, helpful and understanding. I shall be recommending the Centre to my GP Surgery in Sittingbourne.</td>
</tr>
<tr>
<td>PSS ID</td>
<td>Date of attendance</td>
<td>Comments</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------</td>
<td>----------</td>
</tr>
<tr>
<td>52</td>
<td>10/11/2005</td>
<td>The degree of care and friendliness is welcome and appreciated. Visit more superior than I could have anticipated. Everything was fully explained. Friendly nurses hand to hold.</td>
</tr>
<tr>
<td>53</td>
<td>11/11/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>57</td>
<td>11/11/2005</td>
<td>Everything as it should be—much better than attending Medway Hospital</td>
</tr>
<tr>
<td>30</td>
<td>14/11/2005</td>
<td>Fast and excellent service</td>
</tr>
<tr>
<td>28</td>
<td>15/11/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>83</td>
<td>15/11/2005</td>
<td>The Centre is run as all centres should be—1st Class</td>
</tr>
<tr>
<td>39</td>
<td>15/11/2005</td>
<td>Friendly and cheerful attitude</td>
</tr>
<tr>
<td>23</td>
<td>15/11/2005</td>
<td>I found the staff very friendly and the medical care was such a high standard.</td>
</tr>
<tr>
<td>27</td>
<td>17/11/2005</td>
<td>The staff and surgical team provided me with a very high standard of service before, during and after my operation. Many thanks.</td>
</tr>
<tr>
<td>33</td>
<td>18/11/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>78</td>
<td>19/11/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>80</td>
<td>21/11/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>54</td>
<td>24/11/2005</td>
<td>Nice to be treated as a person and not a number. Best NHS atmosphere I have ever experienced.</td>
</tr>
<tr>
<td>42</td>
<td>24/11/2005</td>
<td>Staff very friendly and helpful</td>
</tr>
<tr>
<td>13</td>
<td>29/11/2005</td>
<td>Staff were all helpful and friendly—enjoyed my short stay.</td>
</tr>
<tr>
<td>58</td>
<td>29/11/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>91</td>
<td>29/11/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>40</td>
<td>01/12/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>11</td>
<td>01/12/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>61</td>
<td>01/12/2005</td>
<td>Thank you all for the care I had on the day</td>
</tr>
<tr>
<td>60</td>
<td>01/12/2005</td>
<td>Should have more automatic doors—nurses struggled to open doors into theatre and out of exit door on ward</td>
</tr>
<tr>
<td>59</td>
<td>02/12/2005</td>
<td>Everyone was very helpful and friendly</td>
</tr>
<tr>
<td>51</td>
<td>02/12/2005</td>
<td>I felt I could not have had any better care or attention. It was how it should be. The aftercare phone call was appreciated also.</td>
</tr>
<tr>
<td>70</td>
<td>05/12/2005</td>
<td>Very professional, Excellent care</td>
</tr>
<tr>
<td>19</td>
<td>05/12/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>18</td>
<td>06/12/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>46</td>
<td>07/12/2005</td>
<td>Had to wait too long but understood why</td>
</tr>
<tr>
<td>65</td>
<td>07/12/2005</td>
<td>Piece of equipment broke</td>
</tr>
<tr>
<td>38</td>
<td>07/12/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>77</td>
<td>08/12/2005</td>
<td>The staff were all very attentive and cheerful—it made the visit a lot less traumatic</td>
</tr>
<tr>
<td>72</td>
<td>08/12/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>63</td>
<td>08/12/2005</td>
<td>No comments</td>
</tr>
<tr>
<td>85</td>
<td>08/12/2005</td>
<td>Didn’t have to wait too long</td>
</tr>
<tr>
<td>43</td>
<td>09/12/2005</td>
<td>Everyone was very kind and I felt very comfortable</td>
</tr>
<tr>
<td>32</td>
<td>12/12/2005</td>
<td>Thank you for all the kindness shown whilst I was in the Treatment Centre. I would recommend the Centre to anyone.</td>
</tr>
<tr>
<td>44</td>
<td>13/12/2005</td>
<td>Cleaner and more efficient than BUPA Hospital at the Alexander. Staff lovely and put me at ease.</td>
</tr>
<tr>
<td>3</td>
<td>14/12/2005</td>
<td>Operative procedure leaflet not provided</td>
</tr>
</tbody>
</table>
Ev 160  Health Committee: Evidence

**PSS ID** | **Date of attendance** | **Comments**
---|---|---
67 | 14/12/2005 | All staff extremely friendly and helpful. Very good for my nerves.
89 | 14/12/2005 | No comments.
35 | 14/12/2005 | All staff very friendly and helpful—could find no faults at all—extremely satisfied.
90 | 14/12/2005 | No comments.
26 | 14/12/2005 | Very good Centre—all staff are great.
29 | 15/12/2005 | No comments.
66 | 15/12/2005 | No comments.
14 | 15/12/2005 | Didn’t like going into theatre and being prepared for operation whilst being awake.
45 | 15/12/2005 | Excellent facilities and the staff were all brilliant.
84 | 16/12/2005 | No comments.
50 | 19/12/2005 | No comments.
56 | 22/12/2005 | All the staff were very helpful and friendly to both me and my wife, making the experience of the operation that more bearable.

---

**Average Time from Referral Received to Treatment Completed for Will Adams NHS Treatment Centre—Gillingham**

*Time period—centre opening—6 March 2006*

<table>
<thead>
<tr>
<th><strong>HRG Code</strong></th>
<th><strong>Description</strong></th>
<th><strong>Number of Procedures</strong></th>
<th><strong>Average Days</strong></th>
<th><strong>Average Weeks</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total All Procedures</td>
<td></td>
<td>319</td>
<td>41</td>
<td>5.5</td>
</tr>
<tr>
<td>F06</td>
<td>Oesophagus—Diagnostic Procedures</td>
<td>11</td>
<td>43</td>
<td>5.7</td>
</tr>
<tr>
<td>F16</td>
<td>Stomach or Duodenum—Diagnostic Procedures</td>
<td>23</td>
<td>48</td>
<td>6.4</td>
</tr>
<tr>
<td>F23</td>
<td>Small Intestine—Major Procedures &lt; 70 w/o cc</td>
<td>2</td>
<td>35</td>
<td>4.5</td>
</tr>
<tr>
<td>F34</td>
<td>Large Intestine—Major Procedures w/o cc</td>
<td>1</td>
<td>63</td>
<td>9.0</td>
</tr>
<tr>
<td>F35</td>
<td>Large Intestine—Endoscopic or Intermediate Procedures</td>
<td>1</td>
<td>38</td>
<td>5.0</td>
</tr>
<tr>
<td>F42</td>
<td>General Abdominal—Very Major or Major Procedures &lt; 70 w/o cc</td>
<td>5</td>
<td>52</td>
<td>7.2</td>
</tr>
<tr>
<td>F44</td>
<td>General Abdominal—Endoscopic or Intermediate Procedures &lt; 70 w/o cc</td>
<td>2</td>
<td>45</td>
<td>6.0</td>
</tr>
<tr>
<td>F53</td>
<td>Inflammatory Bowel Disease—Endoscopic or Intermediate Procedures &gt; 69 or w cc</td>
<td>1</td>
<td>45</td>
<td>6.0</td>
</tr>
<tr>
<td>F54</td>
<td>Inflammatory Bowel Disease—Endoscopic or Intermediate Procedures &lt; 70 or w cc</td>
<td>31</td>
<td>43</td>
<td>5.7</td>
</tr>
<tr>
<td>F61</td>
<td>Gastrointestinal Bleed—Very Major Procedures</td>
<td>2</td>
<td>53</td>
<td>7.0</td>
</tr>
<tr>
<td>F63</td>
<td>Gastrointestinal Bleed—Diagnostic Endoscopic or Intermediate Procedures</td>
<td>10</td>
<td>44</td>
<td>5.9</td>
</tr>
<tr>
<td>F71</td>
<td>Abdominal Hernia Procedures &gt; 69 or w cc</td>
<td>2</td>
<td>41</td>
<td>5.5</td>
</tr>
<tr>
<td>F72</td>
<td>Abdominal Hernia Procedures &lt; 70 w/o cc</td>
<td>1</td>
<td>41</td>
<td>5.0</td>
</tr>
<tr>
<td>F73</td>
<td>Inguinal Umbilical or Femoral Hernia Repairs &gt; 69 or w cc</td>
<td>5</td>
<td>40</td>
<td>5.4</td>
</tr>
<tr>
<td>F74</td>
<td>Inguinal Umbilical or Femoral Hernia Repairs &lt; 70 w/o cc</td>
<td>30</td>
<td>49</td>
<td>6.5</td>
</tr>
<tr>
<td>F92</td>
<td>Anus—Intermediate Procedures &gt; 49 or w cc</td>
<td>3</td>
<td>39</td>
<td>5.3</td>
</tr>
<tr>
<td>F93</td>
<td>Anus—Intermediate Procedures &lt; 50 w/o cc</td>
<td>3</td>
<td>52</td>
<td>6.7</td>
</tr>
<tr>
<td>F94</td>
<td>Anus—Minor Procedures &gt; 69 or w cc</td>
<td>3</td>
<td>66</td>
<td>9.0</td>
</tr>
<tr>
<td>F95</td>
<td>Anus—Minor Procedures &lt; 70 w/o cc</td>
<td>1</td>
<td>54</td>
<td>7.0</td>
</tr>
<tr>
<td>H10</td>
<td>Arthroscopies</td>
<td>59</td>
<td>50</td>
<td>6.6</td>
</tr>
<tr>
<td>H11</td>
<td>Foot Procedures—Category 1</td>
<td>14</td>
<td>43</td>
<td>5.8</td>
</tr>
<tr>
<td>HRG Code</td>
<td>Description</td>
<td>Number of Procedures</td>
<td>Average Days</td>
<td>Average Weeks</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------</td>
<td>----------------------</td>
<td>--------------</td>
<td>---------------</td>
</tr>
<tr>
<td>H13</td>
<td>Hand Procedures—Category 1</td>
<td>18</td>
<td>4</td>
<td>5.2</td>
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<tr>
<td>H17</td>
<td>Soft Tissue or Other Bone Procedures—Category 1</td>
<td></td>
<td>30</td>
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</tr>
<tr>
<td></td>
<td>Less than 70 or w cc</td>
<td>4</td>
<td>30</td>
<td>4.0</td>
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<tr>
<td>H22</td>
<td>Minor Procedures to the Musculoskeletal System</td>
<td>30</td>
<td>14</td>
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<tr>
<td>H28</td>
<td>Non-Inflammatory Bone or Joint Disorders &lt; 70 w/o cc</td>
<td>2</td>
<td>14</td>
<td>2.0</td>
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<tr>
<td>H32</td>
<td>Musculoskeletal Signs and Symptoms &lt; 70 w/o cc</td>
<td>1</td>
<td>13</td>
<td>1.0</td>
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<tr>
<td>H52</td>
<td>Removal of Fixation Device &lt; 70 w/o cc</td>
<td>1</td>
<td>32</td>
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</tr>
<tr>
<td>J30</td>
<td>Major Skin Procedures &gt; 49 or w cc</td>
<td>6</td>
<td>41</td>
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<tr>
<td>J35</td>
<td>Minor Skin Procedures—Category 2 w/o cc</td>
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<td>52</td>
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<td>J36</td>
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<td>J37</td>
<td>Minor Skin Procedures—Category 1 w/o cc</td>
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<td>L35</td>
<td>Urethra Intermediate or Minor Procedures &lt; 70 w/o cc</td>
<td>3</td>
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<tr>
<td>L42</td>
<td>Vasectomy Procedures</td>
<td>14</td>
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<tr>
<td>L43</td>
<td>Scrotum Testis or Vas Deferens Major Open Procedure</td>
<td>14</td>
<td>43</td>
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<tr>
<td>M02</td>
<td>Lower Genital Tract Intermediate Procedures</td>
<td>4</td>
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<tr>
<td>R16</td>
<td>Thoracic or Lumbar Spinal Disorders &lt; 70 w/o cc</td>
<td>7</td>
<td>13</td>
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</table>

Status of all referrals received into centre, Sept 2005 to March 2006

<table>
<thead>
<tr>
<th>Facility</th>
<th>Service Requested</th>
<th>Referral Month</th>
<th>Accepted</th>
<th>Rejected</th>
<th>Waiting Acceptance</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medway Facility</td>
<td>Consultation</td>
<td>Sep-05</td>
<td>23</td>
<td>6</td>
<td>29</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Oct-05</td>
<td>87</td>
<td>44</td>
<td>137</td>
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<tr>
<td></td>
<td></td>
<td>Nov-05</td>
<td>116</td>
<td>58</td>
<td>14</td>
<td>188</td>
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<tr>
<td></td>
<td></td>
<td>Dec-05</td>
<td>102</td>
<td>18</td>
<td>5</td>
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<tr>
<td></td>
<td></td>
<td>Jan-06</td>
<td>107</td>
<td>17</td>
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<td>125</td>
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<td></td>
<td></td>
<td>Feb-06</td>
<td>107</td>
<td>31</td>
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<tr>
<td></td>
<td></td>
<td>Mar-06</td>
<td>97</td>
<td>13</td>
<td>3</td>
<td>113</td>
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<tr>
<td>Endoscopic Investigation</td>
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<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nov-05</td>
<td>2</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Mar-06</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Operative Procedure</td>
<td>Feb-06</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td>Medway Facility Total</td>
<td></td>
<td>643</td>
<td>188</td>
<td>29</td>
<td>860</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>643</td>
<td>188</td>
<td>29</td>
<td>860</td>
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</table>

Patients waiting at end of given calendar month by number of weeks waiting

<table>
<thead>
<tr>
<th>PCT</th>
<th>Group</th>
<th>wait weeks</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>MEDWAY PCT</td>
<td>Colonoscopy</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gastroscopy</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>2</td>
<td>2</td>
<td>4</td>
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</table>
Activity—Number of Tests/Procedures Carried out During the Month January 2006

<table>
<thead>
<tr>
<th>PCT</th>
<th>Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDWAY PCT</td>
<td>Colonoscopy</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Gastroscopy</td>
<td>8</td>
</tr>
<tr>
<td>SWALE PCT</td>
<td>Colonoscopy</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Gastroscopy</td>
<td>2</td>
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<tr>
<td>Grand Total</td>
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<td>18</td>
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</table>

Patients Still Waiting—at Month End February 2006

<table>
<thead>
<tr>
<th>Count of weeks</th>
<th>weeks</th>
<th>PCT</th>
<th>Group</th>
<th>0</th>
<th>3</th>
<th>4</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MEDWAY PCT</td>
<td>Gastroscopy</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Colonoscopy</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SWALE PCT</td>
<td>Gastroscopy</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Grand Total</td>
<td></td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>8</td>
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Activity—Number of Tests/Procedures Carried out during the Month February 2006

<table>
<thead>
<tr>
<th>PCT</th>
<th>Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDWAY PCT</td>
<td>Gastroscopy</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Colonoscopy</td>
<td>6</td>
</tr>
<tr>
<td>SWALE PCT</td>
<td>Gastroscopy</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Colonoscopy</td>
<td>2</td>
</tr>
<tr>
<td>Grand Total</td>
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<td>25</td>
</tr>
</tbody>
</table>

March 2006

Supplementary evidence submitted by the Royal College of Nursing (ISTC 22A)

The Royal College of Nursing is pleased to provide the Committee with additional information in respect of nursing and HR performance indicators, which should be included in the Performance Management Framework for ISTC’s.

We believe good health services are based on a strong workforce that is engaged, consulted and which receives proper investment and fair reward. Competent well trained staff are the building blocks for providing high standards of care. Agenda for Change and in particular the Knowledge and Skills framework provides a robust framework for identifying the competency required, assessing staff competency and identifying training needs. If these are the standards within the NHS then NHS patients receiving care from other providers should expect that the people caring for them are appraised against the same standards.

The implementation of HR performance indicators ensures a level playing field with the NHS; facilitates integration with the NHS; encourages ISTC staff to feel part of an NHS family; supports staff involvement and development; provides for a safe environment for care delivery; and promotes best employment practice.

Key Performance Indicators, which we believe should be included, are as follows:

— An HR Strategy, linked to workforce development and service delivery.
— An Annual Staff Opinion Survey, which informs the annual review of the HR Strategy.
— A mechanism for staff involvement and consultation.
— Participation in Department of Health staff census and NHS workforce planning.
— Continuing Professional Development for staff linked to an appraisal system based on Knowledge and Skills Framework (Agenda for Change).
Workforce data collection, which records race, gender, age, disability of staff linked to payroll information (this would all be achieved if the ISTCs were asked to abide by the public sector statutory requirements for race and forthcoming requirements for gender and disability).

Have a written equal opportunities policy and follow good practice in making appointments, staff management, terms and conditions of employment, training opportunities and promotion.

Agenda for Change implementation.

Monitoring hours of work for both substantive, seconded staff, and NHS staff working non-contracted hours within ISTCs—ensures compliance with the Working Time regulations—including a mechanism for sharing information on seconded and non-contracted hours staff with the NHS employer.

Monitoring the application of the "relaxed" additionality policy by collecting information on staff recruited from the NHS including data on their NHS specialty area, professional group, NHS grade/pay band, and length of service individual had with the NHS.

In respect of nursing indicators, some will be relevant to any environment in which care is delivered whilst others will be specialty specific. In identifying specialty specific nursing indicators we have made the assumption that the case mix in phase 2 will be similar to that in Wave 1. Any variation in the case mix would require a review of specialty specific indicators.

CORE NURSING INDICATORS

- Annual nursing audits to include performance against national programmers eg Essence of Care.
- Quality monitoring tools eg Qualpecs.
- Review/audit of documentation against accepted guidance eg Nursing and Midwifery Council guidance.
- Patient satisfaction measures to include response times to call bells, cleanliness of environment, nutrition, communication and staff attitude to patients.
- Skin care and pressure area care using national evidence based tool.
- Complaints concerns and near misses.
- Feedback from student nurses on clinical placements.

SURGICAL/ORTHOPEDIC PATIENTS

- Pain and nausea control using a recognised tool.
- Effective and comprehensive pre and post operative patient information both written and verbal.
- Timeliness of admission.
- Programs of risk assessment using a recognised and evidence based assessment tool to include skincare, pressures area care, nutrition and falls.
- Monitoring of hygiene and infection rates.

Royal College of Nursing

March 2006

Supplementary evidence submitted by Netcare Healthcare Ltd (ISTC 27A)

GREATERNORTHWESTSURGICALCENTREINFORMATIONRETURNS

187 Separate Data Items Captured Throughout the Patient Care Pathway

10 PATIENTRELATEDOUTCOMESMEASURES(PROMS)QUESTIONNAIRES

Clinical data collected to measure the success of the elective surgery:

- Anderson-McGall Hand Function Questionnaire.
- Foot Function Index.
- Generic follow-up questionnaire.
- Hip Harris Score.
- Knee Injury and Osteoarthritis Outcome Score.
- Knee Society Rating Score.
- Leeds Dyspepsia Score.
— Varicose Veins questionnaire.
— Hiatus Hernia questionnaire.
— Lower Extremity Range of Motion—Foot.
— Oxford Hip Score.
— Upper Extremity Range of Motion—Hand.

AUDITING

KPMG Audit November 2005—Information process review.
BS7799-2—Continual information asset review.
Indigo4—Monthly data quality checks on submitted Commissioning Data Sets (CDS).

DAILY DATA PROCESSING AND QUALITY REVIEWS

Data Checks—performed as first process each morning. Automated reports detect and report on specific erroneous data items that will impact on the validity and accuracy of patient activity and reporting.

Exception Reports—produced after the data checks for use by the relevant GMSC operational managers to ensure data objectives are met before producing the activity reports:

— All data for the previous Pre Operative Assessment clinic has been captured timeously and accurately.
— All data for the previous Follow-Up Assessment clinic has been captured timeously and accurately.
— All data for the discharges for the previous day has been captured timeously and accurately.

Activity Reports—after confirmation of completed data capturing, the activity reports are prepared and submitted to the Primary Care Trusts:

— Preop Appointment Confirmation Report—all appointments booked on the previous day by the Patient Choice Centre.
— Preop Activity Report—outcomes for every Pre Operative Assessment attended at the previous day’s clinic.
— Discharge Summary Report—data on all patients discharged for the previous day.

WEEKLY DATA PROCESSING AND QUALITY REVIEWS

Weekly Data Checks—daily data checks are repeated for the period of the week to ensure all data is valid.

LP8 Report (weekly activity report)—constructed by repeating the daily activity reports and comparing these against the submitted daily activity reports. All anomalies are investigated and information confirmed with the Contract Management Unit prior to submission to the Department of Health.

MONTHLY DATA PROCESSING AND QUALITY REVIEWS

CDS—monthly activity report constructed for Inpatient and Outpatient data after combining and reproducing the daily data checks and reports. CDS shows all activity for the previous month, submitted to Indigo4 for data checks, and ClearNet for submission to the NHS.

26 Key Performance Indicators (KPIs)—produced for reporting on aspects of the Inpatient Admissions. Submitted to the Department of Health. KPI information includes:

— Admissions.
— Discharges.
— Cancellations.
— Returns To Theatres.
— Readmission.
— Complications.
— Transfers out.
— Deaths.

Patient Satisfaction Surveys—All discharged patients are requested to complete a patient satisfaction survey, which is captured for statistical and performance analysis and review.
**Returns to Other Bodies**

**NJR**—National Joint Registry—clinical data for total hip replacement operations and total knee replacement operations.

**NCEPOD**—National Confidential Enquiries into Patient Outcomes and Deaths—reporting on elective surgery outcomes.

**SSI**—Surgical Site Infection Surveillance—reporting on surgical infections.

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**Greater Manchester Surgical Centre Key Performance Indicators**

<table>
<thead>
<tr>
<th>KPI</th>
<th>Data Required</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPI 01</td>
<td>Total # of In-patient DNA’s, Total # of Day case DNA’s, Total In-patient Activity, Total Day case Activity</td>
<td>Incidence of In-patient and/or Day case activities not commenced because of DNA’s will be calculated as a percentage of all activities.</td>
</tr>
<tr>
<td>KPI 02</td>
<td>Total # of Cancellations after admission (non-clinical), Total # In-patient Day case admissions</td>
<td>Procedures cancelled by the Provider for non-clinical reasons on or after the day of admission. For the purpose of performance measurement this is measured as a percentage of all patients admitted to the facility.</td>
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<tr>
<td>KPI 03</td>
<td>Total # of Cancellations after admission (clinical), Total # In-patient Day case admissions</td>
<td>Procedures cancelled by the Provider for clinical reasons on or after the day of admission. For the purpose of performance measurement this is measured as a percentage of all patients admitted to the facility.</td>
</tr>
<tr>
<td>KPI 04</td>
<td>Total # Patients Returning to Theatre, Total Admissions (to the Facility)</td>
<td>Patient returning to operating theatre for procedure that was unforeseen at the time the patient’s previous procedure was completed as a percentage of all patients admitted to the facility.</td>
</tr>
<tr>
<td>KPI 05</td>
<td>Total # Outpatient Assessments per HRG, Total # of Appointments by HRG</td>
<td>Outpatient assessments and appointments for each HRG.</td>
</tr>
<tr>
<td>KPI 06</td>
<td>Total # Patients Reject at Referral, Total # Referrals to the Facility</td>
<td>In respect of the facility, the rate of rejection by the Provider in respect of patients referred within referral protocol (Schedule 3) as a percentage of all patients who are referred.</td>
</tr>
<tr>
<td>KPI 07</td>
<td>Total # Unforeseen In-patient Admissions, Total # In-patient Day case admissions</td>
<td>For Day cases, In-patient admission to the facility or to other Providers’ facilities (including NHS Providers) which was unforeseen at the time of admission. For the purpose of the performance threshold as a percentage of all Day cases in the facility.</td>
</tr>
<tr>
<td>KPI 08</td>
<td>Total # Orthopaedic Day case In-patient Transfers, Total # Other Day case In-patient Transfers, Total # Orthopaedic Day case In-patient Admissions, Total # Other Day case In-patient Admissions</td>
<td>Transfers of patients to another Provider of inpatient treatment that was not in the management plan for that patient on admission to the facility. For the purpose of the performance threshold as a percentage of all inpatients in the facility for Minor Surgery, Orthopaedics and Other Procedures.</td>
</tr>
<tr>
<td>KPI 09</td>
<td>Total # Emergency and Readmission within previous 29 Days, Total # Patients Discharged from the Facility, Total # Emergency and Readmission within previous 29 Days by HRG.</td>
<td>Emergency admissions/readmission of patients who have received inpatient treatment and have been discharged within 29 days of such discharge where such admission or readmission is related to or arising from the relevant inpatient treatment. For the purposes of the performance threshold measured by HRG as a percentage of all patients discharged.</td>
</tr>
<tr>
<td><strong>KPI</strong></td>
<td><strong>Data Required</strong></td>
<td><strong>Description</strong></td>
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<tr>
<td>--------</td>
<td>-------------------</td>
<td>-----------------</td>
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<tr>
<td>KPI 10</td>
<td>Length of Day case Stays in hours by HRG</td>
<td>Length of Day case Stays in hours by HRG.</td>
</tr>
<tr>
<td>KPI 11</td>
<td>Average Length of In-patient Stay in Days by HRG</td>
<td>Average Length of In-patient Stay in Days by HRG.</td>
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<tr>
<td>KPI 12</td>
<td>Average Duration of Induction Period, Average Duration of Surgery Procedure, Average Duration of Recovery Period. All data to be in minutes and by HRG</td>
<td>Average Duration of Induction Period, Average Duration of Surgery Procedure, Average Duration of Recovery Period. All data to be in minutes and by HRG.</td>
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<tr>
<td>KPI 13</td>
<td>Number of Repeat Activity within 5 Years by HRG.</td>
<td>Number of Repeat Activity within 5 Years by HRG.</td>
</tr>
<tr>
<td>KPI 14</td>
<td>Total # Completed Day case In-patient Procedures carried out under Local Anaesthetic by HRG</td>
<td>Percentages of procedures carried out under local anaesthetic by HRG as a percentage of all procedures.</td>
</tr>
<tr>
<td>KPI 15</td>
<td>TBA</td>
<td>TBA</td>
</tr>
<tr>
<td>KPI 16</td>
<td>Provider Performance Data</td>
<td>Timeliness, completeness and accuracy of Provider Performance data provided to the Joint Service Review and/or Sponsor.</td>
</tr>
<tr>
<td>KPI 17</td>
<td>Clinician Performance Data</td>
<td>Timeliness, completeness and accuracy of Provider clinician reporting to referring health body’s clinician.</td>
</tr>
<tr>
<td>KPI 18</td>
<td>Outpatient Satisfaction Level, Day case and In-patient Satisfaction level</td>
<td>Patient/customer satisfaction (by survey) based on a survey of 10% of all patients at each facility in each contract month.</td>
</tr>
<tr>
<td>KPI 19</td>
<td>Total # Outpatient Complaints, Total # Complaints received from Day cases and In-patients, Total # Patients Treated in this Facility</td>
<td>Rate of patient complaints ie number of complaints received as a percentage of all patients referred for outpatient treatment or In-patient/Day case treatment.</td>
</tr>
<tr>
<td>KPI 20</td>
<td>Total # Complaints Not Handled within Contract Timescales</td>
<td>Patient Complaints Handling—Complaints not handled within relevant time scales set out in Agreement.</td>
</tr>
<tr>
<td>KPI 21</td>
<td>Total # Incidents Reported to NPSA or Other Body</td>
<td>Incidents, which are reportable to NPSA or other statutory body.</td>
</tr>
<tr>
<td>KPI 22</td>
<td>Total # of NHS Staff Recruited in Breach of Clause 9</td>
<td>NHS Staff recruited in breach of Clause 9 of the agreement.</td>
</tr>
<tr>
<td>KPI 23</td>
<td>Condition of the Facility</td>
<td>Condition of facility, measured by inspection by a sponsor and/or the Provider and assessed against the requirements of the facility manual and operational procedures.</td>
</tr>
<tr>
<td>KPI 24</td>
<td>Total # Security Breaches Related to Services</td>
<td>Breach of security related to the services where there is an identifiable risk of loss, harm or damage to people or property.</td>
</tr>
<tr>
<td>KPI 25</td>
<td>Total # Breaches by Provider of Confidentiality or data protection</td>
<td>Breach by the Provider of confidentiality and/or data protection requirements in the agreement.</td>
</tr>
<tr>
<td>KPI 26</td>
<td>Total # Treatments After Agreed Treat By date</td>
<td>Failure to meet Treat By Date.</td>
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## Greater Manchester Surgical Centre Data Items

<table>
<thead>
<tr>
<th>Data Items Collected</th>
<th>Classification</th>
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<tbody>
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<td>Estimated Length Of Procedure</td>
<td>Activity / Efficiency</td>
</tr>
<tr>
<td>Induction Start Time</td>
<td>Activity / Efficiency</td>
</tr>
<tr>
<td>Non Attendance Reason</td>
<td>Activity / Efficiency</td>
</tr>
<tr>
<td>Non Attendance Reason For Admission</td>
<td>Activity / Efficiency</td>
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<tr>
<td>Postop Appointment Non Attendance Reason</td>
<td>Activity / Efficiency</td>
</tr>
<tr>
<td>Recovery End Time</td>
<td>Activity / Efficiency</td>
</tr>
<tr>
<td>Time Into Theatre</td>
<td>Activity / Efficiency</td>
</tr>
<tr>
<td>Time Out Of Theatre</td>
<td>Activity / Efficiency</td>
</tr>
<tr>
<td>Allergies</td>
<td>Clinical</td>
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<td>ASA Status</td>
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<td>Deaths</td>
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<td>Discharge Comments</td>
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<td>Discipline</td>
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<td>District Nurse Comments</td>
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<td>Evidence Of Wasting</td>
<td>Clinical</td>
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<tr>
<td>Has The Patient Been Readmitted to GMSC—Details</td>
<td>Clinical</td>
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Netcare Healthcare Ltd

*March 2006*
Supplementary letter from the British Medical Association (ISTC 33B)

**Freedom of Information Act and Alternative Provider Medical Services**

I am writing to raise an issue which I hope you will find relevant in considering your Committee’s final report to be produced following the inquiry into Independent Sector Treatment Centres (ISTCs).

Alternative Provider Medical Services (APMS) is one of the four routes available to primary care organisations to make provision for primary medical services to patients. APMS opens up the provision of essential services to providers other than General Medical Services (GMS) and Personal Medical Services (PMS) practices. Organisations and individuals who can hold APMS contracts include independent sector and voluntary sector organisations as well as groups of health professionals.

Whilst GP practices working under PMS or GMS contracts are specifically included as Public Bodies under the Freedom of Information Act, like ISTCs, APMS contractors do not fall under the provisions of the Act.

The BMA’s General Practitioners Committee firmly believes that, because APMS contractors provide NHS services to NHS patients, these providers should be subject to the same processes, checks and balances as other primary care providers. This is critical in ensuring that a level playing field exists between the various types of provider of NHS primary medical services.

I have previously written to Lord Falconer at the Department for Constitutional Affairs explaining this inconsistency but it has so far proven difficult to implement any change which might rectify this inequality. We believe that Section 5 of the Freedom of Information Act 2000 can be used to designate, as a public authority, an APMS body as it “provides services under contract to a public authority whose provision is a function of that authority”.

Our aim is to ensure that there is equity of access to information for the NHS patient, that quality of care and value for money are upheld across all primary care providers and that public probity is fair across all providers.

For the reasons described, and given the similarity to the position regarding ISTCs (as outlined in paragraph 10.1 of the BMA’s evidence to the Health Committee), we very much hope that the Committee will consider this matter in your deliberations.

We would be very happy to discuss this further with you.

Dr Hamish Meldrum
Chairman, General Practitioners Committee, BMA
17 May 2006

Supplementary evidence submitted by the Healthcare Commission (ISTC 36A)

**Introduction**

1. The Healthcare Commission was pleased to submit written and oral evidence to the inquiry. We hope that this supplementary submission will help to address the Committee’s outstanding questions.

2. A principal reason for establishing the Healthcare Commission in 2004 was to create a single system of regulation that ensures high standards of care for patients wherever they are treated. Our focus is on assuring the same high standards of care for all. However, our responsibilities in the NHS and independent sectors still derive from different legislation (Health and Social Care Act 2003 and the Care Standards Act respectively), so drawing direct comparisons between our work in the two sectors at this stage is not always straightforward. For example, in the NHS we have a statutory role to deal with second stage complaints. In the independent sector, we have no such role, so the numbers of complaints received on a given issue are not comparable. It is also worth noting that the Care Standards Act 2000 confers responsibility on the Commission to pursue enforcement action against independent healthcare providers that do not address failures of compliance with standards, but no such powers are available to us in the NHS.

3. We recently consulted on proposals for modernising the way we regulate independent healthcare. In particular, we asked for feedback on the way in which we will align it with our new system for assessing the NHS—the annual health check—and how (within the existing primary legislative framework) we plan to move towards aligned regulatory systems by 2008. These proposals are a major step forward in this work, however, directly comparable systems can never be achieved until there is a single legislative framework for healthcare. This will also be necessary to address anachronisms within the Care Standards Act that did not anticipate new technologies and service models in the rapidly changing healthcare environment.
4. Subject to the outcome of the current review of regulation and any subsequent legislation, we expect to integrate with the Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission (MHAC) by 2008. We believe the drafting of primary legislation to create the new organisation will provide an excellent opportunity for more fundamental review of the legislative framework for regulating the NHS and independent sectors to allow more direct comparisons. We would welcome the Health Select Committee’s views on this point.

5. Our long-term aim is for assessments to be based on a set of standards that have a stronger focus on the outcome of care.

6. The need for comparable data also needs to be addressed. We make secondary use of numerous data and information flows in our NHS work (eg routine reporting for statutory returns and hospital episode statistics (HES)), and such routine reporting does not exist for the independent sector. The ISTC contracts have requirements for the return of HES data, but this information flow is new and not yet matured. We are keen to redress this, and to have more routine data available from the independent sector for screening and surveillance, and have agreed a process with the providers for 2006–07. In the interim, we have been and will continue to work closely with the Department of Health and healthcare providers to move towards a system that allows direct comparison between providers from different sectors.

7. A more immediate aim for us, which is one of our three key strategic objectives for 2006–07, is to maximise opportunities to publish information for our target audiences in ways that are accessible and meet their needs. We will also aim to be more explicit, particularly for patients and the public, in designing our work in order to make publications as informative as we can. We want to improve our process for reporting findings on providers of the NHS and independent sector, achieving comparability wherever feasible and desirable, and to work with others to create more comprehensive sources of information for patients and the public.

8. Our consultation on alignment is now closed but the consultation document is available on our website at www.healthcarecommission.org.uk. We expect to publish the results shortly.

**Specific Questions Posed by the Committee**

1. **Instances of good practice and innovation in ISTCs which the Healthcare Commission would hold up as exemplary**

9. Instances of innovation that we have found in the ISTCs include:
   - the use of mobile facilities, where the provider supplies clinical services from mobile units in a variety of settings (Netcare Healthcare UK Limited). The sites are agreed with the Healthcare Commission in advance and improve access for patients in remote areas (the “host” sites are included as a condition of the registration of the facility);
   - construction of new facilities designed around the clinical flow of patients which supports increased productivity. These environments support a seamless experience for patients. For example, patients who require services from a variety of departments, such as pathology, imaging and cardiology, have a “one stop” experience in a designated area. An example of this is the Peninsula Treatment Centre in Plymouth, a surgical facility serving Devon and Cornwall operated by Partnership Health Group Limited (PHG).

10. Instances of good practice that we have found in the ISTCs, but which are not exclusive to ISTCs, include:
   - blood conservancy and recycling techniques that reduce the need for transfusions;
   - administering local anaesthetic instead of general anaesthetic for primary joint replacements, which reduces the anaesthetic risk and lengths of stay;
   - using techniques for pain management to allow post-operative physiotherapy to commence earlier;
   - improved use of stock, eg prostheses;
   - introducing peer review of post-operative x-rays for orthopaedic patients as a quality control measure.

2. **Any assessment made of the impact on local health economies of relaxing rules of additinally for Phase 2 ISTC contracts**

11. We have not carried out a systematic, prospective assessment on this issue. Over the last year, the Commission has been setting up regional teams throughout the country, with offices in Bristol, Leeds, London, Manchester, Nottingham and Solihull. We believe that working locally will allow us to build relationships and work more closely with healthcare organisations, healthcare professionals, partners, patients and the public. This new local presence will allow us to gather information and knowledge to better understand local issues. We are happy to consider using our local teams to advise DH on the impact of relaxing the rule on additionality in the future if that would be helpful.
(3) How many inspections of ISTCs has the Commission performed? Can you give an overview of the results of these inspections to date?

12. In the last year we carried out 7 routine inspections and 17 post implementation monitoring visits.

13. The Healthcare Commission registers ISTC facilities in England. A service must be considered fit before it can be registered. This means that the service must have satisfied a range of requirements covering such areas as:
   — probity—all people associated with the service must be honest, truthful and be of professional and ethical standing;
   — the service must be efficient and effective;
   — it must be possible to hold the service accountable for its activities. It must be publicly visible—displaying transparency in its practices and procedures; and
   — there must be good clinical governance, with systems in place to ensure that people are treated safely, effectively and appropriately.

14. Before registration is granted, the service is assessed by such means as site visits, interviews, checks through the Criminal Records Bureau and financial checks.

15. Once a service is registered it is included in a programme of annual inspections. These inspections are undertaken by teams of specialist inspectors and may include clinicians, nurses, pharmacists, and other health care professionals could be involved. The duration of the visit varies according to the type of facility being inspected. A large hospital may require several days of inspection involving four or more inspectors. By contrast a smaller facility may have a shorter visit from a single inspector who has specialist knowledge of the service in question.

16. Following an inspection, a report is published and made available to the public. The report summarises the results of the inspection and gives details of where regulations have been breached or standards have not been met. It also sets out guidance on the improvements needed, and the times by which changes should be made. In response, the providers must produce a detailed action plan showing how they will meet the requirements of the report. All reports can be accessed via the Healthcare Commission’s website.

17. Where problems are identified in the course of our work, an action plan is agreed with the provider and implementation followed up through evidence (eg copy of a new policy or meeting minutes) or visit.

18. From our inspections to date, a strong theme that has emerged in the need for more robust risk management arrangements. These include areas such as:
   — Improving and implementing policies and procedures across a range of topics;
   — Establishing robust service audit programmes;
   — Introducing shared governance arrangements where services are hosted by NHS trusts;
   — Ensuring clear and well monitored service level agreements; and
   — Improving arrangements for reporting untoward incidents.

19. Most ISTCs have been new facilities and many run by providers new to the UK. Inevitably there have been teething problems and this is why we initiated the six-month visits—a new approach adopted specifically for Phase 1 of this programme. From this body of experience our overriding impression has been that providers are keen to learn and improve; the vast majority been very willing to work with us to address any problems positively. Examples of responses have included improving operational policies and holding special staff meetings to ensure lessons are learned.

20. Detailed information on the outcome of our inspection activity is included in Appendix 1.3

Can you give a view on how the ISTCs compare with NHS providers and with other independent providers?

21. We will be moving towards providing this kind of information as our work becomes more aligned across different sectors. As mentioned in the introduction, routine data and information reporting does not exist for the independent sector in the same way it does for the NHS (where we make secondary use of numerous routine information flows). The ISTC contracts have requirements for the return of HES data, but this information flow is new and not yet matured. A further issue is that most NHS information is collected at institutional level, whereas ISTCs equate to sub-departments of hospitals. This further affects information comparability.

22. We are keen to redress this, and to have more routine data available from the independent sector for screening and surveillance, and have agreed a process with the providers for 2006/2007 to begin collecting these.

3 Not printed here.
Can you give examples of the main problems that have been found, and how these were resolved?

23. The types of issues that have been identified are summarised above. The broad process for follow-up has been described and the detailed actions for individual providers are set out in the table.

(4) Can you provide a summary of the complaints made to ISTCs over the last 12 months, by type and nature, and how these were resolved?

24. The Commission does not have a statutory role in handling the private sector second stage complaints as we do in the NHS. The focus of our inspections in the independent sector is on how providers themselves deal with complaints. We do not routinely record the nature of those complaints. There are detailed requirements under the National Minimum Standards for complaints handling and these are assessed as part of the inspection regime. Our work has indicated there are no particular problems with complaints handling within ISTCs. There is a statutory duty on providers to notify the Commission of any serious incidents under regulation 28 (see Para 27 below).

25. However, the Healthcare Commission does receive written complaints about independent healthcare providers where providers have been unable to satisfy complainants. In any given year we receive around 200 complaints relating to the acute sector as a whole. To date the Commission has received one complaint about an ISTC, as we noted in our submission.

Is it possible to compare these with complaints made about other independent providers and NHS providers?

26. As noted above we do not have comparable roles regarding complaints within the independent healthcare and NHS sectors. We do not collect details of all complaints made to providers but rather focus on complaints handling. Only one formal complaint has been received by the Commission regarding ISTCs and hence no generalisable lessons can be drawn from complaints.

(5) Can you provide a summary of the number of notifiable events received from ISTCs, by organisation, and by type of event, over the last 12 months, and whether these were followed up (indicating how long each organisation has been registered with the Commission)?

27. In the last year we received 84 notifications of events from ISTC providers under Regulation 28. Regulation 28 covers:

— the death of a patient—in an establishment; during treatment provided by an establishment or agency; or as a consequence of treatment provided by an establishment or agency within the period of seven days ending on the date of the death—and the circumstances of the death;

— any serious injury to a patient;

— the outbreak in an establishment of any infectious disease which, in the opinion of any medical practitioner employed in the establishment, is sufficiently serious to be notified; and

— any allegation of misconduct resulting in actual or potential harm to a patient.

28. The reporting system is new for some ISTC providers; with some needing to adjust to the requirements. This means the types of events deemed notifiable have varied between providers. Where events have been notified, we have followed up as required and this has included feedback about the appropriateness of the notification. This means the absolute numbers of notifications is not yet a good indicator of safety or quality.

29. Analysis of the notifications shows a spectrum of seriousness (see Appendix 2), but taking account of the variations noted above, this is not thought to represent an abnormal pattern for services of this sort. We will, however, keep this under review.

Is it possible to compare the number of notifiable events recorded by ISTCs with those recorded by other independent providers and NHS providers?

30. Currently, NHS trusts do not directly report these kinds of incidents to the Healthcare Commission. Details are sent to strategic health authorities for non-foundation trusts or to Monitor for foundation trusts. This is because historically this has been dealt with as an aspect of performance management rather than regulation. Even if this information were collected in one place, at this point comparing it would be complicated as the two sectors use different definitions.

31. Clearly, with more patients moving between sectors we need to address this. Identifying this anomaly has been a key learning point from Phase 1 and we plan shortly to open discussions with the Department of Health and other stakeholders to explore how we can work to bring together this type of notifiable information into a format that allows inferences to be drawn across sectors.
How many ISTCs have you investigated? Have you been asked to carry out any investigations into ISTCs, and, if you decided not to, what were the reasons for this?

32. Where the Healthcare Commission has serious concerns about the provision of healthcare it will consider whether it needs to conduct an investigation. Triggers that might alert the Healthcare Commission to the potential need for an investigation include:

— direct contact from patients, the public, NHS staff or the media;
— issues brought to light during Healthcare Commission’s screening processes, reviews or visits;
— trends or issues highlighted in the monitoring of complaints which reach the independent stage; and
— requests from the Secretary of State and Welsh Assembly Government in respect of cross border special health authorities, or from other inspectorates.

33. The criteria used to determine whether to instigate an investigation include:

— a higher number than anticipated of unexplained death(s);
— serious injury or permanent harm, whether physical, psychological or emotional;
— events which put at risk public confidence in the healthcare provided, or in the NHS more generally;
— a pattern of adverse effects or other evidence of high-risk activity;
— a pattern of failures in service(s), or team(s), or concerns about these; and
— allegations of abuse, neglect or discrimination against patients (particularly those less able to speak for themselves or assert their rights).

34. In determining whether to investigate, the Healthcare Commission will consider the extent to which local resolution, referral to an alternative body, or other action might offer a more effective solution.

35. We have received no requests for an investigation into an ISTC. Furthermore, we have been satisfied any concerns coming to light in the course of our work have been addressed appropriately by providers and are subject to monitoring by our inspectors.

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Healthcare Commission
April 2006

Supplementary evidence submitted by Dr Sally Ruane (ISTC 46A)

I should welcome the opportunity to present further evidence regarding the introduction of ISTCs into the UK health care system within the market context. First, I should like to expand further on the use of research on the US health care market, conducted against a backdrop of debate in Canada regarding the introduction of for-profit hospitals. Second I shall consider the likely impact upon the founding principles of the NHS of ISTCs within the evolving UK health care market.

North American Research

The literature surrounding comparisons of different types of hospitals is, as noted, mixed. However, this does not mean that all the research conducted is of equally good quality or should be afforded equal weighting. In the hierarchy of evidence, the systematic reviews and meta-analyses of Devereaux and colleagues must surely rank among the best in this field. These studies offer:

— systematic review of pre-existing research and meta-analysis of pooled data;
— publication in high quality journals following a rigorous peer review process;
— a high degree of methodological sophistication and transparency;
— findings which suggest applicability across different health care contexts; and
— contribution to an active political debate surrounding whether a health-care system (Canadian in Devereaux’s case) should open its doors to for-profit hospitals.

These studies have attracted considerable attention in Canada and have given rise to a debate between authors and critics some of which is in the public domain. This has shed further light on methodological judgements.

More specifically, the strengths of the Devereaux (2002a) research include the following:

— The selection process (in Devereaux et al., 2002a) to determine which pre-existing studies to include
in the systematic review and meta-analysis involved the specification of eligibility criteria; an extensive literature search; teams of two independently screening titles and abstracts for relevance; teams of two independently analysing potentially relevant studies “blind” to their findings to avoid
bias; implementation of a specified process to resolve any differences between those analysing studies independently although agreement on study inclusion was high; exclusion of studies involving hospitals which had changed profit status; exclusion of studies where further information and/or data were required from the authors and where this was not forthcoming or demonstrated that the study was inappropriate for inclusion.

— Adjustment for patients’ severity of illness, for patients’ socio-economic status, for hospital teaching status and other potential confounding variables; non-adjustment for variables under the control of hospital administrators where these might be influenced by profit status and affect mortality such as staffing levels per bed after severity of illness adjusted for. Most studies used the Health Care Financing Administration database which includes data on all US hospitals which serve Medicare patients and generates risk-adjusted mortality rates. Where studies included unadjusted and adjusted results for disease severity, the analysis consistently led to effect estimates which were more favourable to the private not-for-profit hospitals suggesting they serve a population with greater disease severity. As a result, Devereaux et al judged that any residual confounding would make private not-for-profit institutions look worse—that is, the results of the Devereaux et al study may, if anything, underestimate the potential increase in mortality associated with for-profit hospitals.

— In most of the studies, patient care was funded through Medicare; most studies included general acute care, medical and surgical patients; one study examined maternity services.

— Alongside the very large scale research (encompassing 38 million patients across 26,000 hospitals) which compared private for-profit and private not-for-profit hospitals (Devereaux et al, 2002a), a separate report analysed four studies including public as well as private hospitals (Devereaux et al, 2002b). Devereaux concluded that the inclusion of public hospitals in the first piece of research would have, if anything, strengthened the findings in relation to the comparatively poor performance of for-profit institutions.

— Comparatively low numbers of highly trained staff per risk-adjusted bed, the need for investors to make a rate of return on their investments of 10-15% and the bonus and financial packages to senior staff are posited as possible explanations for the observed differences.

One study I am aware of on mortality rates in a UK market context was conducted by Propper and colleagues who found a modest but upward effect on mortality rates of competition in the internal market of the 1990s (Propper et al, 2003). In relation to payments for care (Devereaux et al, 2004), complexity of comparison is not confined to questions of price fix (which in any case may not remain an unmodified feature of the evolving UK market in health care) but rather a number of factors need to be taken into consideration. In weighing up the contribution to the Committee’s deliberations of research based on US studies, the following should be noted:

— The data covered and the results persisted over more than a decade and over significant changes in the structure of US health care, including changes in payment systems for Medicare patients.

— The five studies showing significantly higher payments for for-profit care had variations in their sources of payments (Medicare, insurance and both).

— These observations suggest higher payments for care at private for-profit hospitals are manifest within a variety of health care contexts.

— The inclusion of for-profit health care institutions in the UK may over time and depending upon policy development in the UK include the same US hospital chains.

— Although the tariff is currently fixed in the UK, the development of a market dynamic is likely to lead to pressure for future policy changes or modifications to which I return below.

More specifically:

— Again, a detailed process was employed by the research team to identify and select high quality pre-existing studies which met the inclusion criteria involving eligibility decisions and data abstraction in duplicate.

— Canadian hospitals are publicly funded and the researchers thus focused upon the policy question: how much will government pay for care delivered by private for-profit versus private not-for-profit providers?

— Studies were considered methodologically strong where they adjusted for patient source of payment (as well as patient age, sex, ethnicity, income education, primary diagnosis (case mix), co-morbid conditions, severity of illness, the concentration of hospitals in a region and hospital teaching status).

— Various hypotheses to explain variability in the direction and magnitude of effect across studies were specified in advance. These included whether patient source of payment was public or mixed (as well as whether payments for care were per discharge or per day; whether payments for care
were related to hospital stay or included a period of time after hospital discharge; whether hospitals evaluated were specialty or general; whether the patient population was adult or paediatric; and whether the analysis was adjusted for potential confounders or not).

— The eight publications of observational studies included over 350,000 patients and assessed a median of 324 hospitals per study. Five studies showed significantly higher levels of payment for care at private for-profit hospitals; 1 showed significantly lower levels of payment for care at for-profit hospitals. The primary meta-analysis demonstrated that private for-profit hospitals are associated with higher payments for care; only one of the pre-specified hypotheses helped explain the large heterogeneity across study results (general vs specialty). The studies with the most extensive adjustment for potential confounders reported statistically higher payments for care at private for-profit hospitals. Pooled estimates from both the 3 studies evaluating specialty hospitals and the five studies evaluating general hospitals showed higher payments of care for the private for-profit hospitals.

— Ten publications excluded from the analysis either because no measure of variance was supplied or because public and private not-for-profit had been grouped also all showed higher payments or charges for care at for-profit hospitals, statistically significant in six out of the 10.

— Given the significant variability in direction and magnitude of effect among studies, the authors conclude that whilst the inference that for-profit hospitals result in higher payments for care is secure, the magnitude of the effect may differ according to circumstances.

— The authors believe that the results may underestimate the association between private for-profit hospitals and higher payments for care since, because studies in the systematic review adjusted for case mix, increase in payments resulting from inappropriate upcoding of patient diagnosis to enhance reimbursement is not captured; and because issues of fraud are not addressed (performance of unnecessary surgeries, billing for services not provided, inappropriate detainment of psychiatric patients for billing purposes). (The multimillion-dollar fraud lawsuits in the US have been overwhelmingly against private for-profit hospitals.)

Vaillancourt Rosenau and Linder’s (2003) research is methodologically simpler and arguably less sophisticated than that of Devereaux and colleagues. It does, however, provide the first systematic review of data-based, peer reviewed assessments of the relative performance of for-profit and not-for-profit providers in the United States. The 149 articles which met the inclusion criteria reported 179 performance assessments of four common performance criteria: access, cost/efficiency, quality and amount of charity care. The full universe of eligible studies (since 1980) was included in the systematic review and these were given equal weighting; the synthesis focused upon statements of findings. The authors assume that technical flaws and consequent errors in the studies are randomly distributed.

— 56 of the 149 studies considered cost, only 13 of which reported for-profit providers as superior.

— 69 studies sought to compare quality of care on at least one measure and 41 found not-for-profit providers as superior with a further 20 finding no difference.

— 30 compared on access and 20 found not-for-profit providers superior.

— Out of 24 assessments of charity care performance, 16 found not-for-profits as superior.

**ISTCs: The Market and NHS Founding Principles**

Although ISTC policy must be examined in terms of its technical details, it cannot be reduced to these and any overall assessment within the political process must adopt a broader view, encompassing the political, moral and value basis of the policy. This means that ISTCs must be clearly understood and evaluated in the context of the government policy of moving UK health care away from the NHS as traditionally understood towards a system of health care based on a competitive, partly commercialised market.

The reason ISTCs pose a threat to the rather frayed founding principles of the NHS lies in the dynamic they help create, particularly within the market context, and there are two key aspects to this on which I wish to comment.

ISTCs contribute to a differentiation of health care experience. In itself, this differentiation does not necessarily imply inequality. However, within a competitive market context, differentiation is likely to be characterised by inequality. This is because of the instability and disequilibrium created by a market which results in inequalities among providing units and potential destabilisation of some NHS hospitals (this relates to the question about destabilisation posed by the Committee Chairman at the second hearing). Where NHS hospitals lose their income—either because patients choose to go elsewhere or because their income has, as a matter of policy, been diverted to the establishment and maintenance of the for-profit providers—the scope and quality of the health care they offer is compromised. This is particularly so where they are left with responsibility for more disproportionately complex and costly cases.

One of the less often quoted founding principles of the NHS is that patients should be able to access equally good care wherever they obtain it. This is one aspect of the principle of equity which underpins the concept of the NHS (Whitehead, 1994). Whilst difficult to achieve in practice, this principle poses a test and
reference point by which to evaluate policy initiatives. The more health care becomes differentiated, the
greater the danger that patient experiences will become systematically unequal. The current focus upon
inequalities in health care around ISTC policy centres, on the one hand, upon whether procedures carried
out in ISTCs are of equally good quality (compared with those in the NHS) given existing recruitment
practices and modes of service delivery (eg Wallace, 2006) and, on the other, upon whether the quality of
care across NHS hospitals is becoming unequal as a result of the destabilising dynamic of the market with
the resulting loss of income, training opportunities, surgical skills etc. in hospitals affected by ISTCs on their
patch. Evidence to date is limited but concerns expressed so far include the viability of eye and endoscopy
services, with implications for holistic and comprehensive care; compromises to the quality of care where
the management of follow-up and complications is thwarted by fragmentation and poor communication
and where MRI scans have been poorly and remotely conducted (eg SCR, 2006; RCO, 2006). The ability
of these affected NHS units in the future to offer good quality health care will be influenced by the outcomes
of the currently evolving policy on purchasing training from ISTCs and the impact of this and other loss of
investment in NHS services and capacity because resources have instead been spent on temporary private
contracts. At present, we do not know whether patients accessing different providing units differ in terms
of class, sex, ethnicity and age.

This is not to say that planned systems automatically guarantee equally good care wherever it is accessed
but rather that markets automatically tend towards difference and inequality; moreover, costly regulation
and incentives may be insufficient to redress this.

There is another dynamic, however, which poses a threat to the founding principles of the NHS, and this
is a political one. The introduction of for-profit companies into the routine workings of the NHS allows the
representatives of those companies a seat at the policy making table. We are already seeing calls for the
ISTCs to be more integrated and for the private companies to become involved in workforce planning as
an example. For-profit companies will have a role in shaping health policy and it is reasonable to suppose
that they will do this in a way which advances their interests. In practical terms, this will involve seeking to
secure higher rates of profit through an increased share of the market and/or through increased prices. The
tendency of for-profit providers to accrue ever greater shares of public expenditure, to foster dependency
upon their services and to resist effective regulation has been well documented in relation (for example) to
PFI and long-term care for older people (Pollock, 2004).

At the same time, the dynamic of the market itself could exert an upward pressure on costs, as Nigel
Edwards (2005) has pointed out. This arises from such factors as the administration of a competitive market
(contracting, billing, strengthened governance arrangements for increasingly independent providers; trying
to hold back supplier-induced demand, via structures of demand management, treatment pre-authorisation
and service use reviews, as providers try to secure a higher share of health care expenditure); provider
behaviour such as differentiating market “products” through advertising and information given to patients;
and wastage arising from duplication and redundant facilities (as Kevan Jones MP reported to the House
of Commons in October relation to MRI scanners, for instance). The steps taken to try to control the
undesirable consequences of the workings of a market (including fragmentation) are costly and may not
succeed. The implementation of financial incentives is problematic, particularly in the profoundly moral
context of health care (eg Marshall and Harrison, 2005) and the current political and economic climate is
moving away from regulation, not towards it as the prolonged political battle to remove health care from
the ISTCs to be more integrated and for the private companies to become involved in workforce planning as
an example. For-profit companies will have a role in shaping health policy and it is reasonable to suppose
that they will do this in a way which advances their interests. In practical terms, this will involve seeking to
secure higher rates of profit through an increased share of the market and/or through increased prices. The
tendency of for-profit providers to accrue ever greater shares of public expenditure, to foster dependency
upon their services and to resist effective regulation has been well documented in relation (for example) to
PFI and long-term care for older people (Pollock, 2004).

This combination of rising costs—costs which, it should be noted, are not directly spent on health care
and arguably contribute little to improved health outcomes—and effective political lobbying and policy
influence exercised by the for-profit companies will, it is not unreasonable to anticipate, lead to political
pressure to introduce additional charges, such as through top-up fees for above basic service or co-
payments. This should not be regarded as fanciful or scaremongering. For instance, the prospect has already
been discussed within the pages of the BMJ (Donaldson and Ruta, 2005); proposals surrounding more
privatised modes of health care funding have been developed by right of centre think-tanks (eg Booth, 2002);
and a voucher scheme formed part of Conservative Party health policy at the 2005 General Election.

The encouragement to relate to the NHS and other public services as consumers rather than citizens is
likely to undermine the sense among the public that health care should be considered in terms of equity and
need rather than want and personal satisfaction. Further, whilst the necessary funds for this more expensive
market system could be raised through curbing tax avoidance schemes, only limited action so far has been
taken (Tax Justice Network, 2006) and raising taxes on the very well off does not appear to be on the political
agenda at all. The conditions would then be created in which the principle of health care free at the point
of delivery—the NHS founding principle which is often cited by ministers—is seriously undermined.
Whatever the undertakings given by the current government, there will be pressure on future political leaders
to respond to this, with potentially very unequal outcomes for health care users. Thus, this other pillar of
the NHS principle of equity is also ruinously weakened.

ISTCs have been located geographically not merely or even principally, so far as we can tell, on the basis
of additional capacity needs but rather to kick-start the new market in health care. Markets are typically
not appropriate for securing policy goals such as equity. The growing role and influence of commercial
interests in the NHS has moved the institution in a particular direction over the past decade or two; the
“direction of travel” intended by government is increasingly clearly articulated. The Committee's
assessments of ISTCs must have regard to this growing contradiction between a market embracing commercial providers and the principle of equity institutionalised by the NHS for, as Bevan put it, the serenity of our society.

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Evidence submitted by the King’s Fund (ISTC 50)

CONTEXT

There is a paucity of information available on the impact of ISTCs and so it is difficult at this stage to provide an evidence-based view of their impact.

There is ongoing an independent evaluation of the performance of NHS TCs conducted by University College London which has not yet reported. However, while this evaluation may touch on some issues related both to NHS and ISTCs, it will not, according to one of the researchers, provide definitive answers to key policy questions concerning the latter.
There has also been a review of five private providers for the Department of Health by the National Centre for Health Outcomes Development, published in October 2005. This study was an overview of the retrospective performance of four schemes covering five providers in operation under the ISTC programme. The review concluded that ISTCs had a robust quality assurance system in place, more ambitious and demanding than that for NHS organisations. Early results from the monitoring of quality were encouraging. The key performance indicator (KPI) data to be collected and provided by ISTCs was described as more extensive than that used by the NHS. However the study also found that there were significant problems in the availability, quality and format of data collected by ISTCs which made analysis of some KPIs very difficult. For each of the five providers studied, some KPIs were found to be well “within expectation” (although that is not defined) but there were a few instances of suboptimal performance in particular on clinical cancellation of surgery, non clinical cancellation of surgery and unforeseen patient admissions.

Until the results of more evaluative studies are published it is not possible to come to any firm conclusions as to the impact of ISTCs per se, or in comparison with NHS treatment centres. However, it is possible to suggest some key lines of inquiry in relation to the objectives the Department of Health have suggested for the introduction of ISTCs.

**Policy Objectives**

There are (at least) four policy objectives in relation to the introduction of ISTCs:

1. Increase capacity to help reduce waiting times.
2. Increase patient choice.
3. Increase innovation.
4. Create a competitive/contestable market.

For any policy objective there are two questions to ask:

- Is the objective a desirable goal?
- Will the policy not only be an effective, but a cost effective way of achieving the objective?

Bearing in mind these questions, below we examine the stated objectives in relation to the policy on ISTCs.

**Reducing waiting times:**

Waiting times have been falling significantly before ISTCs started operating. We do not know if the advent of ISTCs has had any added effect.

We do not know whether ISTCs have been treating long wait patients.

Further, it is not known whether significant extra capacity is actually necessary to reduce waiting times. Waiting list reductions to date have not been reflected in increases in the numbers of admissions from waiting lists (see figure). Rather, and amongst other things, it seems that it is reductions in DTAs (decisions to admit) onto waiting lists that is responsible. It may be that if the NHS were more efficient and able to treat more patients at home, then more supply could be freed up to treat patients off the waiting list.

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6 Independent Sector Treatment Centres: A Report From Ken Anderson, Commercial Director, Department Of Health To The Secretary Of State For Health, 16 February 2006.
Increasing patient choice:

More providers would, in theory, provide greater choice for patients. However, the extent to which this happens in practice will depend on the way ISTCs are set up and the nature of their contract with the NHS. For example, to avoid financial penalties (i.e., paying for treatments not carried out due to referrals falling below the “minimum take” level specified in current ISTC contracts), PCTs may have to direct referrals (possibly via referral management schemes) to ISTCs to maintain activity. This could interfere with patients’ choices.

Increasing innovation:

There is, as far as we are aware, very little documented evidence of innovative clinical practice arising from the ISTC programme (over and above the very nature of treatment centres themselves). There is some early evidence from the UCL study of NHS TCs of some innovative practices such as nurse-led activities and the earlier involvement in patients’ care of other professions such as occupational therapists.

Market creation, increasing competition/contestability

Market creation is a longer term goal. At present contracts with ISTCs are for 5 years and protect ISTC income (through minimum take). This may well be a legitimate and temporary arrangement to encourage more private providers to enter the market. But in the short term it is difficult to see what incentive there is with this contractual form for NHS to compete with ISTCs. At best this is competition “for the market” not competition “in the market”.

There is some anecdotal evidence that the introduction of ISTCs has created some contestability, with nearby NHS units responding as if facing a competitive threat to their business. Again, however, there is as far as we are aware no hard evidence of this sort of behaviour induced by the presence of ISTCs (or, indeed, of NHS TCs).

Cost effective/value for money?

Again there is very little evidence of this to date. Ken Anderson (DH lead on ISTCs) has stated that, “although contract prices vary above and below equivalent cost, they remain significantly below spot purchase prices.” “Spot price” purchasing is probably the most expensive way of buying care from the private sector. Long term, ISTCs will only be paid at NHS tariff prices. At present the five year contracts with ISTCs involve prices that are above the NHS tariff, and there is no date set for when this will happen.

There may be an argument that paying high prices now (or for five years) is worth it as it enables a competitive market to develop. This depends on whether the benefits of such a market are realised or worth it of course. Again this will need to be evaluated.

Increased productivity

In addition to the objectives already noted above, it is claimed that ISTCs are more productive than the NHS. Again, however, there is a paucity of data on this. Ken Anderson’s report (ibid) only gives figures on productivity for the ISTC mobile cataract units. Anderson states that these units have to date performed 39 cataract removals per day compared with an NHS rate of just five. This latter figure is calculated on the basis of dividing the total number of NHS performed cataracts in 2002–03 (around 270,000) by the number of NHS units (141) and then dividing by 365 to arrive at a per diem rate. This assumes of course that the NHS performs cataract operations 365 days of the year (which it does not); it is not clear that the same assumption has been made for the mobile units.

Anderson claims that the higher ISTC productivity has been achieved because the units are able to concentrate on one operation in modern purpose built units. However, ISTCs also have to select patients on the basis of suitability for the mobile technology, while the NHS has to deal with the full range of patients—many with co-morbidities who are unsuitable for quick in and out cataract removals and require longer stays in hospital and higher levels of care.

A better productivity comparison would be with NHS TCs. But this data is not presented by Anderson.

Conclusions

Whether run and managed by the NHS or the independent sector, treatment centres—where routine elective care can be provided in a ring-fenced way in units concentrating on one or two types of intervention—could clearly make a positive impact both in terms of the use of NHS resources and the experience of patients.

For both NHS and independently run treatment centres—the question is whether, in practice, the costs of the treatment centre programme outweigh the benefits. To date, and despite some years experience, there is still a distinct paucity of hard data on both the cost and benefit sides of the equation to reach a judgement about the worth of this policy. And in particular, there is a lack of data on which to reach a firm conclusion as to whether independent sector-run treatment centres represent value for money.

John Appleby
King’s Fund
March 2006

Evidence submitted by the Royal College of Radiologists (ISTC 51)

In offering this evidence, the Health Select Committee is invited to note that the Royal College of Radiologists has not to date had direct involvement with or experience of Independent Sector Treatment Centres (ISTCs). However, the College has had extensive experience of the rollout of, and dealing with the issues arising from, the first wave of imaging procurement from the independent sector which was for the provision of straightforward Magnetic Resonance Imaging (MRI) Scanning Services. The College’s experience in this context offers insights and observations which are germane to the ISTC enquiry.

The Committee may also wish to be aware of the role of Radiologists within the framework of a clinical team. As radiological techniques have advanced over recent years the role of radiologists has changed and developed so that they are now pivotal to patient management, providing clinical advice and consultation. Thus cases are referred to radiologists for a radiological and clinical opinion rather than merely a radiological report.

There were several major problems identified upon the introduction and rollout of the independent sector MRI Fastrack service in 2004. However in many instances the service has improved significantly in the interim period. The Royal College of Radiologists rapidly engaged at a number of levels to identify and attempt to resolve the problems and this work is referred to below. Some issues still remain to be addressed and these are alluded to in the responses we give to the Committee’s specific questions.

For Wave 2 of the outsourcing contracts, the College has identified key concerns that need to be addressed:

— Relaxation of additionality with respect to radiology and radiography by means of seconded work in co-operation with NHS Trusts. This would resolve the important issues related to clinical governance and allow integration of the independent sector provision with NHS services thus providing a seamless service for patients.

— Introduction of NHS clinical leadership within the outsourced radiology services which would also address clinical governance issues and avoid fragmentation of the service.

— Introduction of training into the independent sector in radiology. Removal of additionality is essential if the promised involvement of the independent sector in training is to be realised.

— Financial support for administrative work to provide integration between the independent sector and NHS radiological services.

— Improved utilization of several Department of Health NOF funded MR Units. Several of these recently installed top-of-the-range machines are “mothballed” (UCH, Charing Cross etc) or running at much reduced capacity (eg Yarmouth), largely because of the Wave 1 Fastrack scheme.

The Royal College of Radiologists stand ready to assist and work with the Department of Health on all these issues.

The College undertook a number of initiatives to try and address the Wave 1 issues collaboratively with the Department of Health as follows:

(1) Engaging with the Department at the highest levels and also with the newly appointed National Clinical Lead for Diagnostic Imaging (Dr Erika Denton).

(2) Involvement in and support for the appointment of an RCR/DH MRI Fastrack “Clinical Guardian”—Professor Adrian Dixon—whose role is to oversee clinical governance and whose work, which has been extensive and comprehensive, has included vetting the CVs of all reporting radiologists under the contract and also troubleshooting and problem resolution.

(3) Undertaking an audit in January 2005 comparing the service provided by the NHS with that provided by Alliance Medical Limited (who won the contract for the first wave provision). The audit showed there were delays in reports produced by the independent sector, the technical quality of the MR examination were similar, the language was better in most NHS reports and clinical opinion was judged slightly better in most NHS reports. Only one discrepancy in the independent sector was regarded as a potentially serious error. The service has improved since that 2005 audit. Preliminary analysis of a new audit carried out at the beginning of 2006 and due for publication in April shows considerable improvement, with reporting times at least as good as those in the NHS.
(4) The MRI Clinical Guardian was instrumental in obtaining funding for administration and multi-disciplinary team support and this must be incorporated into future contracts.

(5) Many bodies including the RCR have played a key role in achieving some relaxation of additionality. Clinical radiologists in the UK who are contracted to work for 40 hours per week within the NHS can offer to do a further four hours per week for their Trust. However, if the Trust does not wish to take up that time, radiologists could do eight hours’ work within the independent sector. Further comment is made on this point in response to the specific questions.

The College is also working on three further initiatives:

— the introduction of a Radiology Service Accreditation Scheme which would be multi-disciplinary involving radiographers and physicists among others and would apply both to NHS and independent sector services;

— re-engaging its leads in the regions and establishing their links with the Strategic Health Authorities to provide clinical radiological advice and leadership for Wave 2; and

— to provide its referral guidelines for imaging services as an online resource for the NHS in the UK and is also producing a framework for primary care access to imaging services.

Specific Questions and Answers from the Royal College of Radiologists

What is the main function of ISTCs?

Answering this question in the context of experience of independently procured MRI services—the role is to provide extra capacity for diagnostic imaging which is a shortage specialty with respect to radiologists and radiographers and in which investment in equipment over recent years has not met the increasing demands for service. The new service provides competition and aims to set new standards for access thereby raising overall quality of service.

What role have ISTCs played in increasing capacity and choice and stimulating innovation?

The major role in MRI services has been an increase in capacity for a limited range of examinations/procedures. Were the Government to review this progress it would be wise to consider whether the planned next wave is entirely necessary in terms of required capacity. The planned requirement of 50 per 1,000 head of population per annum (ie 1 in 20) may be in excess of what is really needed for good clinical practice. Whilst patients have had a choice and have been able to access services faster, there were and still maybe some delays between an MRI examination and the subsequent outpatient appointment or operation.

What contribution have ISTCs made through reduction of waiting times and waiting lists?

As a result of the outsourced MRI services, waiting lists have been dramatically reduced—down to 13 weeks from 18 months to two years in some cases.

Are ISTCs providing value for money?

The expenditure on outsourced MRI services has to be set against the incomplete usage of existing MRI capacity. There were early problems which largely stemmed from the lack of integration of the service.

A concern which persists is that the radiological reports from European radiologists tend to be descriptive with no definitive conclusion for management. Furthermore they frequently recommend several additional investigations which may be unnecessary. All this leads to inefficiency and waste of resources.

Radiologists at NHS Trusts frequently are required to re-report scans from the outsourced centres because local clinicians do not have confidence in radiologists they do not work with on a day-to-day basis and from whom the reports are indecisive.

Does the operation of ISTCs have an adverse effect on NHS services in their areas?

Yes—there has been fragmentation of services to patients with re-reporting of images in some instances therefore increasing workload. The input to multi-disciplinary team meetings has been impaired and there has been no clinical leadership for the outsourced service to integrate the service which is its biggest flaw.
The whole concept of the service clearly did not recognise and therefore undervalued the importance of the clinical role of radiologists.

**What arrangements are made for patient follow-up and the management of complications?**

For the MRI services, few arrangements were made initially for follow-up and previous imaging was not available. This caused clinical governance problems and potentially had an adverse effect on patient management and implications for patient safety. The work done by the Royal College of Radiologists however has secured around £80,000 funding per cluster for funding the administrative work to provide joined up services. This has helped but persistence of the additionality clause will continue to have an adverse effect on clinical governance arrangements for patients.

**What role have ISTCs played and should they play in training medical staff?**

The outsourced MRI service has had no role in training to date. Training must in future involve the independent sector otherwise radiology trainees will not learn simple procedures and see “normal” reports. Furthermore in the future radiologists will not be able to perform these examinations either within the NHS or in the independent sector. Trainees could travel to remote reporting sites such as in Edinburgh, Brussels, Barcelona, and Cape Town. The group in Brussels has already offered to undertake training of groups of radiologists from the UK, but funding and the practical logistics of this would need to be addressed.

There has been some work done across Europe with a small audit carried out by the European Radiology Training Forum. This has shown that there is a significant adverse impact on training in two centres in Europe where outsourcing is fully operational. In these cases 21–50% of routine MRI scans and 50–70% of Computed Tomography (CT) work has been outsourced. This audit also revealed that there was concern about further impact when Picture Archiving and Communication Systems (PACS) was widely available. This would allow images to be accessed remotely and moved around between services/centres much more easily thereby obviating the need for studies to be reported where the trainees were based.

**Are the accreditation and appointment procedures for ISTC medical staff appropriate?**

Radiologists from mainland Europe are readily accepted onto the UK Specialist Register which is the responsibility of the General Medical Council. EU citizens do not have to undergo a linguistic test (run by the PLAB at the present time, although this is expected to be introduced imminently). However a linguistic test does have to be part of the procedure for English speaking doctors from other parts of the world. Some Eastern European countries (such as Estonia) have limited MRI services but their radiologists could be on the UK Specialist Register and in theory would be eligible to work in the outsourced service. The safeguard is that the MRI guardian vets all CVs. The Wave 1 procurement in MRI services provided general radiologists whereas Wave 2 is seeking to employ specialist radiologists which is an improvement. Furthermore, waiving the additionality clause would help resolve the problem.

**Are ISTCs providing care of the same or higher standards as that provided by the NHS?**

The independent providers’ quality of work is probably about the same as an NHS DGH. The error rate in the independent sector is similar to that in the NHS. There are probably further investigations generated as a result of a descriptive rather than a clinical management reports. There has been considerably faster access to some imaging procedures.

**What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?**

We are not aware of any problems in this respect as regards the outsourced MRI services.

**What changes should the Government make to its policy towards ISTCs in the light of experience to date?**

From the perspective of radiological outsourced imaging services, we would like to see:

- the relaxation of additionality for the second wave procurement (see below).
- a network of official radiology guardians to work with the new Strategic Health Authorities.
- exclusion of ultrasound from the contract because ultrasound is an interactive examination and cannot be reviewed remotely. It is therefore extremely difficult to assure quality.
- secured and ongoing funding through the assimilation of independent and NHS imaging services for supporting multi-disciplinary team reviews.
- training and education to be part of the service.
Additionality must be relaxed so that clinicians will have a radiological report from someone that they work with on a regular basis which offers a ready opportunity for discussion about recommended treatment options for individual patients. This would also ensure clinical governance, access to previous images and would ensure that all radiologists working both in the NHS and independent sector underwent annual appraisal.

Training and research must continue in order to develop the service for the future and this will not be possible in those services which are outsourced unless additionality is relaxed.

The significant investment made by the Government in increasing radiological training (up to 20% increase through the three new Radiology Academies in England) must be recognised and those encouraged into such training posts must have jobs available when they complete their training.

Relaxing additionality would also develop opportunities for the workforce in the light of new ways of working. For example, the workforce of the future will be largely women, many of whom will wish to work less than full time. Such radiologists would be ideally suited to working partly in the NHS and partly in the independent sector thereby retaining their clinical governance links and continued professional development requirements through the NHS departments. Such a plan would also benefit radiographers who could work on a rotation scheme, thereby ensuring continued professional development and supervision within the team.

Clinical leadership would help integrate a seamless service. Relaxing the rules of additionality but maintaining NHS Trust contracts would enable individual consultants to work (for example one day per week) in the independent sector seconded by their Trust. The Trust would receive funding from the private sector provider for the radiologists’ service and the Trust could then employ further radiologists as required. This would also be suitable for those working part-time and those who have recently retired or who are between jobs. In this way the work would be integrated through a single team. Such an approach would work well in some areas of the UK but it is recognised that in some areas this solution would be inappropriate as there are insufficient radiologists. Nevertheless spare capacity in “popular” parts of England such as the south-east could be used to meet the shortfall in provision in other areas such as the Midlands. In some areas overseas reporting would still be required at least for the foreseeable future.

Finally the relaxing of additionality would allow radiological input to and attendance at multidisciplinary team meetings and ensure that the reports in the UK were more in line with current UK practice.

What criteria should be used in evaluating the bids for the second wave of ISTCs?

— Robust Clinical Governance arrangements must be in place.
— Training must be introduced.
— Ultrasound should be omitted from the contract as it is difficult to assure quality in this highly operator dependent technique.
— Administrative arrangements to provide a seamless interface between the independent sector provider and the NHS.

What factors have been and should be taken into account when deciding the location of ISTCs?

As regards the outsourced MRI services, these were initially provided on a geographically even basis and were not directed to areas where radiology services were in short supply. This should have been taken into account and should be in the future. Administrative links must be made and maintained using the additional funding mechanism which was latterly agreed for Wave 1.

The effect on NHS Trusts complying with the “payment by results” tariffs is made much more difficult with the removal of simple and cheap investigations to the independent sector (“cherry picking”) leaving the more complex expensive work in the NHS. Clinical Directors in the NHS need to be engaged to keep interest in NHS work. Individual radiologists may prefer to work in the private sector where the pressures of work and the complexity of the work are much reduced.

The effects on radiographers must also be taken into account. Radiographers are being “poached” from the NHS because they are replacing those working in the private sector who are transferring to the Wave 1 contract providers. If independent sector procurement takes radiographers out of hospitals this puts an increasing strain on existing service and the fragmented nature of the service may not attract new staff into radiography. Furthermore, radiographers could become isolated working in ISTCs which could adversely affect their career development as well as taking radiographers from some hard-pressed NHS Departments. As with radiologists, radiographers may be attracted into the simple work available in the independent sector thus depleting NHS resources further.
How many ISTCs should there be?

The College believes that existing NHS capacity must be used to the full and local requirements should be taken into account for the future procurement of imaging services. The shortage of radiologists and the shortage of radiographers which is particularly acute in some areas should be taken into account when services are planned for the future.

Professor Janet Husband OBE
President, The Royal College of Radiologists
14 March 2006

Evidence submitted by Partnership Health Group (ISTC 52A)

Independent Sector Treatment Centres

PHG is a joint venture company between Care UK Plc and Life Healthcare of South Africa. PHG currently operates two ISTCs, in Barlborough Links and Plymouth, and has two further ISTCs in construction in Maidstone and North East London.

Quality of Care

Patient safety is paramount in PHG and standards mirror or exceed those of the NHS. Attached are our clinical outcomes data and a study comparing results of the Barlborough Treatment Centre with that of the Nottingham City Hospital. The Nottingham study shows that with the exception of dislocation rates for hips postoperatively, all outcomes significantly exceed that of the traditional NHS facility (see appendix 1). In addition out of 7,618 cases done to date (as at the end of January 2006) at PHGs facilities there has not been a single MRSA case.

Whilst we seek to improve further on these outcomes, we believe that this is a creditable performance for a newly commissioned service. The contributors to this performance are multifaceted and include the following factors:

— Specialist clinicians are all on the appropriate specialist register of the GMC and nearly a quarter have had their specialist clinical training in the NHS.

— All surgeons are full time appointments (typically on five year contracts) and there are no “visiting” surgeons (although the NHS makes widespread use of visiting locums).

— The use of overseas’ clinical staff is limited to highly experienced doctors whose references are carefully and independently checked and whose experience is matched to the job that they are required to perform up to “super” specialist level (eg orthopaedic surgeons are not only required to be experienced in their speciality, but also in even narrower aspects of that speciality such as shoulder surgery or knee replacement).

— Candidates are observed operating in theatre and their clinical outcomes are reviewed before being appointed. A further period of two weeks direct observation follows appointment.

— An NHS trained and experienced surgeon is appointed as a lead clinician at each site and is responsible for clinical governance and mentoring.

— Monthly morbidity and mortality meetings, chaired by the clinical lead with x-ray reviews, as well as pathology (lab), nursing (infection control and theatre technique) and therapist (rehabilitation) involvement, take place with an emphasis on learning and continuous improvement. Anecdotally, the atmosphere in these meetings has more integrity and is more robust than equivalent meetings in many NHS settings.

— ISTC contracts require that they collect and report on a wide range of Key Performance Indicators. These are scrutinised monthly and published annually. If a centre falls below targeted levels of performance a “Joint Performance Review” is initiated to address the problem. Where shortcomings have been identified these have been dealt with quickly and resolved, with the resolution being carefully monitored. Disciplinary procedures have been carried out where necessary, including dismissal.

— ISTC providers are contractually obliged to deliver clinically safe, high quality care along agreed patient care pathways. We currently work to Healthcare Commission (HCC) standards that are audited independently and exceed those required in NHS hospitals.
Innovation

Innovations range from the physical layout of facilities to elements of administration and clinical practice. Examples include:

— construction of new facilities designed around more efficient and safer flow of patients;
— a hand held patient feedback system allowing daily feedback from patients that is viewed “real time” by centre managers who can immediately address any problem areas that may have arisen;
— one stop multi disciplinary pre-admission visits involving specialist consultation, MRI/CT scanning, x-ray, blood tests, anaesthetic assessment, physiotherapy assessment and nursing social assessment so that surgery is not delayed and can commence within 10 weeks of being seen by a GP and within six weeks of the pre-admission visit (in the absence of medical complications requiring longer treatment). This avoids the inconvenience to patients of multiple visits and reduces the likelihood of delays arising from changes in patients’ condition whilst awaiting treatment;
— keeping smaller ranges of prostheses so that staff become more proficient and productive in their use;
— administering regional anaesthesia instead of general anaesthesia for primary joint replacements reduces the anaesthetic risk;
— modern pain management techniques allow post-operative physiotherapy to commence earlier and so reduces the length of stay. Length of stay in our facilities is on average 10–20% shorter than in comparable NHS facilities. The benefit of this for the patient is less exposure to potential infection and better long-term outcomes;
— PHG has introduced innovative blood conservation processes that also improve patient outcomes. These are autologous cell saving systems, which soak up the patient’s own blood during and after surgery, separate out oxygen carrying red blood cells, put them in a closed sterile environment and then re-transfuse them in to the same patient. The system boosts 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 donor blood and eliminates the risk of infection from donor blood;
— the post-operative team provides advice and support to patients, where appropriate, following discharge. This includes arranging for the loan of equipment, such as walking frames, and conducting a home visit to provide advice on daily activities. At Barborough Links, PHG is responsible for post-operative physiotherapy and care in patients’ own homes providing better continuity of care than where this is normally provided by district nurses and social services; and
— the introduction of new “image guided surgery” techniques for joint replacement, using state of the art computer based 3-D images for aligning the new artificial joint to the skeleton, reduces average deviation from 4–7% to 1–2%. PHG’s ISTC’s will be amongst the first centres in the country to use this new technology.

Review and Evaluation

— Providers are required to report data on 26 Key Performance Indicators on a monthly basis. This enables the Department of Health to closely monitor performance and ensure that problems can be identified 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.
— 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.”

— 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 PHG consistently run at over 95% on a sample of nearly 50% of patients.

Choice and Competition

— Both PHG centres increase patient choice for elective treatment that improves the patient experience by encouraging both PHG and the traditional NHS providers to be more responsive and patient-centred.
We have found that local NHS Trusts have responded to the opening of PHG’s ISTCs by seeking to reduce their own waiting times. A number of patients who had been on lengthy waiting lists with NHS Trusts have been offered earlier dates for admission by their respective trusts once they had been offered a place at our ISTC.

Once “patient choice” is established and is operating in an open and consistent market, PHG will be prepared to create and provide services without volume guarantees and would consider the transfer of existing NHS personnel and infrastructure.

ISTCs Are Cost Effective

— The overriding benefit of procuring ISTCs is that there is a direct and contractual commitment to provide a given number of operations as opposed to the less certain impact of adding further funding to the established NHS.

— PHG works closely with PCTs to ensure that the targeted case volume is attained. This includes active communication with GPs and flexibility with case mix substitution and phasing of case throughput. PHG’s ISTCs are achieving 99% of the planned case volume.

— PHG was asked to establish an interim service within existing NHS facilities whilst the Barlborough Links facility was in construction and initially this service did have a shortfall against the planned activity. PCTs actively communicated the availability of this new service but were initially hampered by negative campaigning against the service by local Consultants. The allegation that it was an unsafe facility because it lacked a critical care unit was, at best, disingenuous in that the planned case mix did not require such a unit and in that those same Consultants carried out their own private practise in similar units. However, the interim service did become popular as a result of positive patient feedback to referring GPs and the targeted activity level was attained during the latter stage of the interim contract. For information, PHG actually incurred a net financial loss from the interim contract as costs of operating within existing NHS facilities proved to be more onerous than anticipated.

— A complaint against ISTCs is that they “cherry pick” operations. This is an emotive misrepresentation. To date, ISTCs have been focussed on providing routine operations for otherwise well patients as part of a sensible streaming of activity. This enables better treatment for both routine and complex cases and provides for a better patient experience. The Independent Sector would be quite prepared to deal with the total case mix requirement (but would still stream the activity) or with complex cases only. Indeed, PHG is now receiving complex cases, including hip and knee replacement revisions where the initial operation has been undertaken in an NHS Trust hospital.

— The tendency is for the cost of ISTCs to be compared to NHS reference costs. Whilst this offers a useful benchmark, care must be taken to allow for material differences in circumstance. For example, the Independent Sector carries the full cost of VAT, employee pensions and financing costs. These items alone would account for a cost differential of well in excess of 20%. ISTCs also have the cost of setting up new contracts and facilities, along with the cost of international recruitment. On the other hand, NHS Trusts carry the cost of clinical training.

— As has been widely reported, the NHS has traditionally paid incumbent Independent Sector providers a premium of 40% to 100% over reference costs. By bringing in new providers and by establishing long-term commitments, the ISTC programme has brought competition to the private market too, meaning lower costs are sustainable.

— There is a strong lobby for the “additionality” requirement of ISTCs to be relaxed and for there to be greater integration with existing UK clinical staff. Whilst PHG supports selective relaxation of additionality, evidence suggests that the level of competitiveness in the market is not yet sufficiently established. In developing solutions for wave 2 ISTCs, PHG has sought proposals from incumbent UK Consultants and has been surprised by the expected level of earnings, annualising at around £500,000 per Consultant—around four times higher than internationally sourced alternatives.

Training

In the wave 2, ISTCs will be expected to provide training. In addition, a number of ISTCs in the first wave will also offer training, including those in Nottingham, Maidstone, and North-East London. 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.
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;
- management of clinical services, including outcome measurement;
- 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; and
- 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 should be provided in the ISTC setting.

Partnership Health Group

15 March 2006

APPENDIX 1

TRENT AND PENINSULA ISTC’S: CLINICAL OUTCOMES:
22 MARCH 2004–30 JANUARY 2006

<table>
<thead>
<tr>
<th>Patients operated and discharged (excluding re-admissions)</th>
<th>Percentage of operated and discharged</th>
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</thead>
<tbody>
<tr>
<td>Total Surgery</td>
<td>7,617</td>
</tr>
<tr>
<td>Hip Replacements</td>
<td>1,693</td>
</tr>
<tr>
<td>Hip Revisions (Part of Minimum Take)</td>
<td>11</td>
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<tr>
<td>Knee Replacements</td>
<td>2,149</td>
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<tr>
<td>Knee Revisions (Part of Minimum Take)</td>
<td>5</td>
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<tr>
<td>Minor surgery</td>
<td>3,759</td>
</tr>
<tr>
<td>DNA Say Surgery</td>
<td>28</td>
</tr>
<tr>
<td>DNA In-Patients</td>
<td>17</td>
</tr>
<tr>
<td>Surgery Cancelled for Clinical Reasons</td>
<td>121</td>
</tr>
<tr>
<td>Surgery Cancelled for Non-Clinical Reasons</td>
<td>21</td>
</tr>
</tbody>
</table>

1. REASONS FOR CLINICAL CANCELLATIONS (SUMMARISED)

Cancelled after Outpatient Assessment

- Require further diagnostics
- Cardiac Problems
- Hypertension
- COAD
- Circulatory Problems
- Require ITU Facilities
- Other Procedure Required
- No Surgery Required
- Urinary Tract Infection B X-Rays not available
- Circulatory Problems

2. CANCELLED AFTER SURGERY HAS BEEN BOOKED

Clinical Reasons

- Unforeseen other surgery
- Hypertension
— Septic Lesion
— Flu
— MRSA Positive
— Persistent Urinary
— Tract Infection/Blood in Urine Prolapsed Uterus
— LowHB
— Swollen Leg
— Medication/Aspirin
— High CRP
— Abnormal Egg

Non Clinical Reasons
— Patient Choice
— X-Ray not available
— Social Problems

Clinical Outcomes

1. Returned to theatre for unforeseen procedure

<table>
<thead>
<tr>
<th>Patients Operated and Discharged</th>
<th>Return to Theatre</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,617</td>
<td>159</td>
<td>2.08%</td>
</tr>
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</table>

Reasons Return to Theatre (Summarised)
Manipulation under anaesthetic (knee) 17
Dislocation 14
Wound Inspection and Debridement 34
Secondary Suturing 2
Prosthetic Component Replacement/Revision 5
Insertion/Removal of Drain 2
Removal of Pin 2
Removal of K-Wire 1

2. Transferred to another provider for treatment

<table>
<thead>
<tr>
<th>Patients Operated and Discharged</th>
<th>Transferred</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>7,617</td>
<td>25</td>
<td>0.32%</td>
</tr>
</tbody>
</table>

Reasons Transferred (Summarised)
Cardiac Arrest 2
Dislocation—Admired QMC 1
Uncontrolled Hypertension 2
Pneumonia 1
Stroke 1
Bowel Obstruction 1
Urinary Retention 2
Chronic Diarrhoea 1
Respiratory Arrest 1
Ischemic Changes on ECCT 4
Peptic Bleeding Gastric Ulcers 1
on-Procedure related incident (Car Accident) 1
DVT 2
3. Re-admission within 29 days after discharge

<table>
<thead>
<tr>
<th>Patients Operated and Discharged</th>
<th>Re-admitted</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,617</td>
<td>174</td>
<td>2.28%</td>
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Reasons Re-admitted

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returned to theatre (Re-admitted)</td>
<td>72</td>
</tr>
<tr>
<td>Pain Management</td>
<td>12</td>
</tr>
<tr>
<td>Oozing Wound</td>
<td>8</td>
</tr>
<tr>
<td>Suspected DVT</td>
<td>7</td>
</tr>
<tr>
<td>Fall at home</td>
<td>5</td>
</tr>
<tr>
<td>Blisters/cellulites</td>
<td>3</td>
</tr>
<tr>
<td>Swollen Leg/Feet</td>
<td>3</td>
</tr>
<tr>
<td>Haematoma</td>
<td>2</td>
</tr>
<tr>
<td>Social Reasons</td>
<td>2</td>
</tr>
</tbody>
</table>

4. Clinical outcomes

<table>
<thead>
<tr>
<th>Patients Operated and Discharged</th>
<th>Re-admitted</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nosocomial Infection</td>
<td>32</td>
<td>0.4%</td>
</tr>
<tr>
<td>Community acquired infection</td>
<td>19</td>
<td>0.24%</td>
</tr>
<tr>
<td>Unexpected admission to HDU/ITU</td>
<td>9</td>
<td>0.11%</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>3</td>
<td>0.03%</td>
</tr>
<tr>
<td>Adverse incidents</td>
<td>92</td>
<td>1.20%</td>
</tr>
<tr>
<td>Allergic reaction</td>
<td>9</td>
<td>0.11%</td>
</tr>
<tr>
<td>Deep Vein Thrombosis</td>
<td>5</td>
<td>0.06%</td>
</tr>
<tr>
<td>Pulmonary Embolism</td>
<td>2</td>
<td>0.02%</td>
</tr>
<tr>
<td>Death</td>
<td>4</td>
<td>0.05%</td>
</tr>
<tr>
<td>Transfer to NHS Trust Hospital</td>
<td>23</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

Patient satisfaction based on survey—at least 10% of Patients

<table>
<thead>
<tr>
<th>Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patients seen</td>
<td>9,982</td>
</tr>
<tr>
<td>Total Responses</td>
<td>4,790</td>
</tr>
<tr>
<td>Overall Patient Satisfaction</td>
<td>95</td>
</tr>
</tbody>
</table>

Rate of patient complaints as % of all patients Referred

<table>
<thead>
<tr>
<th>Patients</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patients referred</td>
<td>9,982</td>
</tr>
<tr>
<td>Total number of complaints</td>
<td>163</td>
</tr>
</tbody>
</table>

Comparison/Benchmark Outcome Data
Nottingham City Hospital (NCH) & Partnership Health Group (PHG)

1. INTRODUCTION
   - The data collection was not standardised, but approximates each other and for practical purposes adequately illustrates the point being made.
   - The basis of PHG data is DOH KPI returns.
   - The period of comparison is one year’s data but is not the same period.

2. PERIOD OF DATA COLLECTED
   - Nottingham City Hospital (NCH): 18 August 2003—17 August 2004
   - Partnership Health Group (PHG): 1 April 2004—30 March 2005
3. **Number of Operations**

<table>
<thead>
<tr>
<th></th>
<th>NCH</th>
<th>PHG Total Majors—1,462</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>351</td>
<td>626</td>
</tr>
<tr>
<td>Knee Replacements</td>
<td>343</td>
<td>836</td>
</tr>
<tr>
<td>Revision Replacements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Hip</td>
<td>64</td>
<td>6</td>
</tr>
</tbody>
</table>

4. **Median Age**

*Hip Replacement*

<table>
<thead>
<tr>
<th></th>
<th>NCH Male</th>
<th>NCH Female</th>
<th>PHG Male</th>
<th>PHG Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>67</td>
<td>71</td>
<td>69</td>
<td>68</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>65.5</td>
<td>69</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>70</td>
<td>72</td>
<td>70</td>
<td>68</td>
</tr>
</tbody>
</table>

5. **Median Length of Stay by Operation**

<table>
<thead>
<tr>
<th></th>
<th>NCH Male</th>
<th>NCH Female</th>
<th>PHG Male/Female Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>6</td>
<td>7</td>
<td>5.6</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>6</td>
<td>7</td>
<td>5.7</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>7</td>
<td>7</td>
<td>5.5</td>
</tr>
</tbody>
</table>

PHG: LOS not measured by sex and average LOS per procedure, not median.

6. **Post-Operative In-Hospital Complication (Outcomes Data)**

<table>
<thead>
<tr>
<th>Complication</th>
<th>NCH All Compl: 694</th>
<th>PHG All Compl: 1462</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
</tr>
<tr>
<td>Dislocation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DVT</td>
<td>6</td>
<td>0.9</td>
</tr>
<tr>
<td>PE</td>
<td>15</td>
<td>2.2</td>
</tr>
<tr>
<td>MI</td>
<td>6</td>
<td>0.9</td>
</tr>
<tr>
<td>Stroke/CVA</td>
<td>2</td>
<td>0.3</td>
</tr>
<tr>
<td>Urinary Retention</td>
<td>4</td>
<td>0.6</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>107</td>
<td>15.4</td>
</tr>
<tr>
<td>GI Bleed</td>
<td>7</td>
<td>1.0</td>
</tr>
<tr>
<td>Pressure Sore</td>
<td>4</td>
<td>0.6</td>
</tr>
<tr>
<td>Re-op Same Admission</td>
<td>4</td>
<td>0.6</td>
</tr>
<tr>
<td>Haematoma</td>
<td>21</td>
<td>3.0</td>
</tr>
<tr>
<td>Death</td>
<td>2</td>
<td>0.3</td>
</tr>
<tr>
<td>Lower Respiratory Tract Infection</td>
<td>5</td>
<td>0.7</td>
</tr>
<tr>
<td>UTI</td>
<td>9</td>
<td>1.2</td>
</tr>
<tr>
<td>Hosp Acquired Infection</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>Major Wound Infection</td>
<td>12</td>
<td>1.7</td>
</tr>
<tr>
<td>Minor Wound Infection</td>
<td>2</td>
<td>0.3</td>
</tr>
</tbody>
</table>
7. **Post-Operative Complications after Six Weeks**

<table>
<thead>
<tr>
<th>Complication</th>
<th>NCH</th>
<th></th>
<th>PHG</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MUA</td>
<td>0.8</td>
<td>0.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocation</td>
<td>0.2</td>
<td>0.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DVT</td>
<td>1.8</td>
<td>0.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE</td>
<td>1.2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td>0.6</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke/CVA</td>
<td>0.2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower Resp. Tract.</td>
<td>1.0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary Retention</td>
<td>2.0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Wound Infection</td>
<td>4.1</td>
<td>0.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Wound Infection</td>
<td>10.5</td>
<td>0.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haematoma</td>
<td>2.0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. **Re-Admission to Hospital Within 30 Days**

<table>
<thead>
<tr>
<th>Complication</th>
<th>NCH</th>
<th></th>
<th>PHG</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MI</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INR Monitoring (Planned)</td>
<td>0.4</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UTI</td>
<td>0.3</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arm/Wrist</td>
<td>0.3</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. **Re-Admission to Hospital Within 30 Days**

<table>
<thead>
<tr>
<th>Complication</th>
<th>NCH</th>
<th></th>
<th>PHG</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Resp Tract Infection</td>
<td>0.3</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duodenal Ulcer</td>
<td>0.1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUA</td>
<td>0.3</td>
<td>0.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Wound Infection</td>
<td>Not available</td>
<td>Not available</td>
<td>9</td>
<td>0.61</td>
</tr>
<tr>
<td>Dislocation</td>
<td>Not available</td>
<td>Not available</td>
<td>4</td>
<td>0.27</td>
</tr>
<tr>
<td>Revision/Replacement</td>
<td>Not available</td>
<td>Not available</td>
<td>4</td>
<td>0.27</td>
</tr>
</tbody>
</table>

10. **Cancellation, Day of Surgery with Reasons**

<table>
<thead>
<tr>
<th>Reason</th>
<th>NCH</th>
<th></th>
<th>PHG</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancelled Clinical Reasons</td>
<td>3.6%</td>
<td>3.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancelled Non-Clinical Reasons</td>
<td>2.3%</td>
<td>0.95%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* All information was provided by the Strategic Health Authority (Trent)
Supplementary letter from Partnership Health Group (ISTC 52B)

We have noted Unison’s submission to the select committee and thought the committee might be interested in our response in advance of the session on 23 March.

In respect of some of the general issues they have raised, I have enclosed a copy of our letter to Ken Anderson dated 6 February 2006. You will see that it is our view that Unison’s allegations are exaggerated or historical issues that have long been dealt with.

In response to their comments in section 11.2 on page 151, I thought it appropriate to add the following:

PHG’s HR Director commenced in post on 2 November 2005. A letter was received from Unison dated 25 November, addressed to PHG’s Acting Managing Director, raising what they perceived to be a number of workforce concerns. The HR Director contacted Unison by telephone (Adam Geldman) to introduce herself, explain her people management approach and to offer some reassurance about her early intentions to look into and address, where appropriate, the concerns they had raised. In relation to their request for formal recognition, the HR Director requested more time, reminding them that she had only been in post three weeks at that stage.

On 12 December the HR Director wrote to Mr Geldman providing an outline of progress made on some of the issues they had raised, including details of some of the early plans in place to improve employee relations. This included an update on new HR policies (that are ACAS, CIPD and best practice compliant); details of a new management development programme to ensure middle managers were fully trained in people management practices to support staff at the ISTCs; early indication of PHG’s plans in relation to partnership and involvement, including Staff Forums at each ISTC; clarification on confusion around overtime payments and issues to do with staff working at PHG’s satellite clinics. The letter also sought to open up discussions about union recognition for the whole of PHG, rather than dealing with issues on an ISTC by ISTC basis which was not seen to be the most effective model. The HR Director closed the letter by saying that she would be very happy to meet and discuss.

Since late January the HR Director has been attempting to set up a meeting between Mr Geldman, herself, and Mr Rex (PHG’s Managing Director). Due to repeated problems in contacting Mr Geldman (who works part-time) and non-response to email and voicemail messages made by PHG, the meeting date was only agreed on Friday 10 March for the meeting to take place on 13 April (date finally offered by Unison).

PHG’s HR Director is professionally qualified, has twenty years experience and a strong track record in best practice people management. Unison’s view that they have “sought on several occasions to raise the issues with PHG, but sadly they have declined at every stage” is clearly not true. We have made, and continue to make positive strides in respect of employee relations within the organisation. PHG would welcome support from Unison in doing this, but are concerned about their negative approach to date and the inaccuracies conveyed about PHG by them to third parties.

I trust this information is useful when considering Unison’s submission. Please do not hesitate to contact myself or Joanne Clifton, Director of Human Resources should you require any further information.

Grant Rex
Managing Director, Partnership Health Group
20 March 2006

Evidence submitted by the National Centre for Health Outcomes Development (ISTC 53)

1. This is a brief comment to introduce our oral evidence.

2. The National Centre for Health Outcomes Development (NCHOD) is an independent research centre based jointly at the London School of Hygiene and Tropical Medicine, University of London and the Department of Public Health, University of Oxford. It is involved in the design and development of measures of health outcome, production of comparative clinical and health indicators for the National Health Service using available routine data, and electronic publication of extensive statistical and bibliographic information about health outcomes. NCHOD provides an ISTC Performance Management Analysis Service to the Department of Health under contract.

3. A preliminary report presenting an overview of retrospective performance, with regards to 26 contractual Key Performance Indicators (KPIs), of four ISTC schemes covering five providers, was submitted in October 2005 and published by the Department of Health. This report has been referred to a number of times in the evidence presented to the Health Select Committee on 9 March and is attached here for completeness. Analysis for a second report is currently under way.

8 Not printed here.

4. The first report made constructive comments about some shortcomings in the process of data collection, collation and reporting, acknowledging that these were first steps in an evolving service. The following are some of the points we made and progress to date in addressing them:

(a) The specifications of some of the KPIs made interpretation of performance difficult. The specifications have since been reviewed by the Department of Health and tightened, in the light of our comments;

(b) There was substantial variation in the interpretation of the definitions of the KPIs and their component parts between ISTC schemes, between component parts of the schemes and over time within schemes/component parts. The template and instructions for collection of data on the KPIs have since been revised by the Department of Health, in order to ensure consistency of interpretation;

(c) There was variation between schemes in the completeness and quality of data submitted, rendering attempts at commenting on trends and comparisons between schemes and with any external benchmarks difficult. The Department of health has made efforts since to ensure higher levels of completeness and quality of data. We have just received the data for the next round of reports;

(d) Missing from what is potentially a robust and ambitious performance monitoring system were data on clinical outcomes, for example the extent to which hip replacement operations actually lead to the expected improvements in mobility and reduction in pain, the extent to which a cataract operation improves vision etc. Data collection on such indicators is likely to commence in April and should lead to a better assessment of the quality of clinical care;

(e) In making our assessments and judgements we are entirely dependent on data supplied to us by the ISTCs via the Department of Health. We have no way of judging the accuracy of the data submitted and have to take them at face value. We recommended independent validation, for example an audit of a sample by comparison with case notes. The Department of Health is exploring ways of doing this.

5. One of the terms of reference of this inquiry is whether ISTCs are providing care of the same or higher standard as that provided by the NHS. In order to assess this, both the NHS and the ISTCs would need to collect the same data, in the same way, for the same kinds of patients. In the absence of such data, it is important to resist drawing conclusions from anecdotes. The example below, while strictly not applicable, is illustrative of what is needed and the complexities involved in addressing this term of reference.

6. This study, based on existing routinely collected data, shows the proportion of patients readmitted to hospital as an emergency within 28 days of previous discharge, and compares patients treated in NHS hospitals and NHS patients treated by the independent sector (see Table). These data cover all types of patients aged 16 years and over (except those with cancer), not just those types of patients treated by ISTCs. Within the independent sector category, the figures cover all NHS patients treated by the independent sector, not just those treated by the ISTCs. For comparability, the percentages have been adjusted to take into account differences between Trusts in terms of patient age, gender, method of original admission, diagnoses and operations. However, the results may still reflect other differences in the types of patients treated by the two sectors. The percentages, as a reflection of what typically happens in such settings, are subject to random variation. The 95% confidence interval provides a measure of the uncertainty created by such variation and gives the range within which the true percent is most likely to be (with 95% probability) given the number of patients involved. The relatively smaller number of patients treated by the independent sector results in wider margins. Any comparison of percentages and the identification of differences should be done with consideration of the confidence intervals. These unpublished data show that there is no statistically significant difference in the proportion of patients readmitted between patients treated in NHS hospitals and NHS patients treated by the independent sector. The study was undertaken as part of work we have done for the Healthcare Commission, in the context of NHS Performance Ratings and is quoted here for illustrative purposes.

### EMERGENCY READMISSIONS TO HOSPITAL WITHIN 28 DAYS OF PREVIOUS DISCHARGE FROM HOSPITAL, ENGLAND, 2004

<table>
<thead>
<tr>
<th></th>
<th>% readmissions</th>
<th>% lower limit of 95% confidence interval</th>
<th>% upper limit of 95% confidence interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>All NHS Trusts in England</td>
<td>9.25</td>
<td>9.22</td>
<td>9.28</td>
</tr>
<tr>
<td>Small Acute Trusts</td>
<td>8.77</td>
<td>8.68</td>
<td>8.85</td>
</tr>
<tr>
<td>Medium Acute Trusts</td>
<td>9.18</td>
<td>9.12</td>
<td>9.24</td>
</tr>
<tr>
<td>Large Acute Trusts</td>
<td>9.15</td>
<td>9.10</td>
<td>9.20</td>
</tr>
<tr>
<td>Independent Sector</td>
<td>9.39</td>
<td>7.87</td>
<td>11.12</td>
</tr>
</tbody>
</table>

Source of data: Hospital Episodes Statistics, Department of Health.
National Centre for Health Outcomes Development

14 March 2006
Evidence submitted by Mendip Primary Care Trust (ISTC 54)

1. INTRODUCTION

1.1 This paper has been prepared for the Health Select Committee and sets out the development and establishment of the Shepton Mallet Treatment Centre.

2. BACKGROUND

2.1 As outlined in the Department of Health prospectus “Growing Capacity”, issued in December 2002, the National Health Service (NHS) needs to increase its available capacity in order to meet the reduction in waiting times planned for 2005 and beyond to 2008. By December 2005, no patient will have waited more than eighteen weeks for an initial outpatient appointment and no longer than six months for the inpatient treatment they may need. By December 2008, the maximum wait should be 18 weeks. Meeting and maintaining these demanding targets requires a permanent increase in capacity.

2.2 The Government and the NHS have sought a real step change in productivity by seeking to engage the independent sector in this initiative. Commissioning Primary Care Trusts expected dynamic and innovative solutions to provide an environment for patients that is conducive to the provision of first class clinical care. The Independent Sector Treatment Centre programme represented a unique opportunity for the NHS and independent sector to work in partnership.

2.3 The core objective of the Independent Sector Treatment Centre in Dorset and Somerset was to procure a service that would:

— provide clinical services and not simply capital solutions;
— deliver activity in 2005 at the latest;
— provide genuine additionality of staff;
— provide patient choice;
— contribute to the long term development of partnerships between the independent sector and the NHS; and
— deliver high clinical standards and value for money.

2.4 The Shepton Mallet Treatment Centre is one of ten local schemes and has been delivered within a central framework set by a national template for the Project Agreement.

2.5 The defining characteristics of the vision for the Shepton Mallet Treatment Centre are that it:

— exemplifies best practice and forward thinking in the design and delivery of the services provided, with services that are streamlined and modern, using defined patient care pathways;
— delivers high volumes of activity in a pre-defined range of routine treatments and or diagnostics, adding significantly to the capacity of the Dorset and Somerset Health Community to treat its patients;
— delivers scheduled care that is not affected by demand for, or provision of, unscheduled care;
— has services that are planned and booked, with an emphasis on patient choice and convenience together with organisational ability to deliver;
— provides a high quality patient experience; and
— creates a positive environment that enhances the working lives of staff.

2.6 To achieve this vision, it was recognised that the project would require new and innovative ways of working and need to harness world-class healthcare practices to achieve the best possible outcomes for patients and the best value for the NHS.

2.7 The decision to procure an independent sector Treatment Centre as opposed to a traditional NHS development was that it offered:

— rapid access to a major step change in capacity in specialties that had long term waiting times issues such as orthopaedics;
— contestability with local NHS organisations as it would be a catalyst to improve performance further across Dorset and Somerset. It was envisaged that both NHS Trusts and existing independent sector providers would need to change to meet this challenge; and
— an opportunity for innovation and new ways of working.
3. Development of the Shepton Mallet Treatment Centre

3.1. The development of the Shepton Mallet Treatment Centre has been driven through a close collaboration between the Dorset and Somerset Strategic Health Authority and the following five Primary Care Trusts:

- Mendip Primary Care Trust.
- South Somerset Primary Care Trust.
- Somerset Coast Primary Care Trust.
- Taunton Deane Primary Care Trust.
- North Dorset Primary Care Trust.

3.2. In response to the request from the Department of Health for interest in the Independent Sector Treatment Centre programme the Dorset and Somerset Health Community submitted a proposal for a stand alone purpose built Independent Sector Treatment Centre to serve a population of 609,000.

3.3. The population of the five Primary Care Trusts is served by the following NHS Trusts:

- Taunton and Somerset NHS Trust.
- East Somerset NHS Trust.
- Weston Area Health NHS Trust.
- Royal United Hospital Bath NHS Trust.

3.4. The above providers were struggling to deliver the national and local waiting time targets and Primary Care Trusts were already commissioning additional capacity through the local independent sector. The rurality of the population and focus on a small number of local NHS Trusts was felt to limit patient choice and reduce the leverage of the commissioners to modernise services. The Independent Sector Treatment Centre programme was recognised as an opportunity to eradicate waiting times for key specialties and act as a catalyst for modernisation and innovation.

3.5. A strong project team was established to lead the selection of preferred bidders including Primary Care Trust Chief Executives, a Director of Finance, local general practitioners and representatives of the Dorset and Somerset Strategic Health Authority.

3.6. Following an extensive evaluation process involving both the local sponsors and the commercial team at the Department of Health, the Shepton Mallet Treatment Centre was awarded to ORI International specialty hospital developers in 2003. ORI International had formed a partnership with the following two organisations:

- WS Atkins plc to lead the building of the new hospital;
- New York Presbyterian to provide technical and clinical expertise.

3.7. The partnership was awarded the contract on the basis that:

- it could demonstrate value for money;
- through the involvement of WS Atkins plc the partnership had expertise in delivering building projects such as the proposed Shepton Mallet Treatment Centre within very short timescales;
- through the involvement of New York Presbyterian the partnership had experts with world renowned clinical expertise and evidence of the ability to deliver high quality patient care.

3.8. Both the sponsoring Primary Care Trusts and ORI International were committed to introducing new ways of working to increase the capacity of the proposed facility and improve clinical outcomes.

4. Building Programme

4.1. The site at Shepton Mallet, selected for the Independent Sector Treatment Centre, was chosen because it was within a 30 mile radius of the key population centres of Taunton, Yeovil, Bristol, Weston-super-Mare and Salisbury offering potentially large populations for high volume procedures.

4.2. There was an extensive consultation programme involving local councils, public forums and local residents meetings throughout the construction to address any concerns.
4.3 The building was a new build, modern, purpose designed healthcare facility intended to provide on-site diagnostics and surgical treatments for over 11,800 patients a year. By using an innovative modular construction process the centre took only 42 weeks to build and was handed over for the final phase of mobilisation in the middle of July 2005.

4.4 Shepton Mallet Treatment Centre provides:
   — 34 beds;
   — four operating theatres;
   — MRI scanner and diagnostic services;
   — outpatient clinics;
   — on site sterilisation facilities; and
   — 22 doctors and 52 trained nurses (recruited mainly from Europe).

5. Mobilisation

5.1 The sponsoring Primary Care Trusts nominated Mendip Primary Care Trust as the lead commissioner for the project. Mr Robin Smith, Chief Executive, was appointed as Chairman of a Project Implementation Board with membership drawn from key stakeholders in the health community, including social services and general practitioners.

5.2 A mobilisation programme was developed covering key areas, such as:
   — building;
   — human resources;
   — clinical care pathways and quality assurance;
   — performance management;
   — referral processes;
   — information and information technology; and
   — media and communications.

5.3 A Project Director was appointed to lead the project and manage the programme in accordance with identified key milestones. The Project Director was supported by a nominated local general practitioner to act as GP liaison for the project and managers and clinical leads drawn from the health community.

5.4 As planned, the facility opened on 15 July 2005 with a planned ramp up programme of work to allow the clinical teams to gain confidence in the new building and in the equipment and to respond to any early problems. Outpatients commenced on 15 July 2005, day cases commenced on 18 August 2005 and inpatients commenced on 18 September 2005. Between the dates of 15 July to 31 December 2005 the Shepton Mallet Treatment Centre has seen 4,521 outpatients and treated 2,742 patients.

5.5 The maximum waiting times for the Shepton Mallet Treatment Centre from referral to treatment is fourteen weeks and already ahead of the national 18 week waiting time target that has to be achieved by 2008. 60% of patients are treated in less than 9 weeks from referral by their GP to treatment. The population of Dorset and Somerset have for a number of years experienced some of the shortest waiting times in the country and these waiting times at the Shepton Mallet Treatment Centre are below even that level.
5.6 Patient satisfaction is very high, with 97% of patients rating the treatment they have received as excellent or very good.

5.7 Early clinical outcome data is showing clear evidence of excellence in clinical practice when compared to NHS outcome data.

6. THE PROJECT AGREEMENT

6.1 The Shepton Mallet Treatment Centre has been established within a central framework of the Project Agreement. The Commercial Directorate of the Department of Health developed a national framework for commissioning the Independent Sector Treatment Centre programme, including a template for the Project Agreement.

6.2 The contract negotiations for the Shepton Mallet Treatment Centre were led by a Dorset and Somerset Strategic Health Authority appointed Project Team led by Mendip Primary Care Trust. At the point of commercial and legal close, the programme was handed over to the five sponsoring Primary Care Trusts. However, this continued to be led by Mendip Primary Care Trust.

6.3 The approach was linked to the following key policy agendas:
   — Capacity Planning.
   — Financial and Capital Planning.
   — Delivery of Local Delivery Plans and associated targets.
   — Patient Choice.

6.4 The Commercial Directorate within the National Implementation Team at the Department of Health provided additional skills and expertise to ensure the successful negotiation of the contract, particularly in respect of the commercial evaluation of property, hard facilities management and financial modelling. However, the National Implementation Team lacked the detailed knowledge of local NHS operational management and how this independent provider would integrate with the local NHS. Through the life of the project there was a need to get the balance right between national and local requirements in areas such as designing care pathways, mobilisation plans and establishing the Information Management and Technology infrastructure. This was caused some tensions at the time but was overcome by close working between the National Implementation Team and the local Project Implementation Board and addressing issues on a one by one basis.

6.5 The Project Agreement is complex and different to agreements used in the NHS between Primary Care Trusts and NHS Trusts. As a result, there needs to be more contract and performance management than for a similar value NHS Trust Agreement.

6.6 The payment mechanisms are on a cost and volume 95% to 100% contract and Payment by Results is not applied.

7. THE REFERRAL PROCESS

7.1 The contract with the Shepton Mallet Treatment Centre is for a range of HRGs from the three surgical specialties of orthopaedics, general surgery and ophthalmology as well as endoscopy procedures.

7.2 Each specialty has a sub set of procedures that the Shepton Mallet Treatment Centre is able to treat. Within each specialty, each HRG code is broken down into specific operation procedure codes that can be undertaken at the Shepton Mallet Treatment Centre.

7.3 The Shepton Mallet Treatment Centre treats patients who are stable ASA3 or below. Potential high risk patients or those with complex medical history, are not considered suitable.

7.4 All referrals to the Shepton Mallet Treatment Centre are made through a Forward Order Book, which transmits the referral information daily to the Shepton Mallet Treatment Centre. This Forward Order Book is maintained by the Contract Management Team based at the Somerset Referral Management Centre in Bridgwater, Somerset.

7.5 There are four ways of making a referral to the Shepton Mallet Treatment Centre. These are as follows:
   — direct referral from a general practitioner through the Somerset Referral Management Centre;
   — clarification of a general practitioner referral through the Somerset Referral Management Centre, of a suitable referral that has been made to another hospital;
   — direct referral from an orthopaedic interface clinic; and
   — waiting list transfer from another hospital.
7.6 The overall volume of referrals by type for the period November 2005 to January 2006 were:

<table>
<thead>
<tr>
<th>Referrals</th>
<th>November 2005</th>
<th>December 2005</th>
<th>January 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct GP referrals</td>
<td>33%</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>GP referrals after clarification</td>
<td>40%</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>Interface Clinics</td>
<td>6%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Waiting List transfers</td>
<td>21%</td>
<td>19%</td>
<td>21%</td>
</tr>
</tbody>
</table>

7.6 Once a referral has been made to the Shepton Mallet Treatment Centre, the Centre has the opportunity to accept or return the referral. The return rate for the first six months has run at 15% of all referred patients.

8. **KEY ISSUES AND CHALLENGES**

8.1 The establishment of the Shepton Mallet Treatment Centre has been a complex and challenging project involving close partnership between the local health community and the independent sector provider. The project continues to grow from strength to strength, but it is recognised that there remain some challenges to overcome if the full vision is to be delivered.

*Cultural Change and Innovation*

8.2 The opening of the Shepton Mallet Treatment Centre has represented a significant cultural change across Somerset and North Dorset for both general practitioners and NHS Trusts.

8.3 For general practitioners the Shepton Mallet Treatment Centre represents an opportunity to offer patients an alternative treatment location with shorter waiting times. Marketing and maintaining referral levels remains an ongoing issue. It is envisaged that Choose and Book will help highlight this as a choice option for patients.

8.4 For NHS Trusts the Shepton Mallet Treatment Centre represents both an opportunity and a threat. NHS Trusts have already improved their waiting times to compete directly and others are starting to differentiate. An example is ophthalmology where an NHS Trust is concentrating on complex eye surgery and reducing the number of routine cataracts. This service re-design has considerable further potential which is to be addressed by Primary Care Trusts through Local Delivery Plans.

8.5 There has been some isolated examples of resistance to the Shepton Mallet Treatment Centre from both general practitioners and hospital clinicians. These have been appropriately dealt with by local management.

8.6 The introduction of the Shepton Mallet Treatment Centre has seen changes in the behaviours of other independent sector providers. The biggest change has been a reduction in the price charged for and a desire to agree contracts rather than charging for ad hoc referrals on a case by case basis.

8.7 The Shepton Mallet Treatment Centre has introduced a number of innovative practices around their procedures and clinical treatment. It is hoped that where suitable these will be adopted by local NHS organisations. However, it is too early at present to evaluate this.

*Additionality*

8.8 The stipulation of the Project Agreement that the Shepton Mallet Treatment Centre is not allowed to recruit professional staff who have worked for the NHS in the past six months is intended to ensure that the Independent Sector Treatment Centre programme delivers genuine additional capacity to the NHS.

8.9 Additionality was a successful strategy for the establishment of the Shepton Mallet Treatment Centre. As the local NHS is developing and responding to the Shepton Mallet Treatment Centre it is hampering integration. There are now examples whereby local NHS Staff wish to work their uncommitted hours in the Shepton Mallet Treatment Centre but cannot under the terms of the Project Agreement.

8.10 The development of new services and reduction of local clinical resistance would be improved by a review of the current additionality rules.

9. **FUTURE INDEPENDENT SECTOR PROGRAMMES**

9.1 The lessons learnt from this programme have proved invaluable for future independent sector procurement programmes. One of the biggest challenges remains ensuring that all available capacity is used and that this matches demand. Flexibility in service provision and the contractual terms are essential for this to be achieved.
9.2 As waiting times fall across Dorset and Somerset, one of the key attractions of the Shepton Mallet Treatment Centre will be eroded. In four to five years, all organisations in Dorset and Somerset will be operating on a far more competitive basis. The establishment of Practice Based Commissioning, Patient Choice and NHS Foundation Trusts will have an impact on the longer term success of the project.

10. **Conclusion**

10.1 The Shepton Mallet Treatment Centre has already proved it can deliver high quality clinical outcomes, excellence in patient care, and fast treatment to the population of Dorset and Somerset. The project overall has successfully delivered a fully functioning, fully staffed modern facility on time and on budget, within a timescale that would prove difficult for the traditional delivery methods of the NHS to have achieved. In addition to expanding choice and reducing waiting times for patients the establishment of the Shepton Mallet Treatment Centre has had a beneficial wider impact on the whole of the local health community.

Mendip Primary Care Trust  
21 March 2006

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**Evidence submitted by Jane Hanna (ISTC 55)**

This statement is made by Jane Hanna, former non-executive director of South-West Oxfordshire Primary Care Trust (PCT).

My interest in this matter is as a former non-executive Director of South-West Oxfordshire Primary Care Trust (2001–2004) and non-executive Director of the Oxford Radcliffe Infirmary NHS Trust (1993-1997); as a tutor in constitutional and administrative law at Keble College, Oxford and as a district councillor for the Vale of the White Horse, Oxfordshire. I became committed to public and patient involvement in the NHS following the sudden unexpected death of my partner in 1990, which also led to my founding a health charity, Epilepsy Bereaved and working as a member of the Joint Epilepsy Council.

**Summary**

The experience of the Netcare contract below represents a good test case for detailed investigation of ISTCs as there is significant material available revealing fundamental flaws in the existing ISTC programme. There is evidence of abuse of process at the highest levels of the government; a failure in sound planning processes and in particular financial stewardship of public funds and a failure in transparency and accountability. I am aware of serious issues raised about transparency on quality of service and understand litigation is pending.

In Oxfordshire ISTCs have been forced on PCTs regardless of local concerns on quality; financial risks and impact on local services. Accountability has been evaded by PCTs being required to approve contracts but at the same time instructed to present decisions as local decisions of a statutory board. Unless the issue of issue of abuse of process and accountability is tackled it is impossible to properly evaluate the ISTC programme in an objective way either retrospectively or going forward in the future.

**Abuse of Process**

I believe that South-West Oxfordshire PCT was the only PCT board in England to vote against the contracting out of cataract operations to Netcare. The decision of the PCT was necessary to authorise the signing of the contract with Netcare in the absence of national legislation or a national directive from the Secretary of State for Health overriding the devolved decision to the PCT. I would like to reinforce the evidence of previous witnesses highlighting concerns about the imposition of national policy in this area. Our repeated requests for a written directive from the Secretary of State removing the responsibility of the local PCT was refused, but instead policy was imposed through private, informal methods which included threats and bullying. The effect of this was to compromise the independence and objectivity of at least four statutory boards (South-West and South-East Oxfordshire PCTs; Cherwell Vale PCT and Thames Valley Strategic Health Authority). Until this abuse of power is accounted for and measures put in place to prevent this happening in the future, it will not be possible for the public to have any satisfactory confidence in the ISTC programme.

Regarding abuse of process the former Chair of the Strategic Health Authority and the former Chair of the South-West Primary Care Trust have previously submitted evidence to this committee on changes in primary care which support the factual basis of my memorandum to the Health Select Committee on Changes to Primary Care but also add to it by providing evidence that the responsibility for the abuse of process that occurred lay with the highest levels of government. Certainly both Nigel Crisp and the former Secretary of State for Health, Dr John Reid were made aware of serious allegations of abuse of process including bullying from December 2004 through to June 2005 through questions in Parliament and
interviews on the Radio 4 Today and File on Four programmes. There has been no public or internal investigation into what happened and all job losses have fallen on 5 non-executive members of Boards who raised questions concerning the matter (one non-executive member was sacked in January 2006 and has started litigation against the NHS Appointments Commission).

DISREGARD FOR LOCAL INTERESTS

The SW PCT Board voted not to approve the private cataracts unit because it was against the local public interest. The Board was being asked to approve a contract that would transfer activity from the local NHS provider that had an excellent reputation as a centre of excellence and was already target to meet the six month waiting target before any private treatment centre would open its doors.

The PCT Board decision to consult with the local population was overridden because of an interpretation by the Department of Health that treatment centres did not constitute a “significant variation in the provision of a service.”

Despite the policy being built on patient choice, there was a complete lack of regard for securing the views of patients and the public or of local clinicians. Although the costs of the ISTC were small in relation to the overall budget, the costs might well have been viewed as significant by a local public facing closures of local hospitals and cuts in local services in other areas. Individual patient choice in Oxfordshire seems highly questionable given the lack of standardised information available to patients as well as some evidence of the NHS service not being included in meetings about the choice agenda with community professionals.

The recent review by the South-West Oxfordshire PCT concludes that “the uptake of slots for Netcare has been slow. The population commonly requiring cataract surgery is elderly, and the Oxford Radcliffe Hospitals have a strong reputation and short waiting lists”. The review notes that in relation to the general surgery chain run by CAPIO referrals have also been slow and concludes “The concept of Independent Treatment Centres has been show to catch on”.

LACK OF ROBUST FINANCIAL AND MANAGEMENT PLANNING

Non-Executives experienced serious delays and barriers to accessing available information relating to the Netcare contract. Submissions made by local community based professionals who expressed negative concerns about the quality of a change to Netcare were not disclosed to board members. Further a local impact assessment from the Oxford eye hospital was not given to Board members. The decision-making process was so rushed that the full business case was only given to the board an hour before the PCT meeting. Even then there were massive gaps in information on risks. This was particularly troubling given the lack of any pilot or research evidence on the ISTC programme. I would like to agree strongly with previous evidence of witnesses concerned about rules being made up “as you go”.

The tariff price was a mystery to the non-executives. During a two week period the tariff price would fluctuate. It was also left unclear what exactly was included in the price offered by Netcare compared with the NHS price.

The contract provided for payment to be made to the independent provider regardless of whether operations were performed. My reading of the Netcare contract is that any shortfalls in performance cannot simply be offset over the entire five year contract period. Instead there is a minimum monthly payment under a “Take or Pay” payment schedule. This seemed to be opposite of the policy of payment by results.

A public board paper for the meeting of South-West PCT on 24 November 2005 includes a six month review of the NETCARE contract. Netcare are currently contracted to provide 800 cataracts a year in North and South Oxfordshire from April 2005 for four years. South Oxfordshire is contracted to take on average 456 cataracts and 593 pre-operative assessments per year. The Board Paper shows that in the first 6 month of the contract 255,000 pounds has been paid to Netcare to carry out assessments and operations although only 40,000 pounds of work has been carried out.

A six month review in November 2005 found that only 50 of 323 available pre-operative assessments have been booked and only 43 operations have been done out of 249 theatre slots available. The tariff cost is 72 pounds for preoperative assessments and 824.34 pounds for a cataract operation, but the cost is 6 times the national tariff as the NHS has to pay for all contracted procedures, regardless of whether they are performed. The set up costs of the mobile units and project management are not mentioned in the review but have to be paid for by the NHS.

A concern has recently risen in Oxfordshire that payments for non-performance may not be restricted to the Netcare contract as a contract with Capio due to start in January 2006 has been delayed and significant sums could be due already under this contract. It is impossible to confirm this at present because of an absence of up to date reports at relevant Public Board meetings.

Since the treatment centers have opened in Oxfordshire there has been a lack of regular reporting on the treatment centres to public board meetings. There is a serious gap in information available made easily available to the public.
Recommendations for Future Policy

1. National criteria on future decisions on ISTCs to include public papers to local boards evaluation local need and impact on local services including local training needs involving local specialists and community based professionals and patient groups.

2. Legislation on public consultation to be reviewed to include ISTCs.

3. Review of local accountability of ISTC clinicians ensuring that they are inducted into and are part of a local team of clinicians to ensure peer review.

4. Development of standardised reporting by ISTCs including evidence of clinical outcomes of ISTCs validated independently and available in the public domain.

5. National guidance to Strategic Health Authorities and PCTs that would require regular financial and performance reports to public board meetings.

6. Comprehensive (including all relevant records) clinical audit of clinical outcomes of ISTCs validated independently and available in the public domain.

7. National guidance on what should be properly included within commercial confidentiality.

What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

In Oxfordshire regarding the Netcare contract, the local NHS was on target to meet the six month wait due to innovative working in the NHS.

What contribution have ISTCs made to the reduction of waiting times and waiting lists?

As a result of contacting for additional capacity, the waiting time in the NHS today is five weeks and the NHS is working at a 40% reduction of normal work load. The Netcare contract has been proved to be unnecessary. The independent Finnemore Report in 2004 identified risks to the health system from the Netcare contract and the need for an action to address this. There has been no report in public about how the specific risks identified in the Finnemore report are being managed.

The huge reduction in waiting times for cataracts in Thames Valley is clearly at a cost and at a time when other services are being cut.

Are ISTCs providing value for money?

In Oxfordshire the Netcare contract is a waste of money, which has created risks to the local health system with no corresponding benefits.

I must challenge the evidence of previous witnesses that the problems of payment for non-performance can be overcome over the 5 year cycle of a contract. Under the “Take or Pay and Minimum delivery Clause” in the Netcare Contract payment must be made regardless of whether operations are performed and the purchaser cannot require the provider to perform any number of operations in the future due to underperformance in a previous period. Under the contracts there is a total monthly minimum take value. Unallocated activity is deemed completed activity under the contract and Authority is responsible for payment. The contract provides for offset against shortfall in another contractual month, but the amount that is allowed to be offset is treated as commercially confidential.

Although unwanted slots are now being brokered to Cumbria and Lancashire, the financial information has not been made available concerning the price that they are paying for this activity.

Another key issue is what is included in the tariff. As late as October 2005 emails in Oxfordshire reveal a lack of clarity of who bears the risks of the capital costs of the scheme. The mobile unit in Wantage in Oxfordshire had already generated £98,000 of estates costs in the first eight months of the contract and internal concerns were expressed between managers about the liability for these costs. The Strategic Health Authority promised the PCT as a condition of the emergency meeting to reconsider the Netcare contract that they would underwrite all financial costs to the PCT. It appears from internal emails released under a freedom on information request that this may not be happening in practice.

In relation to another treatment centre in Oxford — a contract with Capio for orthopaedic surgery was due to start in January 2006, but local clinicians have expressed concerns to me that the treatment centre has not yet opened yet operations are being paid for that are not being performed. There is no update report available on any PCT or TVSHA websites to confirm or deny these local anecdotes.
Does the operation of ISTCs have an adverse effect on NHS services in their areas?

The Oxfordshire Health System is in financial crisis and has announced a programme of significant cuts in services. Whilst the budget for ISTC is only a small percentage of the overall budget, the sums are not insignificant. Areas cut or facing imminent cuts in Oxfordshire include hernia operations; paediatric epilepsy services, mental health services and local community hospitals.

The cost of ISTCs is not simply financial but in terms of management time. During my period of office as a non-executive the ISTC programme almost exclusively dominated the work of managers and the Board and prevented necessary work on developing local commissioning arrangements with local NHS providers.

What role have ISTCs played and should they play in training medical staff?

Under the Netcare Contract there is a contractual obligation on the provider to provide necessary training and supervision (Clause 8.4). It was not clear in the lead up to the Netcare contract what actual training and supervision was provided, if any.

Are ISTCs providing care of the same or higher standard as that provided by the NHS?

In Oxfordshire regarding the Netcare contract, the local NHS had been awarded Beacon Status as a centre of excellence. As a PCT Board we were given no evidence that Netcare could meet or improve on the standards of the local eye hospital. We were assured by the Chair of PEC that Netcare could meet the average standards across the NHS.

What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

During the decision-making the experience of non-executives was that commercial confidentiality was often used as a reason not to disclose information or as a reason for meetings to be held in private rather than in the public domain. The whole process was highly secretive.

We did not see a draft contract, although we did eventually get to see the final business case on the morning of our Board decision. Data on quality of services, for example, was not provided to the board.

A freedom of information request made in November 2005 generated a copy of the Netcare contract. Key information that was missing was the actual liability of the purchaser for operations that were not performed; and also the amount of compensation due to the provider should the NHS terminate the agreement with three months notice.

What changes should the Government make to its policy towards ISTCs in the light of experience to date?

There must be some system of public accountability in place that prevents abuse of process and compromising of the independence and objectivity of statutory boards charged with decision-making responsibilities.

National criteria on future decisions on ISTCs to include a public board paper evaluating local need and impact on local services including local training needs involving local specialists and community based professionals and patient groups. Legislation on public consultation to be reviewed to include ISTCs; Review of local accountability of ISTC clinicians ensuring that they are inducted into and are part of a local team of clinicians to ensure peer review; Development of standardized reporting by ISTCs including evidence of clinical outcomes; National guidance to Strategic Health Authorities and PCTs that would require regular financial and performance reports to public board meetings; Comprehensive (including all relevant records) clinical audit of clinical outcomes of ISTCs validated independently.

What criteria should be used in evaluating the bids for the Second Wave of ISTCs?

National criteria on future decisions on ISTCs to include a public board paper evaluating local need and impact on local services including local training needs involving local specialists and community based professionals and patient groups.

Jane Hanna
23 March 2006
EvidencesubmittedbyDrFosterIntelligence(ISTC57)

Iamwritinginresponsetoyourcurrentinquiryonindependentsector treatmentcentres(ISTCs)andspecificallyontheissueofinformationaboutISTCperformance.

Bywayofbackground,IhaveoutlinedthekeyactivitiesofDrFosterIntelligenceincludedasanappendix
tothisletter.

Sincebecomingoperational,allWave1ISTCshavebeenrequiredtosubmitdatamonthlyviatheNHS
WideClearingServiceinthesamewayasNHSorganisations.Thisistoroutineadministratedatawhich
recordsinformationaboutNHSpatientsincludingage,sex,diagnosis,methodofadmission,procedure,
dateofadmission,datedofdischargeetc.

Dataqualityisvariableandthereareanumberofrelevantissues totbearinmindaboutthedata:
—Someprovidershavenotbeenanoperationalforverylongandvolumesarenottyetatthenecessary
levelformeaningfulanalysis.However,ourperformancebenchmarkingsystemtakesthisinto
accountbyusingconfidenceintervals.
—Codingofactivityispoorinsomeorganisations.
—MostISTCprovidersonemulti-siteandthereforeaccurate-site-codingisveryimportant.
—WheretrustshavecontractedwaitinginitiativestoanISTCthedatamayberecordedat
trustlevelratherthanbytheISTC.
—TherearealsosomeprovidersasthosecontractedviaGSUP(contractualarrangementspreceding
waveoneoftheISTCprogramme)whicharenotsubmittinginformation.

However,someISTCprovidersaresubmittinggood,accuratelycodedinformationwhichdoesallowus
toanalysetheirperformance.Theroutinereportsinourinformationsystemallowthebenchmarkingof
providerswiththeirpeersinboththeindependentsectorandtheNHSagainstanumberofmeasures,forexample,dayeratcases,lengthofstay,readmissionsandvolumes.Wecanalsoreportondataquality,in
termsoftheproportionofactivitythatgoesuncoded.

IncludedwiththisletteraretwosamplereportsfromISTCsshowingreadmissionrates andoverall
performanceindicatorsfortwoISTCproviders.

ItisourviewthattheDepartmentofHealthshouldworkwithISTCstoensurethattheysubmitcontract
minimumdatasetsviaNWCSandthatpaymentisdependentonaccuratecodingtoanHRG,asitisfor
NHSprovidersandwillbeforWave2ISTCs.Datagualityandtimelinessshouldbeakeyandenforced
featureofcontractualarrangements.

Ifrequired,wecouldsupplytheCommitteewithfurtheranalyses.We wouldalso be very happy to brief
you, the Committee or your research team on our information systems which could be a useful evidence base
forthisandfutureinquiries.

TimKelsey
Chairman,ManagementBoard,DrFosterIntelligence

12April2006

APPENDIX1
ABOUTDRFOSTERINTELLIGENCE

DrFosterIntelligenceisaninformationandresearchcompany,jointlyownedbytheNHSandtheprivate
sector.Weaimitopromoteserviceandsystemimprovementbyprovidinginformationtoanumberof
audiences,including:
—Clinicians,tosupportprofessionalstandardsandthebesttreatmentandcare.
—Managers,tosupporteffectiveandefficientmanagementandcontinuousperformance
improvement.
—Patients,tohelpthemchoosetheratmentandwhowillprovideit.
—Thepublic,toinformhealthandlifestylechoices.
—Policymakersandregulators,toinformeffectivepolicydevelopmentandimplementation.

We work with the Dr Foster Unit at Imperial College London in the analysis of data and the development
ofindicatorsofclinicalqualityandeffectiveness.TheUnithasapprovedaccesstoHospitalEpisodeStatistics
(HES)viaNHSWideClearingService(NWCS)submissions.Thisistotoroutineadministratedata
submittedbyNHSorganisations.Webalsohaveaccesstonumberofotherdatasetssuchasconsumer
surveydata,prescribingdataanddemographicdata.Weworkclearlywithintheparametersoftheterms
ofaccessthesedatasets,forexample,removingallpatientidentifiableinformation.

DrFosterIntelligencenusesthesesetstocreatearangeofbenchmarking,monitoringanddataanalysis
toolsforusebyNHSorganisations,aswellasundertakingbespokeanalysesandresearchonbehalfof
policy-makers, arm’s length bodies and NHS organisation.
Examples of the analyses we undertake and indicators developed by the unit include:

— In-Hospital Mortality rates for diagnosis and procedures, updated monthly through NWCS. Outcomes are currently available for a variety of clinical diagnoses and procedures. More detailed analysis using risk adjusted CUSUMs combined with monthly updates allow the prospective monitoring of outcomes at trust and consultant team level.

— Waiting times, volumes, length of stay, readmission rates and day case rates for procedures, updated monthly. For day cases we focus on the Audit Commission’s basket of 25 most common procedures.

— Rates of surgery and waiting lists by age or social deprivation group by different areas (eg PCT or constituency) to investigate health inequalities.

— Emergency admission rates by PCT (and GP practice) for conditions eg asthma, fractured neck of femur, standardised for the population of the PCT.

Dr Foster Intelligence has extensive understanding of the issues around use of data for comparison and has developed a number of different approaches many of which have been used in our benchmarking systems and in our publication of comparative data.

Our management information tools are used by the majority of NHS acute trusts and a growing number of primary care trusts and strategic health authorities.

Our other key activities include policy research and consultancy and social marketing services, such as targeting public health messages towards particular audiences.

**APPENDIX 2**

**BUPA READMISSIONS FOR TRAUMA AND ORTHOPAEDICS COMPARED TO BEST PERFORMERS**

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<th>Peet (Best Performers)</th>
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<th>% Expected</th>
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</tr>
<tr>
<td>Nuffield Hospitals (HQ)</td>
<td>1,644</td>
<td>1,644</td>
<td>16.8%</td>
<td>67</td>
<td>4.1%</td>
<td>103</td>
<td>6.3%</td>
<td>65.1</td>
</tr>
<tr>
<td>Royal Liverpool</td>
<td>681</td>
<td>681</td>
<td>7%</td>
<td>15</td>
<td>2.2%</td>
<td>14.8</td>
<td>2.2%</td>
<td>101.1</td>
</tr>
<tr>
<td>Children's NHS Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sheffield Children's</td>
<td>296</td>
<td>296</td>
<td>3%</td>
<td>10</td>
<td>3.4%</td>
<td>10.5</td>
<td>3.5%</td>
<td>95.4</td>
</tr>
<tr>
<td>NHS Trust</td>
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</tbody>
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**APPENDIX 3**

BUPA ADJUSTED Couild rates for Trauma and Orthopaedics compared to best performers.
APPENDIX 3

PERFORMANCE SUMMARY CARE UK (FEBRUARY 2005 TO JANUARY 2006)

<table>
<thead>
<tr>
<th>Trust</th>
<th>Mortality</th>
<th>Length of Stay</th>
<th>Day Case Rate</th>
<th>Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnoses</td>
<td>Mortality</td>
<td>Length of Stay</td>
<td>Day Case Rate</td>
<td>Readmissions</td>
</tr>
<tr>
<td>HSMMR Basket of 56 Diagnoses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complication of device, implant or graft</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complications of surgical procedures or medical care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other connective tissue disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residual codes, unclassified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin and subcutaneous tissue infections</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedures</td>
<td>Mortality</td>
<td>Length of Stay</td>
<td>Day Case Rate</td>
<td>Readmissions</td>
</tr>
<tr>
<td>Arthroscopy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carpal tunnel decompression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excision of Dupuytren's contracture</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excision of ganglion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip replacement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee replacement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puncture of joint</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removal of metalware</td>
<td></td>
<td></td>
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</tbody>
</table>

Evidence submitted by NHS Elect (ISTC 58)

1. Background Information on NHS Elect

1.1 NHS Elect is a network of NHS elective care providers, working to support these providers in piloting innovation and delivering better care, partly though joint working between sites. The programme was originally established in 2002 by a group of NHS CEOs and clinicians to support the development of NHS Treatment Centres (TCs) on their sites and now works to support 18 elective care providers within the NHS. More information on NHS Elect can be found on our website (www.nhselect.nhs.uk).

1.2 In relation to the terms of reference set out for the Health Committee’s enquiry into ISTCs, NHS Elect is only able to comment in any detail on the impact of the development of ISTCs on NHS elective care provision and, in particular, on NHS TCs. It should be noted that the views expressed in this memorandum are the views of the NHS Elect central team and may not reflect the views of our member Trusts.

2. Background Information on the National TC Programme

2.1 The NHS Treatment Centre programme was launched by the Department of Health in 2002. The programme had two key aims: firstly and straightforwardly to provide additional elective capacity to enable the NHS to deliver NHS Plan waiting time targets and secondly to pioneer new ways of working to improve the delivery of elective care.

2.2 There were 46 treatment centres approved within the original NHS TC programme. Most are now open, with a final handful due to open in the next few months. Many of the larger TCs were commissioned to support delivery of NHS Plan targets and were therefore designed with spare capacity, with business cases predicated on securing additional work outside of their host Trust. NHS TCs still, however, receive funding through mainstream allocations only, dependent on the number of patients seen. For NHS TCs, it is therefore imperative that activity meets business case predictions to avoid budget deficits in these facilities. Patient care within the NHS TCs is excellent, with TCs known to NHS Elect routinely scoring in excess of...
95% satisfaction in patient surveys. Furthermore, NHS TCs have embraced the opportunity to change and improve patterns of elective care, with many using pathways pioneered in US treatment centres that optimise efficiency and improve the clinical care and patient experience.

2.3 The ISTC programme was launched separately and one year after the NHS TC programme, creating further additional elective capacity through the use of independent sector providers. These providers have, to date, been commissioned to undertake two sets of activity. Firstly, the Department of Health (DH) has commissioned a further set of TCs to be built and run by the independent sector, with independent sector TCs commissioned from companies in two “waves”. Wave 1 was launched in 2003 and Wave 2 is currently being commissioned. Secondly, in 2004 and 2005, the Department also commissioned “supplementary activity” from the independent sector, providing PCTs with additional elective work funded outside of the mainstream allocations. For the ISTCs, funding arrangements differ from the NHS TCs as the DH guarantees to provide a large percentage of the agreed contract value, irrespective of the number of patients seen and ISTCs have been permitted to price work at above the national tariff.

3. ISSUES FOR NHS PROVIDERS—SPARE CAPACITY

3.1 The programmes described above have delivered a tremendous amount of additional elective capacity in the UK. However, there is now, despite the excellent care offered by NHS TCs, a significant problem in the under-utilisation of commissioned NHS elective care facilities in many parts of the country and for the last two years many NHS TCs have found themselves unable to secure funding to treat additional patients, with resultant under-utilisation of NHS TC capacity. Clearly, this is an issue that has many causes but has been exacerbated by the creation of additional capacity in ISTCs.

3.2 It is difficult to quantify the actual spare capacity within the NHS TCs, as the spare capacity locally identified often differs from that “offered” to the national TC programme and, over the last 3 years, inevitably some NHS Trusts have decided to close or reduce the size of their TC or change the function of the facility. We know from discussions with colleagues that spare capacity exists in many centres. Although we cannot provide a full picture of spare capacity, we can, however, provide details of the spare capacity known to NHS Elect at this time, as follows:

<table>
<thead>
<tr>
<th>Treatment Centre</th>
<th>Capacity currently utilised pa (FCEs)</th>
<th>Additional capacity available pa (FCEs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ravenscourt Park Hospital</td>
<td>6,000</td>
<td>6,000</td>
</tr>
<tr>
<td>ACAD (Central Middlesex)</td>
<td>8,000</td>
<td>3,000</td>
</tr>
<tr>
<td>Kidderminster</td>
<td>12,000*</td>
<td>8,000*</td>
</tr>
<tr>
<td>Crewe</td>
<td>8,400</td>
<td>6,000</td>
</tr>
<tr>
<td>Birmingham City*</td>
<td>7,200</td>
<td>1,500</td>
</tr>
</tbody>
</table>

* Includes endoscopy

The figures given are all approximate but do give some indication of the size of the issue, particularly as few of the “spare capacity” figures include weekend or evening working. The problem can only be exacerbated by the opening of further TCs in the future.

3.3 When looking at the financial implications of this under-utilisation, it is difficult to quantify the true cost of this spare capacity to the NHS. A number of the NHS Elect TCs have, in the past, carried out a financial analysis of the impact of their own spare capacity, which does provide an indication of the cost to the NHS of this under-utilisation. To give one particularly extreme example here—at Ravenscourt Park Orthopaedic Hospital in West London, clinicians currently carry out approximately 6,000 operations per year. The TC needs to carry out 10,000 operations to cover its fixed costs and its business case was approved on this basis. The facility therefore faces a recurrent deficit of around £9 million per year.

3.4 Clearly, the fixed costs of all NHS TCs will need to be met by the NHS, irrespective of the amount of capacity provided on each site. Any under-utilisation of NHS TCs will therefore increase the unit cost of the services provided in these facilities and represents a “fixed overhead” cost to the NHS. This is particularly pertinent to note in relation to the procurement of IS activity, as, using the case of Ravenscourt Park again to provide an example, the IS would need to offer a saving of in excess of £2,200 per case before offering real savings compared to using existing spare capacity within the NHS. While this is clearly an extreme case, it does serve to demonstrate the financial implications of the under-utilisation of NHS TCs.

4. ISSUES FOR NHS PROVIDERS—OPPORTUNITIES FOR COLLABORATION

4.1 One of the stated aims of the ISTC programme was to stimulate innovation in elective care delivery. In response to this, a number of NHS and IS providers have, over the last three years, developed proposals to work collaboratively, attempting to transfer learning between the IS and the NHS and improve models of care across both sectors. As part of this, NHS and IS providers have prepared proposals to undertake DH funded work together, often using existing NHS facilities, thus making best use of existing and paid for physical capacity. For example, a number of NHS TCs collaborated with colleagues in the IS to submit bids
to undertake additional activity as part of the “Year 1 supplementary activity” and a number of NHS Trusts had declared an intention to work with interested IS partners in the so-called Wave 2 of the ISTC programme.

4.2 These proposed collaborative ventures have not been widely supported by the DH, with only one NHS TC known to NHS Elect hosting a joint programme with an IS partner as part of the national procurement. This would appear to be a lost opportunity for sharing of innovation and for the creative use of existing facilities.

4.3 In addition, the separate nature of the IS programme has led to some operational difficulties in managing care for patients. For example, lack of communication has meant that the arrangements made for follow-up and the management of complications are problematic in some areas, with IS providers providing only part of the pathway for certain patients and NHS providers unwilling to follow-up patients operated on in an IS facility. Furthermore, IS providers in some areas have very tight criteria for accepting patients, requiring more complex patients with co-morbidities to be treated by the NHS. While there are some good examples of successful integration, the separate nature of many ISTCs can cause difficulties (operational, clinical and financial) for the NHS provider, particularly in delivering care for a more complex set of patients.

5. Concluding Remarks

We hope this memorandum is helpful in setting out the issues facing NHS providers in relation to the ISTC programme. We would stress that NHS providers are keen to work in collaboration with IS partners and that the overall policy of plurality is one that is strongly supported by NHS Elect. Indeed, one of our key aims as an organisation is to encourage NHS elective care providers to embrace innovative models of care from all sectors and health systems and we routinely organise study tours to IS providers to learn from their models of care and their ways of delivering improved customer service that is more responsive to patient needs. Furthermore, we know that many of our own members and other NHS providers are keen to develop joint ventures with IS colleagues and that many IS companies would welcome opportunities to work with the NHS. In recent months, the DH has indicated that it is now prepared to consider seriously sensible proposals for collaboration and partnership between the NHS and IS in the delivery of elective care and we are very encouraged that this represents a new phase in the plurality programme. We hope that there will now be an opportunity to move towards more sophisticated models of plurality and return to a system where additional capacity is only created in response to the genuine need for further provision to meet national targets and that models that build on joint working between the NHS and the IS are embraced by policy makers.

NHS Elect
13 April 2006

APPENDIX 1

SUMMARY RESPONSES TO SPECIFIC QUESTIONS FROM THE TERMS OF REFERENCE

NHS Elect is able to provide a response to only some of the specific questions set out in the terms of reference. We have attempted to respond to these in the information provided above. For ease of reference, we have also prepared this appendix to provide some additional information and to cross-reference the information given in the main body of this memorandum.

What role have ISTCs played in increasing capacity and choice and stimulating innovation?

ISTCs have been important in increasing capacity and choice for patients. Their role in stimulating innovation has been limited (see paragraphs 4.1 to 4.2, above) as there is little formal sharing between the IS and the NHS.

What contribution have ISTCs made to the reduction of waiting times?

ISTCs have contributed to the overall reduction in waiting times within the NHS.

Are ISTCs providing value for money?

Most ISTCs operate under the “dual-tariff” system, with IS providers unable to deliver services within national tariff and thus receiving a supplement to this via “dual-tariff”. ISTCs do not routinely provide training to NHS junior medical staff and usually focus on treating patients without complex co-morbidities (often because of a lack of high dependency/intensive care provision on site), as detailed in
paragraph 4.3 above. It would therefore appear that, historically, ISTCs have received a higher cost-per-case than NHS providers, while tackling a less complex case mix and without the cost of training junior medical staff. We understand that this may be changed in future procurements.

Does the operation of ISTCs have an adverse effect on NHS services in their areas?

See paragraphs 3.2 and 4.3, above.

What arrangements are made for patient follow-up and the management of complications?

See paragraph 4.3, above.

What role have ISTCs played and should they play in training medical staff?

Existing ISTCs need to be regarded as a sustainable change in the provision of health-care in the UK. They therefore need to become involved in the training of medical staff, particularly surgeons and anaesthetists. This is particularly pressing in some areas where the ISTC is scheduled to provide a large part of the straightforward elective case-load delivered in that locale. Junior staff need to gain experience in operating on and caring for these patients and it is therefore imperative that these ISTCs train junior staff. This will also help ISTCs in demonstrating better value for money, as at present they are not routinely providing training for junior staff within their agreed tariff price.

Are ISTCs providing care of the same or higher standard as that provided by the NHS?

The national ISTC programme does require the ISTCs to monitor a wide range of standards relating to both patient experience and clinical quality. The requirements here are impressive and are more stringent than those requested of the NHS TCs. We would expect that it is too early yet to use this data to assess the quality of care provided, but this should be possible in the near future. This would be particularly useful if NHS providers decided to collect similar data to allow comparison and NHS Elect strongly encourages its sites to improve data collection in line with ISTC requirements.

What changes should the Government make to its policy towards ISTCs in the light of experience to date?

It is our view that there needs to be more opportunities for collaboration between the NHS and the IS, to support the sharing of learning, improve the management and integration of patient care and ensure that capacity is developed where it is most needed and can be afforded. See all of above narrative.

What criteria should be used in evaluating the bids for the Second Wave of ISTCs?

ISTCs should be created where there is a clear need for additional capacity or a need to use existing capacity (usually within NHS facilities) in a new way to introduce choice and/or stimulate innovation. Bids should be evaluated primarily according to whether they deliver capacity that is needed to meet the December 2008 waiting time targets at a price affordable to the local NHS. Additional consideration should be given to the commitment of the ISTC provider to work with the local NHS (primary and secondary care) to share experience and stimulate innovation across the piece and to ensure that care provided to patients is seamless.

What factors have been and should be taken into account when deciding the location of ISTCs?

To date, the policy has focused on ensuring that IS services are developed in all areas of the country, largely irrespective of levels of existing capacity. We need to move from this to a commitment to develop ISTCs only where there is a need for additional capacity to deliver waiting time targets. Where there is a need to stimulate innovation or increase patient choice, but no need for additional facilities, IS providers should be asked to deliver services in collaboration with NHS colleagues, using existing buildings.

How many ISTCs should there be?

Detailed work has been undertaken by the DH on the levels of capacity needed to deliver waiting time targets and, in particular, to ensure that by December 2008 no patient waits more than 18 weeks from referral to treatment. This work should be used to determine if there are any remaining gaps in capacity which could be sensibly and affordably filled by ISTCs.
Evidence submitted by BMI Healthcare (ISTC 59)

BMI HEALTHCARE

Clinical Outcomes Data collection for GSup2 Contract

The Second General Supplementary contract (GSup2) was awarded in Summer 2005. BMI Healthcare was one of the successful bidders and was awarded a large volume of orthopaedic procedures to be carried out under the terms of the project agreement.

The contractual reporting requirements related to both Key Performance Indicators (KPIs) and also to patient HRG specific tracking information.

Key Performance Indicators

The KPIs required reporting on a monthly basis and were presented both electronically and in hard copy at the monthly Performance Management Review (PMR). The purpose of the PMR was to enable formal review of the progress made towards completing the contract and for discussion of all KPIs to identify any trends and to agree necessary actions.

In tandem with this reporting process, a regular contact was established between the Central Contracts Management Unit (CCMU) clinical lead and the BMI clinical contract lead. This enabled each party to understand the workload being undertaken at each BMI hospital undertaking G Sup 2 work and to review and understand any adverse KPI data. It should be noted that there was no necessity for any “Joint Service Review” during the period of the contract.

All KPI data was presented to the DH as required by the contract. The breadth and depth of the data was in line with what is regularly collected from all BMI hospital and as such provided comprehensive view of the clinical outcomes across the contract, consistent with that which we collect for all BMI patients.

The data areas collected are as shown below:

- Did Not Attends (DNAs)-Daycases
- DNAs-Inpatients
- Cancellations for clinical reasons
- Cancellations for non-clinical reasons
- Unplanned Returns to theatre
- Rejections at referral
- Total referrals
- Unforeseen day case to inpatient stays
- Transfers to another facility
- Emergency admissions within 29 days
- Procedures under local anaesthetic
- Provider performance data
- Clinician performance data
- Patient satisfaction level (daycases)
- Patient satisfaction level (inpatients)
- Complaints received
- Complaints not handled within timescales
- Incidents reported to the NPSA
- NHS staff recruited
- Facility condition
- Security breaches
- Data protection breaches
- Patients treated after treat by date
HRG KPI Data

In addition to the above, KPI data was also collected by HRG. The following areas were recorded by HRG:
- Total Outpatient sessions attributed to each HRG
- Emergency admissions by HRG
- Length of stay by HRG (day-case and inpatient)
- Average length of induction by HRG
- Average duration of surgery by HRG
- Average length of recovery by HRG
- Total procedures under local anaesthetic by HRG

Again the data was submitted consistently to the CCPP and was discussed at the PMR meetings.

BMI Patient Tracker

On a weekly basis the contract required submission of a tracking form to identify each patient and what point they had reached in the patient pathway. The tracker included the following information:
- SHA
- NHS Number
- HRG Code
- Breach date
- Date referral received
- Date medical notes received
- Outpatient assessment date
- Outpatient appointment outcome
- Pre-operative assessment date
- Pre-operative assessment outcome
- Admission date
- Procedure date
- Procedure outcome
- Discharge date
- Follow up status
- Episode complete date
- Reason patient failed to start pathway
- Patient contacted date

The completion of the tracker allowed both the DH and the local SHA to have an accurate view of the situation regarding each patient.

Additional Information

As the contract drew to a close, BMI were asked to present data to the DH relating to reasons for rejected referrals. It is understood that this was required to enable The Department to fully understand the referral processes and ways of improving them across the NHS in the future. BMI provided this data in a timely way as requested.

Conclusions

Data provision to the DH for the duration has been a straightforward process and has not presented a significant problem to BMI in terms of compliance or delivery.

Jane Rooney
Clinical Service Director, Amicus Heathcare

28 April 2006
Supplementary evidence submitted by UNISON (ISTC 42B)

1. INTRODUCTION

1.1 On 23 March 2006 UNISON gave evidence to the Health Select Committee Inquiry investigating Independent Sector Treatment Centres (ISTCs). As part of our evidence we expressed concern on the following issues:

— Lack of transparency
— Value for money
— Accountability
— Standards of care
— Democratic process
— Capacity

1.2 UNISON was asked by the committee to provide further written evidence surrounding our concerns on employment issues, standards of care and professional development. Included with this submission are a number of witness statements from UNISON members, notes from UNISON members' meetings and the correspondence from UNISON's Head of Health, Karen Jennings, to Lord Warner together with his response.10 We feel this will assist the committee during its deliberations and enable you to see this information in the context of our evidence. We would also like to apologise to the committee for the delay in this information being submitted for your consideration.

1.3 The staff are fearful of reprisals from PHG; as a result we have agreed to protect their anonymity. In addition a number of staff have indicated that they would be prepared to meet with you privately to discuss these issues if the committee felt it would be helpful.

1.4 We would also like to make the committee aware that since presenting our original evidence, both written and oral, a meeting has taken place with representatives of Partnership Health Group (PHG) and UNISON on 13 April 2006.

2. BACKGROUND

2.1 In the autumn of 2005 we received an email from an employee of PHG; this came in via our health web site. The individual was raising concern on behalf of a number of staff, none of whom were members of UNISON at that point. These concerns surrounded patient safety and employment issues and in light of what we heard we scheduled an open meeting for any employee who wanted to attend and talk to us about the issues that they had identified. This was the start of our involvement; we have included some of the witness statements which corroborate the staff concerns. Names of individuals have been removed to protect their anonymity.

3. PARTNERSHIP HEALTH GROUP (PHG) AND UNISON

3.1 Since giving evidence to the committee we have been able to have one meeting with two representatives of PHG, namely the HR Director and the Nursing Specialist Manager. They did state that they are not prepared to recognise us for collective bargaining processes and they have indicated that they wish to establish a staff council instead. However, our view is that it will have no benefit for industrial relations as it is inconsistent with the practises in the NHS. They are willing to allow us to help with them with their training, and we have offered to put them in touch with some organisations that will be able to provide post basic qualifications. It is clear that up until late last year they had no Human Resource policies and that they have been working through a number of their clinical policies. It also became clear that training had not been in place for mandatory programmes. They are now intending to use a new computer system which they say will enable them to look at training more consistently.

3.2 The governance process leading up to the contractual procurement appears to have been robust but problems appear to have occurred following contractual close. We believe that the DoH need to review this again and that stronger measures need to be put in place to monitor the implementation once the contract is signed to ensure that the commitment to governance and standards of care are fully implemented.

3.3 We hope to be able to develop a working relationship with PHG, indeed this has always been our preferred aim. However, the basis of good and effective industrial relations is partnership and it is difficult to see how we can achieve this if they do not recognise us as a trade union formally within their organisation. This is a practice that works very successfully throughout the NHS but this successful working arrangement between employers and trade unions is something that has not extended to the ISTCs.

10 Not printed here.
3.4 We are now reviewing the outcome of the patient fatality in the PHG Plymouth site and await the clinical review of this. We have offered support to the staff there and will be meeting with many of them again shortly.

3.5 PHG have acknowledged that there have been poor management standards and ineffective levels of communication with staff. They have now made a commitment to providing management training to try and address these concerns. We have offered to help to facilitate this as in our experience joint delivery is always more beneficial in standards of practise. However, it is clear to UNISON that there is a culture of bullying and harassment and we are now actively encouraging staff to raise these concerns formally. There does remain a fear of what will happen if staff decide to take this course of action and without trade union recognition there is no clear opportunity for us to support them through what is always a very difficult and emotional time.

4. CONCLUSIONS

4.1 We will continue to seek an improved working relationship with PHG and as stated earlier we believe that this can be better achieved through recognition. PHG appear to doubt the issues raised by their staff and their perception appears to still be that we are causing difficulties where they do not exist.

4.2 There were no human resource policies in place for PHG until the early part of December 2005 despite having been operational for over a year. This has clearly affected the operational management of the site and it is extremely alarming that a private provider offering services to the NHS for more than 12 months can have been allowed to do so without reprisals.

4.3 We are concerned at the lack of transparency surrounding governance issues as PHG do not publish statistics on infection control rates nor on the levels of complications. We know from staff that they have concerns at high levels of infection control and we know also that a number of patients have suffered with deep vein thrombosis post operatively whilst still as an in patient. Given that in the main they are not treating complex cases it is difficult to compare the patient experience and standards of care across both areas. However, DVT’s within 48–72 hours in the NHS following a joint replacement are no longer a frequent occurrence as they are treated by prevention including a sub cut injection of Fragmin.

UNISON

May 2006

Evidence submitted by BUPA Hospitals (ISTC 60)

It was a pleasure to host the visit by you and your colleagues to the BUPA Redwood DTC last week. As I am sure you will have seen, we are extremely proud of what has been achieved there in partnership with our NHS colleagues. BUPA is using the centre as a prototype to develop processes we hope to be able to deploy elsewhere through our participation in Phase Two of the government’s ISTC procurement.

I hope you found the opportunity to meet patients added a greater insight to the written evidence warranting staff useful and that the visit submitted.

Claire Hollingsworth
BUPA Hospitals

25 April 2006

Synopsis of Key Questions Raised in Discussion

Q: Is the DTC “cherry-picking” the easy cases, leaving the local NHS with complex and urgent cases, thus diluting the benefits to the health economy as a whole?

A: Whilst it is true that the current contract focuses on routine operations, the whole system benefits from high elective throughput and greater productivity. The number of cancelled operations has been reduced and the number of cases on each operating list has gone up dramatically.

Q: Why could the NHS not have done exactly the same thing without needing an independent sector partner involved?

A: The NHS can and does operate “fast track” surgery centres along the same lines as BUPA Redwood. Many of the benefits of Treatment Centres are gained from concentrating exclusively on elective care, irrespective of who operates it. However, BUPA believes there are additional benefits from allowing the independent sector to run a proportion of these centres. These are:
Organisations like BUPA bring a particular expertise in running customer-focused elective treatment and diagnostic services. This is what we have been doing in our private hospitals for over 20 years. — The ISTC programme has enabled us to transfer some of this experience to serve NHS customers.

The involvement of independent sector providers increases the choice available to patients and GPs. In our experience patients welcome the opportunity to choose a BUPA-run facility which is free of charge and organised as part of the local NHS provision. This choice promotes healthy internal competition within the NHS which in turn will stimulate innovation and a general improvement in standards of provision.

At a time when NHS management has to cope with a myriad of challenges, the ISTC programme has brought in organisations which are solely focused on delivering quality elective healthcare in a cost-effective way. Redwood has demonstrated that this focus from a dedicated BUPA management team has fostered a strong partnership with clinicians and other staff, process improvements and excellent patient satisfaction.

Q: How does the cost of Redwood compare with the NHS Tariff?

A: Redwood was set up before the NHS introduced the policy of Payment by Results and before the launch of the Wave One of the ISTC procurement. Because of this the arrangements are unique and are not directly comparable to today’s NHS tariff. Particular differences are that the host Trust pays for the medical staff and benefits from a profit share arrangement. Nevertheless, BUPA and the Trust has calculated that if reasonable adjustments are made to take account of these features, the cost of Redwood in 2005–06 is broadly comparable to that which would have been incurred if the contract were priced at the prevailing local NHS tariff rate. BUPA expects that at the end of this contract period we will operate Redwood in line with NHS tariff without it creating material difficulties.

Q: Is it the case that Redwood works because of the unique circumstances of the local situation so it is not a solution to the objections levelled against the wider ISTC programme?

A: No. BUPA thinks that the Redwood model could be applied elsewhere as a way to bring the independent sector to play a much bigger role in NHS elective provision. The key principle is that ISTCs must fork in partnership with the local NHS health economy. It was difficult for the Wave One ISTCs largely due to the misguided application of the policy of Additionality. This problem has been addressed in Phase Two ISTC contracts so there is no reason why schemes on the Redwood model cannot be developed elsewhere.

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Supplementary evidence submitted by Capio (ISTC 35A)

1. What data you are contractually obliged to provide to the Department of Health

Capio is required to provide the Department of Health with relevant data to satisfy 26 key performance indicators (KPIs). These KPIs are listed and detailed in appendix 1. An example of the KPI data Capio produces monthly for each ISTC is given in appendix 2 (please also see the appendix 2 explanation sheet). Capio shares further information about each KPI with both the PCT contractor and Department of Health. For example if a patient is returned to theatre after their original procedure (KPI 4), Capio would provide information on when and where this happened, the reason the patient was returned to theatre and the subsequent procedure details.

Capio is also required to provide patient tracker information to both the PCT contractor and Department of Health. This gives specific information on when a patient was referred, their appointment and procedure dates and when their operation was completed. An example of a tracker report for the Capio Woodlands NHS Treatment Centre is given in appendix 3 (please note this has been desensitised to remove patient confidential information).

Additionally, Capio is required to supply data to a number of other governmental organisations when requested such as the National Protection Agency. Further information about this can be found in appendix 4, showing the part of the contract which details the information Capio is required to supply.

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11 Not printed here. These KPIs are the same as listed in the DoH submission on page Ev 107.
12 Not printed here.
13 Not printed here.
2. *What data you collect on a monthly basis, and whether you collect more than is contractually required*

Appendices 2 and 3 demonstrate the type of data Capio shares with the commissioning PCT and the Department of Health each month. As previously stated, Capio provides further information relating to specific KPIs or incidents at the Joint Committee Review (see 3).

In a number of incidences, Capio has been asked by the commissioning PCT to collect additional information and Capio has been happy to oblige. For example Northumberland, Tyne and Wear SHA is operating under the Choose and Book system and needed Capio to record which GP arid GP surgery had referred each patient in order to track payments.

— Information relating to accidents and incidents.
— Patient feedback and comments.
— Certain surgical speciality outcome data (eg for colonoscopy procedures: the completion rate).
— Infection control data.
— Human resource information including staff satisfaction, sickness absenteeism, turnover and continuing professional development.
— Information on anaesthetic standards.
— A regular audit of patient clinical notes.

3. *The minutes of the reviews of monthly data*

Attached in appendix 5 is a sample selection Of the minutes from the Steering Group meetings and the Joint Committee Review held for each of Capio’s ISTCs. Capio can supply further examples of minutes if the Health Select Committee requires these.

— Steering Group: meet biweekly to review progress with the contract and exchange information about the ISTC. The Steering Group includes representatives from the sponsor PCT and Capio and the meeting is facilitated by the Contract Manager from the Central Contract Management Unit, Department of Health.
— Joint Committee Review: meet every quarter to review the ISTC KPI data. The Joint Committee Review includes representatives from the sponsor PCTs and Capio and the meeting is facilitated by the Contract Manager from the Central Contract Management Unit, Department of Health.

4. *The range of NHS prices for procedures (mentioned in Q180 of the transcript)*

The National Tariff is a weighted average of the procedures within an Health Related Group (HRG) and within each HRG national tariff the only variation is the Market Forces Factor.

The tariff is based on the reference cost for the HRG (from the 2003–04 Reference Costs for TELIP (Trust Elective Inpatient) and TDC (Trust Daycase)). This reference cost data is presented in appendix 6 for three common procedures and shows the average cost, the upper quartile cost and the lower quartile cost. The full range of costs for 2004 and 2003 is wider than the interquartile range. Capio has asked for the maximum and minimum figures from the Department of Health and these figures will provided to the Select Committee upon receipt.

This data is sourced from the Department of Health.

**APPENDIX 4**

14.7 **CONTRACT MANAGEMENT**

(a) The Provider shall produce reports sufficient to complete the Key Performance Indicators (KPIs) as set out in Schedule 6 (*Payment Mechanism and Performance Monitoring Regime*) Part 5 Table 1 KPIs. Reports sufficient to complete KPIs table 1.

(b) The Provider shall submit Data definitions for review within three (3) months of the date of this Agreement.

(c) For the purposes of this paragraph 14.7, “Data Definitions” mean a description of the required data elements to calculate the KFI in Schedule 6 (*Payment Mechanism and Performance Monitoring Regime*) including a statement of rules for excluding or including specific data values and the method of calculating KPIs.

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14.8 **COMMISSIONING DATA SETS**

(a) The following Commissioning Data Sets will be submitted by the Provider via the NWCS Service as required:

(i) Admitted Patient Care CDS Type—General Episode.
(ii) Out-Patient Attendance CDS Type.
(iii) Ward Attendance CDS Type.

(b) The following Commissioning Minimum Data Sets will be submitted by the Provider to the NWCS Service as required:

(i) Elective Admission List CMDS-End Of Period Census.
(ii) Elective Admission List CMDS-Event During Period.
(iii) GP Referral Letter CMDS.

(c) The Provider shall comply with changes to the CRS and CMDS data sets described in Data Set Changes Notices (DSCNs) published by the NHS Information Authority.

14.9 **CLINICAL DATA SETS**

(a) The Provider shall submit the following Clinical Data Sets as required:

(i) Acute Myocardial Infarction.

(ii) Cancer—National Cancer Data Set.
   (A) Breast Cancer.
   (B) Colorectal Cancer.
   (C) Lung Cancer.
   (D) Head and Neck Cancer.
   (E) Urological Cancer.
   (F) Upper GI Cancer.
   (G) Gynaecological Cancer.
   (H) National Cancer Waiting Times Data Set.

(iii) Coronary Heart Disease Data Set.

(iv) Diabetes Data Set.

(v) National Joint Registry Minimum Data Set.

(vi) Older Peoples Data Set.

(vii) Social Services Data Set.

(viii) National Cataract Data Set.

14.10 **LOCAL PERFORMANCE MANAGEMENT AND COMMISSIONERS INFORMATION**

(a) The local performance management and commissioners information is defined in the IM&T Services specification document referred to at paragraph 14.2(a) of Part C of this Schedule 3 Part 4.

14.11 **CENTRAL MANAGEMENT INFORMATION**

(a) Information will be required to be submitted to the Healthcare-associated Infection and Antimicrobial Resistance (HCAI & AMR) Department of the Communicable Disease Surveillance Centre (CDSC) at the Health Protection Agency (HPA) in Colindale.

(b) Information on patient deaths will be required to be submitted to the National Confidential Enquiry into Patient Outcome and Death on a monthly basis according to the format and procedure specified at http://www.ncepod.org.uk/reporters.htm#submission.

(c) The following information will be required to be submitted weekly to support (including but not limited to providing a timely report) the NHS process on reporting to the Department of Health in relation to the Department's Strategic Executive Information System (STETS):

(i) Completed activity in the previous four weeks.

(ii) Patients currently waiting for treatment (and the length of time they have been waiting—including time on NHS Waiting lists before being referred to the Provider for Treatment).

(iii) Cancelled operations.

(iv) Bed Occupancy.
(d) The Provider will be required to support (including but not limited to providing a timely report) the NHS process on reporting to the Department of Health in relation to current central returns which the Provider is likely to be required to submit as follows (forms referenced can be found in the NHS Data Dictionary):

(i) Monthly returns: the Provider is likely to be required to provide support to submit monthly returns to the Department on:
   (A) completed activity in the month; and
   (B) patients currently waiting for treatment.

(ii) Activity information is likely to be required on all patients treated, by type of case (e.g., in-patient, day case, outpatient) and speciality.

(iii) Quarterly returns: the Provider is likely to be required to provide support to submit quarterly returns to the Department on:
   (A) Number, type and status of patients waiting for admission (see form KH07 and KH07A for current requirements).
   (B) Decisions to admit patients, and subsequent events (see form KH06).
   (C) Outpatient activity (see form QMOP).
   (D) Cancelled operations (see form QMCO).
   (E) Cancer waiting times (see form QMGW).

(iv) Annual returns: the Provider is likely to be required to provide support to submit annual returns to the Department of Health on:
   (A) Complaints received from or on behalf of NHS patients (see form K041(A) for present NHS requirements).
   (B) Bed availability and occupancy (KH03).
   (C) Adult intensive care and high dependency provisions (see form KH03A).
   (D) Ward attenders (i.e., patients treated on an outpatient basis in wards, by staff other than doctors) (see for KH05).
   (E) Imaging and radiological examinations (see form KH12).
   (F) Specialist nursing activity (see form KC59).
   (G) Coloscopy clinic referrals and activity (see form KC65).
   (H) Occupational therapy services (form KT27).
   (I) Speech and language therapy services (for KT29).
   (J) Annual information governance returns.

(v) Depending on the nature of their services, Providers may be able to submit nil returns to some quarterly and annual returns.

(vi) The Provider will also be required to contribute where appropriate to a number of regular surveys and censuses including:
   (A) Annual NHS medical and dental workforce census, non-medical workforce census and NHS vacancy survey.
   (B) Annual NHS patient satisfaction surveys.
   (C) The mandatory healthcare association infection surveillance system.
   (D) The NHS Estates Agency’s ERIC Database.

Capio Healthcare UK
April 2006

Evidence submitted by Professor Sir Ara Darzi (ISTC 62)

DATA COLLECTION FOR ISTCs

There should be a standardised method of capturing data for all patients, regardless of their provider. Quality of life assessment should go beyond a standardised questionnaire—it needs to be multi-faceted, procedure- or disease-specific, and should be centrally collected. Given the narrow range of procedures performed in ISTCs, procedure-specific information should be captured and useful comparisons of case-mix should be possible (ideally, risk-adjusted outcomes should be assessed). This should be applied to both
the NHS and ISTCs. In particular, coding needs to be identical in the NHS and in ISTCs for the same procedures, and this is not currently the case. Quality measures (ideally risk-adjusted, prospectively collected, procedure-and disease-specific) should be centrally collected in both NHS Treatment Centres and ISTCs.

Professor Sir Ara Darzi
Imperial College, London
July 2006

Further supplementary memorandum submitted by the Department of Health (ISTC 01H)

FOLLOW-UP TO 28 JUNE 2006 EVIDENCE SESSION

1. INFORMATION ON WHY SEVEN SCHEMES ARE NOT PROCEEDING

1.1 West Yorkshire Elective Scheme
   — Independent Sector provision for contestability and choice not needed at level envisaged initially.
   — Local needs better met by SHA undertaking local procurement to replace spot purchasing activity, and using the existing wave 1 facility more intensively.

1.2 West Yorkshire Plastic Surgery Scheme
   — Review of capacity requirement concluded it was not viable.

1.3 South West Peninsula Multi Specialty
   — Final review of scheme proposal concluded it would be unlikely to secure value for money bids in its original form—difficult to balance value for money and providing a sufficiently localised service in such a rural area.

1.4 South Yorkshire General Surgery
   — Local needs better met by SHA undertaking a local procurement to replace spot purchased activity with longer-term contractual arrangements that comply with national policy developed for the ISTC programme (eg additionality).

1.5 South Yorkshire Cardiology
   — Rotherham Foundation Trust decided not to proceed with the scheme and the impact on the casemix meant the scheme was no longer commercially viable.

1.6 County Durham and Tees Valley Multi Specialty
   — Enough existing IS Capacity (if exploited) to meet the 18 weeks requirement.

1.7 Birmingham and Black Country
   — Affordability Gap resulting from the PFI unitary charge and the assessed potential financial loss by the Trust meant this scheme was not commercially viable.

2. PROFESSIONS COVERED BY THE ADDITIONALITY POLICY FOR THE NEXT PHASE OF DIAGNOSTIC AND ELECTIVE PROCUREMENTS

2.1 The list of shortage professions has been drawn up based on the results of qualitative and quantitative analysis by the Workforce Review Team—a body attached to Hampshire and Isle of Wight SHA, responsible for analysing NHS workforce data. The list will be the basis of the Additionality clause in the relevant diagnostic and Elective Services Agreements. This clause is a form of restrictive covenant. As such, the clause and the list must go no further than is demonstrably necessary to protect the interests of the NHS. However, there are other sections of the NHS workforce—not covered by the list—which may raise risks to NHS capacity. In relation to them, proper caution and risk management is also required. For example, Agenda for Change Band 6 covers a wide range of clinical staff and skills, some of which are very specialist and are key to delivering service in both the NHS and the IS.
2.2 Because Band 6 is very broad, it is not appropriate to include people within it in the list of shortage specialisms or the restrictive covenant. However, bidders are specifically reminded of their contractual obligation to participate in good faith in NHS workforce planning. This will include the obligation to liaise closely with the relevant Strategic Health Authority and to co-operate in ensuring fair access to these key elements of the workforce, avoiding predatory recruitment practices and co-operating with NHS employers in ensuring adequate resourcing and succession planning across the local health economy.

2.3 The shortage professions covered by the wave 2 elective and diagnostic procurement additionality policy are:

2.4 All the professions involved in:
   — pathology;
   — audiology;
   — sleep/respiratory physiology;
   — neurophysiology; and,
   — Cardiac physiology, including echo-cardiology.

2.5 Professions involved in anaesthetics and clinical radiology including anaesthetists, anaesthetic and critical care nurses, clinical radiologists, therapeutic radiographers and diagnostic radiographers.

2.6 In addition to the nursing groups already highlighted, all the bands 7 and 8 within the registered nursing workforce.

2.7 Biomedical scientists at all bands.

2.8 In addition to the healthcare scientists groups already highlighted, all the bands 7 and 8 within the healthcare scientists profession.

2.9 In addition to the medical groups already highlighted, trauma and orthopaedic surgeons and consultants in nuclear medicine.

2.10 In addition, the following health professionals are also identified: occupational therapists, pharmacists, qualified practitioners working in operating departments, and very specialist physiotherapists.

3. Update on The Will Adams NHS Treatment Centre, Gillingham

3.1 This treatment centre opened in October 2005, since then local NHS sponsors and the provider have been working in partnership to maximise the utilisation of the contract over the full term of the contract.

3.2 In particular, the NHS and the provider have implemented the following to improve activity levels:
   — improved marketing to local GP referrers and the local population. This has included treat centre based GP events, education events and hospital visits by TC clinicians to meet local clinicians in their workplace;
   — transfer of relevant non-breach waiting list activity from the acute trust to the centre. Transferred activity has been successfully delivered; and,
   — transfer of non-breach activity from surrounding PCT areas—although subsequent investigation failed to identify a demand for this.

3.3 The NHS now consider that there is a need for increased partnership working between the centre and the local acute Medway NHS Trust. A local Executive Group has been set up including CEOs from Medway PCT, the Acute Trust and senior representatives from Mercury Health. The Group will focus on:
   — re-distributing workload and facilitating the transfer of additional elective activity from Medway NHS Trust to the centre;
   — rationalising the use of available staff resources, to include medical staff secondment from Medway NHS Trust to the centre;
   — improving clinical working relationships between the centre and the Medway NHS Trust;
   — pro-actively managing and jointly reconfiguring referral processes and clinical pathways to improve patient comfort, convenience and continuity of care;
   — applying the necessary legal and HR processes for secondment, including staff consultation; and,
   — reconfiguring the case mix, where this will sustain activity at the required levels and is both clinically and financially viable.

4. Phase 2 Business Case Approval Process

4.1 The process for the development, review and approval of full business cases (FBCs) includes the following:
   — oversight and guidance by HMT and subject to Gateway Review by the Office of Government Commerce (OGC);
of a template based on HMT and Departmental standard guidelines;
— review of each scheme-level FBC by the Department’s Capital Investment Branch (CIB),
operating as an HMT-appointed “independent unit within DH’s finance team”;
— approval of each FBC by:
  — workstream leads in the procurement team;
  — the CIB;
  — the Commercial Director General;
  — the Finance Director General;
  — the IS Programme Board (which includes the Department’s Policy & Strategy Director
General, Workforce Director General, and Commissioning Director General); and, 
  — (where specified) HMT;
— provision to HMT of written assurances on key issues by the Department’s Accounting Officer 
prior to Financial Close.

4.2 Phase 2 scheme FBCs follow on from, and are consistent with, two programme-level outline business 
cases (OBCs) for electives and diagnostics (approved by the Secretary of State for Health and HMT), and 
a series of scheme-level OBCs.

4.3 The development and approval of business cases correspond with key successive stages in the 
procurement process:

<table>
<thead>
<tr>
<th>Business case/Other stage</th>
<th>Procurement stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme-level OBC (including analysis and selection of procurement strategy based on VfM approved before:</td>
<td>Advertisement</td>
</tr>
<tr>
<td>Scheme-level OBC (including investment appraisal and preferred procurement option, stakeholder involvement) approved before:</td>
<td>ITN issue</td>
</tr>
<tr>
<td>Report confirming scheme still commercially viable and required and recommending Bidder selection prior to:</td>
<td>Preferred Bidder appointment</td>
</tr>
<tr>
<td>FBC (including confirmation of OBC requirement, demonstration of VfM, documentation of affordability, assurance of policy and commercial fit) approved before:</td>
<td>Contract signature and Financial Close</td>
</tr>
</tbody>
</table>

4.4 The FBC Template has been shared with and commented on by the CIB. The FBC Template complies 
with the DH’s “Five-Case Model” comprising “strategic case”, “economic case”, “financial case”, “commercial case” and “management case”.

4.5 The basic template has been developed into “FBC Template + Generic text” documents for both 
Electives and Diagnostics schemes, which are also subject to further comment by CIB and approval by the 
IS Procurement Board. These documents are used by scheme teams to prepare their scheme-specific FBCs.

4.6 Scheme-level FBCs are subject to detailed review by a) the procurement team’s Subject Matter Expert (SME) Reviewers (two rounds of review) and b) DH’s Capital Investment Branch.

4.7 CIB’s reviews of FBCs are complemented/informed by briefings, documentation relating to the 
appointment of Preferred Bidder and scrutiny of Services Agreements (ie contracts) and related 
derogations—all of which are provided to CIB by the procurement team.

4.8 The proposed activity included in Diagnostics FBCs and that in SHA-led Electives FBCs is subject 
to written confirmation by SHAs. Proposed activity in Centrally-led Electives schemes is discussed with 
SHAs and is also subject to the Policy & Strategy-commissioned “Capacity Mapping” exercise.

4.9 The IS Phase 2 programme is subject to Gateway Reviews by the Office of Government Commerce (OGC). Scrutiny of FBCs by OGC is a significant feature of these reviews. The Gate 3 Review of the IS Phase 2 Programme is scheduled for September 2006.

5. Imperial College Assessment of Registered UK Surgeons (ICARUS)

5.1 The Commercial Framework Agreement for provision of the ICARUS tool as part of a surgical 
assessment to be undertaken by all ISTC Providers was signed on 10 February 2006 between the Secretary 
of State and Imperial College London.
5.2 ICARUS is based on an independent, objective third party review of videos of procedures, generic skills assessment in a bench top environment, and generic surgical proficiency assessment in a standardised “mock” theatre environment at Imperial College London.

5.3 Surgeons appointed to ISTCs will be assessed for competence using the ICARUS tool which will be mandated for Phase 2.

Department of Health

July 2006