The Health Committee

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Written evidence

Evidence submitted by the Department of Health (ISTC 1)

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

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

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

4. The result of this exercise led to the identification of capacity gaps across the country, particularly in specialties such as cataract removal and orthopaedic procedures, where additional capacity was needed beyond the increased capacity planned by existing NHS providers. As a consequence, a procurement exercise was launched.

5. In December 2002, the Department invited expressions of interest from the independent sector to run a series of Treatment Centres, in order to enable yet more NHS patients to benefit from faster access to surgery.2

6. In September 2003, the Department announced preferred bidders for the majority of the Independent Sector Treatment Centres (ISTCs). Contracts were subsequently awarded on the basis that bidders meet the core clinical standards required by the NHS, provided high standards of patient care, offered additional staffing capacity and provided good value for money to NHS commissioners. The first contracts were signed in September 2003 and the first ISTC commenced services in October 2003 at Daventray.

7. As of 31 December 2005, 10 contracts have reached full service commencement and 20 schemes are open (excluding an interim facility at Brighton). They have performed over 44,000 elective procedures and over 9,000 diagnostic procedures for NHS patients. We expect there to be a total of 15 contracts for the provision of 30 ISTC facilities from this first wave of procurement, with the remainder being fully operational during 2006 and 2007. The programme is expected to provide an average of over 170,000 Finished Consultants Episodes (FCEs) a year over five years and represents an investment of approximately £1.6 billion.

8. In addition to the procurement for the provision of treatment centres, the Department has also let two additional one-year contracts (for years 2004–05 and 2005–06) for the provision of supplementary activity to NHS commissioners from existing capacity available in the independent sector, and a five-year contract for the provision of the MRI scans to NHS commissioners.

9. Given the terms of reference of the Committee’s enquiry, this Memorandum of Evidence covers the procurement of ISTCs and not other aspects of the IS procurement programme (such as the supplementary procurements, the MRI procurement, or other pathfinder projects (eg Commuter Walk-in Centres and chlamydia screening)) in England.

10. A further, substantial procurement of additional capacity from the independent sector (known as “phase two”) was launched in March 2005. The next wave of procurements are well advanced and comprises two main areas—elective procedures and diagnostic procedures:

— phase 2 Electives is expected to deliver up to 250,000 procedures per year and create an Extended Choice Network (ECN) of Independent Sector Providers who will deliver up to an additional 150,000 procedures per year, on an ad hoc basis. Overall, this represents an investment of approximately £3 billion over five years. The additional capacity will be provided through a variety of facilities, such as existing ISTCs, new build centres, refurbishments and existing NHS facilities, and will collectively contribute towards the provision of patient choice; and

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

1 Delivering the NHS Plan: next steps on investment, next steps on reform, DH, April 2002.
2 Growing Capacity: Independent Sector Diagnosis and Treatment Centres, DH, December 2002.
IN RESPECT OF THE ISSUES RAISED BY THE COMMITTEE

Q.1 What is the main function of ISTCs?

11. The ISTC programme is intended to be an efficient and cost-effective use of independent sector capacity and capability to reduce waiting times and offer more choice to NHS patients. ISTCs provide elective surgical activity for a range of conditions, including orthopaedics and cataract removal.

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

13. The programme will increase patient choice. Since 1 January 2006, patients have had a choice of at least four providers for their first consultant-led appointment. As well as NHS providers, patients are able to choose to have their treatment provided from the independent sector. Some of the PCT choice options will already include independent sector providers and this number will increase as additional capacity is made available. Choice of elective treatment will both improve the patient experience and encourage providers to develop more responsive, patient-centred services.

14. The aims of the treatment centre programme are to:
   — help provide extra capacity needed to deliver swift access to treatment for NHS patients;
   — support the implementation of patient choice;
   — stimulate innovative models of service delivery and drive up productivity; and
   — introduce contestability between providers of healthcare services for NHS patients.

15. The defining characteristics of treatment centres are that they:
   — exemplify best practice and forward thinking in the design and delivery of the services provided, with services that are streamlined and modern, using defined patient pathways;
   — deliver high volumes of activity in a pre-defined range of routine treatments and/or diagnostics, adding to the capacity of the NHS to treat its patients successfully;
   — deliver scheduled care that is not affected by demand for, or provision of, unscheduled care either on the same site or elsewhere;
   — have services that are planned and booked, with an emphasis on patient choice and convenience together with organisational ability to deliver; and
   — provide a high quality, positive patient experience.

Q.2 What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

16. As of December 2005, 10 ISTC contracts have reached full service commencement, which is being delivered through 20 facilities. They have treated and provided diagnostic services to over 50,000 NHS patients. In total, we expect there to be a further 11 ISTCs open during 2006 and 2007 treating an average of 170,000 patients per annum in total. In addition, the second phase of procurements from the independent sector will further increase this number.

17. The wave 1 ISTC Programme was designed to provide additional elective surgery to help meet waiting time targets as well as contribute to the policy aims of choice and contestability. These three outcomes required a genuine increase in capacity, including workforce capacity. The Additionality policy was designed to prevent a draining of NHS human resource capacity. In addition, on some schemes (which involve a transfer of activity from the NHS to the provider), the Retention of Employment Model has been deployed as the mechanism to ensure that there is no unintentional transfer of NHS staff to the provider.

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

19. Some of the activity that is planned for this first wave of ISTCs has been transferred at the request of the local NHS to free up capacity in existing facilities for other important clinical activity. In these cases, existing NHS staff can operate in the units on a structured secondment basis or a Retention of Employment arrangement to ensure there is no dilution of existing NHS staff and resources. This enables the NHS to learn from innovative approaches from the independent sector whilst retaining and transferring the strengths of the NHS and protecting the high standards of care that have been developed in NHS hospitals.

20. The ISTC programme will play an important role in implementing patient choice. Patient choice is being introduced in stages. Since 1 January 2006, eligible patients are offered a choice of at least four providers, where clinically appropriate where they need a referral for elective care. PCTs are responsible for commissioning the choice options for their local communities and may include NHS Trusts, NHS
Foundation Trusts, NHS or independent sector treatment centres and other independent sector providers. Currently around a third of PCTs’ choice options include the independent sector (ISTCs and other IS providers). Choice at referral will benefit some 9.4 million patients by meeting their needs and preferences.

21. During 2006, choice will extend to include NHS Foundation Trusts, all centrally procured ISTCs and other subsequently centrally procured independent sector providers. By 2008, patients will be able to choose to be treated by any healthcare provider that meets NHS standards and can provide care within the price the NHS is prepared to pay.

22. The ISTC programme is not intended to offer a “one size fits all” solution to the aims of increasing capacity, reducing waiting times and improving patient choice. Rather, the procurement has been designed to allow the independent sector to work in partnership with local healthcare economies to provide solutions which reflect and cater to local requirements. The ISTCs are being set up and run by leading international independent sector healthcare companies, which have extensive experience of running elective surgical centres and diagnostic facilities. The procurement encourages the IS to utilise its experience to offer innovative solutions to local requirements.

23. Innovation exists in many parts of the NHS. It is important to find means by which it can be shared. The NHS is not an homogenous organisation; pockets of innovation exist in both service delivery and facility design within the NHS as they do in the independent sector and other health economies. The ISTCs have been able to build on the best practice in the NHS. They are being run by leading international independent sector healthcare companies, which have extensive experience of running elective surgical centres and diagnostic facilities and have leveraged this experience, along with that of a broad range of international clinical staff, to combine the best of the NHS model with best-practice from abroad, and have delivered various innovative high-quality, patient-centric solutions.

24. Innovations range from the physical layout of facilities to elements of administration and clinical practice, and examples include:
   
   — mobile solutions where the provider supplies clinical services from mobile units which can be set up on agreed sites to improve access to healthcare services for patients in remote areas;
   
   — construction of new facilities designed around the clinical flow of patients, thus increasing productivity;
   
   — process design, to improve the patient’s experience by increasing throughput without compromising patient safety or clinical quality. This is apparent in the mobile ophthalmology units capable of delivering 20–23 cases per day due to the streamlined process enabling efficient use of theatre space and surgical resource;
   
   — taking extraneous administrative processes off-line so that surgery is not delayed and can commence at the start of the working day;
   
   — stocking smaller ranges of prostheses allowing theatre staff to become more proficient and productive;
   
   — administering local anaesthetic instead of general anaesthetic for primary joint replacements reduces the anaesthetic risk as well as the period of stay by the patient to an average of 5.3 days from 8 days experienced in the NHS;
   
   — introducing blood conservancy and recycling techniques that reduce the need for transfusions (an NHS trust that copied these protocols lowered transfusion rates from 30% to 7%);
   
   — the double reading of post operative x-rays for orthopaedic patients, thereby introducing a greater level of peer review and integration between the independent sector and NHS; and
   
   — using effective pain management techniques to allow post-operative physiotherapy to commence earlier thus reducing the length of stay.

25. There has been a considerable reduction in waiting times and waiting lists over the last three years across a wide range of specialties. In the period from April 2002 to March 2005 the headline waiting list numbers have fallen from roughly 970,000 to 744,000. It is, however, difficult to attribute these reductions to a single cause. Targets, investment leading to a surge activity in the NHS and the introduction of ISTCs have all had an impact. ISTCs have treated over 44,000 patients over the past three years thereby contributing to the fall in waiting lists by 226,000 since 2002.

26. ISTCs have been particularly helpful in areas where the local NHS was having difficulty in meeting targets. For example, the ISTC facility at Southampton provided additional capacity to ensure that NHS patients approaching the six month waiting time limit could be transferred to this new facility for treatment.
Q.4 Are ISTCs providing value for money?

27. The NHS has always made use of the independent sector. Historically, however, it has been conducted on an ad hoc basis at a local level. The ISTC programme has systemised much of this activity, and through bulk procurement has cut significantly the cost of doing business with the IS. Traditionally the NHS has paid incumbent IS providers a premium upwards of 40% over reference costs. By managing a national, high-volume procurement, the Department has secured substantial savings on these amounts which we estimate to be £500m once wave one is completed. In addition, based on recent years' spot purchase data, there appears to be a downward trend where spot purchasing continues.

28. Value for Money (VfM) in the ISTC programme comprises two key components: the cost of the programme compared to the “NHS equivalent cost”; and the value of the additional benefits brought by the IS programmes.

29. During the conception of wave one of the ISTC programme, the need to pay a premium to NHS equivalent cost was recognised for the purpose of seeding a new market. The average premium to NHS equivalent cost for 2004–05 was 11.2% above equivalent NHS costs for operational wave one schemes. It is worth noting that the variation around the average NHS cost is not unique to the independent sector. NHS trusts themselves display a considerable variation of costs.

30. Phase two of the ISTC procurement is currently under way and we do not expect the same premium as in wave one.

31. The cost of the additional capacity is only one component of the VfM assessment. The delivery of policy aims and quality benefits, the value elements of VfM, are also important factors in the assessment.

32. The ISTC programme aims not only to deliver extra capacity to publicly funded healthcare but also to deliver greater patient choice and contestability through improving access to elective healthcare and to different providers, This provides benefits to those patients directly using ISTC services through reducing waiting times and allowing them to select care most appropriate to their individual needs and preferences.

33. Furthermore, a recent report by the healthcare market analysts Laing & Buisson asserts that the introduction of ISTCs is already exerting a downward pressure on specialists' fees and forcing a restructuring of private sector provision.

34. Studies of the cost comparisons between wave 1 ISTC and NHS equivalent costs demonstrate that there are some structural considerations that can be used to drive further efficiencies in ISTC contracts and offer improved VfM. These include:

— larger contract packages;
— a narrower range of specialities in a single location;
— a narrower casemix within individual specialities; and
— greater additional activity, which allows the IS more flexibility to design their clinical model and innovate.

35. These findings have been used to inform the second phase of elective procurement in the way schemes are packaged and put to the market in order to drive down contract costs and deliver best VfM.

Q.5 Does the operation of ISTCs have an adverse effect on NHS services in their areas?

36. ISTCs are one of a number of facilities available to NHS commissioners to treat NHS patients that include NHS Acute Trusts, Foundation Trusts, NHS treatment centres, and other IS providers: all providing services—free at the point of delivery—to NHS patients.

37. It is too early to judge whether or not there is any adverse effect on NHS services from ISTCs. The majority of wave 1 ISTCs have either recently commenced services or will be functioning from 2006–07 and we will evaluate their impact over time.

38. ISTCs provide a high volume of routine surgery; in doing so, they are also providing NHS patients with access to timely, high-quality care. Because ISTCs are generally separate units they are unaffected by emergency or seasonal demands that can affect other non-treatment centre providers in the NHS. This means that they are better able to offer patients scheduled procedures at pre-booked times and this is something that patients may well value when using choosing whether to attend an ISTC. Along with the introduction of patient choice and payment by results, ISTCs—which introduce contestability between


4 Estimated by taking the difference between the amount paid under wave one contracts and the equivalent spot purchase price.


providers of healthcare for NHS patients—are expected to drive up performance and standards of other providers. This may mean that poorly performing NHS services are affected if patients choose alternative service providers.

Q.6 What arrangements are made for patient follow-up and the management of complications?

39. Appropriate post-operative follow-up and management of complications are essential to delivering high quality patient care. Where applicable, ISTCs providers are contractually obliged to use NICE guidance. In the first wave of ISTC procurement each contract specifies the approach and quality of post-discharge patient care based on requirements of local NHS commissioners. Further information on the clinical governance arrangements that operate in ISTCs is given in the answer to question 9.

40. Each contract describes the “patient pathway” from the initial GP referral until the conclusion of their treatment and follow-up care that will involve interactions with both the NHS and the independent sector provider. This process should be seamless, in the same way that any referral from primary care to an NHS provider, and back again, should be seamless. Having agreed referral and discharge protocols, and a shared understanding by each provider of what comes before and after the care offered in an ISTC, and by the NHS parties of what takes place in the ISTC are ways we use to try and achieve seamless pathways. It is critical therefore that the points along the “patient pathway”, where the patient enters and exits the care of the provider, are clearly understood by both providers (NHS and independent sector) and commissioners.

41. Individual contracts specify what is required from the independent sector detailing the terms of follow-up and treatment of complications.

42. The purpose of setting out patient pathways in the contracts is to:
   (a) confirm the NHS commissioners’ understanding of what they have commissioned;
   (b) confirm to the provider’s clinical staff clear expectations of care and treatment;
   (c) define the key clinical steps along the entire patient pathway to allow the clinical model and assumptions to be evaluated and quality assured; and
   (d) set out the points along the total patient pathways at which the patient is admitted to or is discharged from the ISTC so that it is clear whether the provider or an NHS party is primarily responsible for the patient’s care and treatment at any given point.

43. The wave 1 Project Agreements place responsibility on providers for the management of follow-up care and complications within a defined post-operative period. NHS patients treated in an ISTC retain their status as NHS patients, regardless of the location of treatment.

44. The follow-up care details will be specified in the contract, outlining types of assessments or further treatments and the numbers of times these are expected to be performed before the patient is transferred back to the NHS. Where necessary, the need for community care and equipment after discharge will be assessed at the time the patient is seen in the pre-operative clinic. The patient’s GP is informed of these arrangements through a letter that is sent after the patient has been discharged.

45. The contract will specify that a patient should be treated for post-operative/post discharge complications within the ISTC where possible and this will happen in the vast majority of cases. There are circumstances where ISTC treatment may not be clinically appropriate or possible and arrangements will be made to have the patient treated in a setting that meets their clinical needs. For example, a GP may decide to refer an ISTC patient to an NHS Accident and Emergency Department if he or she presents with symptoms compatible with a blood clot in their lung. There may be a need, in exceptional circumstances, to refer to a more specialist centre if there is complicated revision surgery required that is beyond the scope of capabilities of the ISTC provider. It may happen that a patient re-enters the NHS stream without the ISTC provider’s knowledge (as in the case of an emergency). Providers are encouraged to develop strong relationships with their NHS colleagues to identify when patients are being treated outside their pathway and, if practicable, to make arrangements to transfer them back to the ISTC as soon as possible.

46. The guiding principle in treating patients with complications is to ensure that the patient’s welfare and safety is paramount and that all other considerations are secondary.

47. Providers must provide detailed evidence of policies and procedures that support re-admission criteria, admission protocols out of hours, contact with the GP and patient post-operatively and transportation arrangements to re-admit the patient.

48. Patients undergoing treatment in an ISTC receive a comprehensive patient information pack at their pre-operative visit and detailed discharge instructions when they are discharged home. The Provider is contractually obliged to provide this information to patients, with the exact requirements varying by casemix. The pre-operative information packs include information on:
   — the provider;
   — the patient care pathway and any pre-assessment procedures that may need to be undertaken;
   — the procedure and expectations about the surgery;
   — the complaints procedures; and
— cancellation and travel arrangements.

This information is explained at various points before the procedure is undertaken and forms part of the information required for the patient to give informed consent.

49. When patients are about to be discharged, they are provided with information, including:
— oral and written discharge instructions, detailing frequently asked questions about the patient’s recuperative phase and when to seek further advice;
— a 24 hour telephone number staffed by senior clinical staff to contact in case of problems or emergency; and
— details of their follow-up appointment times.

Q.7 What role have ISTCs played and should they play in training medical staff?

50. Training will be offered where there is transferred activity and secondment. This will be expected in the following ISTCs located in Nottingham, Maidstone, north-east London, Hemel Hempstead, Stevenage, Brighton, York, Burton, Daventry, Somerset, Greater Manchester, and Portsmouth. Local training committees have been established or are about to be established with a view to developing training contracts. When fully established the contracts will include provision for junior doctor, nurse or allied health professional training. They will cover operative techniques appropriate to the case-mix, general nursing care of the surgical patient and clinical techniques for allied health professionals according to the case mix.

51. Many surgical anaesthetic and other activities that will be provided in ISTCs are part of the core training requirements of NHS staff. Through the provision of modern facilities and delivery of new ways of working, ISTCs can provide NHS staff with the opportunity to access new and innovative work practices in these areas. ISTCs will also provide the opportunity for training and transfer of knowledge in the following areas:
— innovative clinical techniques and new ways of working;
— management of patient flows and processes leading to greater clinical productivity; and
— management of clinical services, including outcome measurement.

52. 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.

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

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

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

56. Training in ISTCs will, in line with current NHS practice, be multi- and inter-professional. NHS consultant trainers who are seconded to independent sector providers will provide their NHS medical trainees with supervised training based in ISTCs. Similarly, NHS nurse and therapist mentors can provide training, guidance and support to pre- and post-registration clinicians. The provision of training for other professions in ISTC settings is being developed, for example radiologists, radiographers, pathologists and GP registrars, where appropriate.

57. The providers are contractually committed to the provision of continuing professional development and training for their own staff. This training will include induction and the training required to operate within the ISTC safely, and training for continuing professional development. Some providers have entered into formal agreements with overseas clinicians’ home governments requiring training and development to be provided for those clinicians while based in the UK so that they can return to their country of origin with new skills.

58. ISTCs are part of the national independent healthcare sector and are regulated by the Healthcare Commission. NHS trainers carry forward their present training accreditation but the facilities/equipment/techniques used may differ from where they have trained previously. NHS Trusts and their NHS trainers and trainees have to be accredited for training by the Postgraduate Medical Education and Training Board
(PMETB) and its agents, the medical Royal Colleges (or professional bodies such as the Nursing and Midwifery Council (NMC) and Health Professional Council (HPC)). Trusts must apply for medical training accreditation to PMETB and are subject to inspection by appropriate Royal Colleges. Where such training is transferring to an ISTC, the Royal Colleges will report to PMETB as to whether they believe the ISTC is a suitable training facility. Medical training cannot take place in an ISTC until approval has been obtained from PMETB.

59. Local training requirements are to be confirmed by the DH in partnership with local stakeholder groups. The providers and the Trusts responsible for the trainees will aim to work together to programme NHS training, by session, case and procedure, well in advance. NHS trainers and trainees will have the opportunity to be involved in appropriate cases throughout the ISTC Patient Pathway.

60. The development and conduct of NHS training in ISTCs will be overseen at national and local levels. The National ISTC Training Steering Group is led by DH training leads and is integrated with local NHS workforce leads. It is a multi-professional and multi-agency group (including IS Providers) charged with monitoring and developing training policy and practice within ISTCs. Local ISTC Training Steering Groups have now been established for most schemes. Their role is to bring together all appropriate local training stakeholders to support NHS training at the local ISTCs, to assist in the local accreditation process and the confirmation of training requirements and programming for the scheme.

Q.8 Are the accreditation and appointment procedures for ISTC medical staff appropriate?

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

62. All professional staff must appear on the appropriate register of their professional body. All doctors must appear on the specialist register for their speciality with the General Medical Council. Doctors working for providers in ISTCs do not work as consultants in the same sense as NHS doctors as they may not be required to carry out the full range of consultants responsibilities including administration and management, service development and research. Although they are specialists in their respective fields, they are not appointed through a consultant’s appointment panel as is found in the NHS. Practice Privileges must be granted before any doctor can work in an ISTC. These should be granted after review by the Medical Advisory Committee, where doctors who may also work in the NHS would participate. The numbers of procedures that each doctor performs are checked during this process.

Q.9 Are ISTCs providing care of the same or higher standard as that provided by the NHS?

63. The clinical governance principles for the ISTC programme are rigorous and closely mirror those found in the NHS. Providers are obliged through their Healthcare Commission registration to have clear, workable clinical governance frameworks in place and they also have a contractual responsibility to ensure that these frameworks reflect good clinical practice. Although great efforts are made to prevent the occurrence of incidents, they have occurred within ISTCs. Providers have a responsibility to report and internally investigate incidents and to put measures in place to ensure that patients are not put in further danger as a result of any such incidents. Lessons are expected to be learned to prevent recurrence of such incidents and these lessons are expected to be extended locally and corporately in the provider organisation and may also be shared with other ISTCs and the wider NHS, if applicable. Some providers have been criticised for being too harsh in dealing with clinical staff who have been involved in incidents, by invoking immediate suspension of practice privileges before an investigation takes place and all of the facts have been considered.

64. All clinical programmes are subject to adverse events in which, on occasions, patients may be harmed. They are a feature of complex modern healthcare wherever carried out. The important thing is to ensure that incidents are properly investigated to discover the root cause (and deal with the less common issues of performance failure or incompetence) and that lessons are learnt and disseminated to prevent future occurrences. For example, in the ISTC in Daventry, concern about the condition of a small number of patients following general anaesthetic prompted the sponsor and the Contract Management Board to commission a review of the anaesthetic service, leading to a decision to suspend general anaesthetic activity while the provider’s policies, procedures and processes were further investigated and reviewed. This suspension of activity was reported to the Healthcare Commission. A full Joint Service Investigation was carried out and recommendations have been made, including a second expert review of policies and procedures and a full audit of general anaesthetic activity once the service has been resumed. Considerable resources are being utilised to support the provider in developing and maintaining a safe and effective anaesthetic service.

65. Reporting of healthcare professionals to their professional bodies and submission of requests for alert letters to Regional Directors of Public Health are also part of the process, if warranted. The point of the alert letter system is to make it less likely that unsuitable or incompetent clinicians are appointed elsewhere.
This process is currently under review and will greatly enhance communication with providers on where there is concern about a clinician’s performance. Early reporting of incidents and investigations to the NHS Litigation Authority, where applicable, has been positively received.

66. The governance frameworks are in turn regularly monitored by the Department of Health through Performance Management Review Boards or Joint Service Reviews. They are also monitored at various intervals by the Healthcare Commission. Providers are obliged to report untoward Incidents to both the central contract management unit (CCMU) and the Healthcare Commission, and arrangements have been agreed that providers may use the CCMU form to report jointly to both organisations.

67. We were aware that the clinical governance arrangements and monitoring procedures undertaken by the Department of Health in the early days of the programme were not always well understood in some localities. There were isolated incidents where poor communication between providers, sponsors, CCMU and other stakeholders created confusion. This has been addressed and NHS sponsors are invited to attend and participate in all investigations. There has been considerable effort to involve sponsors and to ensure that other stakeholders are now part of the communication process which has been considerably improved. Lessons learnt from this have been incorporated in order to strengthen the working arrangements which are now robust.

68. The ISTC service agreements specify standards through:
- detailed clinical pathways;
- adherence to accepted best practice clinical guidelines;
- good clinical practice;
- investigation of any untoward incidents; and
- performance monitoring.

**Detailed Clinical Pathways**

69. For ISTCs in the first phase of procurement, clinical pathways were determined in advance of service commencement and agreed between the provider and local NHS sponsors. In the future, pathways proposed by providers in the bid stage will be assessed against a framework drawn up by a panel of clinical experts in the Commercial Directorate (vetted by the relevant Royal Colleges). The framework is built on NICE recommendations and clinical standards drawn from UK and international best practice, and is reviewed and ratified by an independent Department of Health Clinical Reference panel. The clinical pathway sets the parameters within which the provider must operate, ensuring a given level of care.

**Best Practice Clinical Guidelines**

70. Specific reference is made in the contract that obliges the providers to implement acknowledged best practice guidelines, particularly National Institute for Clinical Effectiveness guidelines.

**Good Clinical Practice**

71. Performance management of the contracts is designed to manage the delivery of service, good clinical practice and compliance with key Performance Indicators.

72. The Joint Service Review (JSR) is the body that provides a performance management mechanism that identifies that the provider is meeting its contractual obligations and is delivering continual quality improvement. There is one JSR for each ISTC that meets quarterly or more often as is deemed necessary. The JSR has equal representation of commissioners and providers and is chaired by the NHS Representative. The NHS Representative is appointed from the local NHS health economy that supports the ISTC contract. The JSR process also promotes a direct link with the local clinical governance structures and processes. Where the JSR finds that there is a potential breach of the contractual obligation or of a Key Performance Indicator (KPI) threshold, it may commission a Joint Service investigation (JSI) to obtain further information. Depending on the outcome of the JSI, the JSR can recommend that the provider follows a rectification plan. If the provider fails to comply with the rectification in the agreed timescale, it can recommend that sanctions are applied, which may include the award of financial penalties, or in the most extreme case, termination of the contract.

**Investigation of Any Untoward Incidents**

73. In addition to the local and national policies and procedures in place to ensure robust clinical governance, the contracts are also monitored in accordance with a “Serious Untoward Incident” (SUIs) procedure. The ISTC programme has contractual obligations for addressing adverse incidents and serious untoward incidents. Essentially, the protocol enables the SUIs to be graded, investigated and monitored. All independent sector providers are also bound by Regulation 28 to report SUIs to the Healthcare Commission.
74. NHS sponsors and the provider agree escalation procedures and processes so that all parties are in agreement ahead of any incident that might occur. Sponsors also take part in the investigation process following a JSI.

**Performance Monitoring**

75. Twenty-six key performance indicators are used to evaluate the performance against pre-set thresholds in wave 1 contracts through the JSR process. These thresholds are designed with reference to NHS benchmarking (where possible) or international best practice. A preliminary report on four early ISTC schemes by the National Centre for Health Outcomes Development (NCHOD) concluded—recognising the constraints of assessing an emerging programme—that:

“It is not appropriate to generalise across the whole ISTC programme given the differences between the types of service provided and KPIs reported. But we do make two key conclusions:

— 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; and

— early results of quality monitoring are encouraging.”  

76. A key principle reflected in the contract is that the standard of care delivered by the provider will be at least equivalent to that provided in the NHS. However, it is not the intention of the ISTC programme that providers should be required to adopt the same working, clinical or management practices used in the NHS. This principle is reflected in the contract in the following ways:

— the provider must provide the clinical services in accordance with agreed clinical standards;

— the contract sets out agreed patient pathways in relation to each surgical procedure;

— the provider can only begin to provide the Clinical Services once the facilities satisfy the required Healthcare Commission standards and it has received all other necessary registrations and permissions from the Healthcare Commission;

— all clinical staff employed by the provider must be registered with an appropriate professional body; and

— the contract allows the Patients’ Forum of each PCT, which makes referrals to the provider, and the Local Health Authority Overview and Scrutiny Committee to access the Facilities and review the services.

77. The providers are contractually obliged to ensure that they have robust clinical governance arrangements in place. These arrangements are carefully scrutinised during the procurement process before contracts are awarded.

Q.10 What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

78. There are confidentiality requirements in relation to ISTCs resulting from:

— the requirements of the procurement process, which may vary at different stages in the procurement process, and receipt of commercially confidential information during that process;

— the contents of commercial agreements with bidders; and

— the need to maintain confidentiality of patient data and records.

79. Our approach is to release information regarding the ISTC programme in accordance with application of the Freedom of Information Act 2000. In relation to commercially sensitive information, sections 41 and 43 provide exemptions if the release of information would expose the Department to a claim for breach of confidence, or is likely to prejudice commercial interests of either the Department or the party supplying the information.

80. Whether or not information identified by a bidder as commercially confidential is involved, preservation of the confidentiality of certain information is generally necessary to ensure a fair and proper procurement process, in accordance with procurement law, regulations and guidelines. In these circumstances confidentiality is seen as necessary in order to ensure a fair and proper procurement process (and thus avoid prejudice to the commercial interests of the Department in a way which would harm the public interest).

81. At different stages in a procurement or series of procurements (where those procurements are related) different considerations may apply to a similar request for information. Therefore, each request must be considered in the context of the relevant procurement.

82. Examples of information which it may be necessary to keep confidential include:

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— the identity of those expressing an interest in the procurement;
— the identity of bidders;
— information provided in response to pre-qualification questionnaires;
— information provided in response to invitations to tender; and
— reasons for selecting (or de-selecting) a preferred bidder.

83. A key advantage to maintaining fair procurement processes (aside from legal compliance) is to maximise the number of organisations which bid, to increase competition on quality, service delivery and price. This ultimately delivers better public services and value for money.

84. The contracts that the Department has negotiated with the independent sector providers of treatment centres contain normal confidentiality provisions to protect the commercial interests of the Department and the providers. Those provisions state that all information relating to the contract is confidential and cannot be released without the consent of all signatories, with limited exceptions.

85. There are circumstances in which such information may however be released. These are by exception, many of which are generally stated in the relevant contract. Examples include:
— information which is in the public domain;
— requests under the Freedom of Information Act, save to the extent that an exemption to disclosure applies—e.g. the s41 exemption for information which, if disclosed, would expose the Department to a claim for breach of confidence, or the s43 qualified exemption for trade secrets/information likely to prejudice commercial interests of either the Department or the party supplying the information; and
— certain information requirements of auditors appointed by the Audit Commission and examination of documents by the Comptroller and Auditor general.

86. In considering any decision as to whether to disclose confidential information relating to a contract, the commercial sensitivity of that information is assessed on a case-by-case basis at the time the request for disclosure is made, taking into account the stage any relevant procurement programme has then reached.

87. It is considered likely that, if the Department were to disclose commercially sensitive information, this would reduce the pool of potential bidders, thereby reducing competition and our ability to obtain best value for money. At contract close we release information on the number and type of procedures and the approximate, though not exact, cost. We will also release an annual report covering the clinical outcomes data of all operational ISTCs. Patients will also be provided with appropriate information as part of choice.

Q.11 What changes should the Government make to its policy towards ISTCs in the light of experience to date?

88. Following from the experiences of running the wave 1 procurement, the Department has made a number of changes for the next phase of procurements. These changes also reflect the developments to the NHS and the health economy since 2002 when the first wave of procurements were launched.

89. Integration with mainstream NHS services for choice—providers in the phase 2 programme will need to integrate their services with other NHS providers in the health economies they are based. They will need to provide services on a similar basis to other NHS providers in order to ensure that patients can make meaningful choices between service providers.

90. Full patient pathway and broader case mix—wave 1 was about helping the NHS reduce waiting times and therefore it concentrated on the treatment element of the patient pathway with referrals from existing waiting lists and from the specialties with the longest waits e.g. orthopaedics, general surgery and ophthalmology. The point at which the IS provider enters the patient care pathway varies on wave 1 contracts in accordance with the needs of the respective sponsor PCTs. Providers bidding for contracts under the phase two procurement will be expected to provide a full patient pathway for treatment from outpatients to inpatient treatment, rehabilitation and follow up.

91. Phasing out take or pay contracts—wave 1 contracts were based on volumes and values and PCTs signed off contracts on the basis of these. The terms of these contracts provided risk cover to the providers whereby if the level of referrals was not sufficient from the PCTs the provider would still be paid for the agreed level of contract. These contracts were appropriate at the time of the wave 1 procurement to enable the entry of new providers of healthcare to NHS patients but have been reviewed for the next phase of procurements.

92. Phase two contracts will be based only on indicative volumes of procedures in recognition of the introduction of patient choice. Providers have been asked to bid on the basis of tapering guarantees for contracts. PCTs will only pay tariff for the treatment patients in their areas receive and any risk guarantee or cost of agreed price over tariff will be handled centrally by DH. The intention being that IS providers should all be providing services at NHS tariff equivalent by the end of the initial guaranteed contract period in line with the level playing field and free choice.
93. Additionality—wave 1 contracts imposed strict additionality requirements on all IS providers. This meant that providers were not allowed to recruit healthcare professionals that were currently working in the NHS or had worked in it within the last six months. In a number of cases Wave 1 contracts resulted in the potential transfer of some NHS staff to IS providers but this was prevented with the use of Retention of Employment or Structured Secondment arrangements.

94. For phase 2 legal advice to the Department is that the retention of an additionality policy can only be justified where there are specific shortages of NHS clinical and professional staff. The Department following advice from the Workforce Review Team is publishing a list of workforce shortage areas where strict additionality will apply. In addition, the contracts will allow clinical and other professional staff to offer their non-contracted hours to IS providers engaged in phase 2 contracts subject to the approval of their employers and that the use of this non-contracted time is consistent with patient safety.

95. Training—wave 1 has focused on the provision of Junior Doctor Training within the ISTC for those schemes where there is transferred activity. Training pathways and facilities have been provided to replicate those which would have otherwise taken place in the local Trust, therefore ensuring that Junior Doctors are not disadvantaged. With phase 2 increasing the amount of training which will take place in ISTCs, providers will bid for phase 2 contracts on the basis that the productivity cost of the training provision is already included in the price of the contract, where training is necessary and makes sense.

Q.12 What criteria should be used in evaluating the bids for the Second Wave of ISTCs?

96. It is important to note that the phase 2 ISTC procurement is ongoing and therefore detailed information pertaining to the evaluation of bids is extremely commercially sensitive.

PREQUALIFICATION QUESTIONNAIRE (PQQ)

97. The objective of the selection process for the PQQ stage is to assess the capability and capacity of bidders to meet the requirements of the project/scheme and select bidders to proceed to the next stage of the procurement.

98. Selection criteria for the PQQ is a combination of clinical, financial and non-financial factors and considers:

— Capacity and capability—assessment of the totality of resources and core competences available to the bidder including, without limitation, clinical, technical, workforce, facilities and organisational elements and taking into account the ability of the bidder to manage simultaneously its bid for the electives schemes at the same time as managing other transactions, whether or not forming part of this procurement.

— Economic and financial standing—whether the bidder is in a sound financial position to participate in a procurement of this size as detailed in Regulation 15 of the Public Services Contracts Regulations 1993 (SI 1993 No 3228) (notwithstanding the non-application of Regulation 15). This may entail independent financial checks.

— Eligibility—whether the bidder or bidder members satisfy any of the conditions for which they may be deemed ineligible to be awarded a public contract, as detailed in Regulation 14 of the Public Services Contracts Regulations 1993 (SI 1993 No 3228) (notwithstanding the non-application of Regulation 14).

99. Those bidders that are short-listed based on their answers to the PQQ will be issued with an Invitation to Negotiate (ITN). Their response to the ITN is their bid.

INVITATION TO NEGOTIATE (ITN)

100. The process for evaluation of bids for phase 2 is designed to identify the most economically advantageous offer, which meets the appropriate clinical standards for each scheme. Evaluation will assess the extent to which each bid meets the requirements of the scheme, as defined in each ITN/ITT, together with an assessment of price and affordability of each solution.

101. Selection decisions will be based on the following parameters:

— performance;
— price;
— risk; and
— timing.

Indicative evaluation criteria is shown in Annex A.
Q.13 What factors have been and should be taken into account when deciding the location of ISTCs?

102. The locations of ISTCs are not in all cases decided upon by the Department of Health. In the first instance DH discusses potential locations for ISTCs with the local health economy (SHAs and PCTs) and the following factors are taken into account:

— accessibility for patients (often in terms of travel time);
— availability of NHS facilities (for some ISTC schemes, NHS facilities have been made available to providers), and
— opportunity for innovation by the provider (for example, leaving sufficient flexibility for the provider to propose solutions that meet the requirements of the scheme, whilst avoiding being prescriptive on the exact location).

103. Bids are subsequently evaluated on their ability to meet the requirements of the scheme, including proposed location.

Q.14 How many ISTCs should there be?

104. There is no formal target for the number of ISTCs. However, by 2008 patients will be able to choose to be treated by any healthcare provider (including the independent sector) that meets NHS standards and can provide care within the price the NHS is prepared to pay.

Department of Health

13 February 2006

Annex A

EVALUATION CRITERIA

The information in the tables below was provided to Bidders at PQQ stage of the Phase 2 Electives procurement in order to aid Bidders’ understanding of how bids would be evaluated; these criteria have now been subsumed within the detailed requirements set out in each ITN.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Clinical outcomes</td>
<td>The ability consistently to deliver good clinical outcomes resulting from high clinical standards, clinical innovation and responsiveness to customer/patient needs.</td>
</tr>
<tr>
<td>Clinical innovation and redesign</td>
<td>Ability to deliver new ways of working to improve patient experience, patient safety, clinical effectiveness and efficiency.</td>
</tr>
<tr>
<td>Clinical safety and quality</td>
<td>Ability to deliver clinical services at least equivalent in safety and quality for patients and staff to those provided in the NHS.</td>
</tr>
<tr>
<td>Clinical capability and capacity</td>
<td>Demonstration of the ability to be a high-performing health care organisation, with possession of the organisational infrastructure (including facilities, equipment, staff), skills, competence, experience and performance record to deliver the required clinical services safely, effectively and efficiently.</td>
</tr>
<tr>
<td>Clinical accountability</td>
<td>The effectiveness with which the organisation holds to account the people responsible for continually improving the quality of their services and safeguarding high standards of care.</td>
</tr>
<tr>
<td>Good Industry and Good Clinical Practice</td>
<td>Demonstration of the ability to use standards, practices, methods and procedures conforming to the law and exercising that degree of skill, care, diligence, prudence and foresight which would reasonably and ordinarily be expected from skilled and experienced organisations and persons engaged in similar services.</td>
</tr>
<tr>
<td>Patient-centred care</td>
<td>The ability consistently to deliver high levels of patient satisfaction resulting from customer/patient-focused approaches to health service delivery. This includes the quality of proposals relating to patient experience.</td>
</tr>
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### Workforce

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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<tbody>
<tr>
<td>Resource capacity and capability</td>
<td>Ability to secure and retain appropriate quality and quantity of all necessary staff groups for each stage of the Scheme from Bid submission, through financial close and mobilisation, to service delivery and throughout the contract term.</td>
</tr>
<tr>
<td>Resource quality</td>
<td>Proposals to ensure appropriate quality of staff in all necessary staff groups, for each stage of the project, including for example (and where relevant) qualification and experience requirements, registration, training, criminal record checks and English language tests.</td>
</tr>
<tr>
<td>Management</td>
<td>Ability to manage human resource issues, for example (and where relevant) performance management, compliance with Working Time Directive and management of secondees.</td>
</tr>
<tr>
<td>Training</td>
<td>Commitment (in addition to the training of Provider and seconded staff) to facilitate and support NHS training of doctors-in-training and other clinicians.</td>
</tr>
<tr>
<td>Additionality</td>
<td>Commitment to embrace the principles of Additionality and ability to comply with the Additionality requirements of the Services Agreement.</td>
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### Facilities

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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<tbody>
<tr>
<td>Quality of infrastructure solution</td>
<td>Appropriateness of the built asset solution (whether that solution be new build, refurbishment, mobile or other) to the clinical and non-clinical aspects of the Requirements.</td>
</tr>
<tr>
<td>Infrastructure capability</td>
<td>Demonstrable possession of the ability, skills and experience to procure and deliver the infrastructure, facilities and environments to the required standards and in the required timescales.</td>
</tr>
<tr>
<td>Facilities Management</td>
<td>Acceptable approach to maintaining the quality and fitness for purpose of the facilities and their installations (including, without limitation, operational management, maintenance, contingency and continuity planning, technical standards compliance, technology refresh, record keeping, procurement and monitoring processes).</td>
</tr>
<tr>
<td>Technical specification and standards</td>
<td>Compliance with all relevant standards, regulations and registration requirements.</td>
</tr>
</tbody>
</table>

### IM&T

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Quality of IM&amp;T solution</td>
<td>Appropriateness of the IM&amp;T solution to the clinical and non-clinical aspects of the requirements throughout the contract term.</td>
</tr>
<tr>
<td>IM&amp;T capability</td>
<td>Demonstrable possession of, or ability to secure, the infrastructure, skills and experience to deliver the proposed IM&amp;T systems.</td>
</tr>
<tr>
<td>Technical specification and standards</td>
<td>Compliance with all relevant IM&amp;T standards and requirements (including, without limitation, Connecting for Health and all relevant aspects of the NPfIT).</td>
</tr>
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</table>

### Legal

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<tr>
<th>Criteria</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Sign up to terms</td>
<td>Confirmation that the Bidder has accepted and is fully committed to the terms of the Services agreement, the provisions of the draft standard form sub-lease (if applicable), the provisions of the draft standard form subcontract (if applicable) and the provisions of the draft standard form secondment agreement (if applicable).</td>
</tr>
</tbody>
</table>
COMMERCIAL

<table>
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<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value for money</td>
<td>Evaluated using methodology to be specified in the ITN, taking account of (without limitation) price, quality of solution, risk transfer, contract end proposals and residual value.</td>
</tr>
<tr>
<td>Affordability</td>
<td>Whether the proposed solution meets procurement requirements within the available budget.</td>
</tr>
<tr>
<td>Corporate structure</td>
<td>Assessment of the suitability and robustness of the bidding entity.</td>
</tr>
<tr>
<td>Funding Structure</td>
<td>Whether the funding package (eg corporate/third party/leasing debt/ equity and working capital) is appropriate and deliverable within the timeframe of the Procurement and can demonstrate the appropriate level of commitment (and level of diligence) from the providers.</td>
</tr>
<tr>
<td>Financial Robustness</td>
<td>Robustness of the Bidder’s Bid, associated input assumptions, outputs and financial capacity and commitment to meet its obligations under the Services Agreement. This includes provision of performance security and compensation on termination.</td>
</tr>
<tr>
<td>Contract flexibility</td>
<td>Extent to which the Bid offers the DH flexibility and shares risk over the contract period (eg relating to casemix, referral patterns, training, location or technology requirement changes).</td>
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OPERATIONAL

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<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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<tbody>
<tr>
<td>Mobilisation and service commencement</td>
<td>Extent to which the Bidder demonstrates the ability to mobilise resources to deliver early service commencement. This includes (without limitation) liaising effectively with key stakeholders where necessary, procuring suitable facilities and mobilising appropriate volumes and levels of resource (including staff and equipment).</td>
</tr>
<tr>
<td>Contract Management</td>
<td>Ability to deliver key contract deliverables in terms of activity, quality and cost, and to ensure effective stakeholder engagement around contingency planning and performance management.</td>
</tr>
<tr>
<td>Contestability</td>
<td>Quality of proposals to stimulate demand for the Services.</td>
</tr>
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</table>

INTEGRATION

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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<tbody>
<tr>
<td>Clinical and cultural fit</td>
<td>Ability to integrate fully with the local NHS and other providers to deliver care that is seamless for patients and professionals.</td>
</tr>
<tr>
<td>Workforce integration</td>
<td>Extent to which proposals fit with local requirements and systems, including secondment of NHS staff, performance management and training requirements.</td>
</tr>
<tr>
<td>Infrastructure integration</td>
<td>Extent to which proposals satisfy physical location and access requirements and quality of proposals to manage relevant issues such as use of shared facilities and equipment.</td>
</tr>
<tr>
<td>IM&amp;T Integration</td>
<td>Demonstrated ability to integrate necessary and required IM&amp;T elements within existing and future planned NHS IM&amp;T infrastructure including Connecting for Health and all relevant aspects of the NPfIT.</td>
</tr>
<tr>
<td>Relationships</td>
<td>Quality of proposals to win the confidence and support of local NHS organisations to becoming a part of their local health economy.</td>
</tr>
<tr>
<td>Waiting times</td>
<td>Extent to which proposals will facilitate meeting the 18-week waiting time target within the local health economy.</td>
</tr>
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Annex B

KEY STAGES WAVE 1 PROCUREMENT PROCESS

There were four key stages in the Wave 1 procurement process:

Stage 1—OJEU Advertisement;
Stage 2—Pre-Qualification and Short listing;
Stage 3—ITN Bid submission and Negotiation; and
Stage 4—Contract Finalisation.

A description of each of these stages is below.

**Stage 1: OJEU Advertisement**

An advertisement was placed in the Official Journal of the EU for the procurement. Organisations that wanted to take part in the procurement submitted an expression of interest (EOI).

**Stage 2: Pre-Qualification and Short Listing**

All organisations that submitted an EOI during stage 1 were sent a Pre-qualification questionnaire (PQQ). Bidders that wished to participate in the competition submitted a completed PQQ response. The DH evaluated the PQQ responses in accordance with evaluation criteria notified to Bidders. The focus was on three main areas:

1. Eligibility in terms of insolvency, grave misconduct, etc;
2. Economic and financial standing; and
3. Capability and capacity.

Subject to receiving sufficient satisfactory PQQ responses, for each scheme, between three and five Bidders were short listed and invited to bid in response to the ITN.

**Stage 3: Invitation to Negotiate (ITN) Bid Submission and Negotiation**

Short listed Bidders were issued with ITNs containing additional information on the DH requirements for the particular scheme(s) for which they were short listed. ITNs requested Bidders to prepare Bids (detailed proposals to form the basis for negotiations between the DH and the selected Bidders). Bids were evaluated in accordance with evaluation criteria designed to determine the most economically advantageous offer that offered appropriate levels of clinical services delivery.

Following the deadline for submission of Bids, where necessary, the DH held further meetings to discuss and/or negotiate any issue contained in the Bids, the contractual arrangements or any other relevant matters.

A Preferred Bidder was appointed for each scheme. A Reserve Bidder, where appropriate, were also appointed. In situations where a Bidder failed to provide a technically and clinically acceptable solution with a fixed price on agreed contractual terms that reflects the desired risk allocation and good Value for Money (VfM) the scheme did not proceed.

**Stage 4: Contract Finalisation Stage**

Immediately following appointment, the Preferred Bidder worked with the DH representatives to finalise the clinical model and staffing details, service method and contract terms.

A Full Business Case (FBC) for each Scheme was developed to provide accurate and complete information required for senior management to make an informed investment decision. Its aims were to:

- Verify the continuing need for investment in the Scheme.
- Demonstrate that the preferred solution represents VfM.
- Establish that the supplier is capable of delivering the Scheme.
- Confirm that the planned investment is affordable.
- Demonstrate that the organisation is capable of managing a successful implementation and subsequently sustaining success.
- Provide an essential audit trail for decisions taken.
- Identify how benefits will be realised and monitored.
- Confirm the investment decision.

The FBC was approved before contract were awarded, and therefore must provide sufficient assurance to senior management that a project can proceed and resources can be committed.

After approval of the FBC, the Schemes moved to Financial Close, which is when the Preferred Bidder entered into the Services Agreement with the DH.
### Annex C

#### WAVE 1 ISTCs

<table>
<thead>
<tr>
<th>GAP</th>
<th>Operational Status</th>
<th>Casemix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmic Chain</td>
<td>Full Service</td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>East Cornwall</td>
<td>Full Service</td>
<td>Ophthalmology, General Surgery, Gastroenterology, Gynaecology, Urology</td>
</tr>
<tr>
<td>East Lincs</td>
<td>Full Service</td>
<td>Ophthalmology, urology, hernias, varicose veins, colonoscopies and minor skin</td>
</tr>
<tr>
<td>West Lincs</td>
<td>Full Service</td>
<td>Ophthalmology, gastroscopies, colonoscopies, orthopaedic, urology and minor skin</td>
</tr>
<tr>
<td>North Oxford (Horton)</td>
<td>Full Service</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>NEYNL</td>
<td>Full Service</td>
<td>General Surgery, Trauma and orthopaedics</td>
</tr>
<tr>
<td>Southampton</td>
<td>Full Service</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Northumberland</td>
<td>Full Service</td>
<td>Upper scopes, hernias, varicose veins, minor skin</td>
</tr>
<tr>
<td>TV3500</td>
<td>Full Service</td>
<td>General Surgery, Urology, Trauma and orthopaedics, Dermatology, Gynaecology</td>
</tr>
<tr>
<td>GC4 West Surrey</td>
<td>Under Negotiation</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Kidderminster</td>
<td>Full Service</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Cheshire &amp; Merseyside</td>
<td>Mobilisation</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Nottingham</td>
<td>Mobilisation</td>
<td>Orthopaedic, Gynaecology, General surgical, Dermatology, Endoscopies, Oral and Maxillofacial Surgery, Vascular Surgery, Chronic Pain, Diagnostics</td>
</tr>
<tr>
<td>Maidstone</td>
<td>Mobilisation</td>
<td>Chemotherapy, minor surgery and diagnostics</td>
</tr>
<tr>
<td>Outer North East London (BHRT)</td>
<td>Mobilisation</td>
<td>Ophthalmology, Orthopaedics, ENT, Oral, General Surgery, Urology</td>
</tr>
<tr>
<td>Brighton</td>
<td>Mobilisation (services through interim contract)</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Wycombe</td>
<td>Full Service</td>
<td>Diagnostics only (MRI, x-ray, echo and ultrasound)</td>
</tr>
<tr>
<td>Medway</td>
<td>Full Service</td>
<td>General Surgery, Gastroenterology, ENT, Orthopaedics, Urology, Oral Surgery, Diagnostics—endoscopy only</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>Full Service</td>
<td>Walk in centre/minor injuries unit, day surgery, diagnostics, ophthalmology</td>
</tr>
<tr>
<td>Havant</td>
<td>Not operational</td>
<td>Diagnostics only</td>
</tr>
<tr>
<td>Lister Surgi centre</td>
<td>Under Negotiation</td>
<td>Paed, paed ENT, endoscopy, urology, ophthalmology, gynaecology and other specialities</td>
</tr>
<tr>
<td>Hemel Hempstead Surgi centre</td>
<td>Under Negotiation</td>
<td>Paed, paed ENT, endoscopy, urology, ophthalmology, gynaecology and other specialities</td>
</tr>
<tr>
<td>Bradford</td>
<td>Full Service</td>
<td>General Surgery, Gastroenterology, ENT, Gynae, Ophthalmics, Orthopaedics, Plastics, Urology, Oral Surgery, Ultrasound scans—general, Ultrasound scans—doppler, CT scans, MRI scans, Plain films and x-rays, Fluoroscopy</td>
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<tr>
<td>Burton</td>
<td>Mobilisation</td>
<td>General Surgery, ENT, Gynaecology, Ophthalmology, Orthopaedics, Plastics, Urology, Oral Surgery, Rheumatology, Pain procedures, Ophthalmology</td>
</tr>
<tr>
<td>Trent &amp; South Yorkshire</td>
<td>Full Service</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Daventry</td>
<td>Full Service</td>
<td>Ophthalmology, Orthopaedics, Plastics, Oral Surgery, Upper GI Endoscopy</td>
</tr>
<tr>
<td>Shepton Mallet</td>
<td>Full Service</td>
<td>Orthopaedics, ophthalmology, general surgery and endoscopy</td>
</tr>
<tr>
<td>Greater Manchester</td>
<td>Full Service</td>
<td>Orthopaedic, general surgery and ENT</td>
</tr>
<tr>
<td>Plymouth</td>
<td>Full Service</td>
<td>Orthopaedics</td>
</tr>
</tbody>
</table>
### Ophthalmic Chain

**Provider:** Netcare Healthcare UK Limited  
**Region:** National/Mobile  
**SHA:** N/A  
**Lead PCT:** N/A  
**Contract Signatories:** The Secretary of State for Health, Netcare Healthcare UK Limited, Adur, Arun and Worthing PCT, Birkenhead and Wallasey PCT, Bebington & West Wirral PCT, Ellesmere Port & Neston PCT, Central Cheshire PCT, Cheshire West PCT, Eastern Cheshire PCT, Halton PCT, Warrington PCT, Central Liverpool PCT, South Sefton PCT, Blackwater Valley Hart PCT, North Liverpool PCT, South Liverpool PCT, St. Helens PCT, Knowsley PCT, Southport & Formby PCT, Fylde PCT, Blackpool PCT, Wyre PCT, Chorley & South Ribble PCT, Preston PCT, Hyndburn & Ribble Valley PCT, Blackburn with Darwen PCT, Burnley, Pendle & Rossendale PCT, Morecambe Bay PCT, Carlisle and District PCT, Eden PCT, West Cumbria PCT, Cherwell Vale PCT, Chiltern & South Bucks PCT, South East Oxon PCT, South West Oxon PCT, Reading PCT, Vale of Aylesbury PCT, Wycombe PCT, Gateshead PCT, Newcastle PCT North Tyneside PCT, Northumberland Tyne and Wear Primary PCT, South Tyneside PCT, Sunderland PCT, South West Kent Primary PCT, Taunton Deane PCT, Teignbridge PCT  
**Full Service Commencement Date:** 25.01.04  
**Contract End Date:** 31.03.2009  
**Total Procedures for contract:** 44,737  
**Casemix:** Ophthalmology: Day-Case Cataract Surgery  

Netcare Healthcare UK Limited Cataract Chain has been in operation since the 26th January 2004. Netcare Healthcare UK Limited provides day case cataract treatment. This service is innovative in that it provides its service through the use of two mobile units/vans. One of the units/vans incorporates the pre-assessment service with the other unit/van providing the theatre and day ward. Each unit/van is independently staffed with an overall manager being in place for the whole service.

### GC4 Spine Chain

**Provider:** NT8 Capio UK  
**Region:** Spine Chain  
**SHA:** South West Peninsula SHA, Trent SHA, Thames Valley SHA, NEYNL SHA, Hampshire and Isle of Wight SHA, Northumberland, Tyne and Wear SHA, Surrey And Sussex SHA  
**Lead PCTs**  
- North and East Cornwall PCT  
- East Lincolnshire PCT, West Lincolnshire PCT, Cherwell Vale PCT, Selby and York PCT, Eastleigh and Test Valley South PCT, Newcastle PCT, Milton Keynes PCT, Surrey Heath and Woking PCT  
**Other Commissioning PCTs**  
- Central Cornwall PCT, Cherwell Vale PCT, Yorkshire, Wolds and Coast PCT, Scarborough, Whitby & Rydale PCT, York Hospitals NHS Trust, Craven, Harrogate and Rural District PCT for interim service only, Southampton City PCT, New Forest PCT, Sunderland Teaching PCT, North Tyneside PCT, South Tyneside PCT, Northumberland Care Trust, Northumberland PCT, Gateshead PCT, Reading PCT, Slough PCT, Newbury and Community PCT, Wokingham PCT, Vale of Aylesbury PCT, North East Oxfordshire PCT, Cherwell Vale PCT, Oxford City PCT, South East Oxfordshire PCT, South West Oxfordshire PCT, Bracknell Forest PCT, Windsor, Ascot and Maidenhead PCT, Chiltern and South Bucks PCT, Wycombe PCT, Hounslow PCT, North Surrey PCT, Guildford & Waverley PCT and Surrey Heath and Woking PCT  
**Financial Close Date:** 13.05.04  
**Contract End Date:** 31.03.10  
**Total Activity for contract:** Procedures: 100,521; Diagnostics 2,000  
**Casemix:** General Surgery, Urology, Trauma and Orthopaedics, ENT, Oral surgery, General medicine, Gastroenterology, Dermatology, Thoracic medicine, Rheumatology, Paediatrics,
Gynaecology, Dietetics, Physio assessment, Ophthalmology, Plastic Surgery, minor skin, Hernias, Varicose veins, Colonoscopies, Upper scopes

<table>
<thead>
<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bodmin NHS Treatment Centre</td>
<td>Bodmin, Cornwall, PL31 2QT: Interim site Capio Duchy, Truro, Cornwall, TR1 3UP</td>
</tr>
<tr>
<td>Boston NHS Treatment Centre</td>
<td>Boston West Business Park, Sleaford Road, Boston PE21 8EG</td>
</tr>
<tr>
<td>Gainsborough NHS Treatment Centre</td>
<td>John Coupland Hospital, Ropery Road, Gainsborough, Lines DN21 2TJ</td>
</tr>
<tr>
<td>Horton NHS Treatment Centre (Banbury)</td>
<td>Oxford Road, Banbury, Oxfordshire, OX16 9AL</td>
</tr>
<tr>
<td>Clifton NHS Treatment Centre</td>
<td>Bradford, West Yorkshire; interim site The Yorkshire Clinic</td>
</tr>
<tr>
<td>Capio New Hall Hospital NHS Treatment Centre</td>
<td>Bodenham, Salisbury, Wiltshire, SP5 4EY</td>
</tr>
<tr>
<td>Capio King Edward VII Hospital NHS Treatment Centre</td>
<td>The Silverlink North, Cobalt Business park, north Tyneside NE27 0BY</td>
</tr>
<tr>
<td>The Cobalt NHS Treatment Centre</td>
<td>Swallows Croft, Wensley Road, Reading RG1 6UZ</td>
</tr>
<tr>
<td>Capio Reading NHS Treatment Centre</td>
<td>New Site: Smeaton Close, Milton Keynes (interim site Capio Woodland Hospital, Rothwell Road Kettering)</td>
</tr>
<tr>
<td>Capio Blakeland NHS Treatment Centre</td>
<td>London Road, Ashford, Middlesex, TW15 3AA</td>
</tr>
</tbody>
</table>

GC4 EAST CORNWALL

Provider: NT8 Capio UK
Region: Y44 Southern Cluster
SHA: Q21 South West Peninsula SHA
Lead PCT: 5KR North East Cornwall PCT
Other Commissioning Central Cornwall PCT

Interim Service Commencement Date: 01.10.05
Full Service Commencement Date: 03.01.06
Contract End Date: 31.03.10
Total Procedures for contract: 26,767
Casemix: Ophthalmology, General Surgery, Gastroenterology, Gynaecology, Urology, Daycase facility

<table>
<thead>
<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
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<tbody>
<tr>
<td>Bodmin NHS Treatment Centre</td>
<td>Bodmin, Cornwall, PL31 2QT</td>
</tr>
</tbody>
</table>

The purpose built Bodmin NHS Treatment Centre on the St Lawrence’s site, will initially provide outpatients and a range of day cases in Ophthalmology, Gastroenterology, General Surgery, Gynaecology and Urology for NHS patients living in and around the area, reducing the need for travel to either Truro or Plymouth. The service will be staffed and operated by Capio UK with direct referrals from GPs and treat around 6,000 patients per year.

GC4 THAMES VALLEY (HORTON)

The Thames Valley Gap is serviced by facilities in Reading, Horton and Milton Keynes.

Provider: NT8 Capio UK
Region: Y44 Southern Cluster
SHA: Q16 Thames Valley SHA
Lead PCT: 5CQ Milton Keynes PCT, Hospital Campus, Standing Way, Eaglestone, Milton Keynes, Buckinghamshire, MK6 5NG
Other Commissioning Reading PCT, Slough PCT, Newbury and Community PCT, Wokingham PCT,
PCTs: Vale of Aylesbury PCT, North East Oxfordshire PCT, Cherwell Vale PCT, Oxford City PCT, South East Oxfordshire PCT, South West Oxfordshire PCT, Bracknell Forest PCT, Windsor, Ascot and Maidenhead PCT, Chiltern and South Bucks PCT, Wycombe PCT

Full Service Commencement Date: 01.04.05
Contract End Date: 31.03.10
Total Procedures for contract: 5,735
Casemix: General Surgery, Urology, Trauma and orthopaedics, Dermatology, Gynaecology:
Inpatient facility with over 200 beds

<table>
<thead>
<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horton NHS Treatment Centre (Banbury)</td>
<td>Oxford Road Banbury, Oxfordshire, OX16 9AL</td>
</tr>
</tbody>
</table>

The Capio Horton NHS Treatment Centre was built with money left by Mary Ann Horton, whose father had amassed a fortune from his invention of an elastic yarn for stockings. When it opened in 1872 the hospital had just 12 beds. In recent years the hospital has been much expanded and modernised. The Horton is an acute general hospital providing a full range of services, including Accident and Emergency, Maternity, Medical and Surgical wards which continue to improve and develop as part of the Oxfordshire Radcliffe Hospitals NHS Trust.

GC4 NEYNL

Provider: NT8 Capio UK
Region: Y41 North East Cluster
SHA: Q11 NEYNL SHA
Lead PCT: 5E2 Selby & York PCT
Other Commissioning PCTs: Yorkshire, Wolds and Coast PCT, Scarborough, Whitby & Rydale PCT, York Hospitals NHS Trust

Interim Service Commencement Date: 01.07.05
Full Service Commencement Date: 25.01.06
Contract End Date: 31.03.10
Total Procedures for contract: 9,964
Casemix: General Surgery, Trauma and orthopaedics; Inpatient facility with 24 beds

<table>
<thead>
<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clifton NHS Treatment Centre</td>
<td>Clifton Park NHS TC, York</td>
</tr>
</tbody>
</table>

The Clifton NHS Treatment centre will open January 2006. This modern state of the art centre has been designed to provide exceptional facilities with the latest equipment for the assessment, diagnosis and treatment of day care and inpatient procedures.

The treatment centre has 24 in patient beds in total made up of 6 individual patient rooms and 9 double rooms all with en-suite facilities nurse call system and television. All patients will be under the care of York Trust Consultants as part of a partnership arrangement with York NHS Trust, with a Resident Medical officer providing 24 hour medical cover. The centre has high dependency facilities for those patients requiring specialist nursing care. The Out patient facilities includes, 5 consulting/ examination rooms, facilities for undertaking diagnostic tests including an innovative in house laboratory service with the immediate provision of blood results, along side x-ray and ultra sound investigations, and pre-operative assessment. The Physiotherapy department has a well equipped modern gymnasium providing for both in and out patients services.

Two spacious theatres equipped with up to date modern equipment to undertake a range of operations, which will be performed under general and local anaesthetic. There will be a state of the art decontamination facilities will allow for the in house control of all decontamination requirements for the treatment centre.
GC4 EAST LINCOLNSHIRE

Provider: NT8 Capio UK
Region: Y43 Eastern Cluster
SHA: Q24 Trent SHA
Lead PCT: 5H9 East Lincs PCT, East Lincolnshire Primary Care Trust Headquarters, Boston West Business Park, Sleaford Road, Boston, Lincs PE21 8EG

Other Commissioning PCTs: N/A

Full Service Commencement Date: 20.04.05
Contract End Date: 31.03.10
Total Activity for contract: Procedures 7,263; Diagnostics 2000
Casemix: Ophthalmology, urology, hernias, varicose veins, colonoscopies and minor skin; Daycase facility

<table>
<thead>
<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston NHS Treatment Centre</td>
<td>Boston West Business Park, Sleaford Road, Boston, PE21 8EG</td>
</tr>
</tbody>
</table>

Boston NHS Treatment Centre opened in April 2005 has state of the art clinical facilities enabling us to put the patient and their families at the heart of what we do.

Clinical facilities include a special reception, Outpatient Suite with 4 consulting rooms, pre operative assessment area. Our spacious operating theatre allows us to be efficient in delivery high volumes of surgical procedures by a skilled surgical team. Following surgery, patients are transferred to a well-equipped postoperative recovery room with state of the art monitoring equipment where they remain until discharge.

Support services include a 3 stage TSSU, which meets the stringent standards, set by the Department of Health.

The Treatment Centre works in close partnership with East Lincolnshire Primary Care Trust to deliver day care surgery to the residents of Boston and surrounding areas. With a resident surgeon and anaesthetist, nursing staff with many years of clinical expertise are able to deliver a service that puts patients at the top of our priorities. Patients have access to a 24-hour helpline following discharge.

GC4 NORTHUMBERLAND

Provider: NT8 Capio UK
Region: Y41 North East Cluster
SHA: Q09 Northumberland, Tyne and Wear SHA
Lead PCT: 5D7 Newcastle PCT, Benfield Road, Newcastle Upon Tyne, Tyne and Wear, NE6 4PF

Other Commissioning PCTs: Sunderland Teaching PCT, North Tyneside PCT, South Tyneside PCT, Northumberland Care Trust, Gateshead PCT

Full Service Commencement Date: 25.05.05
Contract End Date: 31.03.10
Total Procedures for contract: 10,080
Casemix: Upper scopes, hernias, varicose veins, minor skin: Daycase facility

<table>
<thead>
<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cobalt NHS Treatment Centre</td>
<td>The Silverlink North, Cobalt Business Park, North Tyneside NE27 0BY</td>
</tr>
</tbody>
</table>

The Cobalt NHS Treatment Centre opened in May 2005, is a modern purpose built facility designed to provide exceptional facilities and equipment for the assessment, diagnosis and treatment of conditions on a day case basis.

The treatment centre has an outpatient department providing a suite of consulting and examination rooms together with facilities for undertaking diagnostic tests and pre-operative assessments.

A spacious operating theatre is equipped for undertaking a range of routine operations under general and local anaesthetic with a second theatre equipped and dedicated to endoscopy procedures.
Following a procedure patients receive close monitoring and observation in one of four recovery bays, before being transferred to a comfortable sit up area with reclining chairs to complete the recovery process.

GC4 Northern Oxford

Provider: NT8 Capio UK  
Region: Y44 Southern Cluster  
SHA: Q16 Thames Valley SHA  
Lead PCT: 5DU Cherwell Vale PCT  
Other Commissioning PCTs: None

Interim Service Commencement Date: 01.01.06  
Full Service Commencement Date: 01.08.06  
Contract End Date: 31.12.11  
Total Procedures for contract: 11,197  
Casemix: Orthopaedics Inpatient facility with 40 beds

<table>
<thead>
<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horton NHS Treatment Centre (Banbury)</td>
<td>Oxford Road, Banbury, Oxfordshire, OX16 9AL</td>
</tr>
</tbody>
</table>

The Capio Horton NHS Treatment Centre is a new Independent treatment Centre, managed by Capio and is being built on the Horton Hospital site. The new centre, which will be run with the close co-operation of the Trust, will provide orthopaedic services. It is due to open in the summer of 2006. The Horton is an acute general hospital providing a full range of services, including Accident and Emergency, Maternity, Medical and Surgical wards which continue to improve and develop as part of the Oxfordshire Radcliffe Hospitals NHS Trust.

GC4 Thames Valley (Reading)

The Thames Valley Gap is serviced by facilities in Reading, Horton and Milton Keynes.

Provider: NT8 Capio UK  
Region: Y44 Southern Cluster  
SHA: Q16 Thames Valley SHA  
Lead PCT: 5CU Milton Keynes PCT, Hospital Campus, Standing Way, Eaglestone, Milton Keynes, Buckinghamshire, MK6 5NG  
Other Commissioning PCTs: Reading PCT, Slough PCT, Newbury and Community PCT, Wokingham PCT, Vale of Aylesbury PCT, North East Oxfordshire PCT, Cherwell Vale PCT, Oxford City PCT, South East Oxfordshire PCT, South West Oxfordshire PCT, Bracknell Forest PCT, Windsor, Ascot and Maidenhead PCT, Chiltern and South Bucks PCT, Wycombe PCT

Full Service Commencement Date: 01.04.05  
Contract End Date: 31.03.10  
Total Procedures for contract: 5,735  
Casemix: General Surgery, Urology, Trauma and orthopaedics, Dermatology, Gynaecology: Inpatient facility with 52 beds

<table>
<thead>
<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capio Reading NHS Treatment Centre</td>
<td>Swallows Croft, Reading, RG1 6UZ</td>
</tr>
</tbody>
</table>

Capio Reading NHS Treatment Centre is integrated with and uses the facilities of the Capio Reading Hospital. Capio Reading Hospital was purpose built in 1993 and was designed to combine exceptional standards of patient accommodation with the technical equipment and facilities that modern medicine demands.

The hospital has 52 individual patient rooms and nine twin bedded rooms all with en-suite facilities, nurse call system, telephone and sky television. All patients are under the care of a Consultant and, a Resident Medical Officer provides a 24-hour service. The hospital has a two-bedded High Dependency Unit for patients requiring specialist nursing.
The theatre department has 3 main theatres, two with laminar flow, a seven-bedded recovery area and a dedicated Endoscopy Suite with a recovery area. The theatre department is available for routine and emergency surgery. An on-call team is available at all times.

The Outpatient Department in the Mansion adjacent to the hospital has 19 consulting rooms with associated examination and treatment facilities, and a minor operating theatre. Other outpatient facilities include a large Physiotherapy Department with a well equipped, modern gymnasium, Audiology, X-ray, ultrasound, MRI scanning and a Pathology Laboratory.

**GC4 SOUTHAMPTON**

<table>
<thead>
<tr>
<th>Provider:</th>
<th>NT8 Capio UK</th>
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<tbody>
<tr>
<td>Region:</td>
<td>Y44 Southern Cluster</td>
</tr>
<tr>
<td>SHA:</td>
<td>Q17 Hampshire and Isle of Wight SHA</td>
</tr>
<tr>
<td>Lead PCT:</td>
<td>5LY Eastleigh and Test Valley PCT</td>
</tr>
<tr>
<td>Other Commissioning</td>
<td>Southampton City PCT, New Forest PCT</td>
</tr>
</tbody>
</table>

| Full Service Commencement Date: | 01.04.05 |
| Contract End Date:             | 31.03.10 |
| Total Procedures for contract: | 11,468   |
| Casemix:                       | Orthopaedics; Inpatient facilities with a total of 182 beds |

**Treatment Centre Name** | **Treatment Centre Address**
--- | ---
Capio New Hall Hospital NHS Treatment Centre | Bodenham, Salisbury, Wiltshire, SP5 4EY

Capio New Hall Hospital NHS Treatment Centre offer a range of medical and surgical procedures together with extensive diagnostic and treatment facilities.

**GC4 GAINSBOROUGH**

<table>
<thead>
<tr>
<th>Provider:</th>
<th>NT8 Capio UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region:</td>
<td>Y43 Eastern Cluster</td>
</tr>
<tr>
<td>SHA:</td>
<td>Q24 Trent SHA</td>
</tr>
<tr>
<td>Lead PCT:</td>
<td>5D2 West Lincs PCT, Cross o Cliff, Bracebridge Heath, Lincoln, LN4 2HN</td>
</tr>
<tr>
<td>Other Commissioning</td>
<td>None</td>
</tr>
</tbody>
</table>

| Full Service Commencement Date: | 01.04.05 |
| Contract End Date:             | 31.03.10 |
| Total Procedures for contract: | 6,365    |
| Casemix:                       | Ophthalmology, gastroscopies, colonoscopies, orthopaedic, urology and minor skin; Daycase facility |
Gainsborough NHS Treatment Centre

Gainsborough NHS Treatment Centre is based at the John Coupland Hospital situated on Ropery Rd Gainsborough. This historic building is situated in lovely grounds and offers patients a local service that is responsive and efficient. The hospital itself has a minor injuries unit Diagnostic services, extensive support services and excellent catering facilities.

Capio currently provide day case surgical facilities two days per week at John Coupland Hospital and have the use of a six bedded day care area, operating theatre and recovery area, outpatient consulting room, dedicated minor operations suite for eye surgery and an endoscopy unit.

A wide variety of surgical day case procedures are offered at Gainsborough NHS Treatment Centre by skilled experienced surgeons all at Consultant level. A duty Doctor is on site for the duration of our week in Gainsborough. Patients have access to a 24-hour helpline following discharge.

GC4 Thames Valley (Milton Keynes)

The Thames Valley Gap is serviced by facilities in Reading, Horton and Milton Keynes.

Capio Woodland Hospital NHS Treatment Centre—Interim Site

Capio Woodland Hospital NHS Treatment Centre has been designed to combine exceptional standards of patient accommodation with the technical equipment and facilities that modern medicine demands.

The Hospital has 39 single rooms, all with en-suite facilities. Each room has its own telephone, TV and radio as well as comfortable facilities for your visitors.

Capio Reading Hospital NHS Treatment Centre—Interim Site

Capio Reading Hospital NHS Treatment Centre was purpose built in 1993 and has been designed to combine exceptional standards of patient accommodation with the technical equipment and facilities that modern medicine demands.

The hospital has 52 individual patient rooms and nine twin bedded rooms all with en-suite facilities, nurse call system, telephone and sky television. All patients are under the care of a Consultant and, a Resident Medical Officer provides a 24-hour service. The hospital has a two-bedded High Dependency Unit for patients requiring specialist nursing.

The theatre department has 3 main theatres, two with laminar flow, a seven-bedded recovery area and a dedicated Endoscopy Suite with a recovery area. The theatre department is available for routine and emergency surgery. An on-call team is available at all times. The Outpatient Department in the Mansion
adjacent to the hospital has 19 consulting rooms with associated examination and treatment facilities, and a minor operating theatre. Other outpatient facilities include a large Physiotherapy Department with a well equipped, modern gymnasium, Audiology, X-ray, ultrasound, MRI scanning and a Pathology Laboratory.

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<thead>
<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
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<tbody>
<tr>
<td>Capio Blakeland NHS Treatment Centre</td>
<td>Site under Construction: Smeaton Close, Milton Keynes</td>
</tr>
</tbody>
</table>

GC4 WEST SURREY

Provider: NT8 Capio UK  
Region: Y44 Southern Cluster  
SHA: Q19 Surrey And Sussex SHA  
Lead PCT: 5L7 Surrey Heath and Woking PCT  
Other Commissioning PCTs: Hounslow PCT, North Surrey PCT, Guildford & Waverley PCT and Surrey  

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<tr>
<th>Interim Service Commencement Date</th>
<th>Full Service Commencement Date</th>
<th>Contract End Date</th>
<th>Total Procedures for contract</th>
<th>Casemix</th>
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Ashford Hospital has 250 beds and provides a wide range of medical and surgical services, with a busy emergency department, short term intensive care, outpatients services, ophthalmology, a dedicated stroke unit, and a six day renal dialysis unit (operated by Hammersmith Hospital).

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<tr>
<th>Treatment Centre Name</th>
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<tbody>
<tr>
<td>Ashford Hospital</td>
<td>London Road, Ashford, Middlesex, TW15 3AA</td>
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GC5E NOTTINGHAM

Provider: NTA Nations Healthcare (Nottingham) Limited  
Region: Y43 Eastern Cluster  
SHA: Q24 Trent SHA  
Lead PCT: 5FC Rushcliffe PCT, Easthorpe House 165 Loughborough Road, Ruddington, Nottinghamshire, NG11 6LQ  
Other Commissioning PCTs: Nottingham City PCT, Broxtowe & Hucknall PCT, Gedling PCT, Newark and Sherwood PCT, Erewash PCT, Amber Valley PCT, Ashfield PCT, Bassettlaw PCT, Central Derby PCT, Greater Derby PCT, Chesterfield PCT, Derbyshire Dales and South Derbyshire PCT, East Lincolnshire PCT, High Peaks and Dales PCT, Lincolnshire South West Teaching PCT, Mansfield District PCT, North Eastern Derbyshire PCT, West Lincolnshire PCT, Charnwood and North West Leicestershire PCT, Melton Rutland and Harborough PCT

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<tr>
<th>Full Service Commencement Date</th>
<th>Contract End Date</th>
<th>Total Procedures for contract</th>
<th>Casemix</th>
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<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
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<tbody>
<tr>
<td>Queen’s Medical Centre, Nottingham</td>
<td>Derby Road, Nottingham NG7 2UH</td>
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</table>
Operations at the Nottingham NHS Treatment Centre at QMC are scheduled to begin in late autumn 2007. Queen’s Medical Centre, Nottingham is the 2nd largest teaching hospital in Europe and includes:

- 6 surgical theatres.
- 2 treatment rooms.
- Comprehensive diagnostic imaging.
- Extensive multi-specialty consulting.

GC5W CHESHIRE & MERSEYSIDE

Provider: NTD01 InterHealth Limited
Region: Y42 North West and West Midlands Cluster
SHA: Q15 Cheshire & Merseyside
Lead PCT: 5H3 Cheshire West PCT
Other Commissioning PCTs:
- Bebington and Wirral PCT (5F8)
- Birkenhead and Wallasey PCT (5H2)
- Central Cheshire PCT (5H4)
- Central Liverpool PCT (5HA)
- Cheshire West PCT (5H3)
- Eastern Cheshire PCT (5H5)
- Ellesmere Port and Neston PCT (5H6)
- Halton PCT (5J1)
- Knowsley PCT (5J4)
- North Liverpool PCT (5G9)
- South Liverpool PCT (5HC)
- South Sefton PCT (5M5)
- Southport and Formby PCT (5F9)
- St Helens PCT (5J3)
- Warrington PCT (5J2)

Full Service Commencement Date: 01.06.06
Contract End Date: 31.05.11
Total Procedures for contract: 24,817
Casemix: Orthopaedics, Inpatient facility with 44 beds

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<tr>
<th>Treatment Centre Name</th>
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<tbody>
<tr>
<td>Cheshire and Mersey NHS Treatment Centre</td>
<td>Halton Hospital site, Runcorn, WA7 2DA</td>
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</table>

The Cheshire and Mersey NHS Treatment Centre is a new-build Treatment Centre designed to provide modern, state-of-the-art facilities for orthopaedic services. The Treatment Centre will provide a range of orthopaedic procedures for the population of Cheshire and Merseyside. Extensive diagnostic services including MRI and CT will be provided at the Treatment Centre so that multiple patient attendances can be avoided. 44 in-patient beds together with dedicated day case and physiotherapy suites will be available.

GC5W KIDDERMINSTER

Provider: NTD01 Interhealth Care Services (UK) Limited
Region: Y42 North West and West Midlands Cluster
SHA: Q28 West Midlands South
Lead PCT: 5DR Wyre Forest PCT
Other Commissioning PCTs:
- Redditch & Bromsgrove PCT, South Worcestershire PCT

Full Service Commencement Date: 01.02.05
Contract End Date: 31.01.10
Total Procedures for contract: 9,000
Casemix: Orthopaedics Daycase facility

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<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
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<tbody>
<tr>
<td>Kidderminster Treatment Centre</td>
<td>Bewdley Road, Kidderminster, Worcestershire, DY11 6RJ</td>
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</table>

Kidderminster Treatment Centre (24 beds plus 20 day case beds) is currently being developed as a Diagnostic and Treatment Centre (DTC).
Once complete, the £14 million DTC development will provide day case and short stay elective treatment, diagnostic facilities and a local emergency centre—with staff also having extra back-up from telemedicine video links to the A&E departments at Worcester and Redditch.

There is a rehabilitation and intermediate care ward and a midwifery led maternity unit. The Millbrook Suite provides oncology services in a newly refurbished area. A satellite Renal Dialysis Unit opened in February 2002.

There is a full range of therapy and rehabilitation services including Physiotherapy, Occupational Therapy, Speech and Language and Cardiac Rehabilitation. Outpatient services are delivered at Kidderminster across all the major specialties.

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**GC6 MAIDSTONE**

**Provider:** Partnership Health Group  
**Region:** Y44 Southern Cluster  
**SHA:** Q18 Kent & Medway SHA  
**Lead PCT:** Maidstone Wield PCT  
**Other Commissioning PCTs:** South West Kent PCT

**Full Service Commencement Date:** 16.10.06  
**Contract End Date:** 15.10.11  
**Total Diagnostics for contract:** 48,993  
**Total Procedures for contract:** 55,589  
**Casemix:** Chemotherapy, minor surgery and endoscopes.  
**Daycase facility**

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<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
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<tr>
<td>Maidstone Hospital</td>
<td>Hermitage Lane, Maidstone, Kent, ME16 9QQ</td>
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</table>

The hospital trust was set up on 1 April 2000 to take over the services previously run by the Kent and Sussex Weald NHS Trust and the Mid Kent Healthcare NHS Trust.

Providing a comprehensive range of “acute” (mainly hospital-based) health services, the trust serves residents of Maidstone and Tunbridge Wells and the surrounding areas including Tonbridge, Sevenoaks and parts of north-east Sussex. It also provides some services, such as oncology and ophthalmology, across a wider area.

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**GC7 LONDON**

**Provider:** Partnership Health Group  
**Region:** Y45 London Cluster  
**SHA:** Q06 North East London  
**Lead PCT:** Barking and Dagenham PCT  
**Other Commissioning PCTs:** Redbridge PCT, Havering PCT, Waltham Forest PCT

**Full Service Commencement Date:** 08.02.07  
**Contract End Date:** 30.11.11  
**Total Procedures for contract:** 56,043  
**Casemix:** Ophthalmology, Orthopaedics, ENT, Oral, General Surgery, Urology. Inpatient facility 22 beds

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<tr>
<th>Treatment Centre Name</th>
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<tr>
<td>King George Hospital</td>
<td>Barking Havering &amp; Redbridge NHS Trust, Romford, Essex, RM3 0NE</td>
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</table>

The King George Hospital operates two A&E departments at King George and Oldchurch hospitals, alongside other acute services consisting of all the major specialties of large district general hospitals.
A joint cancer centre with St Bartholomew’s Hospital in London and a regional neuroscience centre at Oldchurch are offered in addition to these services.

The Trust is committed to working closely with its partners in the community to place patients’ needs at the centre of its services.

A lot of work has been done in association with local authorities, PCTs and other local care organisations in both meeting current demand and in planning for the future.

The Trust’s primary aim is to provide the right care, in the right place and at the right time to the highest standards.

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**GC8 SOUTH-WEST CHAIN**

| Provider: | NT6 Mercury Health |
| Region: | South-West England |
| SHA: | Thames Valley SHA, Kent and Medway SHA, Hampshire and Isle of Wight SHA |
| Lead PCTs | Wycombe PCT, Medway PCT, Portsmouth City Teaching Hospital, East Hampshire & Fareham & Gosport PCTs |
| Other Commissioning PCTs | Vale of Aylesbury PCT, Chiltern and South Bucks PCT |

- Financial Close Date: 09.12.04
- Contract End Date: 31.07.10
- Total Procedures for contract: 216,489
- Total Diagnostics for Contract: 201,930
- Casemix: General Surgery, Gastroenterology, ENT, Orthopaedics, Urology, Diagnostics-endoscopy, Diagnostics, Ophthalmology, Walk in centre/minor injuries unit, day surgery

**Treatment Centre Name** | **Treatment Centre Address**
--- | ---
Mid & South Buckinghamshire NHS Diagnostic Centre | Unit 2, The Merlin Centre, Cressex Business Park, High Wycombe HP12 3QL
Will Adams NHS Treatment Centre | Beechings Way, Gillingham, Kent ME8 6AD
St Mary’s NHS Treatment Centre | Milton Road, Portsmouth, Hants, PO3 6AD
Sussex Orthopaedic NHS Treatment Centre | Princess Royal Hospital, Cowes Road, Haywards Heath, West Sussex RH16 4EX
Havant NHS Diagnostic Treatment Centre | TBC

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**GC8 BRIGHTON**

| Provider: | Mercury Health |
| Region: | Y44 Southern Cluster |
| SHA: | Q19 Surrey and Sussex |
| Lead PCT: | 5LQ Brighton and Hove City PCT |
| Other Commissioning PCTs: | Mid-Sussex PCT, Sussex, Downs and Weald PCT |

- Interim Service Commencement Date: 01.02.05
- Full Service Commencement Date: 12.06.06
- Contract End Date: 31.05.11
- Total Procedures for contract: 26,451
- Casemix: Orthopaedics, Inpatient with 36 beds

**Treatment Centre Name** | **Treatment Centre Address**
--- | ---
Sussex Orthopaedic NHS Treatment Centre | Cowes Road, Haywards Heath, West Sussex RH16 4EX

Opening in June 2006 Sussex Orthopaedic NHS Treatment Centre will be providing day-surgery and in-patient (including out-patient appointments) orthopaedic surgery, on an elective basis, to patients within the Brighton and Hove, Mid-Sussex and Sussex Downs and Weald PCT’s.
The centre will provide patients with the following types of orthopaedic procedures:

- Hip and knee replacement.
- Hip and knee revisions.
- Anterior cruciate ligament reconstruction.
- Arthroscopy.
- Spinal decompression.
- Minor hand and foot procedures—eg removal of metalwork, carpal tunnel release.

The centre is being built on the Princess Royal Hospital site in Haywards Heath and will house the following facilities:

- In-patient beds.
- Day-case beds.
- Operating theatres.
- High dependency beds (HDU).
- Consulting rooms.

GC8 HAVANT

Provider: Mercury Health
Region: Y44 Southern Cluster
SHA: Q17 Hampshire and Isle of Wight
Lead PCT: 5FD East Hampshire PCT
Other Commissioning PCTs: N/A

Full Service Commencement Date: 01.01.08
Contract End Date: 31.12.10
Total Diagnostics for contract: 78,600
Casemix: Diagnostic

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<tr>
<th>Treatment Centre Name</th>
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<tr>
<td>Havant NHS Diagnostic Treatment Centre</td>
<td>New Build, TBC</td>
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</table>

GC8 PORTSMOUTH

Provider: Mercury Health
Region: Y44 Southern Cluster
SHA: Q17 Hampshire and Isle of Wight
Lead PCT: 5FE Portsmouth City Teaching PCT
Other Commissioning PCTs: East Hampshire PCT, Fareham & Gosport PCT

Full Service Commencement Date: 19.12.05
Contract End Date: 28.11.10
Total Procedures for contract: 34,155
Total Diagnostics for contract: 48,450 Diagnostics; 150,000 MIU; 100,000 Walk-Ins
Casemix: Walk-in centre/minor injuries unit, day surgery, diagnostics, ophthalmology; Daycase facility

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<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
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<tr>
<td>St Mary’s NHS Treatment Centre</td>
<td>Milton Road, Portsmouth, Hants, PO3 6AD</td>
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</table>

Opening in December 2005, St Mary’s NHS Treatment Centre will be providing day-surgery procedures (including out-patient appointments), diagnostics, a minor injuries unit and walk in centre to patients within Portsmouth City, Fareham and Gosport, East Hampshire PCT’s.
The centre is providing patients from Portsmouth and South East Hampshire with procedures within the following surgical specialties:

— Ophthalmology eg cataract removal.
— General surgery eg hernia repairs, ganglion removal, bunion removal.
— Orthopaedics eg carpal tunnel release.
— Gastroenterology eg Endoscopy, colonoscopy, sigmoidoscopy.

A minor injuries unit and walk in centre which will be open from 8 am to 10 pm 7 days per week, with no appointments necessary will provide the following services for patients:

— Treatment for minor injuries such as wounds, sprains and broken limbs.
— Health information, advice and treatment for a range of minor illnesses such as coughs, colds and infections.

The minor injuries and walk in centre is not for life threatening conditions—these will continue to be dealt with by A&E at local hospitals.

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**GC8 MEDWAY**

Provider: Mercury Health  
Region: Y44 Southern Cluster  
SHA: Q18 Kent and Medway  
Lead PCT: 5L3 Medway PCT  
Other Commissioning PCTs: Swale PCT

| Full Service Commencement Date: | 03.10.05 |
| Contract End Date: | 30.09.10 |
| Total Procedures for contract: | 19,770 |
| Casemix: | General Surgery, Gastroenterology, ENT, Orthopaedics, Urology, Diagnostics-endoscopy only; Daycase facility |

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<tr>
<th>Treatment Centre Name</th>
<th>Treatment Centre Address</th>
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<tr>
<td>Will Adams NHS Treatment Centre</td>
<td>Beechings Way, Gillingham, Kent ME8 6AD</td>
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</table>

The Will Adams NHS Treatment Centre opened in October 2005 to provide day-surgery procedures and related out-patient appointments for patients within the Medway and Swale PCT’s.

The centre is providing patients with procedures within the following surgical specialties:

— Urology eg cystoscopy, vasectomy.
— General surgery eg hernia repairs, lump removal etc.
— Orthopaedics eg arthroscopies, carpal tunnel release.
— Gastroenterology eg colonoscopy, sigmoidoscopy.

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**GC8 WYCOMBE**

Provider: Mercury Health  
Region: Y44 Southern Cluster  
SHA: Q16 Thames Valley  
Lead PCT: 5G5 Wycombe PCT  
Other Commissioning PCTs: Vale of Aylesbury PCT, Chiltern and South Bucks PCT

| Full Service Commencement Date: | 08.08.05 |
| Contract End Date: | 31.07.10 |
| Total Diagnostics for contract: | 74,880 |
| Casemix: | Diagnostics only (MRI, x-ray, echo and ultrasound) |
The Mid & South Buckinghamshire NHS Diagnostic Centre opened in August 2005 to provide direct access diagnostic services for patients within the Wycombe, Vale of Aylesbury and Chiltern and South Bucks PCT’s.

The centre is providing patients with the following diagnostic investigations:

- X-ray.
- MRI (Magnetic Resonance Imaging).
- Ultrasound.
- Echocardiography.

GC9 Hemel Hempstead SurgiCentre

Provider: Clinicenta
Region: Y43 Eastern Cluster
SHA: Q02 Bedfordshire and Hertfordshire SHA
Lead PCT: N/A
Other Commissioning PCTs: Bedfordshire Heartlands PCT, Dacorum PCT, Hertsmere PCT, Luton PCT, North Hertfordshire and Stevenage PCT, Royston, Buntingford and Bishop’s Stortford PCT, South East Hertfordshire PCT, St. Albans and Harpenden PCT, Watford and Three Rivers PCT, Welwyn Hatfield PCT

Full Service Commencement Date: 01.10.07
Contract End Date: 01.10.12
Total Procedures for contract: 68,030
Casemix: Surgical Paeds (eg ENT), Pain Procedures, Ophthalmology, ENT, OMFS, Endoscopy, Orthopaedics, General Surgery, Urology, Gynae, Vascular, Spinal Surgery, Orthopaedic Surgery; Inpatient facility

The services that will be delivered at the Hemel Hempstead SurgiCentre from a new building containing the latest equipment, treating approximately 18,000 patients a year—including hip and knee replacements, hernia repairs and other procedures such as endoscopies—will be for NHS patients.

This is in addition to a range of other services that will continue to be provided by the East and North Hertfordshire NHS Trust and local primary care trusts from the main hospital site. This includes all emergency work, including A&E and the intensive care unit, as well as full outpatient, pathology and radiology services along with inpatient surgery and maternity services.

GC9 Lister SurgiCentre

Provider: Clinicenta
Region: Y43 Eastern Cluster
SHA: Q02 Bedfordshire and Hertfordshire SHA
Lead PCT: N/A
Other Commissioning PCTs: Bedfordshire Heartlands PCT, Dacorum PCT, Hertsmere PCT, Luton PCT, North Hertfordshire and Stevenage PCT, Royston, Buntingford and Bishop’s Stortford PCT, South East Hertfordshire PCT, St. Albans and Harpenden PCT, Watford and Three Rivers PCT, Welwyn Hatfield PCT
The services that will be delivered at the Lister SurgiCentre from a new building containing the latest equipment, treating approximately 18,000 patients a year—including hip and knee replacements, hernia repairs and other procedures such as endoscopies—will be for NHS patients.

This is in addition to a range of other services that will continue to be provided by the East and North Hertfordshire NHS Trust and local primary care trusts from the main hospital site. This includes all emergency work, including A&E and the intensive care unit, as well as full outpatient, pathology and radiology services along with inpatient surgery and maternity services.

LP2 Bradford

Provider: NTA Nations Healthcare (Bradford) Limited
Region: Y41 North East Cluster
SHA: Q12 West Yorkshire SHA
Lead PCT: 5CH North Bradford PCT
Other Commissioning PCTs: Leeds West PCT, Leeds North West PCT, Bradford City Teaching PCT

Full Service Commencement Date: 01.04.05
Contract End Date: 06.06.10
Total Diagnostics for contract: 73,750
Total Procedures for contract: 27,416
Casemix: General Surgery, Gastroenterology, ENT, Gynaecology, Ophthalmic, Orthopaedics, Plastics, Urology, Oral Surgery, Ultrasound scans—general, Ultrasound scans—doppler, CT scans, MRI scans, Plain films and x-rays, Fluoroscopy. Daycase facility

The Eccleshill NHS Treatment Centre primary function is to meet the diagnostic and day surgery health needs of people registered with General Practices in North Bradford and North and West Leeds.

The Centre’s facilities:

— Private areas for consultations with consultants and other clinical staff.
— Four fully equipped and fully up to date theatres for surgery.
— A treatment room.
— An endoscopy suite.
— Comprehensive radiology facilities including an MRI, CT, ultrasound and general X-ray.
— Recovery areas.
— Good access for people with disabilities.
LP3 Burton

Provider: NTA Nations Healthcare (Burton) Limited
Region: Y42 North West and West Midlands Cluster
SHA: Q26 Shropshire and Staffordshire SHA
Lead PCT: 5ML East Staffordshire PCT
Other Commissioning PCTs: East Staffordshire Primary Care Trust, Burntwood, Lichfield and Tamworth

Full Service Commencement Date: 02.05.06
Contract End Date: 01.05.11
Total Procedures for contract: 64,814
Casemix: General Surgery, ENT, Gynaecology, Ophthalmology, Orthopaedics, Plastics, Urology, Oral Surgery, Rheumatology, Pain procedures, Daycase facility

Treatment Centre Name Treatment Centre Address
Burton NHS Treatment Centre Queens Hospital, Burton

Burton NHS Treatment Centre in Burton upon Trent, Staffordshire is situated on the campus of Burton Hospitals NHS Trust, operations at the new Treatment Centre facility are tentatively scheduled to begin in the summer of 2006.

Details:
- On NHS campus.
- 6 surgical theatres.
- 2 treatment rooms.
- Extensive ophthalmology consulting.

LP4 Trent

Provider: NT5 CUAH (Trent) Limited
Region: Y43 Eastern Cluster
SHA: Q24 Trent SHA
Lead PCT: 5EM Nottingham City PCT
Other Commissioning PCTs: Amber Valley Primary Care Trust, Ashfield Primary Care Trust, Bassetlaw Primary Care Trust, Broxtowe and Hucknall Primary Care Trust, Central Derby Primary Care Trust, Chesterfield Primary Care Trust, Derbyshire Dales and South Derbyshire Primary Care Trust, East Lincolnshire Primary Care Trust, Erewash Primary Care Trust, Gedling Primary Care Trust, Greater Derby Primary Care Trust, High Peak and Dales Primary Care Trust, Lincolnshire South West Teaching Primary Care Trust, Mansfield District Primary Care Trust, Newark and Sherwood Primary Care Trust, North Eastern Derbyshire Primary Care Trust, Nottingham City Primary Care Trust, Rushcliffe Primary Care Trust, West Lincolnshire Primary Care Trust, Barnsley Primary Care Trust, Doncaster Central Primary Care Trust, Doncaster East Primary Care Trust, Doncaster West Primary Care Trust, Rotherham Primary Care Trust, North Sheffield Primary Care Trust, South East Sheffield Primary Care Trust, Sheffield South West Primary Care Trust, Sheffield West Primary Care Trust

Full Service Commencement Date: 01.04.05
Contract End Date: 31.03.10
Total Procedures for contract: 22,000
Casemix: Orthopaedics, Inpatient facility with 36 beds + 4 HDU
The Barlborough NHS Treatment Centre is a new £9M purpose designed surgical facility servicing Lincolnshire, Derbyshire, South Yorkshire and Nottinghamshire. It was opened successfully in July 2005. The centre has two laminar flow operating theatres, 36 ward beds, critical care beds and a physiotherapy gymnasium.

**LP5 Daventry**

**Provider:** Birkdale Clinic Limited  
**Region:** Y43 Eastern Cluster  
**SHA:** Q25 Leicestershire, Northampton and Rutland SHA  
**Lead PCT:** 5AC Daventry and South Northants PCT  
**Other Commissioning PCTs:** None

- **Full Service Commencement Date:** 01.10.03  
- **Contract End Date:** 30.09.06  
- **Total Procedures for contract:** 5,959  
- **Casemix:** Ophthalmology, Orthopaedics, Plastics, Oral Surgery, Upper GI Endoscopy; Daycase facility

**Treatment Centre Name**  
**Treatment Centre Address**

The Birkdale Clinic  
Danetre Hospital, London Road, Daventry, Northants, NN11 4DY

The Birkdale Clinic is adjacent to Danetre Hospital. The unit features a single theatre, with pre and post anaesthetic recovery rooms, a consulting room and patient rest area.

Daventry Treatment Centre is operated by Birkdale Ltd, a small health care provider with hospitals in Rotherham, South Yorks and Crosby Liverpool.

**LP7 Shepton Mallet**

**Provider:** UK Specialist Hospitals  
**Region:** Y44 Southern Cluster  
**SHA:** Q22 Dorset and Somerset SHA  
**Lead PCT:** 5FX Mendip PCT  
**Other Commissioning PCTs:** None

- **Full Service Commencement Date:** 15.07.05  
- **Contract End Date:** 14.07.10  
- **Total Procedures for contract:** 56,242  
- **Casemix:** Orthopaedics, ophthalmology, general surgery and endoscopy; Inpatient facility 34 beds

**Treatment Centre Name**  
**Treatment Centre Address**

Shepton Mallet NHS Treatment Centre  
St Peters Road, Shepton, BA4 4PG

Facilities at the new Shepton Mallet NHS Treatment Centre include:

- 34 in-patient beds—eleven 2-bed rooms and four 3-bed rooms.
- Four operating theatres with central sterilising services unit.
- Endoscopy suite with procedure room and endoscope cleaning facility.
— 18 day case beds for pre-operative, primary and secondary recovery care.
— Eight consulting rooms for out-patients.
— Multi-modality imaging medical imaging department with state of the art MRI, plain x-ray and ultrasound, all linked digitally.
— Physiotherapy gym and treatment/rehabilitation room.
— Near-patient pathology testing.
— Teleconferencing facilities, enabling in-house training opportunities for staff.
— Café and central waiting area in the atrium.

LP8 GREATER MANCHESTER

Provider: NT7 Netcare Healthcare UK Limited
Region: Y42 North West and West Midlands Cluster
SHA: Q14 Greater Manchester SHA
Lead PCT: 5J5 Oldham PCT
Other Commissioning PCTs: Ashton, Leigh and Wigan PCT, Bolton PCT, Bury PCT, Central Manchester PCT, Heywood and Middleton PCT, North Manchester PCT, Rochdale PCT, Salford PCT, South Manchester PCT, Stockport PCT, Tameside and Glossop PCT, Trafford North PCT, Trafford South PCT, Trafford Healthcare Trust

Full Service Commencement Date: 19.05.05
Contract End Date: 18.05.10
Total Procedures for contract: 44,863
Casemix: Orthopaedic, general surgery and ENT;
Inpatient facility—48 beds, 3 laminar flow theatres

Greater Manchester Surgical Centre based at Trafford General Hospital; this £7.8 million unit funded by GMSHA has a casemix that is reflective of the elective surgical procedures most likely to experience longer waiting times in the Greater Manchester conurbation. With capacity to treat approx 9,000 patients per year, Procedures undertaken will range from minor ENT surgery and hernia repairs through to more complex ACL reconstructions and hip and knee replacements. Referrals will be via GPs following assessment of clinical suitability and patient choice.

LP9 PLYMOUTH

Provider: Partnership Health Group Limited
Region: Y44 Southern Cluster
SHA: Q21 South West Peninsula SHA
Lead PCT: 5F1 Plymouth PCT
Other Commissioning PCTs: South Hampshire PCT, North & East Cornwall PCT, North Devon PCT

Full Service Commencement Date: 03.05.05
Contract End Date: 02.05.10
Total Procedures for contract: 16,512
Casemix: Orthopaedics; Inpatient facility with 28 beds

Peninsula NHS Treatment Centre

Building 3, Derriford Business Park, Plymouth, PL6 5QZ
Procedures at the Peninsula NHS Treatment Centre: Approximately 6,400 of the total number of cases are for primary hip and primary knee replacement surgery, with a small number of revisions included in the contract. The Treatment Centre also performs shoulder and knee ligament surgery as well as a large variety of daycase procedures.

Radiology, pathology and cardiac tests are also provided on site as part of the outpatient and pre-assessment one stop shop at the Centre. In addition, around 340 shoulder procedures (sub-acromial decompression and shoulder stabilisations) and 310 anterior cruciate ligament repairs are expected over the same period. The remaining treatments are orthopaedic day cases including arthroscopies, hand, foot and soft tissue or muscle procedures.

Evidence submitted by Action against Medical Accidents (AvMA) (ISTC 43)

1. Action against Medical Accidents (AvMA) was originally established in 1982. It is the UK charity specialising in advice and support for patients and their families affected by medical accidents. Since its inception AvMA has provided advice and support to over 100,000 people affected by medical accidents, and succeeded in bringing about major changes to the way that the legal system deals with clinical negligence cases and in moving patient safety higher up the agenda. The legal reforms of Lord Woolf in the clinical negligence field and the creation of agencies such as the National Patient Safety Agency and the Healthcare Commission have followed after years of campaigning by AvMA.

2. AvMA is proud of the key role it has played in making clinical negligence a specialist within legal practice. It continues to accredit solicitors for its specialist panel (without membership of AvMA’s or the Law Society Panel a law firm is not entitled to a clinical negligence franchise) and promotes good practice through comprehensive services to claimant solicitors. AvMA’s interest in the matter of ISTCs is two-fold: first as an organisation campaigning for patient safety; second, it relates to our concern to ensure justice (particularly redress) following the aftermath of an adverse medical incident.

3. AvMA is increasingly concerned about the indemnity arrangements that apply to private sector treatment centres where services have been commissioned by the NHS to treat NHS patients. We have already had examples provided to us by solicitor members, of cases where confusion over where liability lies being a significant problem. The government’s controversial plans to increase the role of the private sector gather apace with seemingly little thought given to the protection of patients seeking redress following an adverse event after treatment in such a centre. It is important to emphasise here that although the committee seeks to address the issues surrounding ISTCs in particular, the concerns that we have regarding the NHS indemnity arrangements as they apply to ISTCs also equally apply to private sector involvement in NHS services generally. The range and mix of health services delivered by companies and/or individuals (clinicians as well as ancillary staff) involve complex contractual arrangements, some of which have (for reasons we make apparent below) been insufficiently thought through with potentially dramatic consequences for patients seeking redress (particularly financial compensation) following a medical accident.

Principles

4. The Clinical Negligence Scheme for Trusts (CNST) handles all clinical negligence claims against member NHS bodies where the incident in question took place on or after 1.4.95 (or where the body joined the scheme if later). Although membership of the scheme is voluntary, all NHS trusts (including currently foundation trusts) and PCTs in England belong to the scheme.8 NHS bodies are legally liable for the negligent acts and omission of their employees and should have arrangements for meeting this liability.

5. Where these principles apply, NHS bodies should accept full financial liability where negligent harm has occurred. They should not seek to recover the costs either in part or in full from the healthcare professional concerned. NHS bodies may carry this risk entirely or spread it through membership of the clinical negligence scheme of the Trusts (CNST).

6. The NHS is unable under the statutory instrument which governs CNST to indemnify the private sector direct.

7. In 2004, Sion Simon MP, a Trustee of AvMA submitted two parliamentary questions for written answer to the Secretary of State for Health. Hansard reports these Questions and Answers on the 9 September 2004 and 20 October 2004 as follows:

8 The above points are covered in more detail in NHS indemnity arrangements for clinical negligence claims in the NHS, issued under cover of HSG 96/48.
20 October 2004, Questions for written answer

Mr Simon: To ask the Secretary of State for Health whether the (a) NHS Litigation Authority and (b) the Primary Care Trust which has made arrangements for out-of-hours general practitioner cover will be liable in cases of clinical negligence where the negligent treatment was provided by an out-of-hours service commissioned by a Primary Care Trust. [1872371]

Mr Hutton: If an out-of-hours service is commissioned by a Primary Care Trust (PCT), the provider of the service will be expected to obtain their own insurance cover. The National Health Service Litigation Authority is not liable for claims as it administers the clinical negligence scheme for trusts on behalf of trusts, who retain the legal liability for clinical negligence claims.

If the PCT provides out-of-hours services itself, then any negligent act would be covered by the PCT.

9 September 2004, Questions for written answer

Mr Simon: To ask the Secretary of State for Health whether the NHS Litigation Authority will be liable in cases of clinical negligence where the negligent treatment was provided by a private or foreign healthcare provider under contract for the NHS. [187382]

Ms Rosie Winterton: The NHS Litigation Authority administers the clinical negligence scheme for trusts (CNST) in England. The CNST provides indemnity against claims for clinical negligence for member organizations, which include National Health Service Trusts and Primary Care Trusts (PCTs).

Indemnity for cases arising from clinical negligence is as follows:

Before July 2004, indemnity for clinical negligence for independent sector treatment centres (ISTCs) was covered by commercial insurance arrangements. Subsequently, on a progressive basis, indemnity is now provided through the CNST cover provided to PCTs. The arrangements between ISTCs and PCTs are covered in their contracts.

For patients referred to foreign healthcare providers, indemnity for clinical negligence is usually covered by the CNST arrangements of the referring PCT or NHS Trust.

For other private organizations the liability depends upon the terms and conditions of the contract between the PCT, NHS Trust and the private body concerned.

8. Last year we wrote to the NHSLA with our concerns governing legal liability in relation to private commissioning arrangements. We asked them to explicitly advise us as to the position regarding NHS indemnity arrangements relating to the private sector. The response from John Mead dated 29 December 2005 stated:

“...the position from our perspective is as follows:

(1) Independent Sector Treatment Centres

We have agreed a special arrangement with the Department of Health whereby cover for clinical negligence suffered by NHS patients is afforded by CNST. We are unable under the Statutory Instruments which govern the CNST to indemnify private companies directly. However, the way in which cover is organised is via the Primary Care Trust which refers the patient to the ISTC. This arrangement will pick up most patients who are referred to the private sector by the NHS.

(2) Other commissioning initiatives

These are governed by individual contractual arrangements between the NHS and the private sector, which usually states that liability for clinical negligence will rest with the private company. You will appreciate that such arrangements over-ride the common law position. I agree that this can lead to the complications which you describe.”

9. We met with John Mead of the NHSLA, on 24 January 2006 to seek clarification on a number of the points addressed in his letter:

“SPECIAL ARRANGEMENT”

10. No regulation or statute governs the indemnity position where the NHS contracts its services to another private sector company. Therefore contrary to the statement that “this arrangement [with ISTCs] will pick up most patients who are referred to the private sector by the NHS—this is not the case. There is no written agreement between the DOH and the NHSLA. The “arrangement” that the NHSLA has reached with the DOH consists of no more than a series of discussions between the NHSLA and the Department of Health. This is clearly unsatisfactory. Most NHS patients would be appalled to learn that responsibility for what they thought was NHS treatment rests with the private clinic to whom they were referred. AvMA has learned from the bitter experience of patients being treated by private doctors (including GPs who are
independent contractors) how difficult it can be to establish liability amongst the clinic and doctors. We have experience of many cases where doctors do not have adequate indemnity insurance or in some circumstances none at all.

**Independent Sector Treatment Centres**

11. Many patients will be surprised to learn that when the NHSLA refers to ISTCs these need to be distinguished from arrangements between the NHS with the private sector generally. An ISTC is distinguished from a hospital, clinic or other treatment centre by virtue of its having been accorded designated ISTC status. Although 34 treatment centres were open by the end of 2005, we were informed by Mr Mead that only approximately 20 in total have had CNST cover extended to them. These include some mobile clinics, MRI scanner clinics, eye surgery units, amongst others. These centres have been granted retrospective cover and the NHSLA will now be on risk in respect of these designated centres from the date from which they entered into a contractual arrangement with the NHS provider.

**Other Commissioning Initiatives**

12. These initiatives will capture “waiting list” initiatives whereby hospitals contract out services to private providers and situations where GPs (independent contractors) or PCTs refer NHS patients to private sector clinics (eg abortion clinics).

13. In circumstances where a treatment centre has not been formally integrated into the CNST, the NHSLA advice is that claims ought to be made in the first instance against the Primary Care Trust with responsibility for commissioning services from these private sector centres. The NHSLA advise us that they will consider such claims in the first instance and review the contractual arrangements between the Primary Care Trust and the private company. If the NHSLA repudiate liability then they will disclose the contractual agreement between the Primary Care Trust and the private clinic/company to the complainant. If a hospital contracts out services to another private hospital/treatment centre, the claim ought to be made against the acute Trust. However, the NHSLA will always consider the contractual position. Unless the ISTC is “designated,” it is questionable whether CNST will be extended.

**Issues**

14. There is now a danger of patients/claimants falling through a “black hole” when it comes to obtaining redress against those who may not be covered by CNST. Having now spoken to John Mead, it is quite clear that despite his assurances in his letter of 29 December, the arrangements that the NHSLA has reached with the Department of Health will not “pick up most patients who are referred to the private sector by the NHS”. On the contrary, he was specifically suggesting that only those designated centres would be covered in the first instance and while the NHSLA will look at other cases there is no guarantee that they will take them on. On the contrary, he made it clear that the liability would most likely fall with the private company in most cases. This is a retrograde step taken by the Government. We have long had concerns about difficulties in obtaining redress against private doctors, clinics and GPs. These structural arrangements only intensify these problems further.

15. We have grave concerns that Primary Care Trusts, that are certainly not used to having claims made against them [given that primary care in the main is delivered by General Practitioners] are not geared up for responding to these claims. They do not have the resources, capacity or knowledge to deal with these claims. It appears that the information that has been disseminated to Primary Care Trusts and other Trusts has been minimal if any exists at all. We are not convinced that Trusts are up to speed with regard to the complexity of these contractual arrangements. Most Primary Care Trusts do not even have Claims Managers let alone in-house legal teams.

16. We envisage problems arising with regard to NHS indemnity in the following areas:

   - Waiting list initiatives—in situations where Trusts have an overwhelming objective to meet their waiting list targets they are contracting out to the private sector to undertake routine or not so routine operations, eg hip replacements. John Mead gave us no assurances that in situations where an acute Trust commissions additional resources in this way from the private sector and where the NHS patient ends up in a private hospital that the patient would be indemnified by the NHS hospital under the CNST. On the contrary, John Mead advised us that contractual arrangements would have to be looked at before the NHSLA agreed to accept liability.

   - Overseas treatment—As in the well-publicised case of Yvonne Watts who was forced to have her hip replacement surgery undertaken in France.

   - GP referrals to abortion clinics. Again, will the PCT be liable? Much depends upon the contract between the PCT and the clinics to whom the GP refers. The NHSLA will look at these cases on a piecemeal basis.
— What of the situation whereby a GP refers a patient for a smear test to a woman’s health clinic (a designated ISTC) but the cytology is undertaken by another diagnostic unit? In a situation where Cytology Limited go bankrupt, there would appear to be no redress for the Claimant who is diagnosed with advanced cervical cancer as a result of mis-reporting of a smear.

— Many GPs, following the new GP contract, contracted out of “out of hours” cover with the effect that PCTs have taken on responsibility for providing “deputising” services. In practice, PCTs have commissioned these services from other providers. The Secretary of State’s answer to the parliamentary question of 20 October 2004 states that the private provider will be responsible unless the PCT supplies the cover itself.

— With regard to “other commissioning initiatives” although John Mead advised contractual arrangements between the NHS and the private sector will override the common law position, he did concede that if a Trust commissioned services from a body whose consultants proved incompetent/insufficiently qualified without adequate checks the Trust would most probably be liable in negligence.

PATIENT SAFETY: OVERSEAS DOCTORS

17. Foreign companies in the main were invited and recruited to run the ISTCs, primarily because such companies could import staff, thus reducing the risk of “hiving off” NHS staff to these centres. The Royal College of Surgeons has articulated its concerns about adequacy of training of overseas surgeons particularly given the fact that surgeons do not need to be on the specialist register even though they must be registered with the GMC. We share concerns that have been expressed by health professionals’ regulators about the varying arrangements for education, training, audit and fitness to practice procedures across European Union states. Under European law doctors have a right to work in any member state.

18. At the moment independent healthcare providers are required to comply with the standards of the Healthcare Commission (HC). The HC is currently consulting on bringing inspection of private providers in line with the NHS. Therefore, the drive to increase ISTCs is ahead of the regulation being in place to ensure adequate standards.

19. AvMA has learned through the bitter experience of patients being treated by private overseas doctors who subsequently seek redress when treatment goes wrong of how difficult it is to locate doctors or establish whether they have adequate indemnity arrangements in place. Frequently insurance cover is inadequate if not non-existent.

20. The Department of Health appears to have taken these steps with little or no attention to patient safety. The fragmented and complex nature of these arrangements means that the advantage the NHSLA always had in identifying patient safety issues, disseminating learning and feeding this into clinical governance will be lost.

PATIENT AND PUBLIC INVOLVEMENT (PPI)

21. The private sector does not have a good record on PPI.

22. Clarity needs to be forthcoming on how complaints handling is to operate in circumstances where complications arise or issues arise following treatment in an ISTC/private treatment centre.

23. Patients need to be informed about nature of treatment and after-care in private treatment centres. How easy will it be for the patient to be remitted into the NHS following a complication in a private centre rather than expecting the same centre to resolve the issue itself?

SUMMARY

24. Many issues and concerns surround the subject of ISTCs. Many problems are now becoming apparent since the inception of ISTCs two years ago. We suspect that even more difficulties will surface as time goes on. Many of our lawyer members are reporting incidents where complications have arisen, particularly with patients demonstrating co-morbidities. The troubling feature has been that when something has gone wrong, no-one seems to accept the blame—each party pointing the finger at another. No patient ought to be caught in the web of the complex commissioning arrangements established between the NHS, clinicians and private sector organizations. We have sought to highlight the problems inherent in these arrangements. Much anxiety regarding indemnity arrangements could be alleviated by extending CNST to all companies contracting with the NHS. In turn, the NHS can seek indemnities from the companies responsible—The NHS will thus be in a position to audit performance and quality and ensure safety and justice for patients always comes first.

Fiona Freedland
Legal Director
AvMA

13 February 2006
Introduction

1. Amicus is the third largest trade union in the National Health Service with a membership working in primary care trusts, mental health trusts, and acute trusts. The major health professional groups who work within acute trusts are pharmacists, health care scientists, theatre nurses and other perioperative practitioners.

2. Amicus welcomes the Health Select Committee’s enquiry into Independent Sector Treatment Centres and is pleased to submit evidence for the committee’s consideration.

3. Amicus is keen that the evidence base which supports the government’s proposals for the development of ISTC providers is identified and supports the policies which have been made at the outset of the ISTC programme.

4. The evidence which we submit below focuses on key issues which we believe are important matters for the committee to consider. They include:
   - the proposed enlargement to the principle of additionality for recruitment of staff by ISTC providers;
   - the risk of engendering a long hours culture where NHS staff work increased hours in the independent sector and the monitoring arrangements required to maintain standards;
   - the need to have sufficient evaluation of the first wave ISTC providers to inform the establishment of a second wave;
   - the challenge of the two-tier workforce and the application of the best value code agreed with the government; and
   - ensuring that the contractual arrangements with the independent sector providers deliver the expected outcomes.

The ISTC Commitment

5. The establishment of the ISTC programme three years ago was central to the government’s commitment to creating greater patient choice and wider plurality of providers. Amicus recognises that the enlargement of capacity intended by the ISTC programme is part of the government’s commitment to the largest ever sustained investment in the NHS which will mean that by 2008 NHS spending will constitute ten per cent of the country’s GDP. We recognise the importance of this commitment to create a health service which better meets the needs and expectations of the population.

6. Amicus, other NHS unions, the Department of Health and NHS employers have established an HR partnership group since the summer of 2004 to develop the HR policies and procedures intended to support the ISTC programme. Shortly after the establishment of that group, the Prime Minister announced a second wave of independent sector treatment centre procurements. There was concern at an announcement being made for the further development of the ISTC programme when there was insufficient evidence to demonstrate the impact, effectiveness and success of the first wave of ISTC providers. In the election campaign in 2005 the Labour Party’s manifesto gave a commitment to purchasing 460,000 procedures annually through the ISTC procurement programme. Following the election, the new Secretary of State announced details of the ISTC programme which included a commitment to spend £3 billion over five years.

ISTCs and Impact Upon the NHS

7. The Department of Health’s central contract management unit announced in January 2006 that the independent sector providers had undertaken over 185,500 scans and treatments by the end of November 2005. It stated “This was a considerable achievement, resulting in real benefits in patients throughout England”.

8. Whatever the ISTC providers give to the NHS must be in addition to the services already provided and is therefore an enlargement of capacity for patients and not a transfer of work currently undertaken within the NHS to the private sector.

9. To ensure that this principle has determined the process of procuring independent sector involvement there has been a commitment to the principle of “additionality”. All ISTC providers have been required to follow the additionality principle which has meant no NHS health professional can be recruited to work in the independent sector provider where that health professional has been employed in the NHS within the previous six months. As a consequence the wave one ISTC providers have relied upon medical, nursing and allied health professional staff from outside the NHS and outside the UK. This principle has been vital to ensuring that the NHS is not harmed or undermined by the loss of key professional staff with experience and expertise. Amicus has supported the principle of additionality.
10. On 28th June 2005 the Secretary of State announced changes to the additionality rule. The announcement was made outside the partnership arrangement which had been established between the NHS unions, the Department of Health, and the NHS employers during the previous twelve months. The announcement stated there would be a relaxation of the additionality rule allowing NHS staff who did not work in shortage specialties to be employed by the ISTC providers with no application of the six month rule. Furthermore, the independent sector providers could employ staff from the NHS during their NHS non-contracted hours.

11. Since that announcement, the ISTC HR group has been committed to developing a process for identifying shortage specialties in which NHS staff would not be free to be employed immediately by the independent sector. Work also commenced on the development of an HR framework for the second wave of ISTC providers which would address the issue of staff working for the NHS being employed during their non-contracted hours for the independent sector providers.

12. The issue of identifying shortage specialties causes Amicus considerable concern. The first issue is why should staff who are in specialties not regarded as shortage be enabled to work for the independent sector providers whose purpose is to create additional capacity? It has been claimed by the Department of Health that, where it cannot be demonstrated that a health professional is working within a shortage specialty, there could be a challenge from those health professional staff who believe they should be free to move from NHS employment to independent sector employment. It is not apparent why the Department of Health believe such a challenge could take place, nor who would make such a challenge and the likelihood of a legal challenge succeeding.

13. Amicus takes the view that the overriding principle of maintaining all current NHS services and adding to them could not and would not be subject to a legal challenge from any quarter. We consider it helpful for the committee to establish details of the legal opinion which has led the secretary of state to expand the definition of additionality in this way. We would further contend that, whilst recognising the significant increase in the number of staff working in the NHS since 1997, there is no evidence to support the implication that there are areas where we have enough staff or surplus staff in certain specialties which would permit the transfer of those staff from NHS employment to independent sector employment. Health professionals currently employed in the NHS are employed because their skills, expertise and qualifications are needed. There is no scope for losing those staff where there is an underlying principle of increasing capacity to improve patient choice and reduce waiting lists for elective surgery and diagnostic procedures. Although the unions have worked in partnership on identifying shortage specialties, there is no jointly agreed list.

14. The issue of NHS staff working their non-contracted hours for independent sector providers may be regarded as less contentious. However, it is apparent from the approach adopted by the Department of Health and its advisers that the opportunity to work non-contracted hours is one heavily favoured by medical staff. This may, in part, have been prompted by concerns expressed by hospital consultants that the impact of a successful independent sector provider could adversely affect their opportunities for private practice earnings. Consequently the opportunity to work for those ISTC providers outside of NHS contracted hours may be seen as compensation for that loss of private practice income.

15. The ISTC HR group is finalising the content of the HR framework in preparation for the wave two (also called phase two) independent sector providers. This framework will identify the key points which will permit NHS staff to work in an ISTC outside NHS contracted hours. The NHS unions, the Department of Health and the NHS employers are committed to ensuring that there are no risks arising from NHS staff working in the independent sector centres. These risks would include breaches of the working time regulations, the accountability of those staff and employers, and the need to ensure there is no detriment to the quality of standards within the NHS and patient safety within the NHS and the independent sector treatment centres. It is the view of Amicus that there should be clear and stringent monitoring arrangements where staff are employed in both the NHS and in independent sector treatment centres. It is also our view that such arrangements should not be a catalyst for the NHS long hours culture.

AMICUS POSITION ON ISTC PROVIDERS

16. The government initiative to expand capacity of health care and provide greater patient choice is supported by Amicus. The issues which need to be addressed arise from whether the development of the ISTC programme since 2004 has delivered the anticipated results. There remains the question “Would the billions to be spent on ISTC providers create the same benefits if spent on developing services within the NHS framework?”
17. The results from the independent sector providers in wave one have been predicated on £1.6 billion delivering 200,000 surgical procedures annually over five years. It has also been claimed that mobile MRI procurement has given the NHS 600,000 additional MRI scans procured at less than half the NHS cost. In consequence waiting times for MRI scans have been dramatically reduced alongside the significant reductions in cataract surgery. It is further claimed by the department that there are significant cost savings arising from the ISTC procurement process. It has been estimated that up to £500 million would have been saved by 2007–08 on the contract arrangements with independent sector providers when compared with prices previously paid under spot purchase arrangements with independent health care providers.

18. If the data put forward by the department are accepted, what is still not apparent is the evaluation of quality, outcomes and patient satisfaction. Amicus believes that this information is required before the whole-hearted commitment to the second wave of ISTC providers rolling out from the end of 2006.

19. The decision to enlarge the principle of additionality has been addressed in partnership between the Department of Health, the NHS unions and the NHS employers. What is lacking is a clear commitment from the government that this move to enlarge the definition of additionality does not presage future moves in the same direction. Since the government is committed to increasing capacity and not undermining the NHS there is no reason why the Secretary of State should not give a clear commitment that there will be no further enlargement of the principle of additionality which would give greater freedom for ISTC providers directly to recruit NHS staff.

20. ISTC providers must work closely with the NHS. The contract terms for the wave two providers will include requirements to provide training for the health professionals employed by those independent sector companies. This is to be welcomed since otherwise we will be facing the prospect of the independent sector employing staff whose skills and qualifications have been provided solely by the NHS and then utilised by the independent sector. However, there is the prospect of a two-tier workforce in health service provision. On the 16th March 2005 the then Minister for the Cabinet Office wrote to the General Secretary of the TUC regarding the two-tier workforce in the public sector. In his letter the Minister affirmed a commitment to the retention of employment model for NHS PFI contracts but specifically ruled out the application of the agreed best value code to independent sector providers. It was claimed that it would not be appropriate for the code to apply to independent sector providers. Amicus takes the view that the code should apply and that a commitment to ensuring high quality standards of care across the NHS and the independent sector providers who support the NHS will be best served by a commitment for the best value code to apply to those providers. Since the independent sector is eyeing up the prospect of bidding for work offered by the government in the £3 billion available over the next five years, we would contend that providers would be prepared to embrace the code as part of the tendering requirements.

21. Amicus has concerns about the contractual arrangements for the wave one ISTCs and those proposed for the wave two providers. The information provided above by the Department of Health indicates a significant increase in work for both diagnostic and surgical procedures. However anecdotal feedback has suggested that ISTC providers have been working with some slack in the system. This appears partly to be attributable to lack of referrals and consequent gaps in throughput. As a consequence, the current independent sector providers may have been paid for work not undertaken due to the lower then expected referral rates. This is an issue which needs further consideration before contractual terms are finalised with the wave two independent sector providers.

CONCLUSION

22. Amicus members, overwhelmingly highly trained and qualified health professionals, are not averse to change where that change serves the needs of the patients to whom they are committed. They have led and embraced innovation and modernisation, and championed many new ways of delivering improved and more cost effective services. Against this background we are anxious that the enquiry and findings of the select committee identify the gains which have been made and which could be made if this programme is to continue and that the billions of pounds to be spent in this process are justifiable expenditure compared to options for further developing services within the NHS.

23. Despite the difficulties created by ministerial announcements delivered outside the established partnership arrangements, we should like to record out thanks for the effective partnership working which has been undertaken between ourselves, the department of health and its legal advisers and the NHS employers.

Amicus Health Sector

10 February 2006
Evidence submitted by the Association of Anaesthetists of Great Britain and Ireland (ISTC 40)

SUMMARY

The AAGBI is the senior body representing anaesthetists with 10,000 members including most of the anaesthetists in the UK, the largest group in the hospital medical workforce (16%).

What role have ISTCs played in stimulating innovation?

ISTCs have a different balance for stimulating “innovations” but patient safety, must come first. Their role should concentrated on the more efficient and speedy implementation of existing, acknowledged safe practices as they do not have (and may be would not want) the research development and audit overheads now necessary.

Are ISTCs providing value for money?

By selecting only fit patients (ASA I and II) ISTCs can benefit from the current system whilst superficially seeming to work to the same tariff and on an even playing field with ordinary NHS Trusts. This may not be value for money. This also explains the value of patients being adequately preoperatively assessed and any comorbidities being optimised prior to surgery and anaesthesia to reduce the high risk 10% group to say 5%, with benefits to all, particularly the patients.

What arrangements are made for patient follow-up and the management of complications?

In the immediate and early postoperative period it is important for the anaesthetist to be easily available to manage complications. The ISTC management seem to have been reluctant to take account of this clinical governance issue despite it being drawn to their attention.

What role have ISTCs played and should they play in training medical staff?

We are not aware of any medical staff receiving training in ISTCs at present. NHS consultants will only wish to carry out the training in ISTCs on the basis of equal pay for work of equal value.

Are the accreditation and appointment procedures for ISTC medical staff appropriate?

We do not think so. The Expert Group on Cosmetic Surgery (28 January 2005) recommendations may be applicable.

Are ISTCs providing care of the same or higher standard as that provided by the NHS?

The NHSLA provides ISTCs medical indemnity cover based on CNST standards and any reduction would breach that arrangement. Shepton Mallett ITC planned to work below this standard by not employing dedicated qualified assistance for anaesthetists. Is the mechanism for monitoring this robust enough and sufficiently informed?

What changes should the Government make to its policy towards ISTCs in the light of experience to date?

The DH funding the NHS contracts with ISTCs wish to maintain an arms length relationship with ISTCs on the Parity issue. The Government should change this policy.

What criteria should be used in evaluating the bids for the Second Wave of ISTCs?

The Independent Providers operating ISTCs, Capio, Nuffield, BMI and BUPA have not been following the NHS principle of equal pay for all consultants, including anaesthetists and surgeons. This new departure from Government and NHS policy results in an unfair discrimination on grounds of gender, since there is a far higher proportion of women amongst consultant anaesthetists (34%) than there is amongst consultant surgeons (7%).

Compliance with the principle of equal pay for work of equal value should a criterion for evaluating the bids for the Second Wave ISTCs and other NHS work. Non compliance should result in exclusion.

1. The AAGBI is the senior body representing anaesthetists in the country with nearly 10,000 members including the majority of UK anaesthetists, who make up the largest group of the hospital medical workforce (16%).
2. It was founded in 1932 with the objective of “developing anaesthesia” and it has successfully instigated all the major developments in the speciality since. In 1935 the first examination for anaesthetists, the Diploma in Anaesthetics (DA), in 1948 The Faculty of Anaesthetists of the Royal College of Surgeons (FFARCS) and in 1988 The College of Anaesthetists which later (1992) became the Royal College of Anaesthetists (RCA). Along the way the AAGBI inaugurated the first UK Safety Committee in 1976 before safety was talked about, set up the “Sick Doctor Scheme” in 1978 and pioneered mortality audit when it was controversial starting the Confidential Enquiry into Perioperative Deaths (now NCEPOD) in 1987. The AAGBI has published over 50 guidelines and standards documents including “Standards of Monitoring” 1986 and “Consent for Anaesthesia” 2006 and is the largest provider of Continuing Medical Education (CME) for anaesthetists through our educational meetings and journal “Anaesthesia”. We are also the largest provider of anaesthetic research grants and support trainee anaesthetists through our Group of Anaesthetists in Training (GAT).

3. Anaesthetists in the UK are involved in the care of two thirds of all hospital patients (Audit Commission Report). Their expertise extends beyond the main operating theatre to acute and chronic pain management, leading resuscitation teams, managing Intensive Care Units, working in maternity units, accident and emergency departments, radiology, the care of some dental patients and the transfer of critically ill patients.

PREAMBLE: PATIENT CARE STANDARDS AND PARITY

4. The AAGBI welcomes this inquiry into ISTCs and is pleased to summit written evidence towards it. Our consistent stance has been to uphold and progress standards of patient care wherever it takes place and share this aim with many other organisations contributing to this inquiry.

5. Appreciating the Health Committee’s workload and as an Anaesthesia specialty organisation we will concentrate on particular evidence in relation to our speciality. Apart from Standards of patient care one particular ISTC issue which concerns us greatly is a general principle, affecting our speciality most at the moment, and that is “Parity” the founding principle of the NHS providing equal rates of pay for consultants (and other grades irrespective of speciality). I would emphasise that this “Parity” is not about actual amounts of pay but a much more fundamental principle which if it continues to be ignored by ISTCs will have far wider long term repercussions ultimately reflecting back on patient care. As we are the currently affected speciality the committee may not receive much evidence about this from other contributors so we feel it important to include it in some detail.

What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

6. “Innovation” and “Anaesthesia” are synonymous. From chloroform masks to conscious craniotomy the whole culture and development of the speciality has been based on innovation, new devices, technology, intensive care, drugs and patient pathways. For example the development of Acute Pain Services and Acute Pain Nurses as a result the 1991 report, which must be one of the top practice changing documents of British Medicine. Anaesthesia embraced this and following a somewhat uphill struggle surveys demonstrate that NHS implementation was always in advance of Europe has now even overtaken the USA in this regard.

7. The possibility to do many procedures as day cases is largely as a result of improvements in anaesthesia, applying techniques that permit faster recovery, return to street fitness and more effective post operative pain relief. Nationally and locally anaesthetists have driven this innovation.

8. Behind every headline of new surgical innovations by our surgical colleagues is a parallel and often crucial anaesthetic innovation that without which the heralded surgical development would not be possible. For example, “Awake Cardiac Surgery” was the same operation for the surgeon but a totally new epidural technique for the anaesthetist.9

9. There are many more examples but suffice it to say they will continue to take place wherever anaesthetists work. Most potential innovations have actually been theoretically considered before but only when the circumstances, technology, pharmacology, materials permit do they take place. The factor driving these innovations for anaesthesia however has always been improving patient care, and although doctors are not remote from economic considerations some innovations have cost more (eg pain nurses, although may have saved length of stay) and some have cost less (eg day case developments). ISTCs, most with shareholders, do alter the cost benefit balance of stimulating “innovations” but the raison d’etre of the whole exercise, the patients and their safety, must come first. Our experience of an ISTC not wishing to provide qualified assistants outlined below (para 23–24) is probably an example of this.

10. Should the ISTCs role be to use their expertise on the more efficient and speedy implementation of existing, acknowledged safe practices as they do not have (and may be would not want) the research development and audit department overheads now necessary.

11. Others are probably better qualified to consider capacity and choice questions.

9 http://news.bbc.co.uk/1/hi/health/3146837.stm
Are ISTCs providing value for money?

12. This is complicated but it may be useful for the Health Committee to reflect on the following:

Consider 100 patients with NHS tariff of £1/patient and total cost of group care £100

It is generally accepted that within any group of patients having a particular procedure, hip replacement, cardiac surgery, hernia repair, because of other coexisting illnesses eg diabetes, respiratory disease when considering the cost of the group as a whole 10% of the patients will use up 50% of the resources.

So 10 patients (10%) operations cost £50 (£5 each) and the other 90 patients (90%) cost £50 (£0.55 each).

If we can reduce the expensive first group by 1%

Nine operations cost £45 so the remaining £55 can now fund 99 operations (£0.55 each). So a total of 108 patients now cost £100 an increase of 8% for no extra cost.

If we can halve the expensive group to 5%

Five operations cost £25 so the remaining £75 can now fund 135 operations (£0.55p each) so 140 patients now cost £100 an increase of 40% for no extra cost.

If we can completely remove the expensive group (eg possibly through expensive patients being excluded at the outset by ISTC contracts)

180 operations cost £100 (so at NHS tariff price of £1/patient 80% surplus possible).

13. Therefore by selecting only fit patients, ASA I and II (see below) hospitals such as ISTCs can benefit from the current tariff system whilst superficially seeming to work to the same tariff and on an even playing field with ordinary NHS Trusts. This may not be value for money.

14. The NHS Trust which has to treat the 20 expensive cases associated with such a group (10% selected out of 200 leaves 180) needs £100 (20 × £5) to fund the care for which under tariff they will receive £11 (20 × £0.55p)

15. These considerations also explain the value of patients being adequately pre-operatively assessed and any comorbidities being optimised prior to surgery and anaesthesia to reduce the 10% to say 5%, with benefits to all, particularly the patients.

16. ASA Physical Status Classification System.

Classification system adopted by the American Society of Anesthesiologists (ASA) for assessing preoperative physical status:

I. A normal healthy patient.
II. A patient with mild systemic disease.
III. A patient with severe systemic disease.
IV. A patient with severe systemic disease that is a constant threat to life.
V. A moribund patient who is not expected to survive without the operation.
VI. A declared brain-dead patient whose organs are being removed for donor purposes.

The addition of an “E” indicates emergency surgery.

What arrangements are made for patient follow-up and the management of complications?

17. In the immediate and early postoperative period it is important for the anaesthetist to be easily available to manage complications. In smaller more isolated units such as ISTCs it is less likely that there would be other colleagues on site to cover and so an anaesthetist or surgeon who travels/resides further away will not be in a position to quickly return unless they have made alternative arrangements (The NHS has regulations on residence distance) This could be a reduction in the standard to that normally available. For example anaesthetists have been travelling daily from Birmingham to do ISTC/GSup work in the BUPA Hospital Leicester and from Leeds and Hull to the Nuffield Hospital in York with no local post operative cover arrangements in place. This is because local consultants are not volunteering to do the NHS work for the unequal pay being offered by BUPA Hospitals and Nuffield Hospitals. The ISTC managements seem to have been reluctant to take account of this clinical governance issue despite it being drawn to their attention.

What role have ISTCs played and should they play in training medical staff?

18. We are not aware of any anaesthetic trainees having received training in ISTCs and believe that ISTCs have played no role in training any other medical staff to date. If the numbers of cases suitable for training (eg ASA I and II) treated at ISTC’s significantly deplete the numbers of these patients being treated at NHS Trusts this will reduce the current anaesthetic and surgical training opportunities available. These Trusts
are where the existing Schools of Anaesthesia are well established, set up and resourced for training anaesthetists and our Royal College of Anaesthetists who oversee and accredit this training would be best placed to advise.

19. Training and trainer ISTC contracts for all specialities would be a new departure and probably complicated. NHS consultants familiar with UK training and examinations would meet the job specification and be ideally placed to be involved but consultants carrying out the training in the NHS Trusts are employed on the basis of equal pay for work of equal value and it has already been demonstrated that they would be unlikely to wish to be involved on any other basis.

Are the accreditation and appointment procedures for ISTC medical staff appropriate?

20. We do not think so. As medical staff will often be practicing independently current standards for that ie NHS Consultant appointment should be replicated. Appraisal and revalidation of NHS consultants is already established in local trusts. The current Medical Advisory Committee (MAC) structure in Independent Sector Hospitals is in its infancy as regards approving visiting rights for consultants de novo. In the past it has usually only been asked to further approve local consultants mostly already known to them who have also previously undergone the rigorous NHS consultants appointment committee process with external representatives including impartial Royal College advisors etc.

21. A number of ISTC MAC Chairmen refused to, or declared themselves not in a position to, grant visiting rights to short term overseas specialists so the ISTC companies then bypassed the process. Nuffield hospitals set up a “virtual” or National MAC to rubber stamp such applications, some of which proved disastrous for patients (eg Nuffield Hospital Cambridge). 10

22. The Expert Group on Cosmetic Surgery (28 January 2005, DH Gateway Reference number: 2005/0032) looked at this issue in some detail and recommended that all cosmetic surgeons and nurses provide to potential and actual patients details of their qualifications, registration, membership of professional organisations, and other medical training and education. Harry Cayton, Director for Patients and Public, said: “I believe that the recommendations in our report will help ensure that people can make informed choices before undergoing cosmetic surgery, and that they can be confident that cosmetic surgery and procedures are well regulated.” We agree and if this is good enough for patients having cosmetic “lifestyle operations” how much more important for say hip replacement and gall bladder surgery etc?

Are ISTCs providing care of the same or higher standard as that provided by the NHS?

23. The AAGBI has been involved in successfully developing standards of perioperative care over many years and has unrivalled experience of the issues and pitfalls in not maintaining them in anaesthesia and hospital care 11 We would be most concerned if the same standards as in the NHS were not maintained by ISTCs and as the NHS Litigation Authority is providing medical indemnity cover on the basis of the Clinical Negligence Scheme for Trusts (CNST) standards applying this would also be a breach of that arrangement. One area that is of particular concern for anaesthetists included in these standards (and our own AAGBI recommendations—Anaesthesia team 2nd Edition 2005) is the provision dedicated qualified assistance for anaesthetists wherever anaesthesia is administered (eg Operating Department Practitioners, ODPS) etc. This is for example just as important as the surgeon always having a scrub nurse present when operating.

24. This is a real concern as we are already aware of an attempt by one ISTC, the Shepton Mallett Independent Treatment Centre (SMITC) to work below this standard in April 2005. This was drawn to our attention and following correspondence and a meeting with representatives of the Mendip PCT and the ISTC the Chairman of our Safety Committee Dr John Carter was reassured by Kate Glass, Project Director, Mendip Primary Care Trust that the standard would be upheld. (Annex 1 and Annex 2).

25. In this regard it seems that the contracting PCT and NHS representative for the ISTC may be the initial point of monitoring for these standards, is this mechanism robust enough and sufficiently informed?

What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

26. We would be concerned that all remuneration to medical staff is transparent in connection with our issues of Parity (see para 28–51) Some ISCTs claiming to pay parity have then made further additional payments on tenuous grounds, eg paying surgeons the same amount again as the operating fee for an outpatient visit. Unnecessary commercial confidentiality is used as cover for this.

10 http://news.bbc.co.uk/1/hi/england/cambridgeshire/4133158.stm
11 http://www.aagbi.org/guidelines.html
27. The DH who are funding and laying down many other standards in these NHS contracts with the ISTCs say for some reason wish to maintain an arms length relationship with ISTCs on the Parity issue and will not act. (see para 28–51) The Government should change this policy.

28. Compliance with the principle of Parity should be one of the criteria used for evaluating the bids for the Second Wave ISTCs and other NHS work. Non-compliance should result in exclusion.

29. The Independent Sector Providers operating ISTCs, Capio, Nuffield, BMI and BUPA Hospitals have not been following the principle of equal pay for all consultants, including anaesthetists and surgeons. This principle was established at the foundation of the NHS and is the basis for remuneration of 4 million NHS procedures every year. Quite apart from the departure from Government and NHS policy of equal pay for work of equal value, this oversight results in an unfair discrimination on grounds of gender, since there is a far higher proportion of women amongst consultant anaesthetists (34%) than there is amongst consultant surgeons (7%).

30. As they are contractually bound by the employment legislation framework any ISTC Provider that has not complied with this condition in previous NHS contracts (eg BUPA, Nuffield, Capio, BMI) they should not be considered for further work unless a binding agreement is made to implement it immediately. The Government should rigidly apply this criterion.

BACKGROUND TO THE PARITY ISSUE

31. We attach our letter to Surinder Sharma the NHS Equality Czar (Annex 3) which summarises the background and led to discussions with Mr Bob Ricketts last autumn and a copy of an AAGBI press release (Annex 4) following an agreed statement approved by Sir Nigel Crisp, Mr Andrew Foster and Mr Ken Anderson (DH Commercial Directorate).12

32. Anaesthetists and the AAGBI are particularly concerned about the arrangements for remuneration for medical staff in the ISTC’s and regret anaesthetist were never involved in the original discussions about them. It has taken over 18 months to meet with the DH to discuss it. This is even more surprising following the publication of the DH Guide “Promoting Equality and Human Rights in the NHS”.

33. Ever since 1948 consultant anaesthetists and consultant surgeons and have been paid the same, equal pay for work of equal value. This principle of “parity” has served the NHS and its patients well for 57 years. We know of no medical organisation that does not support the principle and several have made statements about it.

34. BMA Guidance on Parity for NHS work:
   “The BMA believes that in relation to NHS work there should not be a differential in fee between specialists for the same procedure where the same amount of work is undertaken.”12

35. Hospital Consultants and Specialists Association (HCSA) Guidance on Parity for NHS work:
   “Parity of pay has been a fundamental principle of the NHS since 1948 and the HCSA fully supports its maintenance and implementation in connection with NHS work in the Independent Sector”.
   Dr P A Ritchie President, HCSA 18 October 2005

36. Medical Women’s Federation:
   “The MWF fully support the stance you are taking to maintain parity as a point of principle.”
   Dr Selena Gray President 28 February 2005

37. Association of Anaesthetists’ position statement on Parity of Pay:

Association of Anaesthetists continues to fully support the NHS principle, established in 1948, of parity of pay for all Consultants employed to care for NHS patients.
This principle is consistent with modern employment law and has served the NHS and its patients’ well for over 55 years in maintaining high standards of patient care and safety throughout the service.
The new development of NHS patients being cared for in Treatment Centres does not change this principle.

AAGBI Council December 2004

NHS Pay Philosophy

38. Equal pay and status for consultants of all specialities was an important issue at the start of the NHS including public concern about equal geographical access to professional skills. Two levels of consultant had been suggested, surgeons and physicians in one and pathologists, radiologists and anaesthetists etc in the other. Eventually it was the President of the Royal College of Surgeons, Sir (Lord) Alfred Webb-Johnson, who convinced everyone of the importance of equality of pay and esteem to the success and development of safer anaesthesia for surgical patients and the NHS. The British Medical Association (BMA) also supported the principle and history has proved its justification in that mortality from anaesthesia has fallen from around one per 1,000 anaesthetics in 1948, to one in 240,000 today. Anaesthetists are also recognised as a driving force for the improvement of safety, clinical and management standards throughout the NHS and the National Audit Commission identified its crucial role in the care of over 60% of NHS Hospital patients. With the NHS now recognising the value of being “an organisation with a memory”, the lesson of parity must not be ignored.

39. All NHS Consultants remuneration is based on exactly the same pay scale, now published annually by the Doctors and Dentists Review Body, providing equal pay for equal professional time spent caring for patients. This principle was all reconfirmed in the new 2003 Consultant Contract.

40. Because this NHS work was taking place in ISTC operating theatres the Independent Hospital managers unthinkingly did what is normally done for Private patients and offered the surgeons fees per case 250% greater than those paid to the anaesthetists e.g. £100 for the surgeon £40 for the anaesthetist. This large differential in Private Fees is historical in Great Britain largely influenced by the different Surgical and Anaesthetic Benefits schedules of the leading insurer BUPA who have 40% of the market. The justification for this differential is that surgeons have to cover greater expenses than anaesthetists, requiring more secretarial help and sometimes spend more time seeing the patients postoperatively etc.

41. None of this however applies for this ISTC work as the NHS patients have already been seen and assessed in the traditional NHS and a large number are day cases or short stay. All medical indemnity costs also continue to be covered by the NHS Litigation Authority scheme. For all these reasons anaesthetists believe that one the NHS founding principles of equal rates of pay (“parity”) for all consultants should be maintained for this NHS work.

NHS Work

42. Some Independent Providers notably Mr Keith Cunningham, manager BUPA Hospital Leicester (a BUPA ISTC Lead) tried to convince local consultants that these were Private Patients to justify his refusal to comply with Parity. He consistently queried the NHS aspect of this work at the outset we believe it is clearly NHS work for the following reasons:
— they are NHS patients;
— their care is an NHS responsibility;
— this is part of the NHS Plan;
— the NHS and its Trusts are arranging the contracts specifying NHS standards of care and performance;
— the NHS is providing indemnity cover to CNST standards; and
— it is all officially NHS funded and the NHS will have to care for the late post-op and further treatment episodes after the contract period.

43. No one in authority has ever suggested that this is not NHS work and that is why anaesthetists do not feel able to volunteer for it for non parity pay rates. Indeed the NHS contracts prescribe a lot of the detail, Sir Nigel Crisp has recommended that all providers to use the NHS logo and even BUPA Insurance does not insist on its logo being used by the BMI or HCA hospitals.

Unlawful Discrimination

44. Rt Hon Patricia Hewitt’s statement in her first speech as Health Minister on 13 May 2005 spoke of “embedding the principle of equal pay for work of equal value” in NHS work. She had also previously been approached by the AAGBI when Minister for Women as unequal pay in these circumstances would represent indirect sex discrimination against women: women currently constitute 34% of consultant anaesthetists but only 7% of consultant surgeons. A similar submission was made to the “Women and Work Commission” chaired by Baroness Prosser which to date has not reported. For the Service to permit a departure from the principle of equality of pay for those of its staff seconded to work in the Independent Sector on NHS patients at the time when this disparity has become apparent would expose the Service as well as those providers in default to allegations of indirect discrimination on grounds of gender.
45. On 21 July 2005 the DH published a new Guide to Promoting Equality in the NHS. (DH Reference number: 2005/0264), saying the NHS is at the forefront of promoting equality within both national and local economies. Health Minister, Rosie Winterton said: “If the NHS is to maintain and develop its position as a world-class service, it must be a service that treats its patients and staff with fairness, dignity and respect.”

47. On 6 October 2005 the DH instructed the Independent Sector Providers supplying catering, portering and cleaning services to the NHS to pay equal pay for work of equal value rates.\(^{13}\)

**THE CURRENT POSITION**

48. When all this has been pointed out to the DH who are funding and laying down many other standards in these NHS contracts they say for some reason wish to maintain an arms length relationship with ISTCs on this issues and will not act. The DH officials privately say they agree with parity, would not expect anaesthetists to do the work for anything else and do not think anaesthetists are being unreasonable asking for it and not volunteering to work without it. For NHS consultants the DH describe this work as “NHS work in non-contracted hours” For 40 hours of the week our normal contracted NHS work is paid on the basis of parity what is so different about further NHS work in a few additional non contracted hours?

49. At present we are waiting for the meeting the DH said they would ask the Independent Health Care Forum (IHF) to facilitate between the AAGBI, the BMA and the IHF to discuss these issues. The IHF Chief Executive Tim Elsigood has resigned, the organisation in disarray and we now believe Mathew Kay of the DH Commercial Directorate is now organising the meeting directly. There is no guarantee that Parity arrangements in ISTCs will be the outcome of this meeting.

50. Anaesthesia, as in 1948, is at a crossroads here again and anaesthetists feel that parity of pay is a fundamental NHS standard indirectly affecting the care of patients. This matter has the support of the BMA, HCSA, MWF and other practitioner organisations and as the NHS is proposing to further develop ISTC work and require the services of anaesthetists it is important that this standard is maintained and clearly specified in any such ISTC contracts.

51. We would ask the Health Committee to support these staff through the ways suggested above in the interests of NHS patients.

Dr David Whitaker
Association of Anaesthetists of Great Britain and Ireland
14 February 2006

Annex I

**Letter from John Carter, Chairman, Safety Committee (AAGBI), to Kate Glass, Mendip PCT**

**SHEPTON MALLET INDEPENDENT TREATMENT CENTRE (SMITC)**

I understand that the working practices at the Shepton Mallett Independent Treatment Centre are to be based on North American practice and as such will not include trained exclusive anaesthetic assistants. This is in direct contravention of the current guidelines in “The Anaesthesia Team—Revised Edition 2005”, published by the Association of Anaesthetists. (Copy enclosed).

The NHS Chief Executive, Sir Nigel Crisp, has recently been quoted in the Health Service Journal as stating that Independent providers will have to meet NHS standards. Clearly this will not be the case at Shepton Mallett ITC.

Whilst it may be considered safe practice in New York, I doubt whether these practices can be readily transposed to an isolated Treatment Centre in rural Somerset with European, Scandinavian and Australasian anaesthetists. At the very least I would expect informed patient choice to include an explanation that the practices undertaken in this Treatment Centre will not be up to the standard required at every NHS and Independent Hospital in the country.

This is a major safety issue. The standard of anaesthetic care in the NHS is excellent and the same standard must be available to all our patients regardless of where they are treated. The Association of Anaesthetists has developed a considerable number of guidelines and recommendations on various important topics including monitoring standards, checking anaesthetic equipment, recovery and infection control. These are all available on the Association website (www.aagbi.org), and I would expect all Independent Treatment Centres to comply with all of these.

I would welcome your reassurance that nationally trained, exclusive anaesthetic assistance will be provided at the SMITC.

8 April 2005

\(^{13}\) *(Agenda for Change, BBC News site) http://news.bbc.co.uk/1/hi/health/4316602.stm*
Annex 2

Letter from John Carter, Chairman, Safety Committee (AAGBI) to Kate Glass, Mendip PCT

Thank you for arranging the meeting earlier this month with you, the lead clinician for the PCT and the nursing lead and the manager of the SMITC.

As you know from my previous correspondence I was concerned that as the Treatment Centre was going to be run on North American lines, the standard of assistance provided to anaesthetists working in the SMITC would be of a lesser standard than the Association of Anaesthetists recommends in their guidelines, and consequently less than that provided in NHS Hospital Trusts.

I was very pleased to have such a full and frank discussion with all of you, and I was reassured to be told that you would be employing trained anaesthetic assistants with nationally recognised qualifications who would be available to assist the anaesthetist continuously throughout each case. It was also reassuring to be informed that the clinical governance practices would be equivalent to those undertaken in NHS hospitals, in particular audit, critical incident reporting and appraisal.

I have reported back to the executive officers of the Association of Anaesthetists and we are happy that our concerns have been discussed, and also with your reassurance that the standard of assistance provided for the anaesthetists will be comparable to that required in NHS Hospital Trusts.

17 June 2005

Annex 3

Letter from the AAGBI to Mr Surinder Sharma, National Director for Equality and Human Rights, Department of Health

1. CURRENT PLANS

A Patient-led NHS: delivering the NHS improvement plan, published recently sets out the next stage of delivery for NHS organisations. Up to 8% of NHS patients requiring of elective operations will be directed under patient choice initiatives to extra, additional capacity available in the Independent Sector Treatment Centres (ISTC’s) and other hospitals. “Over time”, all independent providers supplying NHS care would be expected “to display the NHS logo as a sort of kitemark” and in the words of the Department of Health, “Treatment Centres are expected to provide treatment to NHS patients in accordance with NHS principles”. All this NHS work in the Independent Sector in England is now covered by the NHS Litigation Authority (NHSLA) Clinical Negligence Scheme for Trusts (CNST) through the referring PCT, following a similar arrangement by the Welsh risk pool in Wales.

2. THE EXISTING NHS PAY PHILOSOPHY

As this is entirely NHS work we believe it is fundamentally important to maintain the long established NHS principle of equal pay for work of equal value (parity of pay) for anaesthetists and surgeons.

Equal pay and status for consultants of all specialties was an important issue in 1948 at the start of the NHS. Eventually the President of the Royal College of Surgeons, Sir (Lord) Alfred Webb-Johnson, convinced everyone of the importance of equality of pay and esteem to the success and development of safer anaesthesia for surgical patients and the NHS. The BMA also supported the principle and history has proved its justification in that mortality from anaesthesia has fallen from one per 1,000 anaesthetics in 1948, to one in 240,000 today. Anaesthesia is also recognised as a driving force for the improvement of safety, clinical and management standards throughout the NHS and the Audit Commission identified its crucial role in the care of over 60% of NHS Hospital patients. With the NHS now recognising the value of being an organisation with a memory, the lesson of parity must not be ignored.

Since the start of the NHS all Consultants remuneration has been based on exactly the same pay scale, now published annually by the Doctors and Dentists Review Body, providing equal pay for equal professional time spent caring for patients. This principle was all reconfirmed in the 2003 Consultant Contract.

3. THE SIGNIFICANCE OF THE CHANGE

If the importance of equality were to be forgotten there would be far-reaching disadvantages for patients and the Service. As work in ISTCs becomes a significant proportion of NHS activity and Foundation Trusts have the freedom to issue their own contracts, distortions in recruitment patterns would begin to arise and the numbers and quality of doctors entering anaesthesia would change. It would be disastrous if this occurred and future progress were to be put in jeopardy because of an oversight in the haste to implement the ISTC programme.
If parity of esteem between the specialities were to be lost, the gains in patient safety since 1948 would be jeopardised. Many believe that the moral of many recent changes in the NHS is that you don’t know what you’ve got till it’s gone. We take for granted the parity of esteem that enables all members of the surgical team to stand up equally firmly for their aspects in the interests of the patient. That is the bedrock on which all have co-operated to render peri-operative mortality an extraordinary event rather than a routine part of the work, in less than 60 years.

4. WHY IS THIS HAPPENING?

The problem seems to have arisen because although the GSup contract was negotiated nationally between the Department of Health and CAPIO/Nuffield Hospitals, supposedly guaranteeing that all usual NHS standards would apply, the parity of pay for NHS consultant staff seconded to do this work has been ignored when left to a variety of local managers who have applied the rates in two completely different BUPA Insurance Benefit schedules. It is very important to note that the BUPA Anaesthetic Benefit scale only pays the anaesthetist 40% of the benefit for exactly the same procedure on the BUPA Surgical scale. Application of these private insurance scales is totally inappropriate for a number of reasons: they reflect the fact that:

- surgeons treating private patients have to rent expensive rooms and maintain more secretarial support; and that
- surgeons usually see their patients more extensively pre- and post-operatively and are not always paid separately for this.

None of these apply in the case of Treatment Centres. Equally none of these apply under the GSup arrangements. There are no private rooms or secretaries to pay for. In many cases, the anaesthetist sees the patients more outside the Operating Theatre than the surgeon does, since under GSup other surgeons often do the pre-operative work-up and post-operative management, and a large proportion of these patients are day cases. There is no marketing to be done by the individual doctor.

5. UNLAWFUL DISCRIMINATION

Quite apart from the departure from Government and NHS policy of equal pay for work of equal value, this oversight results in an unfair discrimination on grounds of gender, since there is a far higher proportion of women amongst consultant anaesthetists (34%) than there is amongst consultant surgeons (7%). We believe that there should be no discrimination in the fees paid to anaesthetists and surgeons treating any NHS patients. We have already written to the Rt Hon Patricia Hewitt, when Minister for Women, and because the Women and Work Commission terms of reference state that the public sector warrants particular examination, as a substantial employer of women, we have submitted evidence on this for their Autumn report. The Medical Women’s Federation is fully supporting the maintenance of parity as a point of principle and the Department of Health has said, “the NHS is the largest employer in Europe and aims to be the best.” We have been advised that we could litigate this point, but think it would be unfortunate from every point of view for anaesthetists to find themselves in litigation with the Service of which they are proud to be a part.

6. THE WAY FORWARD

The only logical way to base any discussions on the BUPA schedule is for all involved to use the same benefit table and for any modifications from that to reflect more or less time spent with the patient. One sensible way forward, which has been adopted by the Chester Nuffield Treatment Centre for GSup work, is to pay anaesthetists and surgeons parity rates both based on 60% of BUPA surgical benefits.

Alternatively, it may be better to get away from the BUPA schedules altogether and base discussions around the same hourly rate for both surgeons and anaesthetists. A national survey last year showed 78% of Waiting List Initiative work paid on a sessional basis in the NHS was paid at the same rate to surgeons and anaesthetists. (NB 90% in 2005 survey now completed) National parity arrangements exist for NHS Waiting List Initiatives in Wales. Other places have agreed parity for all day cases. Scotland is looking to start this work soon.

On 13 May Patricia Hewitt in her first speech as Health Minister, spoke of “embedding the principle of equal pay for work of equal value” and John Reid has said, “providers need to comply with all applicable legislation”. Against this background we suggest that a simple solution to this matter would be to specifically include the usual NHS principle of equal pay for work of equal value for anaesthetists and surgeons in any contracts for NHS work of this type. We understand that GSup2 and other ISTC contracts are in the process of being drawn up and it should certainly be part of those documents. Being a principle, like the legal requirement not to discriminate on grounds of gender, which it appears to be necessary to enforce, it would no more breach competition law nor interfere with providers commercial practices than the other NHS Standards specified. In this way the oversight can to be corrected as soon as possible. In order to ensure that this is done properly, it is necessary only for the Commercial Directorate of the Department of Health to say to GSup and ISTC contractors that it requires them to respect NHS principle of equality of pay between different specialities. Implementation would then be straightforward. If such contractors continued to offer
fees to surgeons and anaesthetists that did not reflect equal pay for work of equal value the Commercial Directorate could refuse to shortlist them for future work or cancel their existing contracts for non-compliance.

Anaesthetists are keen to improve patient care and reduce waiting lists, as their efforts in the past have well demonstrated. However this clear inequality regarding remuneration, as one would expect, makes them naturally reluctant to volunteer for this extra work. The national disinclination at present overwhelmingly suggests that this issue of parity is something of the first importance to anaesthetists.

We feel that parity of pay is a fundamental NHS standard indirectly affecting the care of patients. This matter has the support of the BMA, HCSA, Medical Women’s Federation, Federation of Independent Practitioner Organisations (FIPO), and other practitioner organisations and as the NHS is proposing to further develop this type work and require the services of anaesthetists it is essential that this standard is maintained and clearly specified in any such contracts.

I wonder if it would be possible to arrange to meet you either at the Headquarters of the Association of Anaesthetists at 21 Portland Place or anywhere else more convenient for you to discuss the matter further.

PS

The recent publication of the DOH Guide “Promoting Equality and Human Rights in the NHS” (21 July 2005, Gateway Ref 5256) has further elucidated some of the issues and I quote a section of it with my comments in Italics:

Within large organisations like the NHS, and despite much excellent work around equality, discrimination by the organisation as a whole, and by individuals who work within it, can arise through:

— a lack of vigilance;

_The “Parity” issue seems to have been completely overlooked whilst otherwise expediting the massive development of NHS work in the Independent Sector’s capacity._

— a lack of awareness including the use of casual assumptions or stereotypes rather than informed opinion and person-centred assessment;

_There has been a serious lack of awareness on both the NHS and Provider sides of these contracts of the existing equal pay in the NHS since 1948 and its absence when applying different BUPA schedules in the Independent Sector._

— unacceptable behaviours arising from prejudicial views held by individuals;

_Particularly a feature of some Independent Sector Providers apparently unaware that this was NHS work and or prepared to accept the accompanying reforms._

— out-dated processes and procedures that may have discrimination built into them.

_The knee jerk reaction to use two historically and completely different surgical and anaesthetic insurance benefit schedules, which were never designed for this context, is a central cause of the problem and a clear example of this._

Individuals wishing to enter, or develop their careers in the NHS may feel hampered or under-valued if they receive less favourable treatment because of who they are or their beliefs, rather than what they can contribute through their skills, knowledge and experience. This runs counter to the modern NHS as an employer of choice and can only harm the NHS as talented people may not wish to join or remain in it, and health outcomes for patients may suffer as a result. Such consequences would tarnish the considerable progress the NHS has made in recent years in being a welcoming and fair employer to all.

There are legal duties placed on all public authorities, and individuals who work within them, to require and encourage fairness towards their workforces and to ensure respect for their rights. Board members should ensure that they understand these legal duties and are aware of further developing legislation. Current “equality” legislation in Annex A includes:

— The Sex Discrimination Act (as amended) 1975.

— The Equal Pay Act (as amended) 1970.

Future/developing legislation includes:

— The Equality Bill.

_The Equality Bill was re-introduced in Parliament on the 19 May 2005. The Bill’s main provisions include:_

— to create a duty on public authorities to promote equality of opportunity between women and men (“the gender duty”), and prohibit sex discrimination in the exercise of public functions. This will also include a specific duty on public bodies to produce a Gender Equality Scheme.

We have been talking to the Independent Sector Providers about this issue for around a year and they still seem to fail to appreciate the whole framework in which this NHS work is contracted. Rt Hon John Reid wrote to us confirming that any Providers must comply with all applicable legislation. This specific legislation, already confirmed to us, has now been clearly laid out in Annexe A of the new guide. Providers
must also demonstrate that they are conforming with good employment practice. The sanctions for any non-compliance with either of these have not yet been made clear, but in similar situations they would be at least the cancellation of existing contracts and failure to shortlist them for further NHS work.

Rt Hon Patricia Hewitt has stated that embedding equality in NHS activities is a fundamental principle she wishes to see fully implemented and that alone should be sufficient reason for the present. I do hope we can arrange a meeting to discuss how we can help with this issue for NHS work in the Independent Sector.

If you require any further information please do not hesitate to contact me.

23 August 2005

Evidence submitted by the British Association of Day Surgery (ISTC 26)

The British Association of Day Surgery (BADS) was founded in 1989 to encourage the expansion of day surgery throughout the United Kingdom, to promote education and high quality patient treatment. The Association is a multi-disciplinary organization with a current membership of 750 comprising surgeons, anaesthetists, nurses and managers involved in Day Surgery throughout the country. Our Council consists of 23 members reflecting the interests of the membership and also includes two lay-members to represent patient views.

What contributions have ISTCs made to the reduction of waiting times and waiting lists?

ISTCs have contributed to the Government’s targets for the reduction of surgical waiting times and waiting lists.

Are ISTCs providing value for money?

While ISTCs have contributed to the achievement of the Government’s day surgery targets there is limited evidence at present to demonstrate the cost-effectiveness of such initiatives.

Does the operation of ISTCs have an adverse effect on NHS services in their areas?

At present, NHS day surgery units provide quality care through their dedicated nurse, anaesthetic and surgical teams. While direct recruitment of NHS staff by an ISTC is prohibited (within six months) recruitment may originate from other private healthcare providers and create a “domino” effect whereby other private health care providers recruit of existing day surgery personnel from NHS.

What arrangements are made for patient follow-up and the management of complications?

Where an ISTC is offering a limited 12 hour facility the question arises as to the treatment of unplanned overnight admissions ie failed day cases.

This figure currently runs at approximately 3% throughout the NHS.

By necessity such patients from ISTCs would require emergency admission to an NHS facility for overnight stay.

What changes should the Government make to its policy towards ISTCs in the light of experience to date?

What criteria should be used in evaluating the bids for the Second Wave of ISTCs?

What factors have been and should be taken into account when deciding the location of ISTCs?

Stand alone ISTC distant from an existing NHS facilities (necessitating an ambulance journey to deal with unforeseen complications) have limited effectiveness in delivering the Government’s day surgery target.

Limited opening, eg 8 am to 8 pm, creates a loss of productivity of more major day surgery procedures in the afternoon day surgery theatre as there is insufficient recovery time before the evening closure of the unit to allow safe patient discharge.

Traditional 12 hour opening times limits operating to minor and intermediate day surgery procedures rather than the more major day surgery procedures (eg laparoscopic cholecystectomy or bi-lateral varicose vein surgery) which are required to enable Government targets to be met.

ISTCs with limited day time opening hours are only able to treat the fittest of patients (eg limited co-morbidity, the non-obese and, by implication, younger patients). By 2019, the population over retirement age will increase from 18.3% to 22.2% Population Projects 1994 based on Government Actuary Department 1996).
RECOMMENDATIONS

In the interests of quality of care and patient safety, surgical productivity and patient access the British Association of Day Surgery recommends that Government policy towards ISTCs should focus on integrated units within an existing 24 hour NHS facility.

The following members of the British Association of Day Surgery Council would be willing to give oral evidence:

Mr Douglas McWhinnie, Consultant Surgeon, Milton Keynes Hospital
Dr Ian Jackson, Consultant Anaesthetist, York Hospital NHS Trust

Douglas McWhinnie
British Association of Day Surgery
10 February 2006

Evidence submitted by the British Geriatrics Society (ISTC 21)

THE BRITISH GERIATRICS SOCIETY

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,200 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

GERIATRIC MEDICINE

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.

The Society welcomes the opportunity to contribute to this debate and would comment on the particular questions below:

1. Are ISTCs providing value for money?
   1.1 They are providing value for money but in future, costings will need to include an element for delayed discharge.

2. Does the operation of ISTCs have an adverse effect on NHS services in their areas?
   2.1 The operation of ISTCs could have an adverse effect on NHS Services in their areas through the inevitable selection of younger fitter people for simple procedures. This could concentrate the levels of highly dependant older people within the NHS services. Treatment centres could then be seen to be ageist.

3. What arrangements are made for patient follow-up and the management of complications?
   3.1 If older people develop complications they require rapid access to multi-disciplinary medical care. In addition post operatively they will often need to have help and support from the multi-disciplinary team of therapists and social workers.

4. What role have ISTCs played and should they play in training medical staff?
   4.1 ISTCs should be made to share costs of training health care professionals. There will be good training opportunities but these would need to be regulated.

5. Are ISTCs providing care of the same or higher standard as that provided by the NHS?
   5.1 They should complement local health services and not undermine them

6. What changes should the Government make to its policy towards ISTCs in the light of experience to date?
   6.1 In the light of experience to date ISTCs need to take account of the multiple needs of older people. Who are more likely to have multiple diseases and long-term conditions associated with impairment, disability and handicap.

7. What criteria should be used in evaluating the bids for the Second Wave of ISTCs?
   7.1 The needs of older people.
8. What factors have been and should be taken into account when deciding the location of ISTCs?

8.1 They need to be accessible for older people and near transport links.

Dr Jeremy R Playfer MD FRCP
President
The British Geriatrics Society
13 February 2006

Evidence submitted by the British Hip Society (ISTC 17)

I write to give evidence to the Committee. I am the President of The Hip Society with over 300 Consultant Hip Surgeons as members. We, as a group, are concerned about a number of matters regarding the ISTC’s. We include the GSUP initiative in this evidence. We have hard evidence of a number of issues:

Our concerns are dealt with under the following headings (not in any order of priority).

1. Distorting influence on casemix for Total Hip Replacement THR at main NHS and the financial implications for major NHS Trusts.

2. The impact on training of Specialist Registrars when “easier” cases who are fitter are “creamed off” or “cherry picked”. This is clear in Ophthalmic Surgery but less clear in Orthopaedics although in the Southampton region this is a problem (personal communication)

3. Quality of clinical care and the number of complications and outcome—documentation and follow up according to Hip Society guidelines.

4. The lack of a clear appointments process for surgeons working in ISTC’s or GSUP (as with Statutory NHS consultant appointments process) and the absence of detailed scrutiny assessing their fitness to practice as Orthopaedic Surgeons in a particular subspeciality.

The data I have examined with my Hip Fellow (Mr M K Sayana) includes the following:

A. ASA (American Society of Anaesthetists fitness score):
   1. Fit.
   2. Non active disease.
   3. Active disease contributing to hazard of surgery and anaesthetic.
   4. Major comorbidity contributing hazard anaesthetic and surgery.

Score data for patients having THR scores at my hospital—(University Hospital of North Staffordshire) and correlation with length of stay and theatre time is available and the changing casemix as the “easier fitter” patients are creamed off and the financial implications for my hospital.

B. NJR (National Joint Registry) data on ASA scores of all patients having THR whether in ISTC’s/private hospital or big NHS hospital

C. Dr Foster data from individual NHS hospitals submitting data centrally on length of stay and condition. This sort of data is not unfortunately available from ISTC’s or private hospitals undertaking NHA work. All institutions where “NHS” patients are operated upon should contribute data to the central database of codes/LOS/etc see next section.

D. Data from various published papers on “farmed out” waiting list initiatives to remote providers.

Data not available that I believe the Committee should request

(i) NJR figures on “Overseas Surgeons” casemix. It is to be noted that unless patient consent is taken at the primary operation for release of identity it is not possible to cross check backwards when any subsequent or revision procedure is performed. This should be remedied.

(ii) Re-admission rates within one year. Comparative data from (a) NHS hospitals for primary THR and (b) ISTC’s and (c) GSUP. (Note it is the writer’s experience that re-admissions from (b) and (c) are usually to the local NHS hospital and data capture may be difficult—See (i) above where although subsequent ops have the origin of the primary operation recorded it may not be possible for the NJR to cross check to assess who the original surgeon was).

(iii) (a) Outcome scores; and

(b) X-ray analysis for quality of THR implantations at various institutions undertaking THR on the NHS:

(a) this is only likely to be available if patients can be traced and contacted (as in the Trent Arthroplasty Register). the NJR does not provide outcome data on complications directly—it has a “surrogate” endpoint available ie when revision surgery is performed there is a field to fill in about the original operation.
(b) This is very time consuming and is currently being undertaken in Leeds comparing X-ray appearances on THR of GSUP overseas surgeons and local NHS surgeons.

I attach:
(a) Paper accepted by the British Hip Society for their March 06 meeting on ASA score and distortion of casemix.
(b) Paper submitted to University Hospital of North Staffordshire, my hospital, on costs of casemix distortion.
(c) My response to Dr Foster figures on length of stay National Data for THR. 14

My conclusion from my careful scrutiny of the Evidence is that “cherry picking” of easier fitter THR patients has altered casemix to such an extent that current Tariffs (which do not reflect altered casemix) mean that NHS Trusts undertaking the riskier more difficult cases are at a major financial disadvantage. I can hardly believe this has been allowed to happen with the current administration. The impact on training is less clear in Orthopaedics but recent Log Book central submissions to the Edinburgh College may make this clearer.

The evidence on the quality of THR surgery undertaken by ISTCs and GSUP overseas surgeons is less easy to come by but I have personal experience of catastrophic complications on operations performed by overseas GSUP surgeons performing THR and TKR locally to me—I have had to put things right.

I would be pleased to give further evidence to the Committee should they so wish.

Charles Wynn Jones FRCS
Consultant Orthopaedic Surgeon
University Hospital of North Staffordshire
12 February 2006

Evidence submitted by the British Medical Association (ISTC 33)

Executive Summary

The BMA does not oppose treatment centres run by the independent sector outright but, in our evidence, we highlight a number of risks that an expansion of this policy could engender if not properly planned and monitored.

The BMA wishes to see much stronger measures established to ensure that ISTCs, working alongside conventional NHS organisations, are properly integrated with existing structures to avoid the fragmentation of services and the loss of continuity of care for patients. To achieve this, local NHS clinicians must be fully engaged in the planning for, and the introduction of, ISTCs in local health economies. We are particularly concerned that, due to the current lack of robust audit data on outcomes the public and the NHS are unable to assess properly the quality of services or ensure new providers offer value for money.

The BMA has therefore identified a number of recommendations that the Government must address:
— A level playing field should be established for all providers in respect of the financial cost of providing a high quality National Health Service and maintaining a skilled medical workforce.
— Patients must be provided with a high quality, safe and seamless service, whether they receive treatment in the NHS or in the independent sector.
— There must be a clarification of what function ISTCs will be expected to provide when access targets have been achieved and waiting lists have reached an acceptable level, and what strategies are in place to deal with failing NHS departments/hospitals if patients favour the independent sector as providers of their treatment.
— To ensure patient safety, the care provided in treatment centres should be the subject of robust, peer-reviewed clinical audit that is transparent and not hindered by the issue of commercial confidentiality.
— The training of doctors must not be compromised.

Consequently, criteria that we would strongly wish to see used in evaluating bids for the second wave of the ISTC programme, or any independent sector provision of NHS care, include:
— Ability to deliver clinical care to high standards ensuring quality
— Adherence to clinical governance frameworks
— Ability to deliver undergraduate and postgraduate medical training and integrate research
— Demonstrable value for money

14 Not printed here.
— Ability to augment capacity without negative impact on existing NHS services.
— Commitment to fostering clinical leadership
— Participation in national workforce planning
— Transparency in operation

1. What is the main function of ISTCs?

1.1 From its inception, the ISTC procurement programme’s stated function was to establish additional clinical capacity in specialties that had traditionally suffered from long waiting times, such as orthopaedics and ophthalmology, and support the NHS in meeting government targets. The key benefit of ISTCs is their capacity to achieve a managed separation of elective and non-elective care and thus provide an environment in which scheduled operations are much less likely to be cancelled due to non-clinical reasons. Whilst the BMA supports this model of working in principle, we do not believe that the ISTC programme is the only viable means of putting the model into practice. NHS treatment centres, day surgery units and five-day wards all represent well proven, alternative means.

1.2 The BMA is increasingly concerned that the ISTC programme has developed well beyond the original undertaking to provide additional capacity and instead will see large volumes of activity transferred from conventional NHS organisations to the independent sector. This is particularly evident in the proposals for the second phase of the procurement. Along with this transfer of activity, the government expects the second phase to introduce much greater competition into the healthcare sector and be the main driver in having the NHS confront the realities of market forces. ISTCs are commercial ventures and will be operated with the intention of making a profit for the companies involved.

1.3 We are concerned that the long-term impact of these new functions on the stability of the NHS has not been sufficiently modelled and lacks underpinning evidence of beneficial effect. The BMA questions what function ISTCs will provide when access targets have been achieved and waiting lists have reached an acceptable level. It is not at all clear what role ISTCs would be expected to play if, or when, spare capacity routinely begins to develop in the NHS. In considering this issue, one must reflect on the evidence now emerging that some NHS organisations, despite having sufficient capacity, do not have adequate financial resources to fund the use of this capacity. As a consequence, clinicians are being ordered to stop operating. If capacity continues to expand, then funding issues such as this are likely to be exacerbated.

2. What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

2.1 According to a recent BMA study, there is evidence to suggest that some patients have benefited from improved access and a reduction in waiting times as a consequence of the capacity made available to the NHS through treatment centres. However, we would be concerned if these benefits of increased capacity are being experienced at the expense of the standard of care being received. Of particular concern is the possibility of patient pathways becoming fragmented. The BMA study suggests that patients are often being directed to treatment centres without reference to their consultant in the local hospital trust and that patients are not being fully involved in the referral process.

2.2 Furthermore, we wish to highlight the fact that simply establishing increased capacity through the development of ISTCs does not in itself demonstrate increased effectiveness or efficiency. The BMA study provides evidence that patients are significantly more likely to be rejected for treatment by ISTCs (43%), compared with NHS treatment centres (13%) and the patients most likely to be rejected by the treatment centres are those with the most complex cases. Consequently, though ISTCs offer the prospect of additional capacity they remain reliant on capacity in conventional NHS settings for those patients who require a higher level of care.

2.3 In the long-term, the expected trend of transferring large volumes of NHS work to ISTCs appears to further undermine the intention to use these facilities for additional activity as a means of increasing overall capacity in the health service. This transfer of work represents a shifting of activity and therefore does not constitute a meaningful growth in capacity. Rather, money and NHS resources are being redistributed to the independent sector often to the detriment of existing NHS services elsewhere. We would contend therefore, that the independent sector’s ability to deliver additional capacity is limited. The transfer of activity demonstrates that much of the growth in NHS independent sector provision will be realised by drawing on existing public sector capacity.

2.4 ISTCs are clearly intended to support the patient choice agenda by extending the range of options available to patients with regard to when and where they can be treated. Whilst we welcome greater convenience and access, we believe strongly that patients must be provided with an understanding of the reality of finite resources, where increasing choice and access may mean less continuity and personal care. It is somewhat paradoxical that the opportunity for patients to exercise choice may in fact diminish as a result of local centres being downsized or closed in the face of competition from, and loss of activity to, ISTCs.

2.5 The development of the ISTC programme may encourage and stimulate innovative models of service delivery, both in ISTCs themselves and in conventional NHS providers, though to date evidence of this is lacking. Of course, much innovation already goes on within the NHS. In order to improve productivity and raise the quality of patient care it will always be necessary to take into account best practice and incorporate new processes and technologies. However, we would contend that the participation in research, teaching, and peer-reviewed activity that is vital for innovation in healthcare are not ideally suited to the working environments found within most, if not all, ISTCs. The employment of overseas clinical teams often on short-term, rotating contracts in ISTCs is one example of such a possible shortcoming.

2.6 We would wish to have noted that the early development of NHS treatment centres in England was successfully undertaken by NHS clinicians and managers wherein the innovations and learning processes were integrated into the local health economies and best practice was routinely shared between health communities. We are concerned that as a result of both the increased competition now being experienced in the UK healthcare market and the apparent lack of integration between ISTCs and their local NHS organisations this kind of cooperation will be less likely, to the detriment of patient care and clinical innovation.

3. What contribution have ISTCs made to the reduction of waiting times and waiting lists?

3.1 In assessing the contribution of ISTCs to the reduction of waiting times and waiting lists their productivity must be placed within the context of the wider current efforts to improve access for patients. Whilst the introduction of ISTCs has made a contribution to the reduction of waiting lists, their small number at present suggests this has been limited. Traditional NHS organisations, in response to government targets and by developing new ways of working, have made a far bigger impact in this respect.

3.2 For example, evidence suggests that the recent and marked improvements in waiting times for cataract surgery in England have been wrongly attributed to the mobile ophthalmic ISTC scheme. Waiting times for cataract surgery in England began to fall significantly some time before those ISTCs contracted for ophthalmic procedures became operational.16 It also worthy of note that evidence from a BMA study17 suggests that whilst the benefits to patients from ISTCs centres have included shorter waiting times and improved access, according to the study, patients are more likely to benefit from shorter waiting times where an NHS treatment centre, rather than an ISTC, is in operation.

3.3 A confounding factor in attempting to assess the contribution of ISTCs to the reduction of waiting times is the limited number of these centres that are currently operational. The relatively small volume of procedures that have been undertaken in ISTCs to date is dwarfed by the General Supplementary (GSup) contracts and NHS Trust internal initiatives that were established to improve the management of waiting lists. It is therefore difficult to establish the true extent of the ISTCs’ contribution. However, it is our view that despite the likely impact of ISTCs on waiting times, a similar, if not better, reduction would have been, and could be, attained if the same level of investment (both finance and infrastructure) was channelled into existing NHS facilities and organisations.

4. Are ISTCs providing value for money?

4.1 Due to the commercial confidentiality considerations that apply to ISTC contracts there is a paucity of data in reference to the exact costing of these arrangements. This precludes a useful analysis of the value for money (VfM) of ISTCs established by new providers to provide NHS care. We believe that at present there is little robust evidence to suggest that VfM is being achieved and while the requisite data remains unavailable the true cost of ISTCs to the taxpayer will remain opaque. This lack of data is a real concern.

4.2 What little evidence does exist demonstrates that the NHS and the taxpayer is often paying a premium for independent sector involvement. Certainly, the Government has stated that in 2003–04 the “procedures purchased under the ISTC programme cost on average 9% more than the NHS equivalent cost”.18 Moreover, the contract agreements pertaining to the first phase of the ISTC programme gave rise to a number of instances of ISTC block contracts being paid in full despite the ISTCs failing to deliver the number of clinical procedures stipulated in those contracts. We do not believe that ISTCs, fully staffed and fully resourced, that are operating well below their capacity can represent VfM.

5. Does the operation of ISTCs have an adverse effect on NHS services in their areas?

5.1 Evidence from the BMA study of Clinical Directors shows that where a treatment centre is in operation, most respondents report some impact on either their Trust as a whole (69%) or specifically on their clinical directorate (80%). More than half of these respondents report a negative overall impact of a local treatment centre on the facilities and services provided by their NHS Trust with more than two-thirds reporting a negative impact from an ISTC.

18 HC Deb, 16 March 2005, col 273W.
5.2 Most typically, reported concerns highlight the tendency of ISTCs to distort the case-mix experienced by local NHS services. This distortion results from treatment centres ‘cherry picking’ cases, focusing on simpler, more straightforward elective procedures that do not involve patients with co-morbidities. Whilst this practice reduces complexity and risk for the ISTC it leaves local services with the much more difficult task of taking on the burden of difficult cases and accommodating longer in-patient stays. This has a number of adverse consequences.

5.2 Due to the manner in which the Payment by Results system currently operates the local NHS services do not receive any premium for dealing with the more complex and therefore more costly case-mix. Whilst NHS services are faced with this increased cost pressure, ISTCs benefit from the high volume of simple case-mix, guaranteed referrals and the improved tariffs available to them as well as remaining able to rely on support services in the local NHS organisations if post-operative difficulties arise which again results in a shifting of financial burden. The inequities described here underpin the BMA’s recommendation that the second phase of ISTC procurement must proceed on a ‘level playing field’ where incentives and processes that favoured the independent sector in the first phase are not replicated.

5.3 However, current policy will see those conventional NHS centres reliant on routine work to cross subsidise large fixed overheads become increasingly vulnerable as activity is transferred to ISTCs. Consequently, we can expect severe financial pressures to be experienced that will extend beyond the services directly affected by ‘competition’ from ISTCs but also to the additional services such as non-elective, small specialty or support services, that the conventional NHS is responsible for and that ISTCs do not provide. The adverse effect of ISTCs on the training of medical staff will be dealt with below.

6. What arrangements are made for patient follow-up and the management of complications?

6.1 The Department of Health has given assurances that arrangements for follow-up care and the management of complications are included in the ISTCs contract. However, undertakings (Service Level Agreements) that local NHS services should provide for these arrangements often appear to have been agreed without engagement or agreement of local NHS clinical staff.

6.2 A lack of robust communication channels between ISTC clinicians in treatment centres and those in local NHS services also appears to be a significant problem, where almost three-quarters of respondents in the BMA study report that they are never able to discuss patient cases with staff in ISTCs, compared with a fifth of respondents with an NHS treatment centre. Concerns have similarly been expressed with regard to difficulties in obtaining patient notes and records.

6.3 Two thirds of respondents report that they are aware of patients who had developed complications following treatment in treatment centres and have required readmission to their hospital Trust. This is more likely to be the case for patients who have undergone treatment in an ISTC than in an NHS treatment centre. While post-operative complications do occur in clinical practice, in conventional NHS trusts they are usually dealt with “in-house” by the medical team who performed the original procedure. However, in the case of complications arising from procedures undertaken in ISTCs, patients are being sent back to the local NHS trust for follow-up treatment because it is only there that the appropriate facilities and staffing are available. In the case of the mobile ISTCs they may have moved away. This both fragments the care pathway and increases the workload of the local NHS medical team.

6.4 We are concerned that despite the reassurances from the Department of Health there do appear to be deficits in the clinical governance arrangements in ISTCs. To ensure patient safety and high standards of patient care it is imperative that robust clinical governance systems are in place and that these are integrated with local services. Each ISTC should make a transparent declaration of the formal arrangements it establishes which should include the routine use of clinical advisory groups, regular audit meetings, critical incident reporting systems and clinical governance committees. We wish to highlight the fact that the National Patient Safety Agency (NPSA) is not made aware of patient safety incidents in ISTCs as its remit is currently restricted to NHS providers.

7. What role have ISTCs played and should they play in training medical staff?

7.1 We have serious concerns in respect of the potential threat to established training programmes for junior doctors as procedures most suited to training purposes are transferred to ISTCs. Most respondents to the BMA survey agree that the education and training of medical staff, particularly junior doctors has already or will be affected in the future. The impact of ISTCs “cherry-picking” patients with straightforward pathology, means that these cases are no longer routinely available and this progressively reduces the extent and quality of training received by junior doctors and nursing staff in the NHS.
7.2 Phase one of the ISTC procurement programme initially excluded providers from training responsibilities completely, though a number of pilots will begin in 2006. However, there remains ongoing uncertainty with regard to the detail of proposals for both the pilots and the provision of training in the second phase of ISTCs. The Department of Health recently announced that:

“The Department is committed to provide training for NHS healthcare professionals from independent sector facilities. All Wave 2 surgical ISTC contracts will require providers to undertake training for NHS junior doctors.” (DoH press release, dated 14th December 2005).

Nevertheless, despite seeking clarification of how education and training will be incorporated into ISTCs contracts, in particular the details of funding arrangements, the BMA has yet to receive a satisfactory response. We are concerned that, without a full and open discussion with regard to the proposed mechanisms for protecting the standards of training, the quality of the future medical workforce will suffer.

7.3 This situation arises at a time when training time is already at a premium, with many specialties stating that the combination of Modernising Medical Careers and the European Working Time Directive means that training opportunities are being severely reduced and exposure to relevant cases is already insufficient. There is already evidence that Southampton’s NHS orthopaedic centre is at risk of losing training recognition due to the loss of capacity to the ISTC in Salisbury where no training is carried out.

7.4 If ISTCs continue to be exploited for current purposes and their case-mix remains as at present, then it will be vital that doctors in training have the opportunity to train in these centres to further their development. ISTCs have the potential to offer a favourable environment, though of limited scope, to a number of trainees in some specialties. However, ISTCs wishing to provide training will need to be under the scrutiny of the Deaneries and relevant Medical Royal Colleges. In the same way that NHS training posts are reviewed and quality assured, training posts in ISTCs would need oversight under the same standards (as set out by the Postgraduate Medical and Education Board) and the same Terms and Conditions of Service. Only posts that have this oversight, and are administered by fully accredited trainers, would be approved and recognised for training towards a certificate of completion of training (CCT). Moreover, it is not only inexperienced doctors in training that require routine cases to acquire skills. Clinicians of more mature years require routine cases to acquire new skills and adapt to advancing technologies. There is no point in a doctor’s career where learning is “complete”.

8. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

8.1 We welcome the fact that senior medical staff in ISTCs are now required to be on the Specialist Register and have registration with the General Medical Council. However, such medical staff in the NHS are subject to additional procedures which ensure the suitability of clinicians to their post. For example, consultants are appointed through an Advisory Appointments Committee, founded on a Statutory Instrument, which requires input from the Medical Royal Colleges and peer review. No such equivalent exists in respect of ISTCs. Furthermore, the regular appraisal and job planning systems that are well established in the NHS, as well as regular formal and informal peer review, help to maintain quality and standards for NHS staff.

Short term appointments without this long term continuity fail to deliver similar quality assurances. Historically, questions have been raised over the nature and transparency of the appointment processes for ISTC medical staff in wave one. A failure by providers to fully assess the accreditation and ability of medical staff to perform appropriate procedures clearly threatens patient safety and the quality of healthcare delivered.

9. Are ISTCs providing care of the same or higher standard as that provided by the NHS?

9.1 Concerns regarding the general quality of care provided by ISTCs were raised in the BMA study. Concerns centre on the quality of specialist care provided by the treatment centres, the loss of continuity in medical provision and the lack of long term patient care. Many respondents also comment on the high turnover of consultants working in ISTCs and the impact that this has on co-ordinated working. Many respondents argue that although the quantity of patients being treated may have increased, they have real concerns regarding the quality of patient care.

9.2 High quality clinical care depends heavily on collaboration and joint working between staff—through the formation of clinical networks, which have, for example, played a critical role in improving the quality of cancer services. There is a danger that the growth in ISTCs, by increasing service fragmentation and introducing competition, could put such models of collaborative working and clinical leadership networks at risk and undermine continuity of patient care.

9.3 Due to the resources available to ISTCs and the low-risk nature of their case-mix we would expect a high standard of care to be provided as the services matured. The preliminary report of four ISTC schemes published by the National Centre for Health Outcomes Development (NCHOD) in November 2005 used 26 Key Performance Indicators (KPIs) to monitor a range of factors including clinical quality. However, we believe the report’s findings cannot be considered a reliable audit due to the lack of peer review and the incomplete nature of particular elements which prevent the development of valid comparators. Indeed, the
authors of the report themselves clearly identify the current deficiencies in this attempted audit. As a result of the ISTC programme’s infancy, the BMA would welcome further detailed and peer-reviewed audits of clinical outcomes from ISTCs before commenting further.

10. What implications does commercial confidentiality have for access to information and public accountability regarding ISTCs?

10.1 The NHS has always been subject to close scrutiny and this has been magnified by the Freedom of Information Act. A similar level of accountability, at the least as regards public scrutiny, does not apply to ISTCs, largely due to commercial confidentiality considerations. Consequently, there is a paucity of data which, as outlined above, impacts on opportunities to openly assess ISTCs’ value for money and clinical quality. The commercial status of the companies involved in the ISTC schemes further limits review of their processes and contracting. The process of judicial review, currently the final step in public body commissioning is not available to patients dealt with by private companies. The BMA would be particularly concerned if commercial confidentiality considerations hindered the work of bodies such as the Healthcare Commission or National Audit Office in inspecting ISTCs.

11. What changes should the Government make to its policy towards ISTCs in the light of experience to date?

11.1 Research carried out by the BMA indicates that NHS treatment centres, which are more integrated with the traditional NHS, have better outcomes for patients, can have positive impacts on the services provided by surrounding NHS trusts and have fewer negative impacts than ISTCs on local health economies. The evidence available therefore indicates that the continued development of the ISTC programme should be curtailed and proposed investment be diverted toward further funding of NHS treatment centres.

11.2 In lieu of this, the Government must address the long-term impact of transferring large volumes of routine elective activity into the independent sector on the future viability of integrated health economies and upon the provision of postgraduate medical training. If the traditional NHS is expected to take on the burden of more complex cases it must be adequately rewarded to enable the continued provision of necessary services, both core and support. Without such guarantees, existing high-quality NHS services will be damaged irreparably.

11.3 The BMA therefore recommends that a level playing field is established for all providers in respect of the financial cost of providing a high quality national health service and maintaining a skilled workforce. We wish to see stronger measures established to ensure that current ISTC provision complements traditional NHS institutions and promotes the development of high quality care pathways rather than compromising them. There must be a much greater engagement with, and involvement of, clinicians already working in the NHS in the development of the ISTC schemes.

12. What criteria should be used in evaluating the bids for the Second Wave of ISTCs?

12.1 As noted above there has been a lack of engagement with the profession during the development of the ISTC procurement. Little detail has been shared in respect of the criteria that have been used to evaluate wave one or presently being employed with regard to the current procurement for phase two. It is imperative that any evaluation of bids for the second wave takes into account the lessons of poor contracting learned from the first wave, for example, follow-up arrangements, clinical exceptions and value for money.

12.2 Criteria that we would strongly wish to see used in evaluating bids for the second wave, or any independent sector provision of NHS care, once the clinical/service need has been rigorously established would include:

— Ability to deliver clinical care to high standards ensuring quality.
— Adherence to clinical governance frameworks.
— Ability to deliver undergraduate and postgraduate medical training and integrate research.
— Value for money.
— Ability to augment capacity without negative impact on existing NHS services.
— Commitment to fostering clinical leadership.
— Participation in national workforce planning.
— Transparency in operation.
13. **What factors have been and should be taken into account when deciding the location of ISTCs?**

13.1 Similar to above, little detail has been made available in respect of the criteria that have been used to decide the location of ISTCs. Clearly, the service requirements and clinical needs of local health economies must be carefully determined in order to assess whether it is necessary to establish an ISTC in the locality, or if additional investment in existing services would prove more effective. We are concerned that in pushing forward the plurality agenda there has been a repeated failure to examine existing NHS capacity and sufficiently integrate ISTCs with local services.

13.2 We would wish to question the logic behind a scheme which requires patients to travel from Durham to Middlesborough for an MRI scan provided by the independent sector while an MRI scanner in Durham is idle. Similarly, should it be the case that patients in Southampton are expected to travel to an orthopaedics ISTC provider in Salisbury while Southampton’s own conventional orthopaedics centre has excess capacity and is now in fact having to close capacity due to the loss of work to the ISTC?

14. **How many ISTCs should there be?**

14.1 Whilst we welcome the Government’s commitment to reducing waiting lists and increasing access to healthcare, the development of the ISTC as a means to this end raises a number of concerns that we have outlined above. The BMA believes that the considerable investment earmarked for the ISTC programme would be better spent improving existing NHS services and encouraging innovation within the traditional NHS in order to achieve an integrated, world-class health service for the 21st century.

British Medical Association
February 2006

Evidence submitted by the British Orthopaedic Association (ISTC 25)

**Summary**

5. **Does the operation of ISTCs have an adverse effect on NHS services in their areas?**

   Answer—Yes:
   
   (a) Contracting for all cases but choosing the simple and allowing the remainder to go back to the NHS.
   
   (b) Reducing elective workload at NHS hospital, wasting valuable resources. Capacity in the NHS is underused.
   
   (c) NHS hospitals left taking trauma cases only.
   
   (d) NHS hospitals undertaking the complications arising from ISTCs.
   
   (e) Strategic Planning is not possible owing to uncertainties.

6. **What arrangements are made for patient follow-up and the management of complications?**

   Answer—Inadequate:
   
   (a) Patients with complications are left to see their GP who refers them to the NHS hospital, probably where they were first seen.
   
   (b) NHS hospitals have to pick up the problems, usually without adequate information.
   
   (c) There is near-total loss of continuity of care.
   
   (d) Patients are ill informed as to the process, many believing their consultant has authorised the transfer of care and that they will still be under that consultant’s care.

7. **What role have ISTCs played and should they play in training staff?**

   Answer—(a) none and (b) training opportunities should be provided under nationally-recognised criteria
   
   (a) Training is expensive.
   
   (b) The ISTCs take away training opportunities from the NHS training centre, depleting the competence of the next generation.
   
   (c) Training can only take place in an ISTC if the surgeon employed there is recognised as being a trainer by the Competent Authority.
8. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

Answer—currently, the procedures appear not to be equivalent to the appointment process in the NHS.

(a) The quality assurance of the surgeons is not robust and allows the opportunity for surgeons to take on operative procedures for which they are not trained.

(b) Entry on the GMC Specialist Register should be in the appropriate specialty and the holding of CCST (or CCT) from any European Country does not indicate that the surgeon is of equal ability as a surgeon trained in the NHS.

9. Are ISTCs providing care of the same or higher standard as that provided by the NHS?

Answer—There are too many reports of bad results in orthopaedic surgery coming from the Independent sector.

(a) The Orthopaedic surgeons in the NHS, especially in major joint replacement centres, are seeing above average revision rates and re-admission rates from ISTCs and GSupp work.

(b) All cases undertaken in ISTCs must be rigorously audited and results assessed at least up to five years and probably longer. A higher complication rate means an increased expenditure on health care. NHS hospitals would welcome similar funded audit.

(c) Proof must be sought that the ISTCs are submitting their data to the National Joint Registry, as stated in their contract.

10. What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

Answer—the true rate of complications is obscure as figures are not made available. It is not possible to obtain the names and NHS numbers so that a proper audit can be conducted.

11. What changes should the Government make to its policy towards ISTCs in the light of experience to date?

(a) Contracts with ISTCs should include the care of complications arising during the first five years.

(b) Medical appointment procedures must be as robust as that in the NHS.

(c) ISTCs should fund Audit of their clinical outcomes, especially of joint replacements.

(d) ISTCs must accept all cases referred to them or fund another hospital to undertake the complex work. Cherry picking should not be allowed.

(e) NHS hospitals should be competing on a level playing field.

INDEPENDENT SECTOR TREATMENT CENTRES—THE BOA VIEW

INTRODUCTION

The British Orthopaedic Association (BOA) is the professional association of orthopaedic surgeons in the United Kingdom. It is a charity whose objects are: “the advancement for the public benefit of the Science, Art and Practice of Orthopaedic Surgery with the aim of bringing relief to patients of all ages suffering from the effects of injury or disorders of the musculoskeletal system.”

The BOA has always stated that the long waiting lists in orthopaedic surgery result in inadequate clinical care and has consistently stated, following its Manpower Report in 1994, that a significant increase in consultant numbers was necessary to address the enormous workload and bring waiting lists down. Twelve years later there is still an insufficient number of orthopaedic Surgeons in this country to address the needs of an increasingly aging population. The current ratio of orthopaedic surgeons to population is 1:37,000. Our stated aim is for 1:25,000 and this will require a further 511 to be appointed in England, 620 in the United Kingdom as a whole. The waiting lists have not been created by surgeons, as is often said; they are a result of inadequate investment by all governments in a field of surgery which predictably expanded rapidly, as did patient demand for its services.

The BOA has very serious concerns about a new health system that does not build on the strengths of the well-established and enviable health service in this country. The BOA regrets the missed opportunity of being in the position of providing early advice to the Department of Health in the planning of the development of ISTCs. Many of the problems now facing too many patients could have been alleviated substantially had we been able to proffer our professional experience at an earlier stage. Unfortunately, it was necessary for the BOA to approach the Department when it learned of the plans for ISTCs but by this point the first contracts had already been signed. The BOA remains available and would be pleased to assist governments in providing a high standard of orthopaedic and trauma care.

This memorandum addresses the relevant issues as stated in the Terms of Reference.
5. **Does the operation of ISTCs have an adverse effect on NHS services in their areas?**

(a) The “cherry picking” of simple cases and the rejection of patients with co-morbidities (eg diabetes, heart problems etc) leaves the local NHS Trust with the complex, higher risk and more expensive cases. A complex hip replacement may take a half day list at a cost of £25,000, compared with a straightforward one in which three cases could be done in the same time, each being reimbursed at nearly the same rate per case.

(b) The tariff paid to the NHS does not reflect this complexity. The ISTC gets paid a higher tariff for the same case and even gets paid if it does not do the operation.

(c) The NHS is picking up the early revision surgery of cases done in the Independent Sector. This and (a) above distort the waiting list of the NHS Trust which is then penalised for not reaching targets.

(d) Capacity in the NHS is underused. Some NHS Orthopaedic Units are now doing fewer joint replacements than two years ago because PCTs send patients to an ISTC to meet agreed referral targets.

(e) Units are told they cannot expand because targets are not reached and the unit is uneconomic. (vide supra) Example: The Portsmouth ISTC has removed £5 million from the NHS hospital which has to recoup the loss by savage cuts in all surgical services. The ISTC carries on with a guaranteed 5-year contract and we have been told it gets paid whether the work is done or not.

(f) Strategic planning for local health care providers is not possible due to total uncertainty as to their role in the future. Example: Chapel Allerton Orthopaedic Service (CHOS) near Leeds has just been completed and local targets are being met. The PCTs will not renew their contracts as they are investing in ISTCs in Bradford, Goole and York. The consequence is the closing of beds and theatres and loss of staff.

(g) The introduction of ISTCs has made national workforce planning extremely difficult, if not impossible.

(h) Orthopaedic surgeons provide the trauma care in the UK. ISTCs do not take trauma. Example: In Banbury, all the elective orthopaedic surgery has been given to an ISTC (Capio). This leaves the orthopaedic surgeons to deal with the emergency work (often in unsocial hours) at the NHS hospital. Surgeons will leave. There will be no surgeons left to take care of the trauma. This is also occurring in other hospitals, the most important so far being Southampton General where all elective surgery has been contracted out to independent providers, leaving only trauma.

(i) The BOA believe that public money would have been more efficiently spent in the improvement of the infrastructure in current NHS hospitals and the training of more orthopaedic surgeons so that the workforce reached the recommended BOA level. The UK is still undersupplied with orthopaedic surgeons compared with the rest of the developed world and languishes close to the bottom of the table by comparison with its European neighbours.

(j) It is alleged that the PCTs are ‘forced’ to contract with the ISTC and not with the NHS.

6. **What arrangements are made for patient follow-up and the management of complications?**

(a) It has not been possible for the BOA to find out what is in the various contracts in this area of clinical care.

(b) The BOA receives a large number of reports of patients being discharged after surgery, or after one follow-up visit to the ISTC, and turning up at their original NHS hospital not knowing where to turn for advice. There is a lack of ownership of patients by the ISTCs.

(c) Patients are seriously misunderstanding the system, sometimes to their detriment. Many patients, when contacted by the clerical staff and offered a place at an ISTC, believe that they have to accept or go to the bottom of the waiting list. Furthermore, they believe they will remain under the care of the consultant whom they saw in the NHS clinic.

(d) NHS surgeons pick up the pieces. If surgery does not give the expected result, the patients first of all complain to their GP who does not have the facility to send them back to the ISTC. There is no other alternative than to send them back to the original NHS clinic, where the surgeon is required to explain what went wrong, usually without any operative note or communication from the ISTC.

(e) The standard of writing of operative detail is generally poor or non-existent, according to our members. Evidence can be provided if the Committee require.

(f) Continuity of patient care has been lost. It is good surgical practice prior to any procedure to meet and understand the needs of the patient, discuss the alternative treatments and provide informed consent. Based on a confidence (or not, as the case may be) the patient decides to entrust their treatment to the team they have just met. The patient now meets another surgeon, usually from abroad. This surgeon decides if she/he will perform the operation initially planned, do a different one or even not do it at all if it is considered too difficult.
(g) Some ISTCs employ surgeons from abroad on a rotating basis. This means that the surgeon whom a patient initially sees at the pre-operative visit may have returned home by the time the operation is due. The patient is then faced with a surgeon they do not know at the operating table and when it comes to follow-up they may be faced by yet another surgeon they have not seen before. There is no attempt at longitudinal treatment.

(h) The experience of our members is that there are NO arrangements to look after complications. We have been led to understand that this is not in the contract and no funds are available to deal with the complications. Therefore the GP sends the patient to the nearest NHS hospital. Some complications require emergency admission. However, ISTCs do not take emergency admissions and may not have even have the facilities to deal with them. A dislocation of the hip joint, for example, requires emergency treatment.

7. What role have ISTCs played and should they play in training medical staff?

(a) To our knowledge they have played no part in providing the training of the future generation of orthopaedic surgeons.

(b) The ISTCs have cherry picked the easy cases, thus leaving the training centres void of any “simple” cases on which to be trained. A surgeon needs to start on the easy and progress to the difficult, as in any profession.

(c) The electronic logbook for trainees developed by the BOA is now able to factually support evidence of the dwindling number of cases being undertaken by trainees. There is one example given of a trainee on a knee surgery unit not doing one total knee replacement in a six-month attachment.

(d) The shortening of training time resulting from ‘Modernising Medical Careers’ and the introduction of the European Working Time Directive have reduced and will further reduce the exposure of a trainee to operative surgery. The reduction of exposure by the presence of an ISTC aggravates this problem.

(e) The Southampton General Hospital, one of the major teaching units in the country, may well lose its training recognition because of the loss of elective work to ISTCs.

(f) ISTCs could train as long as the surgeons employed by ISTCs are qualified to train. At present, most are trained overseas and their ability to train is not known.

8. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

(a) The appointment procedures in ISTCs do not match those required of the appointment of an NHS consultant where there is a Statutory Appointment Committee which includes a representative of a Royal College of Surgeons whose role is to assess the training of the surgeon and judge if it is appropriate for the position. This is a time-proven excellent method.

(b) There have been numerous examples of surgeons being appointed who are not trained for the job. The Verita inquiry into the early revision of hip prostheses at Portsmouth is a clear example of this.

(c) The BOA has received reports of the consequences of poor appointment procedures into the Nuffield G Supp work in Cambridge, Cheltenham and Leeds.

(d) When surgeons are appointed to ISTCs, the BOA believe the standards should be the same as for an NHS hospital. This would give the quality assurance that patients deserve.

9. Are ISTCs providing care of the same or higher standard as that provided by the NHS?

(a) The evidence available to the BOA is that they are not in Orthopaedic Surgery.

(b) The results of joint implants cannot be judged on the results of a questionnaire about hospital comforts. It is judged on acute complications and the need for early revision of the implant. It is expected that 80% of implants should last 10 years. A revision at 2–3 years is a failure and is probably due to a faulty prosthesis or deficient surgeon. Early dislocations occur in NHS hospitals and there is an expected number. It is an incidence falling outside the norm which should turn on a red light. It is thus important to compare the results of an ISTC with an NHS hospital, based on matched patients. The BOA, in a meeting with the then Deputy Chief Medical Officer, Professor Halligan, recommended this approach but to our knowledge this was never carried out. Correspondence has taken place since then but we are not aware of any such audit.

(c) NHS orthopaedic surgeons continue to have grave concerns about the standard of surgery. There are many anecdotal stories of overseas surgeons inserting unfamiliar prostheses, not cementing those designed to be cemented etc. There are about 200 different femoral prostheses on the world market, each having its own peculiarities. Surgeons from abroad most probably use different hip
and knee prostheses from those in common use in the UK. ISTCs generally contract for a limited range of prostheses, which is cost-driven. There is a learning curve for each surgeon with each brand of prosthesis.

(d) The National Joint Registry is in its infancy but should eventually have the tools to compare the short term results of prostheses, hospitals and surgeons provided everyone feeds the information into it. We are told by Sir Nigel Crisp that all contracts with ISTCs make this reporting compulsory. However we are told that there is no way of checking that this is happening.

(e) It is not possible to get information from the ISTCs. The number done is kept confidential and there is no obvious way of tracking the patients operated on there. They go to their local NHS hospitals with their complications and are admitted under the consultant there. Even if they were admitted to the ISTC, the surgeon who did their operation may have gone home by this time.

(f) Eventually this information will become apparent but it would be better if patients were not subject to these complications in the first place.

(g) All work undertaken in the Independent NHS-funded institutions needs to be carefully audited. All NHS orthopaedic surgeons would welcome a commitment by the Department of Health to fund audit of their work as well.

(h) The BOA has submitted to the DH two dossiers containing lists of problems encountered in Independent-funded NHS patients. These have been investigated by the DH but the response has not done anything to prevent further problems. It is very difficult for surgeons to report cases due to patient confidentiality problems, reluctance of some Trusts to allow their surgeons to report the complications they see coming from ISTCs, and the time involved to gather all the information. Most surgeons just get on and sort the problem, feeling sorry for the way the patient has been treated.

(i) The BOA is not stating that all surgery done in an ISTC is bad, nor is it stating that all surgery done in an NHS hospital is perfect. It is only through proper audit that the beliefs of the surgeons can be proven. The problems should surface eventually.

(j) Stand-alone Orthopaedic hospitals were shut down during the 1990s because they did not have the medical and ITU backup. ISTCs have flourished in an environment previously thought unsafe.

11. What changes should the Government make to its policy towards ISTCs in the light of experience to date?

(a) Implement a rigorous medical staff appointment mechanism.

(b) ISTCs should fund rigorous audit as part of their contract. Audit should be scrutinised by a national surgical professional body.

(c) ISTCs should contract to take care of all adverse consequences arising from the surgery for a period of 5 years in Orthopaedics.

(d) ISTCs should not be contracted to cherry pick. If they feel it is unsafe to do the surgery, they should pay the NHS hospital the appropriate rate to deal with the complication. This should be formalised and enforced.

Prior to submission of this document, we did a last-minute survey of our members with specific reference to question 5, relating to adverse effects of ISTCs. In three days we received over 120 comments, many lengthy, expressing discontent. Fewer than 5 responders reported no evidence of adverse effects.

Ian J Leslie FRCS
President
British Orthopaedic Association
13 February 2006

Evidence submitted by BUPA Hospitals (ISTC 23)

SUMMARY

1. BUPA opened the first independent sector Diagnostic and Treatment Centre (BUPA Redwood Hospital) in 2003. This centre was the prototype for the subsequent Independent Sector Treatment Centre programme. The NHS funds all the operations at the Centre, which has completed over 35,000 cases for the local NHS. As a result, the Centre has provided better access and more capacity to the NHS and waiting times have fallen dramatically. Patient satisfaction is very high and clinical outcomes are good. BUPA recommends that the Government extends its use of independent sector treatment centres to increase capacity, choice and quality for NHS patients.
ABOUT BUPA HOSPITALS

2. BUPA Hospitals (BHL), which forms part of the BUPA Group, operates 26 independent hospitals in the UK, providing services to privately-insured and self-pay patients and to the NHS. In 2005, BHL treated 200,000 in-patients and day cases, of which 29,000 (14%) were NHS-funded patients, and 640,000 out-patients of whom 26,000 (4%) were NHS patients. These patients provide data for a range of patient-related outcome measures, as outlined later in this submission (see paragraph 25).

BACKGROUND

3. In this submission, BHL provides evidence based on our experience with BUPA Redwood Hospital, which was the first Treatment Centre to provide care in an independent sector unit exclusively for NHS-funded patients. In December 2002, with the agreement of the Department of Health, BUPA entered into a five-year contract with the Surrey and Sussex Healthcare NHS Trust (SASH) to provide both inpatient and day case care in orthopaedics, gynaecology, general surgery and diagnostic endoscopy at Redwood. The Centre is exclusively used for NHS patients and has made a significant contribution to reducing waiting times locally which are now at their lowest recorded level.\(^{19}\)

4. Redwood provides a dedicated elective care facility—this means that planned treatment is not disrupted by the unpredictable needs of emergency and complex acute patients. As a result, the number of cancellations of routine operations has been dramatically reduced from 149 a quarter to 67.\(^{20}\) Consultant medical staff at Redwood continue to be employed by SASH but use the Centre for the majority of their routine elective patients. The regime enables the consultants to access the best of both facilities and so each consultant has been able to treat more patients in the course of a year. Consultant satisfaction with Redwood is extremely good with 72% rating the service as “very good” or “excellent”.

5. Non-medical staffing for Redwood is shared between BUPA and SASH. BUPA provides the management, including a general manager, matron and marketing team. The majority of the nursing and support staff are employed by BUPA, but from the outset around 25 staff transferred from the NHS under a structured secondment agreement. BUPA and NHS staff now work alongside one another, wearing the same uniforms and under the same management. As with consultant satisfaction, staff satisfaction survey at Redwood is also very high.

6. Since 2002 the range of services offered at BUPA Redwood has increased so that the NHS and BUPA ensure maximum patient benefit. Redwood recently treated its 35,000th NHS patient. Redwood is also providing a service for 40 breast care patients a month, including those with breast cancer. By taking on more work, Redwood is helping to dramatically lower NHS waiting times, with particular success in helping the Trust to achieve a two week maximum waiting list in endoscopy for patients suspected of having cancer.

RESPONSES TO HEALTH SELECT COMMITTEE QUESTIONS

1. What is the main function of ISTCs?

7. The aims of an ISTC are twofold: to add capacity to the NHS and to provide high-quality, innovative services. By adding this capacity ISTCs are able to fulfil their main function, which is to help reduce waiting times for NHS patients. By enabling the NHS to shorten waiting lists, ISTCs are helping NHS Trusts to provide services when they are needed. By treating NHS patients, paid for through contracts with the NHS rather than through private means, ISTCs are helping the NHS to achieve its objective of making comprehensive health services available to all, when they are needed, free at the point of use.

8. Independent sector companies can also add capacity to a local health economy rapidly by building new ISTC facilities or by refurbishing existing premises. Timescales for bringing independent facilities into use are typically faster than for equivalent NHS schemes.

9. ISTCs provide examples of best practice in customer service and operational efficiency. Patient satisfaction at Redwood is very high: 87% of patients in a recent survey rated their care as either “excellent” or “very good”. The quality of care has also been improved by implementing generic care pathways working in collaboration with the health professionals. These pathways clearly define the course of a patient’s treatment and allow audits so we can reduce variations in care. For example, at Redwood, the length of stay for a routine hip replacement could be up to five days but now some patients are discharged as early as day two and given additional rehabilitation from a care team. The Centre also innovates by using patient diaries to check that their treatment follows the approved care pathway.

19 On 31 December 2005, there were 4,501 patients on the Surrey and Sussex NHS Trust’s inpatient waiting list, none of whom had waited more than six months. This compares with 7,309 patients at the end of 2002, just before the Centre opened, of whom 2,000 had waited over six months. See also http://www.performance.doh.gov.uk/waitingtimes/2002/q3/kh07—u—rtp.html
2. What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

10. BUPA Redwood has treated 35,000 NHS patients in Surrey and Sussex, so adding to the capacity of the local health economy. It also provides another choice for patients who need treatment for one of the conditions that the NHS has commissioned under the contract. The management of the Centre has stimulated innovation by working with health professionals to streamline the process of care and so improve patient satisfaction. The Centre originally treated about 7,000 patients a year, but has increased its throughput to around 12,000 patients a year and is now planning to increase this to 14,000 in 2006. The Centre has also improved theatre utilisation, while meeting high clinical governance standards.

11. A 2005 London School of Economics study examined the utilisation of operating theatres and using the example of BUPA Redwood found starkly different levels of utilisation between Redwood and the NHS average. Measuring three types of utilisation figures and then calculating an overall score, the study compared the targets set by the Audit Commission in 2003 and results from BUPA Redwood. The overall target for theatre utilisation was 77%. The NHS overall result was only 56.9%. BUPA Redwood, which scored higher than the NHS in every section, had an overall score of 81%, above even the Audit Commission’s optimistic target.

3. What contribution have ISTCs made to the reduction of waiting times and waiting lists?

12. The experience of BUPA Redwood shows that its use has helped to drastically lower waiting lists in the Surrey and Sussex Healthcare NHS Trust. This has been particularly successful in helping the Trust to achieve a two week maximum waiting list in endoscopy for patients suspected of having cancer. As noted above, the Trust’s overall waiting lists have also gone down by over a third and in orthopaedics by over 40%. All of these patients are now treated within six months of being put on the list. This significantly reduces the potential pain and the worsening of their condition that patients experience while they are on waiting lists.

13. More broadly, ISTCs contribute to a more modern and appropriate balance between emergency and elective care. As Hensher and Edwards put it: “the implicit assumption that elective cases are less urgent than emergency cases (and hence can wait) can produce perverse outcomes, whereby patients with urgent surgical needs are forced to wait for care while people with health emergencies are admitted to hospital when they could have been cared for elsewhere.” The ISTC programme is helping to reduce these perverse outcomes. Another aspect of waiting is the time taken to travel to an acute centre. As Healy and McKee said: “… ambulatory care centres can be more dispersed than acute hospitals and thus improve population access to care”.25

4. Are ISTCs providing value for money?

14. BUPA has no data on this for other Centres but in the case of Redwood we are providing services at prices broadly equivalent to the local NHS tariff. The tariff at Redwood is competitive with the local NHS tariff, although exact comparisons are difficult as some of the services (such as medical staff) are shared. As the quality of the service we provide is enhanced by lower waiting times and increased patient satisfaction, we suggest that the Centre increases value for money for taxpayers.

15. While there has been no comprehensive or independent evaluation of Treatment Centres—many of which have not been operating long enough to collect sufficient data—we can demonstrate lower waiting times, good clinical outcomes and enhanced patient satisfaction at Redwood because it has been operating for three years. As the Committee has previously noted, this period of time is the minimum that an organisation would need to gain and be able to display the benefits of a reorganisation.

5. Does the operation of ISTCs have an adverse effect on NHS services in their areas?

16. The operation of ISTCs has a beneficial effect on NHS services in the area because it provides an additional channel through which to send patients for routine operations, so freeing up resources in local NHS hospitals for emergency patients. This helps to prevent the pressure of emergency admissions leading to cancelled operations and so pushing waiting times up. This policy of “streaming” has been advocated by, among others, NHS Scotland’s Elective Care Action Team, who found that: “streaming of scheduled care will undoubtedly provide significant improvement in a range of key outcome indicators, for example, a predictable and increased workflow, reduction in cancellations, value for money, improved recruitment and retention, and importantly, reduced waiting times for patients.”26 They also found that 89% of elective care by volume requires a critical care stay in less than 1% of cases. In other words, the vast majority of operations do not usually need the back-up of a critical care unit.

21 Anastasiou, A. Examining Utilization of Operating Theatres: the example of Redwood Diagnostic and Treatment Centre A dissertation for the MSc Health Policy Degree, London School of Economics (November 2005) (Passed with merit).
17. This separation of planned from emergency surgery is in line with international best practice.27 As the London NHS Modernisation Board put it: “with its work insulated from emergency pressures, the DTC can serve as a reliable and dedicated high volume service which can safely, quickly and conveniently provide routine diagnosis and elective surgery, and the patient can be guaranteed that they will be treated.”28 It means that the less-complex cases are treated rapidly using appropriate facilities in Treatment Centres and so the more complex cases and emergencies can be treated using the full range of facilities available in a General Hospital. As Prof Sir Ara Darzi, National Advisor on surgery said in April 2002: “Diagnostic treatment centres will make a difference. They . . . are one of the exciting, novel solutions that will contribute to taking the NHS forward.” This has proved to be the case in the subsequent few years. The Audit Commission also said in 2002 that the number of day surgery cases could be increased by around 120,000 a year and that 85% of operations could be undertaken as day cases. ISTCs are helping to meet this objective.

18. Treatment Centres typically undertake a relatively narrow range of elective surgery procedures using a small dedicated team of staff. This enables the clinical and operational processes to be optimised to deliver high levels of utilisation and strong clinical outcomes. When this is also combined with a customer centric approach, financial targets can be met. These results can be transferable to other areas of the NHS. For example, BUPA Hospitals has recently been asked to lend its management expertise to another unit in Surrey so as to help achieve the same productivity and patient satisfaction improvements as at Redwood.

6. What arrangements are made for patient follow-up and the management of complications?

19. BUPA Redwood is fully integrated into the local NHS system. Patients are booked for follow-up in the local NHS Trust and contract arrangements stipulate how any complications are to be managed. In practice, the level of complications and unexpected transfers back to NHS facilities is very low. This reflects the appropriate selection of lower risk patients to undergo treatment at the Centre. A survey across a large sample of the independent sector (not just Treatment Centres) showed that in 2004 only 0.2% of discharges were transfers out to the NHS29.

20. Part of the service re-design is to provide more concentrated care and to focus on preventing complications. For example, intensive weekend physiotherapy is available which means that patients recover more quickly and are able to go home sooner. BUPA uses its experience to evaluate outcomes continuously and to make improvements. For example, we are introducing new technology to reduce the risk of deep-vein thrombosis in knee and hip surgery.

7. What role have ISTCs played and should they play in training medical staff?

21. ISTCs should be involved in the provision of medical staff training, and funding should be made available to facilitate this as it is for NHS Trusts. Redwood provides a progressive environment for training and developing medical, nursing and other health professional staff. Junior doctors employed by the NHS work in the Centre in an approved training environment. Training standards for other staff are high, as noted in the recent Healthcare Commission inspection report on Redwood which says, “Any staff with specialist roles receive relevant training in their specialist area . . . Arrangements for the training and assessment of adaptation students are robust.”30

22. ISTCs can also provide an environment for training nurses and other health professionals in innovative techniques. For example, they can be used to train nurses to carry out endoscopies, so economising on the skills of surgeons and providing more capacity to treat patients. Nurse-led gastrointestinal endoscopy is said to be a priority clinical area in the UK and there is evidence that nurses can be trained to provide it.31

8. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

23. BUPA believes that they are. NHS consultants who work at Redwood have undergone the NHS appointment procedures. In addition, NHS staff have to undergo further checks on their suitability when they work in independent sector facilities as these are registered and inspected by the Healthcare Commission under the Care Standards Act 2000. For example, the Commission requires medical staff to pass a Criminal Records Bureau check before they can work in an independent hospital.

28 www.london.nhs.uk/modernising/dtc.htm
30 see http://www.healthcarecommission.org.uk/assetRoot/04/02/22/79/04022279.pdf
31 Kneebone, R L, Nestel, D, Moorby, K, Taylor, P, Bann, S, Munz, Y & Darzi, A (2003) Learning the skills of flexible sigmoidoscopy—the wider perspective. Medical Education 37 (s1), 50–58. doi: 10.1046/j.1365-2923.37.s1.2.x
9. Are ISTCs providing care of the same or higher standard as that provided by the NHS?

24. At present, there is no objective way of comparing the performance of ISTCs with similar NHS units. All ISTCs have to submit regular data on a range of Key Performance Indicators to the Department. If the same regime applied to NHS providers then a more meaningful comparison would become possible.

25. In addition to collecting data on the range of indicators which the Department requires ISTCs to collect, such as re-admissions to hospital and infection rates, we also collect patient reported outcome measures (PROMs) and feed them back to the specialties working at the hospital. This, together with our clinical governance processes, encourages continuous quality improvement. The use of agreed clinical pathways enables audit of care and there is careful scrutiny of clinical data through Medical Advisory Committees in all BUPA hospitals. The BUPA Board also has an independent Medical Advisory Panel to which the group medical director and BUPA Hospitals director of clinical services are professionally accountable.

26. The facilities of independent hospitals, including Treatment Centres, are subject to stricter registration and inspection requirements than the NHS. The Healthcare Commission has a duty under the Care Standards Act to register premises and so a Treatment Centre cannot open until it is approved by the Commission. The Act also requires the Commission to inspect the Centre at least annually against National Minimum Standards. Reports on the hospital’s achievement of standards are posted on the Commission’s website. The Commission can issue an Improvement Notice if any Standard is not met and has powers to close an independent hospital, and to impose penalties including fining or imprisoning its management. None of these provisions apply to NHS hospitals, which can operate without passing registration tests and do not have to meet legally enforceable minimum standards. They cannot be closed down by the Commission.

27. All these provisions help to ensure that ISTCs provide a high quality of service. In terms of patient satisfaction, the evidence of a range of surveys is that independent providers of NHS-funded care score very highly. As noted, Redwood’s latest patient satisfaction scores show 87% of patients rating their care as excellent or very good.

10. What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

28. Due to the competitive nature of NHS procurement of ISTCs and other independent hospital services, a small range of issues are subject to commercial confidentiality. Unless this confidentiality is maintained, the benefits of competitive tender will not continue to be available to the taxpayer. Under the contracts, independent hospitals and Treatment Centres are however fully accountable to the NHS and the Department of Health. With respect to Redwood, the contract was subject to a rigorous affordability scrutiny involving external review by the Department of Health’s advisors.

11. What changes should the Government make to its policy towards ISTCs in the light of experience to date?

29. As noted above, the inspection regime for independent hospitals is more onerous and so the Government should align quality standards for the NHS with the tighter legal requirements it has placed on the independent sector. This would create a ‘level playing-field’ of standards and would help to assure quality. This in turn would help to provide the level of access to care in a plural market of providers which patients enjoy in other countries. It would also allow for the results of inspections to be compared fairly so that patients would be able to make an informed choice of provider.

30. We believe the Redwood model is a successful one and so the Government should use it as the basis of expanding the ISTC programme to bring the benefits to a wider pool of NHS patients.

12. What criteria should be used in evaluating the bids for the Second Wave of ISTCs?

31. These criteria are for the Department of Health and the NHS to decide but we would suggest that they include:

- providing increased access;
- facilitating patient choice;
- shortening waiting times for patients;
- providing value for money;
- evidence of achieving partnership working with the NHS;
- improved patient satisfaction; and
- high-quality clinical outcomes.

32 see footnote 26 above.
13. What factors have been and should be taken into account when deciding the location of ISTCs?

32. This is a matter for national, regional and local planning in the NHS. BUPA has consistently argued for national capacity planning so that investors can have an outline idea of how much work the NHS will procure over, say, the next five years. At regional (SHA) level, independent providers should be fully included in discussions on capacity planning. Locally, the future is for independent providers to integrate themselves seamlessly into the pattern of local health services.

14. How many ISTCs should there be?

33. As with question 13 this is a matter for NHS planning to meet need within available resources and so there is no simple answer. However, the use of additional capacity from the private sector has been found to have the advantages of speed and of providing competition for public providers in a number of countries including Spain, Denmark, Australia, Sweden, Ireland and New Zealand. This suggests that the Government should continue to consider the merits of using independent sector capacity to meet demand.

RECOMMENDATIONS

34. BUPA recommends that the Government considers the following actions:

— Involving independent sector providers fully in national, regional and local capacity planning, so that the sector can play its full part in helping achieve NHS objectives.
— Aligning the regulation of healthcare quality inspection so that all providers—whether statutory or independent—adhere to the same standards.
— Requiring NHS providers to submit an agreed minimum data set to the Department of Health to enable appropriate comparisons to be made between ISTC and NHS performance.
— Adopting the “Redwood model” for treatment centres more widely by replicating the model of working in close collaboration with the NHS and using a combination of both NHS and BUPA staff in more locations.

CONCLUSION

35. BUPA has invited members of the Committee to visit BUPA Redwood, as we feel that is the best form of evidence we can present. Alternatively, we are willing to give oral evidence to a hearing of the Committee, if that would be helpful. We are particularly keen to demonstrate the value of treatment in independent centres on the basis of our experience as we feel this is highly relevant to a fair appraisal of the formal ISTC programme.

Clare Hollingsworth
Managing Director, BUPA Hospitals Ltd
13 February 2006

Evidence submitted by Capio Healthcare UK (ISTC 35)

1. INTRODUCTION

1.1 The UK is behind most western countries in its debate on the value of the independent sector in the provision of publicly funded healthcare services. The vast majority have already accepted that the independent sector can provide a high quality of service and good value for money. The two main political parties now agree that the independent sector can drive NHS reform. The challenge is not whether we should do it, but how we should do it in a way that accelerates the advantages to patients while causing the least disruption to staff and managers in the NHS. Much of this, as always, is about leadership and communication and we believe that by working together with local NHS teams, we can help to introduce the additional services in a more acceptable way.

1.2 The ISTC programme was introduced to create immediate capacity to reduce waiting times. In the longer term, the Government also constructed it to create sufficient capacity to enable choice and competition between providers. This, together with other reforms in financial flows and patient empowerment, has enabled a change in the dynamics of the NHS towards the welfare of patients rather than the hospital buildings and the organisations that run them.

1.3 Much of the resistance to the independent sector is based on misunderstandings and fears of job security. Not on the evidence of consequences for patients. Some who oppose the ISTC agenda claim that the independent sector (IS) cannot put patients or clinical quality first. However a system of robust

accountability, based on time-limited contracts with tough clinical Key Performance Indicators (KPIs) (tougher than those applied to the rest of the NHS) will focus the mind on clinical quality and patient care. We recommend that the indicators used for the IS should be rolled out across the NHS. This will inform patients when both sets are published.

1.4 ISTCs are important partners of the NHS. Capio already facilitates the trains NHS nurses and physiotherapists and will shortly start to facilitate the training of NHS doctors. ISTCs do not cherry-pick patients—the types of procedures the ISTCs are contracted to perform are decided by the local PCT(s). ISTCs provide high-quality and high-efficiency operating units for patients who would otherwise experience damaging delays. This in turn allows NHS hospitals to concentrate on more difficult cases.

1.5 ISTCs are stopping suffering and improving quality of life for thousands of NHS patients every year. Patients give consistently high approval ratings for the care they receive.

1.6 Capio would be happy to arrange for the members of the Health Select Committee to visit any of its ISTCs.

2. Capio Healthcare UK

2.1 Capio is a progressive company with a commitment to fair employment and has five board members who are trade union representatives. We provide healthcare in Sweden, Norway, Denmark, France, Finland, Spain and the UK. Across Europe, 90% of the patients Capio treats are publicly funded. Capio Healthcare UK is the fourth largest provider of independent healthcare services. Before the ISTC programme, Capio had 21 acute units throughout England, plus six mental health units (providing adult, child and adolescent services), two neurological units and a dedicated eye clinic. All continue to treat NHS patients under national and local arrangements.

2.2 Capio shares the values of the NHS, and wants a long term partnership. The company believes its contribution to treating NHS patients is helping to grow a publicly funded health service, not undermine it.

2.3 Capio has a contract with the NHS to establish ten ISTCs across England, from Cornwall to Northumberland. Six of the centres are newly constructed—two are on existing NHS estates and four are new builds in innovative locations, chosen to fit with the requirements of the local Healthcare Community and to improve patient access as pragmatically as possible. Of the remaining Capio ISTCs; two are facilities within existing NHS hospitals, and two are within existing Capio hospitals. Approximately 95,000 NHS patients will be cared for at our centres over the five year contract (until 31 March 2010). The value of the contract is £300 million. A previous Capio contract (G Supp) to treat 13,600 patients (worth £23.9 million) has been successfully completed.

3. Purpose of ISTCs

Capacity

3.1 ISTCs increase capacity and drive down waiting times. Since April 2004, Capio has treated 5,084 people who were languishing on local Trusts’ waiting lists. ISTCs are designed to undertake a high throughput of routine elective surgery. Traditionally waiting times have been highest for these types of procedures because they are often cancelled and delayed in larger acute hospitals due to the priority given to other conditions. Separating elective and emergency work in this way creates greater efficiency and reduces delays and cancellations which may cause the patient’s condition to deteriorate to a degree which makes eventual surgery more difficult. The economic advantages of this extend to the community as well as to the individual as they are able to return to normal life quicker and require less additional care.

Choice

3.2 The least well-off are nearly one-third more likely to need a hip replacement than the best-off—but they are one-fifth less likely actually to get it. ISTCs have provided all patients, independent of wealth or background, with additional choices on where and when they are treated.

Competition

3.3 Many of Capio’s ISTCs have developed strong partnerships with local NHS organisations. Two of Capio’s ISTCs are actually within existing NHS facilities. However, the Government has also made clear that the ISTC programme is only one of a number of tools to improve efficiency and choice in the NHS and to create a truly patient focused health service.

34 Patricia Hewitt speech to London School of Economics (13/12/05).
**Improving services and Innovation**

3.4 The efficiencies provided through the ISTC model reduce waiting lists and improve taxpayer value for money. They also allow new practices to be embedded in NHS practice. Capio ISTCs are undertaking operations on a day case basis which many parts of the NHS still provide as in-patient care. This helps to deliver the Audit Commission recommendation of increasing NHS day case and ambulatory care.

3.5 Capio has adopted an innovative design for its newly built ISTCs. These are built in a horseshoe shape, with the patients moving through the building in one direction. The continuous flow avoids any need for patients to retrace their steps and helps to reduce the spread of infection. Design features include separate entrances and exits not only for patients but for equipment and materials going in and out of theatre. Capio ISTCs currently have extremely low rates of hospital acquired infection.

3.6 Capio ISTCs have developed many innovative new methods of care. These innovations are of course more likely to transfer to the NHS, where we are allowed to work with NHS doctors on secondment. The Boston NHS Treatment Centre has pioneered “See and Treat”. The ISTC is based in a rural community, so asking patients to visit for an outpatient appointment and then making them return later for an operation (as is usual in the NHS) was inconvenient. Patients coming for minor surgery are now referred for a 45 minute appointment in which they are seen and assessed by their clinician and then receive treatment, if necessary, during the same visit.

4. **Impact of ISTCs**

*Adverse effects*

4.1 ISTCs are part of the NHS family, holding contracts with local NHS organisations on the basis of local delivery plans to tackle capacity gaps in local service provision. The arrival of an ISTC may require some change to local service provision, but Capio’s aim is always to complement and add to the sum of local NHS services rather than undermine it. Capio has worked hard to develop strong local partnerships and to integrate as part of the local health economy. Where there has been stronger local leadership, the introduction of ISTCs has produced a better result for patients and NHS trusts alike. Where the local leadership has shown resistance to national policy, there are sometimes unnecessary obstacles to close and effective working.

*Value for money*

4.2 ISTCs provide good value for money. Capio’s ISTC contract is at a slightly higher tariff than the NHS but includes costs for building a number of ISTCs and recruiting clinical staff from overseas. This price is still lower than many NHS providers who operate significantly at above NHS tariff without the requirement to build new facilities or recruit new staff from overseas. The tariff will also taper off over the period of the contract.

4.3 There is concern that NHS hospitals are losing out financially for taking on more difficult cases. This should not happen as tariffs should be higher for more resource intensive cases.

4.4 Capio is accredited to provide NHS care at tariff price in a number of its existing independent hospitals through Choose and Book.

*Waiting times*

4.5 The current average waiting times from referral to a Capio ISTC is 29 days. This means patients are, for example, walking and seeing more quickly than they otherwise would. The Capio ISTCs have already seen 5,084 inpatients and 10,344 outpatients, and once all the centres have opened across the country Capio will be treating 19,000 NHS patients per year in its ISTCs. This means 95,000 less patients waiting in pain and disability for a routine operation.

*Post-operative follow-up care*

4.6 Capio always prefers to provide all post operative care. However, the post operative follow-up actually given reflects what the local PCT(s) requested, as specified in each ISTC contract. In some cases Capio provides full follow-up services and in others the patients transfer back into the hands of NHS providers.

4.7 All patients receive a follow-up call from the ISTC 72 hours after discharge.

4.8 Capio has an extremely low rate of complication and hospital re-admission—0.08%. However, where complications occur, Capio is contracted to take full responsibility of these cases. Every Capio ISTC operates a helpline service which all patients are invited to call after discharge if they experience any problems. This service is manned by an experienced nurse, supported by an anaesthetist and surgeon for advice. If triaged as a non urgent problem, the patient is requested to come back to the ISTC as soon as possible.
4.9 Any necessary treatment is given by the ISTC. If it is considered that the required treatment is not appropriate at that ISTC, then arrangements are made to admit the patient to an appropriate facility. All ISTCs have a formal arrangement with their local NHS trusts and have clinician to clinician dialogue to support this so as to minimize risk and inconvenience to patients. Where a patient requires care for a complication in an NHS trust, the cost is covered by Capio.

Standards

4.10 Capio aims for the highest standards, whether this relates to clinical outcomes, cleanliness or customer service, and strives to be the best healthcare provider in this country. Capio ISTCs are modern sites designed explicitly to provide the right environment for fast through-put, cost effective care with low infection rates. Our patients appreciate the simple advantages of using our ISTCs such as free car parking and, where overnight stay is required, private or double inpatient rooms. Capio is proud of its performance and standards, but is not complacent. It measures and monitors its performance, allowing it to strive continuously for improvement.

4.11 As part of the ISTC contract, Capio is required to report to the Department of Health on a number of KPIs, including clinical. There is no comparable requirement in the NHS. A report published by the National Centre for Health Outcomes Development (NCHOD) in November 2005 assessed the outcomes of these KPIs and found that the volume and quality of data collected by ISTCs is innovative, challenging and vigorous.

4.12 The NCHOD found that Capio had performed within expectations for all relevant KPIs and demonstrated high performance. For example, cancellations for non-clinical reasons were extremely rare (only 3 out of nearly 13,000 admissions). There were also no incidents for the following KPIs: complaints handled outside agreed timescale, reportable incidents, NHS staff recruited in breach of Clause 9, security breaches, confidentiality breaches and failure to meet treat-by date.35

4.13 Our high standards of cleanliness36 help to give us a very low rate of infection and help to keep our patients healthy and safe.

4.14 Capio has commissioned an independent organisation to manage a patient satisfaction survey at each of the ISTCs. Feedback has been extremely positive—with our ISTCs scoring an average of 9.5 out of 10.

Training

4.15 Capio understands that removing volumes of elective surgery from teaching hospitals to ISTCs may restrict the procedures available for the training of junior doctors in those teaching hospitals. This does not mean that the ISTCs inhibit training, but rather that training needs to catch up with the new locations of surgery. Capio already facilitates the training of NHS nurses and physiotherapists in some of its hospitals. It is also very close to signing a contract to facilitate the training of junior doctors in one of its ISTCs, and hopes that similar arrangements can be made in others. Training doctors inevitably results in a lower through-put of cases in a facility, and therefore raises cost per case. ISTCs, like the NHS, will need to be reimbursed for the additional expense of training.

Recruitment

4.16 Doctors working for Capio must be fully registered with the GMC and also be on the appropriate specialist register. Capio’s ISTC recruitment procedure uses Department of Health requirements for the contracts as a base line. Our own recruitment process for medical staff from abroad includes language tests, police checks, qualification and reference verification, health assessment and, if applicable, work permit confirmation. The Capio interview panel ensures the physician’s experience and technical capability is of the highest standard. In addition, new recruits are monitored to ensure they are performing to the standards required.

4.17 Capio recognizes that currently the registration requirements are necessarily more demanding for ISTC doctors, than their NHS equivalents. Capio expects an early leveling of the playing field as the public and medical profession recognise the high quality of clinical care, and in particular surgery, carried out in an ISTC.

4.18 As the ISTC programme grows it will become even more important for the statutory national regulatory bodies to manage the significantly increasing demand for clinical registration. At present, not only is the delay in achieving clinical registration for overseas clinicians unreasonably long (and some regulatory bodies are worse than others), mainly because the regulatory bodies have not adjusted their

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35 Preliminary Overview Report For Schemes GSUP1C, OC123, LP4 and LP5, National Centre for Health Outcomes Development (NCHOD), November 2005.

36 A Snapshot of hospital cleanliness in England, Healthcare Commission (21/12/05). Four Capio hospitals were inspected scoring an average of 92.3 out of 100.
processes to address the changing market place, but the process is frustratingly opaque. The regulatory bodies would do well to work cooperatively with the IS on this issue, as all stakeholders have a real and enduring interest in the provision of safe clinical services.

5. **THE CONTRACT**

Commercial confidentiality

5.1 Capio has published the financial value of its ISTC contract, the volumes and procedures to be provided. In addition, transparency of clinical performance is a vital part of the ISTC programme, and if patients are to make informed choices, it is vital that all providers of NHS services are transparent. As part of the ISTC contract, Capio is required to report to the Department of Health on a number of key performance indicators (KPIs). These KPIs, published in the NCHOD report, are more demanding than any data the Government requires NHS hospitals to collect and publish.

*Potential ways to improve the contracts*

5.2 The additionality rules contained in the first wave of ISTCs have been successful in bringing additional doctors to work in the NHS. We believe that these rules should now be relaxed to allow free movement of staff between providers, as is allowed in any other area of work. There are very few consultants who work purely in the IS, and the rules have forced Capio to deny employment to a number of UK clinicians who have wanted to treat NHS patients in this way.

5.3 Rigid separation of the NHS and ISTC workforces makes it more difficult to share and spread best practice and innovation. Patients will benefit from the movement of staff between the NHS and ISTCs. In particular the ability of ISTCs to deliver safe, high volume elective surgery—more a patient and clinician management process than narrow surgical skills—could transform the clinical productivity currently achieved in the NHS.

5.4 Utilisation of the excellent clinical facilities in ISTCs to facilitate the training of junior doctors, in particular, would also improve the quality of the skills acquired, and expose young doctors and nurses to innovative clinical and patient management processes. Again the benefits to the NHS and patient care would be very significant.

5.5 Capio would also recommend that the Government seeks earlier local involvement in contract discussions between ISTC bidders and PCTs or other NHS partners. Originally these delays were instituted to avoid putting the procurement process at risk but we believe that the Department of Health has recognised this and intends to act upon it.

5.6 Finally we feel that in some parts of the NHS, greater support and commercial training should be given to local teams negotiating and implementing the ISTC contracts. These contracts are legally binding and differ from the “NHS contracts” which most of the NHS is used to working with, which are not legally enforceable.

*Second Wave ISTCs*

5.7 Capio believes that the criteria for evaluation should include:

- Clinical quality.
- Value for money.
- Speed of access.
- A record of successful delivery for the NHS.
- Customer service.
- Flexibility and reliability.
- Adherence to NHS values and public sector partnership.

*Location and Quantity of ISTCs*

5.8 It is impossible to answer this point without collecting together the NHS capacity planning data. However, there is a clear role for ISTCs where additional capacity is needed, either to reduce waiting lists or to provide choice where this is lacking.

5.9 ISTCs should be easily accessible and convenient for patients. Partnerships should explore co-location with other services such as pharmacy, social care, primary care and other acute facilities. However, there are also other important considerations affecting location such as:

- Availability and cost of sites.
- Local Government consent and guidelines (eg building on brownfield and greenfield sites).
— Closeness to NHS sites.
— Transport links.

5.10 It may be of interest to the Committee that the programme is developing life and momentum of its own, away from the nationally driven exercises. Capio has been approached by PCTs and Trusts for information on the value of IS providers to NHS patients.

Capio Healthcare UK
13 February 2006

Evidence submitted by the Chartered Society of Physiotherapy (ISTC 7)

INTRODUCTION

1. The Chartered Society of Physiotherapy (CSP) is the professional, education and trade union body representing the UK’s 47,000 physiotherapists, physiotherapy students and assistants. More than 98% of all physiotherapists in the UK are members of the CSP and physiotherapy is the third largest health care profession. Approximately 60% of chartered physiotherapists work in the NHS. The remainder are in education (including students), independent practice, the voluntary sector and with other employers, such as sports clubs or large businesses.

2. The CSP welcomes the opportunity to submit to the inquiry into independent sector treatment centres as a significant proportion of our members either work for one or work in an area which is served by one.

3. In response to this inquiry, we have asked our members to assess what impact ISTCs have had on their workload, their patients’ experiences and pathways and any other issues which they wished us to raise with the Committee.

4. The majority of them reported that they could not yet give a clear indication of the impact that they have made as they are relatively recent innovations and that there has been so much other change taking place concurrently. The submission, therefore, relies primarily on a small number of cases where some impact has been detected as well as our policy as a national body.

What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

5. The first wave of ISTCs were subject to the rule of additionality (ie staff were recruited from either overseas or from staff who were not currently in the NHS or who had not worked for the NHS in the previous six months) and so were able to increase capacity to some extent. The CSP is concerned that, with this rule not applying to the second wave, that the NHS will lose staff to the independent sector which will hinder the NHS’s ability to innovate. We have no evidence that demonstrates that the ISTCs are innovating more and offering better choices to patients than the NHS treatment centres. There is also some anecdotal evidence to suggest that NHS treatment centres are working more closely with the rest of the local health economy which would have a positive impact on patient pathways and innovative working.

What contribution have ISTCs made to the reduction of waiting times and waiting lists?

6. The CSP acknowledges that there were particular problems in terms of waiting times for some elective surgical procedures and that ISTCs and NHS treatment centres have had a role in bringing them down. However, we have reports from members stating that waiting times for physiotherapy in primary care has increased due to patients requesting that rehabilitation takes place more locally to them than ISTCs or the acute trusts can offer.

Are ISTCs providing value for money?

7. The CSP believes that it is not possible to judge this question as, unlike the NHS, the ISTCs are not operating on the national tariff and have guaranteed income streams regardless of the number of operations undertaken. We are very concerned that this has had an adverse affect on the ability of the NHS to deliver, especially when the rule of additionality is removed for the second wave. Furthermore, as outlined above, ISTCs are sometimes being paid for rehabilitation services which are actually being delivered by the local NHS. This funding does not appear to follow the patient. This can result in an increase in local physiotherapy waiting lists because this additional rehabilitation activity is not been formally funded by PCTs.
**Ev 76  Health Committee: Evidence**

*Does the operation of ISTCs have an adverse effect on NHS services in their areas?*

8. We are concerned that there has been some adverse effect on local NHS physiotherapy, but that it could be rectified through effective planning. If the whole pathway was defined in advance of the operation, including where rehabilitation would be located, then it could reduce the impact on other services. PCTs might then also see this increased activity reflected financially as they are currently paying the wrong provider for rehabilitation while NHS waiting lists lengthen and become more expensive to manage.

*What arrangements are made for patient follow-up and the management of complications?*

9. Evidence from the British Medical Association suggests that the local NHS has borne the brunt of the management of complications, especially for orthopaedic patients. This may have been due to the lack of clarity in the delivery of rehabilitation.

*What role have ISTCs played and should they play in training medical staff?*

10. It is imperative that ISTCs liaise with local NHS services to undertake training and workforce planning. Much of the routine work will be undertaken by the ISTCs and junior physiotherapists will need to have some exposure to these procedures as part of their training. The CSP believes that particular action must be taken to ensure that there is no “cherry picking” by ISTCs and that there is an appropriate workload mix for junior staff.

*Are ISTCs providing care of the same or higher standard as that provided by the NHS?*

11. We have no evidence to comment on this question, but we would wish to see that this is monitored in some way.

*What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?*

12. We have no comment to make on this question.

*What changes should the Government make to its policy towards ISTCs in the light of experience to date?*

13. The CSP believes that there should be a level playing field and that the payment by results system should apply wholesale to all providers. We would also wish to see physiotherapy managers in the locality consulted in advance about effective patient pathways following discharge. Rehabilitation must also form a more explicit part of future contracts.

*What criteria should be used in evaluating the bids for the Second Wave of ISTCs?*

— Whether they offer genuine value for money (in terms of a level playing field).
— Whether they offer genuine additionality of provision.
— Whether they have the support of the local community as a whole and can demonstrate this through a consultation process.
— Whether detailed systems are in place to manage complications following discharge which does not unnecessarily disadvantage the local NHS.

*What factors have been and should be taken into account when deciding the location of ISTCs?*

14. ISTCs must offer additional support to the NHS and therefore should be placed where there is most need, most probably demonstrated through length of waiting lists. They must, though, be accessible, especially to those who are already subject to health inequalities.

*How many ISTCs should there be?*

15. It is not clear whether ISTCs will remain in the market once the national tariff is applied, particularly given that the backlog of operations will have been cleared to a large extent. We believe that this should not be determined in advance and that consideration should be given about whether the independent sector is the appropriate place to expand this service given the, admittedly still limited evidence, that the NHS treatment centres have fitter more neatly into the local health economy.

*Rachel Haynes*
The Chartered Society of Physiotherapy

*9 February 2006*
Evidence submitted by the Confederation of British Industry (ISTC 31)

1. Business has a triple stake in the delivery of an effective health service. Businesses require healthy employees at work to help them compete in the global marketplace. They generate 27% of yearly tax revenues—some of which is used to pay for the NHS. And in recent years businesses have seized the opportunity to become directly involved in health provision. The CBI believes that the independent sector has an important role to play in improving health provision in the UK. The innovation, along with the extra capacity that the private sector can provide, will be important to realise the government’s health reform agenda. New ways of working pioneered by the independent sector, and an increased focus on the individual needs of each patient, have improved and will continue to improve users’ experience of the NHS. Similarly these new approaches, coupled with greater incentives for success, enable the health service to utilise facilities and resources more effectively. This will help the NHS to provide better value for money without undermining its core principle that care is delivered free at the point of use to all who need it.

2. The CBI believes that this picture of success is reflected in the work of the Independent Sector Treatment Centres (ISTCs) programme, launched in 2003. Under this programme, the government selected seven private companies to run an initial 24 fast-track NHS treatment centres in the UK. By 2008, when a second wave of centres will be operating, the programme will be worth £1.2 billion a year including diagnostic work. The new centres and supplementary work that will be provided under the second wave of procurement mean that up to 400,000 extra procedures a year can be carried out. However, despite this huge investment and the projected impact on patient care, the percentage of healthcare provided by the independent sector will still be low—by 2008 it will only be responsible for less than 15% of elective activity in the NHS.

3. Given the success of the ISTCs programme to date, the CBI believes new investment in the programme should continue. ISTCs are popular with patients, have improved services and increased innovation, and have delivered an efficient service which represents value for money. Many of the fears expressed about the programme—such as the belief that the new providers would not be willing to train clinical staff—have not manifested themselves. Indeed, the independent sector has delivered a service that often has more stringent clinical standards than in the NHS. However, while the evidence suggests that the expansion of the programme should continue, there are policy changes that the government could introduce to improve how ISTCs are delivered.

4. In response to the Health Select Committee’s request for views on the ISTC programme, the CBI submits that ISTCs have:
   - increased capacity in the NHS and reduced waiting lists;
   - delivered high levels of patient satisfaction;
   - operated to the highest clinical standards and supported other local NHS services;
   - been efficiently and innovatively run and represent value for money;
   - been open and accountable; and
   - delivered effective services under current market conditions, but the government could improve the programme further.

ISTCs have Increased Capacity in the NHS and Reduced Waiting Lists

5. ISTCs have provided considerable extra capacity for the NHS. By September 2005, 16 ISTCs were operating a full service, with one centre providing an additional interim service. Since their introduction and up until this time, ISTCs had provided over 60,000 procedures for NHS patients. In addition, a contract for supplementary procedures provided by the independent sector (known as the Gsup1 procurement) has delivered treatment for over 27,000 patients. A second supplementary one-year contract is under way, with 14,000 patients to be treated. Phase two of the ISTC programme will see an extra 250,000 procedures provided each year, with an additional supplementary provision of up to 150,000 procedures a year. The independent sector has also provided thousands of diagnostic tests in addition to elective procedures: for example, mobile MRI scanners have served over 100,000 patients.

6. ISTCs have therefore played an important role in helping the government achieve a reduction in the maximum waiting time for treatment in the NHS to six months. Since 1997 the number of people on the overall waiting list has fallen by nearly 400,000, and ISTCs have provided many of the procedures necessary to make this happen. By running centres which often concentrate on a number of minor operations—such as cataract removals—providers have been able to utilise resources more effectively and move patients through the system quickly whilst maintaining high standards of care.

7. ISTCs have had a dramatic effect on waiting times in local areas. The first centre, located in Daventry, reduced local waiting times for cataract operations from nine months to fewer than three. The impact of new independently provided diagnostic centres (originally conceived as an integral part of the programme but now increasingly a separate market) has also been marked: mobile MRI scanners reduced waiting times

37 CBI analysis of the 2005 pre-budget report estimates that in 2005/06 total taxes on business will be £123.5 billion or 27.0% of total tax revenues.
in Huddersfield from 38 weeks to eight and in Ealing from 78 weeks to 12. Even in its otherwise sceptical evidence to the Parliamentary Labour Party, the BMA said that the “rapid introduction of ISTCs has made a contribution to the reduction of waiting lists”.

**ISTCs have Delivered High Levels of Patient Satisfaction**

8. A number of surveys show that ISTCs’ patient satisfaction rates are excellent. The Preliminary Audit of ISTCs carried out by the National Centre for Health Outcomes Development showed that all four centres surveyed had a high level of patient satisfaction. One centre enjoyed a 99% satisfaction rate in a survey of 10,000 patients. The other three centres achieved satisfaction levels of 84%, 97.1% and 100% respectively. The audit showed that the level of complaints is also very low: one centre reported a complaint rate of one per 2,500 outpatients, and one per 2,000 day cases.

9. The results of a survey conducted by BUPA’s Redwood Treatment and Diagnostic Centre also suggest high levels of patient satisfaction. The survey reported that 89% of patients undergoing treatment rated the service at the centre as good, and 50% rated it as excellent.

**ISTCs have Operated to the Highest Clinical Standards and Supported Other Local NHS Services**

10. When the ISTC programme was launched, many commentators voiced fears that the centres would lead to a dilution in clinical standards. Standards have, however, been enforced to a level that is at least equivalent to the NHS, if not more stringent. Doctors wishing to work for one ISTC provider, for example, are subject to a full panel interview, which includes a representative from the Royal College of Surgeons. They must submit three references, and are required to be on the relevant specialist register for the procedures they wish to carry out—not always a requirement in the NHS. Similarly, when complications arise with procedures undertaken by ISTCs, the evidence shows that there is a comprehensive framework of aftercare in place to deal with the problem. One provider has a policy where patients are referred back to the centre and assessed. If the complication is appropriate to be dealt with by the centre, then it will be addressed there. Otherwise, the independent provider refers the patient to a hospital for treatment and covers the cost. Approaches do vary slightly from this example, but all are subject to scrutiny both by PCTs and the Healthcare Commission.

11. Standards more generally are rigorously monitored: centres are required to be registered with, and approved by, the Healthcare Commission before opening and are continually monitored as they operate. All centres are bound by NHS governance and benchmarking processes. ISTCs are members of the same Clinical Negligence Scheme as NHS trusts, meaning that patients are protected by exactly the same rights and protection against negligence that they would have if they had been treated in an NHS hospital. In addition to this, all ISTCs are subject to 26 key performance indicators to assess the safety and quality of their facilities. The Preliminary Audit of ISTCs last year assessed the performance of four of the centres based on the 26 KPIs, with broadly favourable results. This high level of public scrutiny ensures that standards of quality and safety in the centres are maintained.

12. ISTCs have begun to contribute to the future of local NHS services by helping to train clinical staff. The centre at Hayward’s Heath, for example, will provide a full training facility for approximately 20 junior doctors at any one time in elective orthopaedics; the technology for remote teaching will be built into the operating equipment. Wave two of the programme is expected to require all ISTCs to provide training, which providers are keen to do.

13. ISTCs have not led to the deterioration of local NHS services. Rather, local services have benefited from their existence. ISTCs are NHS facilities, not private services, and reduce waiting times for NHS patients. Their high patient satisfaction rates suggest that they have a beneficial impact in improving the quality of local services. Added to this is the incentive for improvement that their increased efficiency provides to traditional, state-run services (see below).

**ISTCs have been Efficiently and Innovatively Run and Represent Value for Money**

14. By concentrating on a number of low risk, minor procedures as well as simple diagnostics, ISTCs have freed up resources from hospitals and other parts of the NHS. This has contributed to the better allocation of resources within the health service as a whole. In addition, the centres themselves have also proved to be innovative and efficient in the way they deal with patients and procedures.

15. By introducing new methods of working, ISTCs have managed to utilise operative facilities much better than in traditional settings. Mobile cataract units set up under the programme, for example, have each delivered an average of 39 cataract removals per day. In 2002-3, by contrast, the NHS carried out more than

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38 BMA Submission to the Parliamentary Labour Party Health Committee (PLPHC), 11 November 2005.
270,000 cataract removals using 141 different providers. This equates to an average of about five cataract removals per centre per day. While most NHS cataract facilities are fixed, mobile independent sector units are able to move to areas where waiting lists are highest and there is the greatest need.

16. A study of one ISTC, BUPA’s Redwood Treatment and Diagnostic Centre, showed the gains in efficiency that can result from using the independent sector. Redwood managed an 81% end utilisation of its two operating facilities, above the Audit Commission target of 77%. The actual scale of this achievement is shown by comparing the figures with the NHS average utilisation for 2005. According to the Healthcare Commission this was only 55% in day-care theatres. Some theatres were operating at less than 35% utilisation in the state-run sector, meaning that they were used for less than eight hours a week.

17. The difference in efficiency and utilisation between traditional settings and the independent sector can be traced to the impact of new innovative ways of working introduced by the new providers. Some centres are beginning to manage cancellations better by providing patients with scheduled appointments of their choice for procedures. Other centres have made sure that the backup is in place to ensure that schedules run as smoothly as possible. The technique of making sure that the next patient to undergo an operation is ready and under anaesthetic at the appropriate time, while any patients who have just undergone a procedure are dealt with by separate staff in a dedicated recovery room, has increased utilisation rates in centres such as BUPA Redwood. Outside of the independent sector, it is often the case that not enough staff or facilities are in place for this to be possible.

18. Case studies of innovation leading to efficiency are numerous. In one centre, for instance, hip and knee care pathways were rewritten, achieving a reduction in the length of stay from a range of 12 to 14 days to just five days. Another centre in Aintree introduced pre-assessment services, making sure that each patient would be fit to undergo their operation. If a patient had a cold, high blood pressure or another illness, the operation would not be scheduled at that point; if they were deemed fit, the procedure would be booked at the time of the pre-assessment. This helped to ensure that less than five per cent of patients on the centre’s waiting list had their operations rebooked as they were not fit enough to undergo them—a creditable achievement, since typically 68% of day case rebookings are traced to patient cancellations.

19. Such efficiency gains have been achieved at excellent value for money for the taxpayer. One provider, which will have four centres by July of this year, has invested over £60 million in the programme. Combined with this upfront investment, which takes place before any income starts to come in, are the costs to the private sector of VAT (which NHS trusts do not have to pay). Value for money is also provided indirectly by the hidden incentives that ISTCs provide to the state-run sector. In an article published last year, Patricia Hewitt, Secretary of State for Health, recognised that state-run treatment centres are seeking to improve their performance in the face of new competition from ISTCs.

ISTCs have been Open and Accountable

20. The issue of commercial confidentiality has not compromised public information on standards of care and clinical results. The enforcement of strict registering and staff accreditation requirements, along with the Preliminary Audit and other surveys of centre performance, have ensured that the programme remains transparent and subject to public scrutiny. Financial accountability is becoming stronger with the changes to contracts in the second wave of procurement. Rather than each centre undertaking a fixed number of procedures for the NHS for a fixed cost, ISTCs will be paid according to the number of procedures they complete. This will ensure that the money provided by the public purse to ISTCs will be firmly linked to results.

ISTCs have Delivered Effective Services under Current Market Conditions, but the Government could Improve the Programme Further

21. The CBI believes that while the programme to introduce ISTCs has been successful, the value of the centres to the health service and to better health outcomes could be improved. For example, more consideration could be given to the number of treatment centres that are needed to ensure patients across the country have a genuine choice of high quality healthcare services. NHS Trusts could also be allowed to work in partnership with the private sector in responding to bids. In addition, the procurement process could be simplified in order to allow more providers, particularly the voluntary sector, to enter the market. Finally, the evaluation process for bidders could be based on a clearer set of criteria, which would include:

— price;
— clinical governance arrangements;

40 Department of Health, Treatment Centres: Delivering Faster, Quality Care and Choice for NHS Patients, p 11.
41 This is a standard measure of operating theatre utilisation, used by the Healthcare Commission. It takes account of cancelled operations, those which under- and over-run, and of unnecessary gaps between operations.
— provider reliability and solidity;
— supply chain management;
— IT systems compatibility with the NHS;
— quality of care; and
— quality of customer service.

Confederation of British Industry
Public Services Directorate

February 2006

Evidence submitted by the General Medical Council (ISTC 38)

The General Medical Council (GMC) welcomes this opportunity to respond to the Health Select Committee Inquiry into Independent Sector Treatment Centres.

The GMC’s role in the regulation of doctors is defined in our statutory and charitable purposes: to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The law gives us four main functions under the Medical Act 1983: keeping up-to-date registers of qualified doctors; fostering good medical practice; promoting high standards of medical education and dealing firmly and fairly with doctors whose fitness to practise is in doubt.

The GMC is not in a position to comment on the main focus of the Inquiry, as it is beyond our remit. However, there are some areas that we feel it would be useful to clarify our position on to assist the Committee in its Inquiry. These areas are outlined below.

Registration of Doctors

All doctors working in the United Kingdom have to hold GMC registration. This applies equally to medical graduates from the UK, the EEA and the rest of the world. All doctors working within Independent Sector Treatment Centres, regardless of the duration of their period of employment in the UK or country of origin, must be registered with the GMC.

The GMC’s ability to require all doctors who want to practise medicine in the UK to be registered is essential to our role in ensuring patient safety. In order to protect this function we successfully fought the proposal originally contained in the Directive on the Recognition of Professional Qualifications that would have allowed EEA doctors to work unregistered in the UK for a period of up to 16 weeks.

If doubts are raised about a UK-registered doctor’s fitness to practise, he or she will be investigated by the GMC’s Fitness to Practise Directorate. Decisions on this are taken regardless of whether the doctor remains in the UK. If necessary a doctor can be removed from the medical register preventing his or her return to practise medicine in the UK.

Once we have taken action, we routinely notify a wide range of interested parties including regulators outside the UK.

Indemnity Insurance

To practise medicine in the UK a doctor must be covered by the necessary indemnity insurance. This applies to all doctors, working in all ISTCs.

Our core statutory guidance for doctors, Good Medical Practice, imposes a professional obligation on doctors to,

“obtain adequate insurance or professional indemnity cover for any part of [their] practice not covered by an employer’s indemnity scheme.”

To strengthen this requirement, the Department of Health has just finished consulting on proposals, developed with the GMC, to make possession of adequate insurance or indemnity cover a statutory requirement for registration. If doctors do not have adequate arrangements in place, they may be refused a licence to practise or risk losing their licence.

It is expected that these changes will be introduced under a Section 60 Order to the Medical Act 1983 later this year.
CONTINUITY OF CARE

We are aware that concerns have been voiced over the continuity of care and services provided in ISTCs.

In our key guidance for doctors, Good Medical Practice, we provide advice for doctors on ensuring best practice in continuity of care. The guidance states:

“It is in patients’ best interests for one doctor, usually a general practitioner, to be fully informed about, and responsible for maintaining continuity of, a patient’s medical care.”

The guidance describes the principles of good medical practice and the standards of competence, care and conduct expected of doctors in all aspects of their work. Serious or persistent failures to meet those standards may result in referral to a Fitness to Practise Panel, which has powers to restrict or remove a doctor’s registration.

MEDICAL TRAINING

The GMC Education Committee sets outcomes and standards for undergraduate medical education in Tomorrow’s Doctors and quality assures this through the QABME (Quality Assurance of Basic Medical Education) programme.

The Committee also sets outcomes and standards for the training of provisionally registered doctors in The New Doctor and in partnership with PMETB quality assures the Foundation Programme, that now incorporates this period of training, through QAFP (Quality Assurance of the Foundation Programme).

It is not clear how far medical students and Foundation Programme trainees will be educated and trained within ISTCs. It will be important to ensure that all such education and training meets the standards set by the GMC and PMETB and is subject to our quality assurance arrangements.

We understand that PMETB is making its own submission to the Inquiry, which will go into more detail on these issues.

Hugh Simpson
Head of Public Affairs
General Medical Council
14 February 2006

Evidence submitted by the Healthcare Commission (ISTC 36)

1. INTRODUCTION

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and Wales.

1.1 In England, we are responsible for assessing and reporting on the performance of both the NHS and independent healthcare organisations, to ensure they are providing a high standard of care. We also encourage providers, in both the public and independent sectors, to continually improve their services and the way they work. In Wales, our role is more limited and relates mainly to working on national reviews that cover England and Wales, as well as to our annual report on the state of healthcare.

1.2 In the first part of this submission we set out the role the Healthcare Commission plays in regulating independent sector treatment centres (ISTCs). In the second part of our submission we go on to cover some of the specific points raised by the Committee in its terms of reference.

2. THE REGULATION OF INDEPENDENT SECTOR TREATMENT CENTRES

In April 2004, the Healthcare Commission took over responsibility for regulating the independent healthcare sector, which was previously the responsibility of the National Care Standards Commission (NCSC).45

2.1 As we move from an NHS very largely provided by NHS suppliers to one in which at least 15% of services are likely to be provided in the independent sector, it is important that the opportunities for mutual learning within the ISTC programme are seized. It is important too that the different elements of the two regulatory regimes which the Commission operates, covering both the NHS and the independent sector—including NHS care by providers in the independent sector—are deployed to the greatest benefit of patients.

45 Our duty to regulate independent healthcare is laid out in the Care Standards Act 2000 (as amended by the Health and Social Care (Community Health and Standards) Act 2003). Details of what we regulate are given in the Care Standards Act and Private and Voluntary Healthcare (England) Regulations 2001.
2.2 There are currently 19 ISTCs registered and running, with 11 more due to be registered as part of the first phase of ISTCs. A complete list of Phase 1 ISTCs is available in appendix A. The regulatory regime for ISTCs will need to develop as the learning from the first phase is drawn out.

2.3 The Healthcare Commission has a number of mechanisms for regulating quality of care in ISTCs. ISTCs are subject to the same regulation and inspection regimes as all other independent healthcare providers. Currently, our work in this area is undertaken by a specialist central team. Over time, the registration and inspection process will pass into the mainstream regulatory activity of our regional teams. The Healthcare Commission uses the Department of Health’s national minimum standards, and the statutory requirements that accompany them, as the basis for regulating ISTCs. In addition, ISTCs are subject to two further procedures. Our specialist team undertakes an additional post-registration monitoring visit (see paragraph 2.7); and NHS patients treated in ISTCs can access both the NHS and the independent sector complaints procedures.

2.4 Our mechanisms for regulating ISTCs are set out in the linked processes below.

2.5 **Registration**

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:

- compliance with regulations;
- demonstration that national minimum standards are met;
- probity—all people associated with the service must be honest, truthful and be of professional and ethical standing;
- it must be possible to hold the service accountable for its activities. It must also display transparency in its practices and procedures; and
- there must be good clinical governance, with systems in place to ensure that patients are treated safely, effectively and appropriately.

2.6 Before registration, the service is assessed on these issues by examination of the organisation’s self-assessment form and by site visits, policies and documentation review, interviews and checks through the Criminal Records Bureau.47

2.7 **Post-registration monitoring visit**

Our specialist team undertakes a monitoring visit to ISTCs, usually within three months of registration, in order to review how systems are bedding in. This visit is supplementary to the usual inspection process for independent sector providers. The clinical teams working in ISTCs will often be new, and many include internationally recruited doctors and nurses, due to the “additionality” rule. ISTCs must not recruit clinicians who have been working in the NHS for the last six months. Such teams may not be used to working together or to complying with current guidance. These visits assist providers by offering advice to help them comply with the standards. It supports our commitment to working with providers to identify problems and find solutions.

2.8 **Inspection**

When a service is registered it is included in a programme of annual inspection. This is undertaken by a team of specialist inspectors appropriate to the particular service and could include nurses, pharmacists and other health professionals. The duration of the inspection visit varies according to the facility being inspected. Following an inspection, a report is published and made available to the public via the Healthcare Commission’s website.

2.9 The report summarises the results of the inspection and gives details of where we believe regulations have been breached or standards have not been met. It also sets out recommendations on the improvements needed and the times by which changes should be made. In response, the providers are asked to produce a detailed action plan showing how they will meet the requirements and recommendations of the report.

2.10 **Monitoring of complaints**

The Healthcare Commission deals with complaints about registered independent sector providers. Anyone can raise concerns with us about a service (for example, by contacting our helpline staff who will refer issues to our complaints team). In the first instance, if a complaint is made to the Healthcare Commission, we ask the provider to investigate the problem, respond to the complainant and inform us of

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47 The self-assessment form is available from www.healthcarecommission.org.uk
48 The additionality rule is a term of the ISTC’s contract with the Department of Health.
49 The Healthcare Commission is currently consulting on the alignment of our regulatory regimes for the NHS and independent sectors. One of our proposals is to move to a more proportionate and risk-based approach, which would mean that some organisations might not routinely receive an annual inspection in the future, in conjunction with the Department of Health proposals to decrease the minimum requirement for inspections to once every five years. Further information can be found in our consultation document Aligning our assessment of the NHS and independent healthcare sectors December 2005, available on our website www.healthcarecommission.org.uk
its response. We then consider the provider’s response and determine whether further action is required. We may, for example, undertake an inspection to establish whether there has been any breach of regulations and to assist in the appropriate resolution of the complaint.

2.11 We also monitor how ISTCs and other independent providers deal with complaints themselves. Regulations require registered providers to supply a summary to the Healthcare Commission annually of the complaints made during the previous 12 months and the action taken in response to these. Prior to inspection, in the case of all acute providers, we ask about resolution (timescales and whether complaints have been upheld) as well as numbers of written and verbal complaints. Providers are also required to keep records of the details, investigation and outcome of each complaint, which the Healthcare Commission can access if appropriate.

2.12 All NHS patients treated in ISTCs also have access to the NHS complaints system in addition to the independent healthcare process outlined above. The Healthcare Commission has a specialist team based in Manchester that deals with the independent review of NHS complaints.

2.13 To date, the Healthcare Commission has received one complaint against an ISTC, which may indicate that any complaints made to the provider are successfully resolved locally.

2.14 Monitoring of notifiable events reporting

The Healthcare Commission monitors the reporting of serious events. Providers are required to inform us within 24 hours of the following incidents:

— 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.

2.15 When a notification is received, the lead assessment manager determines if the event requires any further information to be submitted or followed up. Where necessary, an inspection or investigation may be undertaken.

Our new and developing methodology is designed to ensure better targeting of inspections. As part of this, we are working with experts in the field on the development of more detailed performance indicators looking at patient outcomes. This will include the notifiable events above, and will also cover other clinical and non-clinical indicators. These indicators will be drawn from information already collected by providers; however we will be working with them to ensure that it is collected in a consistent and comparable way. We anticipate this information being submitted on a quarterly basis. Notifiable incidents will still need to be reported within 24 hours.

2.16 Investigations

All concerns raised with the Healthcare Commission are given an initial consideration before a decision is made whether to investigate. During the initial consideration process we gather information about the service from a range of sources including strategic health authorities, primary care trusts, the Department of Health and professional bodies. The Healthcare Commission can make recommendations without an investigation having to be carried out, and undertake announced and unannounced visits.

2.17 Enforcement

If providers do not make the necessary improvements following an inspection or where the Healthcare Commission thinks there is a risk to the health and welfare of patients and users of services, we have legal powers to act appropriately to safeguard patients. The Healthcare Commission has a range of enforcement options available to it.

2.18 Enforcement notices are issued where it is considered that a service has failed to comply with the regulations, and the risk to patients is such that the provider should be compelled to take action. The provider is given time to remedy the problem, but if the problem is not resolved, prosecution for breach of the regulations may follow. Our other enforcement mechanisms include a power to impose conditions on a registration and, on certain grounds, to cancel a registration.

2.19 The regulatory system enables the Healthcare Commission to act on behalf of patients and users of ISTCs to:

— monitor the protection of vulnerable people using these services;

— ensure that patients and their families know what standards to expect;

— ensure that arrangements to assure safety and quality are in place; and

— bring together standards and criteria that will enable a similar approach to assessments and inspections to be adopted across all sectors of the health system.
2.20 The ISTC programme is part of a broader initiative to create additional capacity within the NHS to reduce waiting times and to introduce greater choice for patients. PCTs and strategic health authorities define the requirements set out in their contracts. The first wave of activity was arranged through the general supplementary (GSupp) procurement process and this contract was let by the Secretary of State for Health. These GSupp contracts operated slightly differently to the formal first wave of ISTCs. Independent sector providers involved in the GSupp contracts remain subject to the Commission’s regulatory regime.

3. **Issues outlined in the Committee’s Terms of Reference**

3.1 *What is the main function of ISTCs?*

ISTCs are designed to deliver a limited selection of low risk, high volume elective surgery and diagnostic procedures. The Department of Health’s intention was for the independently run clinics to deliver services for NHS patients with the advantage that they would be unaffected by the seasonal and emergency demands of the NHS. Primarily the ISTCs perform hip and knee replacement surgery and cataract operations.

3.2 *What arrangements are made for the follow up of treatment provided to patients and for the management of complications?*

Arrangements for follow ups are part of the discharge planning protocol which should be included in the integrated care pathway for individual patients, as set out in the national minimum standards. Under these standards the patient should be advised of follow up arrangements prior to them being discharged from the ISTC. Details should be recorded in the patient’s health record and a summary of this record sent to the patient’s GP within a locally agreed timescale (no more than four weeks). The provider should have a policy in place outlining the management of complications which includes transfer to another hospital where required. The written information given to patients should include general risks and risks specific to certain procedures, and complications associated with the surgery or other treatments. Documented post-operative instructions should be given to patients to take home after the procedure.50

3.3 The Healthcare Commission checks these arrangements by examining organisations’ self-assessments and through our inspection process. Our work with providers indicates that a number of improvements are being made in follow up care. For example, after a query from the Healthcare Commission one provider has improved links with local trusts and formed an agreement with consultants regarding the management of complications after surgery. Patients now have the option of either returning to the independent provider or to their local hospital for follow up. The patients themselves are given written post-operative information and staff now provide a follow up telephone call to patients the day after surgery.

3.4 We believe it would be helpful to build on this good practice by requiring ISTCs to draw up clearly defined protocols on transfer arrangements, stating explicitly who is responsible for making decisions and arrangements for transfers, with clear time frames agreed. Both the ISTC and local NHS providers must agree the arrangements and the protocol should be circulated widely.

3.5 *What role have ISTCs played and should they play in training medical staff?*

It is vital that nursing and medical students receive appropriate experience and training. If it is anticipated that ISTCs are to carry out a significant proportion of surgical procedures, (primarily hip and knee replacements and cataract surgery) then it will be important for nursing and medical students, specialist nurses and junior doctors to receive training in ISTCs in order that the education opportunities are optimised. While this is happening in part we would like to see it rolled out to all appropriate ISTCs.

3.6 We understand the Medical Royal Colleges and Deaneries are currently considering introducing accreditation for training in ISTCs and this would be a further welcome development.

3.7 *Are the accreditation and appointment procedures for ISTC medical staff appropriate?*

ISTC providers are responsible for ensuring that the people who provide treatment and care in their establishments or on their behalf are appropriately skilled, qualified and competent. Regulations require providers to have a written HR policy in place, covering recruitment, induction and retention of employees and their employment conditions. Detailed guidance relating to recruitment of staff includes pre and post employment procedures, including interview records, qualifications, employment references and appraisal.51

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50 Further information regarding these policies is available in Regulation 9 of the Private and Voluntary Healthcare Regulations 2001 (“the PVH Regulations”), and Core Standard C30 and Acute Standard A1 of the National Minimum Standards.

51 Further information regarding these policies and procedures is available in Regulations 9, 18 (Staffing), 19 (Fitness of Workers), 20 (Guidance for Healthcare Professionals) and Schedule 2. Specific elements are also identified for example in Core Standard C10 and Acute Standards A3, A4, A5 and A8.
3.8 Consultants who work in ISTCs have to be on the Specialist Register of the General Medical Council. The appointments procedure should include a recommendation by the Medical Advisory Committee of the hospital where they have applied to practise.

3.9 The Healthcare Commission checks these arrangements during the registration process, by examining organisations’ self-assessments and through our inspection process. Consideration should be given to aligning the recruitment procedure for ISTCs with those for the NHS, including introducing an equivalent to the advisory appointment committee system, which exists in the NHS. We know that one independent provider of NHS care\(^{52}\) has reviewed its recruitment policy and taken the decision to strengthen its appointments system. This good practice should be encouraged.

3.10 Are ISTCs providing care of the same or higher standard as that provided by the NHS?

This comparative information is difficult to assess as the programme has been running for a relatively short time with only 19 facilities registered to provide services to date. A preliminary report by the National Centre for Health Outcomes Delivery (NCHOD) in October 2005 suggested that the four ISTCs studied provided a good level of care.\(^{53}\) However, anecdotally concerns have been expressed that ISTCs have excluded some frail patients from surgery. We look forward to the final report from the NCHOD, which will need to ensure that there has not been such “cherry-picking” of patients.

3.11 The Healthcare Commission is undertaking a study looking at how best to gather information on the experiences of patients in treatment centres and we will make the preferred method available to all treatment centres in the near future.

3.12 What implications does commercial confidentiality have for access to information and public accountability with regards to ISTCs?

Due to the commercial sensitivity around the tendering process, the Healthcare Commission has no formal involvement until the preferred bidders are announced by the Department of Health.

3.13 Members of the Healthcare Commission’s ISTC team provide informal guidance to potential providers relating to compliance with national minimum standards and regulations. Our relationship is with the individual provider and all information is treated in the strictest confidence. Occasionally information is shared with Concordat\(^ {54}\) partners with the provider’s consent.

3.14 What changes should the Government make to its policy towards ISTCs in the light of experience to date?

It would be useful to see a formal evaluation of Phase 1, identifying areas of learning. Our feedback from stakeholders suggests the following areas could be considered:

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- early discussion with local NHS trusts, PCTs and clinicians to ensure a “no surprises” policy and enable better planning across the local health community;
- further consideration of training arrangements, which should include discussion with the medical royal colleges and deaneries; and
- review of the additionality rule. While this was initially introduced to counter fears of ISTCs “poaching” staff from the NHS, anecdotally we hear it has limited the opportunity for the exchange of staff and sharing of good practice and experiences between ISTCs and the NHS. The Department of Health has stated that this will be relaxed for the second wave and we would welcome this.

3.15 It would be helpful to explore mechanisms for ensuring that information and learning is being shared between all relevant directorates within the Department of Health, especially as there has been a high turnover of staff in this area.

3.16 What factors have been and should be taken into account when deciding the location of ISTCs?

Geographical capacity gaps should be identified by specialty within a clearly defined timescale, taking into account the proposed date of the commencement of the service. This exercise should involve the current NHS providers in consultation with PCTs and strategic health authorities.

3.18 Consideration should be given to how the addition of a new facility will impact on the local provision of services. The interface with the local health community and stakeholders needs to be considered. Such consideration should include:

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\(^{52}\) NB this concerned the provision of services under the General Supplementary Procurements arrangements rather than an ISTC.

\(^{53}\) National Centre for Health Outcomes Development ISTC Performance management Analysis Service: preliminary overview report for schemes GSUP1C, OC123, LP4 and LP5 October 2005 www.dh.gov.uk

\(^{54}\) The Healthcare Commission is the lead organisation in the Concordat between ten bodies inspecting health services. The Concordat partners work together to deliver a more consistent and coherent programme of inspection.
— location of ISTCs in relation to local NHS providers;
— suitability of a “host” site with a range of shared facilities;
— impact on training and recruitment of staff;
— the need for specialist supporting services;
— transfer arrangements;
— emergency procedures;
— specific requirements for specialist services such as paediatrics; and
— the potential involvement with and inclusion in local networks such as cancer networks.

4. **Concluding Comments**

The regulatory regime for ISTCs is still new and developing and we anticipate that a broader picture of performance will be built up over time. The Healthcare Commission is committed to working with all providers of services to drive improvements in patient care.

Healthcare Commission

*February 2006*

**Appendix A: current registered ISTCs**

**Summary Service List**

**Section Independent Health**

| Establishment | Location          | Owner                                           |
|---------------|-------------------|------------------------------------------------
| Bideford NHS Treatment Centre | Bideford, Devon | Partnership Health Group Limited |
| Out-Patient Department |                |                                                |
| Bideford Community Hospital  |                |                                                |
| Bodmin NHS Treatment Centre  | Bodmin, Cornwall | Capio Healthcare Limited |
| St Lawrence’s Hospital |                  |                                                |
| Boston NHS Treatment Centre | Boston, Lincolnshire | Capio Healthcare Limited |
| Clifton Park NHS Treatment Centre | York, Yorkshire | Capio Healthcare Limited |
| Gainsborough NHS Treatment Centre | Gainsborough | Capio Healthcare Limited |
| John Coupland Hospital | Lincolnshire |                                                |
| Kidderminster Independent Sector NHS Treatment Centre | Kidderminster | Interhealth Care Services (UK) Ltd |
| Kidderminster Hospital | Worcestershire |                                                |
| Mid and South Buckinghamshire NHS Diagnostic Centre | High Wycombe Buckinghamshire | Mercury Health Ltd |
| Nations Healthcare Eccleshill NHS Treatment Centre | Bradford West Yorkshire | Nations Healthcare Ltd |
| Netcare ISTC—North Chain | Whitchurch Shropshire | Netcare Healthcare UK Limited |
| Netcare ISTC—South Chain | Hanover Square London | Netcare Healthcare UK Limited |
| Netcare ISTC Greater Manchester Surgical Centre | Davyhulme Manchester | Netcare Healthcare UK Limited |
| Trafford General Hospital |                  |                                                |
| Partnership Health Group ISTC Boston Pilgrim Hospital | Boston Lincolnshire | Partnership Health Group Limited |
| Partnership Health Group ISTC Lincoln Lincoln County Hospital | Lincoln Lincolnshire | Partnership Health Group Limited |
| Peninsula NHS Treatment Centre | Plymouth Devon | Partnership Health Group Limited |
| Portsmouth NHS Treatment Centre St. Mary's Hospital West | Portsmouth Hampshire | Mercury Health Ltd |
| Shepton Mallet NHS Treatment Centre | Shepton Mallet Somerset | UK Specialist Hospitals Ltd |
| The Barlborough NHS Treatment Centre | Barlborough Chesterfield | Partnership Health Group Limited |
Health Committee: Evidence

**Establishment** | **Location** | **Owner**
--- | --- | ---
The Cobalt NHS Treatment Centre | North Tyneside, Tyne and Wear | Capio Healthcare Limited
The Will Adams NHS Treatment Centre | Gillingham, Kent | Mercury Health Ltd

**Phase 1 ISTCs Due to be Registered:**

<table>
<thead>
<tr>
<th>Establishment</th>
<th>Location</th>
<th>Provider</th>
<th>Registration due date</th>
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<tr>
<td>Burton upon Trent NHS Treatment Centre</td>
<td>Burton-on-Trent</td>
<td>Nations Healthcare Ltd</td>
<td>June 2006</td>
</tr>
<tr>
<td>Blakelands NHS Treatment Centre</td>
<td>Milton Keynes, Buckinghamshire</td>
<td>Capio Healthcare Ltd</td>
<td>June 2006</td>
</tr>
<tr>
<td>Haywards Heath NHS Treatment Centre (Princess Royal Hospital)</td>
<td>Haywards Heath, West Sussex</td>
<td>Mercury Health Ltd</td>
<td>June 2006</td>
</tr>
<tr>
<td>Halton District Hospital</td>
<td>Runcorn, Cheshire</td>
<td>Interhealth Care Services (UK) Ltd</td>
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<tr>
<td>Banbury NHS Treatment Centre (Horton Hospital)</td>
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<td>Capio Healthcare Ltd</td>
<td>August 2006</td>
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<td>Maidstone, Kent</td>
<td>Partnership Health Group Ltd</td>
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<tr>
<td>Hemel Hempstead Hospital</td>
<td>Hemel Hempstead, Bedfordshire</td>
<td>Clinicenta Ltd</td>
<td>October 2007</td>
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<tr>
<td>Lister Hospital</td>
<td>Stevenage, Hertfordshire</td>
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<td>Nottingham, Nottinghamshire</td>
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<td>December 2007</td>
</tr>
<tr>
<td>Ashford NHS Treatment Centre</td>
<td>Ashford, West Surrey</td>
<td>Capio Healthcare Ltd</td>
<td>Post June 2006—month not yet confirmed</td>
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**Evidence submitted by the Hospital Management Trust (ISTC 30)**

The Hospital Management Trust (HMT) is a registered charity established 20 years ago to retain and develop not-for-profit hospitals and nursing homes in UK and we have a particular remit for seeking to be a bridging link between the NHS and the overtly private sector of medicine.

HMT has three hospitals—Claremont Hospital Sheffield, St Hugh’s Hospital Grimsby and Santa Maria Hospital Swansea—and also manages five nursing care homes and undertakes a significant amount of consultancy, including working with representative medical organisations (Federation of Independent Practitioner Organisations [FIPO] and London Consultants Association [LCA]).

Because of the nature of its foundation, HMT has had considerable interest in Government policy on the establishment of ISTCs and the declared intention of the Government to work more closely with the independent sector in Britain. Sadly, however, HMT and the charitable hospitals in general have been largely ignored by the NHS centrally and it has been extremely difficult to have meaningful dialogue because of the emphasis on contracting with non-British companies and the existing major hospital groups.

However, there has been significant co-operation and development with the NHS locally in Sheffield and Grimsby. In Sheffield, the Claremont Hospital has a substantial contract (awarded under OJEC rules) with the Foundation Hospital Trust and has also been accepted as a joint bidder with the Sheffield NHS Teaching Hospitals Trust for the Phase 2 Elective Care Services Procurement. In Grimsby, discussions are well advanced with the North Lincolnshire & Goole NHS Trust for HMT to invest in the establishment of wards in both the Grimsby and Scunthorpe NHS Hospitals for the treatment of patients referred under practice-based commissioning as well as private patients.

HMT therefore has a substantial interest in—and knowledge of—the need for involvement with the NHS and the implications of the establishment of ISTCs.

Our comments are confined to those bullet point questions in the Press Notice which are relevant to HMT’s knowledge and experience.
1. Are ISTCs providing value for money?

Whilst it is possible that the creation of ISTCs has stimulated competition amongst established commercial private hospitals in Britain to bring down prices closer to NHS tariff levels, it seems exceedingly difficult to demonstrate value for money.

It is a matter of recorded fact (available to the Committee via Hansard and DoH but not always available to the public) that contracts awarded to ISTC developers have been at procedure cost prices substantially in excess of NHS tariff rates and often in excess of 15% and sometimes in excess of 20% over tariff. Additionally, the guaranteed value of contracts irrespective of the number of patients treated has led to significant sums of money being claimed by and paid to ISTC providers (press and PQ evidence) leading to a significant unit cost per procedure inevitably resulting from high prices paid for low volumes delivered. At the same time, hospitals such as those run by HMT have been delivering treatment for similar diagnostic procedures for the NHS at NHS tariff prices and within acknowledgeably high clinical governance standards.

It is therefore evident that, so far at least, ISTCs cannot be regarded as having delivered good value for money.

It is also noteworthy that the residual value calculations which may apply at the end of the initial five-year contractual agreements may well provide for significantly profitable returns to the ISTC companies in the event that the contracts are not renewed.

2. Does the operation of ISTCs have an adverse effect on NHS services in their areas?

It is our view from the areas in which HMT operates that there has been a detrimental effect on the local NHS. The requirement of centrally funded ISTCs for PCTs effectively to direct patients to them has meant a loss of revenue to the NHS and also a loss of patient workload which has had adverse impact on the number of cases available for ensuring adequate training of junior doctors. Whilst it may be true that the outward referrals have helped to reduce waiting lists, the requirement for referrals has not taken account of the local relationships between the NHS and the independent sector for the very same patients who have been treated in the local independent hospital by NHS surgeons in their non-contracted time and still within tariff pricing. It has also impacted adversely on patients who have been required to travel distances for treatment greater than in many cases they have wished to do.

In effect it is not infrequent for patients intended to be treated in an ISTC to be paid for twice because, in fact, the treatment has to be funded by a PCT from its own budget in order to avoid waiting list breach times where the ISTC has failed to deliver.

3. What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

It is a matter of considerable concern to organisations like HMT that it is impossible to gain accurate information on patient volume, cost of treatment or quality of outcome resulting from patient treatment in ISTCs. It seems entirely wrong that grounds of commercial confidentiality are used to cover up legitimate public interest when hundreds of millions of pounds of taxpayers’ money are being expended. It has never been possible to establish the true costs of treatment in the NHS and, indeed, that is still the case largely because of poor quality NHS accounting. However, there needs to be a framework built of comparative costing and value for money between treatment in NHS hospitals, ISTCs and established independent hospitals if any meaningful judgement of value for money is to be formed. Individual hospitals do not need to be publicly named but it must be in the public interest for anonymous data to be used both in aggregate and possibly at more detailed local levels.

4. What changes should the Government make to its policy towards ISTCs in the light of experience to date?

We understand that less than 20 ISTCs have so far been opened despite the fact that 33 were meant to be in operation by April 2005. On this evidence, Government policy can hardly be said to be fulfilled. It is the case that the creation of ISTCs and the introduction of competition have had a significant effect on the way that both private hospitals and the NHS have reacted to pricing and to treatment protocols. It could therefore be said that Government policy has had its effect and that there are now other ways of ensuring competition without the need for further specific development of ISTCs.

It is highly probable that there is sufficient capacity between the existing NHS and the private hospitals and developed ISTCs in Britain for future demand to be met given the trends towards decreasing length of stay in hospitals and the ever-growing satisfactory development of day surgery and treatment in a primary care setting.
5. What factors have been and should be taken into account when deciding the location of ISTCs?

Critical to the assessment of the need for deciding the location and size of any more ISTCs is a detailed analysis of the existing capacity and potential workload which can be delivered through existing resources in both the public and private sectors. In our experience, it is highly likely that in the majority of instances sufficient capacity already exists and the introduction of a tariff framework and regulation of quality have the capability of being able to meet public expectation within available financial resources post the NHS expenditure boom ending in 2008.

We hope that the Committee will find these comments useful.

J B Randle
Executive Director, The Hospital Management Trust
13 February 2006

Evidence submitted by Mercury Health (ISTC 6)

INTRODUCTION
1. Mercury Health, a wholly owned subsidiary of Tribal Group plc, is a UK business that supports the NHS by creating additional capacity, thus enabling patients to be treated earlier and to have greater choice, including access closer to home.

2. We currently run three Treatment Centres and will open a fourth in July this year. The centres are located in High Wycombe, Gillingham (Kent), Portsmouth and Haywards Heath. We provide a range of healthcare services including diagnostic imaging, day and inpatient surgery and a minor injuries unit and walk-in centre. Together, the centres cover a range of procedures including MRI, ultrasounds, echocardiographs, hernia repairs, endoscopies, cataract repairs and orthopaedic operations.

3. The Primary Care Trusts who commission the services and the patients who have been treated are generally supportive of the impact we have made on their local health community. To date, 100% of respondents to our patient satisfaction surveys have said that they would recommend our centres to friends and family.

What is the main function of ISTCs?


What role have ISTCs played in increasing capacity and choice and stimulating innovation?

5. Our centres have increased the total capacity in each location in terms of buildings, equipment and staff so that more treatment has been made available for NHS patients. In terms of innovation, we have established a new service providing direct access to a wide range of diagnostics by GPs in High Wycombe and we are building theatres in Haywards Heath with the technology for remote teaching built in to the operating equipment (endosuites). We are also able to offer NHS patients scheduled procedures at pre-arranged times. Many of the procedures are day cases enabling patients to return home more quickly freeing up beds for other NHS patients and other procedures. We have so far seen 12,209 patients and expect to see another 80–100,000 in 2006–07.

What contribution have ISTCs made to the reduction of waiting times and waiting lists?

6. The waiting times at Mercury Health facilities are much shorter than the local NHS Trusts. We have been told by local Trust and PCT CEOs that our presence in the community has helped them motivate their medical staff to shorten waiting times.

Are ISTCs providing value for money?

7. We believe they are. We will have invested nearly £60 million in developing our new centres. Given this level of investment and taking into account the fact that the contract terms are more onerous than for NHS Trusts, that VAT is unfavourably treated in comparison to the NHS, that pensions costs have to be fully accounted and no income is obtained until a centre is open, we are confident that the taxpayer is getting very good value for money. If one also takes in to account the “hidden” impact of the incentive ISTCs have given to trusts to improve productivity and the fact that ISTC provision is likely to reduce in cost in the future the programme has delivered excellent value for money.
Does the operation of ISTCs have an adverse effect on NHS services in their areas?

8. An ISTC is an NHS service. Local services have, therefore, been enhanced and patient choice and access to high quality services has improved. Some institutions will have had to review their fixed cost base in the light of changed local circumstances but this has been a normal feature of new service development in the NHS over time and will often result in a more efficient deployment of resources.

What arrangements are made for patient follow-up and the management of complications?

9. Mercury Health follows up all patients until they are fit for discharge back to the care of their GP. If a complication develops that is appropriate to be treated in the centre, the patient returns and is treated. If treatment is required in another hospital the patient is transferred there and Mercury Health covers the cost.

What role have ISTCs played and should they play in the training of medical staff?

10. In three of our centres we have not been asked to provide training opportunities but would be happy to do so. At Haywards Heath, we will be providing a full training facility for about 20 junior doctors at any one time in elective orthopaedics. These doctors will also benefit from our association with Hospital for Special Surgery, one of the leading orthopaedic hospitals in North America. The Phase 2 procurement is expected to require all ISTCs to provide training.

Are the accreditation and appointment procedures for ISTC medical staff appropriate?

11. Yes. In fact the process for being appointed as a doctor to Mercury Health is probably more onerous than being appointed to an NHS provider. All our doctors are on the relevant specialist register, are subject to full panel interview (that includes an independent representative from the Royal College of Surgeons) and are required to submit three references. No surgeon who is not on the specialist register can operate in our centres, as opposed to NHS providers who regularly use surgeons not on the register.

Are ISTCs providing care of the same or higher standard as that provided by the NHS?

12. We provide a level of care at least as good as that provided by conventional NHS providers. We regularly submit a set of clinical performance indicators which can be compared with NHS provider performance over time. In contrast to most NHS facilities, each of our centres is required to be approved by, and registered with, the Healthcare Commission (HCC) before opening and remain subject to close and detailed inspection by the HCC. All our staff are qualified to at least the same level as NHS staff (for example, all our surgeons are required to be consultant grade) and we have a comprehensive system of clinical governance to safeguard patients.

What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

13. Exactly the same implications as any other public procurement.

What changes should the government make to its policy towards ISTCs in the light of experience to date?

14. The procurement process should be simplified to allow a greater range of providers, including the voluntary sector, to bid for contracts. A “level playing field” should be created to allow NHS Trusts to bid for these contracts on the same terms as other bidders. This would need to address the issues referred to above—VAT, pensions, regulation, contract risk allocation and a range of smaller but relevant issues.

What criteria should be used in evaluating the bids for the second wave of ISTCs?

15. Clinical quality, price and the ability of the proposal to increase choice for patients and provide speedy access to care close to home.

What factors have been and should be taken into account when deciding the location of ISTCs?

16. ISTCs should be established close to populations whose access to care either geographically or in terms of waiting times is currently unacceptable.
**How many ISTCs should there be?**

17. Enough to meet the criteria above (paragraphs 15 and 16)

Mark Smith
Mercury Health
7 February 2006

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**Evidence submitted by Nations Healthcare (ISTC 24)**

**Summary**

Nations Healthcare welcomes the opportunity to submit evidence to the Health Select Committee’s inquiry into Independent Sector Treatment Centres (ISTCs). The company would also like to extend an invitation to the Committee to view Nations’ Treatment Centres at a time convenient to members.

Although we are still an early stage company our experience to date indicates that Nations’ success within the ISTC programme has been and will continue to be predicated on:

- clearly demonstrating benefits to patients;
- being invited and welcomed into local health communities;
- working as an integral and enduring part of those local health economies;
- working in close partnership with the NHS and evidencing this to clinicians, patients and the public;
- providing value for money for the taxpayer; and
- bringing additional examples of innovation and best practice to the NHS.

As one of the forerunners in the ISTC programme, Nations Healthcare has worked with the NHS through the often challenging period of bringing the early stages of policy introduction to fruition. We recommend to the Committee:

- the importance of generating the learning from the programme to date and using the learning to sharpen up and speed the processes of ISTC development from ITN to financial close and beyond;
- evaluating, and more proactively making clear to patients, the public and the NHS the benefits of the choice of dedicated ambulatory care; and
- clarifying the nature of partnership between the NHS and the independent sector; in particular more overtly recognising the realities of the pressures and imperatives informing both party’s stances. This is especially critical in developing a shared view of risk, both commercial and financial.

**Introduction**

1. Nations Healthcare is a UK based company, founded in 2002, with its origins in the US. The company is dedicated to creating the best inpatient and ambulatory care centres and developing clinical practice and a clinical environment where an increasing range of procedures can be treated safely and effectively through day treatment.

2. The Nations Healthcare model is developed in line with international best practice standards giving an innovative and proven effective approach to its service delivery. In the UK this model is being incrementally introduced to ensure innovation is fully supported by clinical teams with the training and ownership of change to maximise the benefits to patients.

3. Nations Healthcare has recruited over 100 staff in its three Treatment Centres in Bradford, Burton on Trent and Nottingham and its London Headquarters. 65 of these are front-line operational clinicians and support staff. This figure will rise to 450 by 2007.

4. The Bradford scheme was opened to treat patients in June 2005 with 45 NHS consultants seconded in from Bradford Foundation Trust as part of a groundbreaking structured agreement. The Burton on Trent scheme is scheduled to open in July 2006 and the Nottingham scheme, which is the largest co-located, single site ISTC in the country, will be opened in December 2007.

5. Nations Healthcare has a consortium of distinguished international companies supporting its operations in the UK including:
   - Johns Hopkins University Health System International in Baltimore—clinical strategic partner and voted number one hospital in the United States for the 14th consecutive year;
   - Harvard School of Public Health—academic partner analysing the public health impact of ISTCs;
   - Alliance Imaging (Nations Imaging in the UK)—diagnostic partner and the largest provider of diagnostic services in the US.
— America Healthways—long term care partner and the biggest specialists in chronic disease management in the US; and
— Vision Group—ophthalmology partner and the leading ophthalmology group in Australia.

6. Nomura, the Japanese Investment Bank, is a major investor in the company and a further consortium member.

7. In the first wave of ISTC procurement:
   — 180+ international companies applied for pre-qualification for the programme. Nations Healthcare was one of only 15 companies pre-qualified.
   — Nations Healthcare was short-listed on more projects than any other company.
   — Nations Healthcare had more wave one “wins” than any other company.
   — Nations Healthcare closed three contracts including the contract for the first comprehensive ISTC scheme (Bradford).

*What is the main function of ISTCs?*

8. Nations Healthcare was pleased to respond to the Government’s invitation to bid as part of the procurement programme for ISTCs and we endorse the Government’s aims for the programme.

9. Through our participation in the programme we aim to support the NHS in achieving:
   — more capacity to deliver faster care for NHS patients;
   — services designed around the patient to improve their overall experience of healthcare and offer them greater choice; and
   — the development of innovative services in partnership with the NHS, building on the best of what the NHS already does.

The company’s approach to the above must in addition enable Nations’ viability and sustainability in delivering healthcare, innovation and value for money in the UK.

*What role have ISTCs played in increasing capacity and choice and stimulating innovation?*

10. Capacity in each of the three local health communities where Nations Healthcare is working in partnership with the NHS will be increased as follows:
   — Bradford: contracted year one to provide 18,000 multi-specialty diagnostic tests and 6000 day surgery operations.
   — Burton on Trent: contracted year one to provide 17,000 ophthalmology outpatients and 13,000 day surgery operations. In addition the PCTs have asked for a further 4,000 outpatients in year one over and above contract.
   — Nottingham: contracted year one to provide 150,000 multi-specialty outpatients (this includes diagnostic tests) and 24,000 day cases comprising a mixture of day surgery and other same day procedures.

11. Choice for patients only exists when GP referrers, patients and the public are aware of their local ISTC and what it provides, and have confidence in the facility, its clinicians and management. In the three areas of Nations’ Treatment Centres, we have been working in close association with the Primary Care Trusts developing strategies to support GPs in understanding their referral choices.

12. The strategy in Bradford is clinician-led and includes GP visits to the centre, information for GPs, consultant surgeons’ presentations to, and engagement with, GP groups. We are also progressing other options including the establishment of a dedicated website for GPs.

13. In addition we continue to actively raise the profile of the Treatment Centres with patients and the public through open days, press releases and feedback from patients. These strategies will be rolled out in Burton and Nottingham.

14. In Bradford the first patient satisfaction survey required by the Healthcare Commission revealed a score of 93.5% on the satisfaction index with a statistical reliability of plus or minus 1.6%.

15. Stimulating Innovation has been achieved by Nations Healthcare in a number of ways:
   — Through the contribution of Johns Hopkins’ clinicians working with our consultant surgeons and anaesthetists in the areas of case selection, care pathway development and treatment centre development. Johns Hopkins has been a leader in both innovation and provision of ambulatory care for almost 20 years.
   — In our Bradford Treatment Centre through the introduction of the “Green Light Laser”, a technique to improve the treatment of prostate cancer and the numbers of men treated. The procedure, which is locally only available in the Treatment Centre, and nationally carried out in a small number of acute trusts, has been spearheaded by a seconded senior NHS urologist.
— The expansion of the “basket” of procedures undertaken by day treatment within the local health communities served.
— The design of our centres and clinical processes both of which are engineered to provide the best and most efficient patient experience. For example North Bradford Primary Care Trust, which commissioned Nations Healthcare to construct and run the Eccleshill NHS Treatment Centre, has recently won the award for “Service Re-design” in the NHS Alliance Acorn Awards.

16. Nations Healthcare is exploring opportunities to further introduce innovation in all of its centres and particularly in Nottingham in conjunction with the Queens Medical Centre.

What contribution have ISTCs made to the reduction of waiting times and waiting lists?

17. Nations Healthcare in its Bradford Treatment Centre treats patients from both Bradford and Leeds. Patients coming to the centre have a maximum two-week waiting time for diagnostic tests and a maximum four-week waiting time for day surgery.

18. We do feel our treatment centres have the potential to make a meaningful contribution to reducing waiting lists and waiting times. However it is our opinion that the host Primary Care Trusts (PCTs) are best placed to offer a balanced view on the contribution of the work undertaken.

Are ISTCs providing value for money?

19. One of the clear areas of learning for the ISTC programme is the challenge to shift the referral patterns of GPs and both Nations and the Primary Care Trusts alike probably underestimated the achievement of this. In Bradford the number of referrals to the centre from Bradford and Leeds has not yet reached the figure covered in the contract between Nations and the PCTs. In the first six months of operating the centre treated 2,091 patients a figure which is 27% lower than that anticipated by the PCTs.

20. Reasons for this include:
— established referral patterns and loyalties;
— a high level of inappropriate referrals which cannot be accepted by the centre;
— a lack of awareness by referrers of what the Treatment Centre can and cannot do; and
— limited use by referrers of the electronic referral methods forming part of Nations contract with the PCTs.

21. Nations has taken four key steps to tackle these issues:
— the company has not imposed the financial minimum take upon the PCTs in Leeds and Bradford and has given them a year to catch up with referrals;
— we have brought in additional resources to train PCT personnel in understanding and using electronic referrals incorporating the patient’s history and diagnosis;
— a clinician-led referrals strategy is being implemented to ‘market’ the Treatment Centre to GPs and build their awareness and understanding of procedures suitable for referral; and
— nations senior managers are meeting regularly with PCT managers and clinicians to monitor referrals and consider additional ways to increase numbers.

22. Alongside this local agenda Nations has proposed to the CCMU a “ramp-up” period built into future schemes to recognise the challenges in achieving a shift in referral patterns.

23. Nations is taking this learning to Burton and Nottingham to start the process of engaging GPs from the earliest possible time.

Does the operation of ISTCs have an adverse effect on NHS Services in their areas?

24. In Bradford the number of patients treated is small compared with those treated by the whole health economies in Bradford and Leeds. Whilst patients would formerly have been treated in the acute trusts they are still treated by NHS consultants, within the policy of additionality, under contract to Nations to provide sessions at the centre. The advantage lies in the centre being a dedicated elective facility and not therefore subject to the pressures of emergencies and associated late cancellations. We do know the consultants welcome this advantage and it is clearly beneficial to patients.

25. Nations does not feel able to comment effectively on the impact of the centre on local services, adverse or otherwise, at this juncture and believes this evidence would be better provided by either the PCTs or the acute trusts or both.

26. In a reference for Nations Healthcare provided by the North Bradford PCT ISTC Project Director, the Director states “The PCT is very happy with the service being provided—primary care has never had such good access to radiological diagnostics or day surgery. This is a model of provision which should be rolled out across the country”. This reference can be made available to the Committee if required.
What arrangements are made for patient follow up and the management of complications?

27. Patient Follow-up—most patients undergoing day surgery in Nations’ Centres do not require follow up and their treatment is completed on the day. Where there is a need for a follow up outpatient appointment this is undertaken within the Centres.

28. Physiotherapy or other follow up treatment needed to support a patient in achieving the best outcomes from surgery is carried out in primary care. This arrangement was agreed as the most effective by the PCTs and it forms part of contracts with Nations Healthcare.

29. Management of Complications—experience from Johns Hopkins in the US indicates that the incidence of complications in patients receiving day surgery is extremely small. In Nations’ Centres, arrangements have been made for the speedy transfer of patients to local acute facilities should any complication arise that cannot, or should not, be managed within the centres. This arrangement again forms part of our contracts with the PCTs and the acute trusts.

30. To date there have been no clinical emergencies associated with procedures carried out in Bradford that require a patient’s transfer to the acute hospital. There have been occasions when diagnostic tests undertaken within the centre have revealed more serious conditions necessitating transfer (not immediate) to Bradford Foundation Trust. For example Nations Healthcare and the senior colorectal consultant/general surgeon in the Trust have developed a co-operative approach to diagnosis and this has earned a Yorkshire Cancer Network nomination for exemplar practice.

What role have ISTCs played and should they play in training medical staff?

31. Nations Healthcare is fully committed to playing its part in the education and training of the next generation of healthcare professionals particularly (but not solely) medical staff.

32. We recognise the potential impact that not being involved in the training of medical staff would have on the viability of training in teaching trusts and this would not be in the interests of either the trusts or Nations Healthcare. Furthermore we are clear that the opportunities for junior doctors, rotating through Nations Treatment Centres, are to gain highly focussed experiences in surgery with surgeons whose lists are not subject to change and emergencies. This latter valuable experience can be achieved within the acute trusts.

33. Nations Healthcare has signed the first major training, education and research contract in the country at the Queens Medical Centre and is also contractually committed to a pilot project for training in Burton.

34. Furthermore, our Medical Advisory Board is leading the development of a clinical leadership programme with a bespoke curriculum designed to foster best practice and change. This programme is accredited in the US by Johns Hopkins and the Harvard School of Public Health.

Are the accreditation and appointment procedures for ISTC medical staff appropriate?

35. Although to date Nations Healthcare’s consultants have been drawn from the NHS, through secondments or contracted sessions in accordance with the additionality policy, and the staff have therefore already been through NHS appointment procedures, nevertheless it is Nations’ policy to check the registration and qualifications of every doctor and nurse.

36. In the event of Nations employing doctors who have not previously worked within the NHS—for example overseas doctors—we have policies in place to ensure the integrity of the procedures and the fitness for purpose of recruited doctors.

37. Lord Turnberg, a past president of the Royal College of Physicians, is the chair of Nations’ Medical Advisory Board.

Are ISTCs providing care of the same or higher standard as that provided by the NHS?

38. All ISTCs are inspected and regulated by the Healthcare Commission and are obliged to meet the standards laid down by the Healthcare Commission.

39. Nations Healthcare believes that NHS standards of treatment are as good as any in the world and our partner Johns Hopkins has endorsed this belief. Where Nations is able to add value is in the innovation the company can introduce to its Treatment Centres, faster access for patients and the experience patients have before and after treatment.

What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

40. Nations Healthcare has held firmly to the view that in all of its work alongside the NHS we would meet all reasonable requests for information to demonstrate public accountability.
What changes should the Government make to its policy towards ISTCs in the light of experience to date?

41. Nations Healthcare takes the view that it is in the interests of the Government, the NHS and the company to share learning from our experience of the ISTC programme to support achieving greater effectiveness in the partnership between the NHS and Nations in the future.

42. Our main comments cover six important areas:

— Patients and the public—feedback from patients treated in North Bradford demonstrates the value they place on fast access to the diagnostics and surgery they need and the patient satisfaction survey showed a high level of satisfaction with the patient experience from start to finish. If patients and the public across the country are to have confidence in ISTCs as a treatment choice such good news stories must be communicated.

— Positioning—from the outset Nations has gone the extra mile to build positive partnerships with local health communities and can evidence ways in which this has been achieved. For example:

— We have actively arranged for groups of clinicians and managers from Burton and Nottingham to visit the centre in Bradford to increase their understanding, offer an educational experience and grow their confidence in the capacity of Treatment Centres. These visits have proved extremely successful.

— Clinicians and managers from local health communities in the areas of all three schemes have spent time with Nations’ clinical and academic partners in the US as an educational opportunity and a chance to judge the efficacy of the clinical practice proposed by Nations in its centres.

— In all three areas, joint arrangements are being developed for crucial organisational processes such as communications, patient involvement and referrer engagement.

We believe this is one of the most critical areas of learning and strong partnership working lays much stronger foundations for positioning our treatment centres as an integral and enduring part of the NHS.

— Engaging referrers—as already mentioned Nations and the PCTs in Bradford made some assumptions about referrals following the needs defined by the PCTs. This has not been the case to the degree anticipated. In Nottingham we have engaged GPs as part of our “Partnership Board” and in our “Partnership in Practice” development programme. It is further our intention to engage with contracted numbers from the opening of the Centre.

— Clinician-led—much of the credibility Nations has gained in the areas of its three Centres results from its philosophy to build a clinician-led organisation. We are not yet in a position to say this has been fully achieved, but where we have made strides the outcomes in building understanding and co-operation between the NHS and Nations and the impact on patient care has been extremely positive. For example, all three of our Treatment Centre General Managers are clinicians.

— Intrinsic understanding of the NHS, its ethos and capabilities—Nations Healthcare has always been clear that melding the best in the UK with the best in the US is a key company aim. For this reason we recruited respected ex-NHS managers to bring an intrinsic understanding of the NHS, its ethos and its capabilities. This strategy has paid dividends in the areas of strengthening partnership, taking commonsense, informed approaches to dovetailing systems and processes, and building a culture putting the patient at the centre through the integration of NHS values with those prevailing in healthcare in the US.

— Speed of development—Treatment Centres are comparatively small NHS facilities, yet the speed of contract negotiations has meant the advantages to patients have taken a long time to be achieved. For example in Nottingham, from the time of the first meeting with QMC to the time of the first patient treated is likely to be in excess of four years. Although this incorporates approximately two years construction time we believe the contract stage of development could be accelerated. Nations Healthcare would be happy to work with the NHS to support achieving this.

What criteria should be used in evaluating the bids for the second wave of ISTCs?

43. Nations Healthcare believes the criteria used to evaluate bids should take account of the learning noted above, build on what has worked to date and avoid the pitfalls that have slowed progress and created tensions.

44. We suggest the following:

— the ability to provide a proven good patient experience;

— the ability to staff treatment centres with “fit for purpose” healthcare professionals working in teams shaped to provide the best patient experience;

— the ability to design, build and run a treatment centre that offers the best patient experience;

— the flexibility to accommodate sponsoring PCTs’ defined needs for the community served and in the future to respond to Practice-Based Commissioning;
established systems and processes to enable the construction of strong working partnerships with the NHS;
- the capability to bring innovation to NHS patients;
- the commitment to supporting training, education and research;
- a strong financial and commercial base with demonstrated good governance arrangements; and
- the ability to articulate the added value to NHS patients of the company’s Treatment Centres.

What factors have been, and should be, taken into account when deciding the location of ISTCs?

45. In the first wave of the ISTC programme, Nations Healthcare bid for a number of schemes to establish its base in the UK. As an established company, we are now able to make more informed judgements about where we would wish to develop treatment centres.

46. The factors to consider in making these judgements include:
- Is the local health community in agreement with the need for a treatment centre?
- Is the location one where there is evidenced under-capacity in the NHS?
- To what extent are referrers currently prepared to refer to a treatment centre?
- Are the innovations Nations offers ones that are not available to NHS patients through other local NHS trusts?
- Can patients relatively easily access the proposed treatment centre?
- Is Nations already part of nearby health communities and therefore connected to local NHS networks?
- Is the treatment centre located sufficiently close to an acute trust to ensure patient safety in any emergency?

How many ISTCs should there be?

47. Nations Healthcare believes that the decision about how many ISTCs are needed to complement NHS provision is not one that can or should be taken by the independent sector.

Nations Healthcare
13 February 2006

Evidence submitted by Netcare Healthcare UK Limited (ISTC 27)

1. Netcare is a leading provider of high quality, accessible healthcare services, with established international operations. In 2005, our consultants treated 900,000 patients. In addition, 2.5 million people were seen by our GPs, and a further 400,000 by our dentists. Our UK operation was established in 2001, and provides highly specialised clinical services to patients under contract to the National Health Service. Existing contracts involve Netcare performing an estimated 90,000 procedures over five years.

2. Our services are designed to be entirely compatible with the NHS’ basic purpose and values. They are free at the point of delivery, with clinical pathways and governance procedures that are built to ensure patients are consistently treated, to the highest standard of care, regardless of circumstances, condition or geography.

Q1 What is the main function of ISTCs?

3. In our experience, the main function of ISTCs has been to add capacity and support the achievement of the 18-week waiting time target, whilst enabling general practitioners and optometrists to offer a broader choice for patients. Many of the patients we treat are very elderly, and are waiting for procedures that will deliver valued and significant improvements to their quality of life. Through shortening the time they are required to wait, Netcare has been able, working closely with a large number of PCTs, to help these patients once again to enjoy a healthy, independent and full retirement.

Q2 What role have ISTCs played in increasing capacity and choice and stimulating innovation?

4. Since our first appointment by the NHS, Netcare has participated in waiting list initiatives in Morecambe Bay, London, Southport and Portsmouth. We are currently participating in the ISTC programme by using mobile operating theatres to offer cataract operations nationwide, and providing orthopaedic, ENT and general surgery in a fixed location in Greater Manchester. We recently completed our 20,000th cataract operation, and are planning to perform nearly 90,000 procedures over the five years of our existing contracts.
5. Our Greater Manchester Surgical Centre, Trafford, is a newly-built 48 bed facility employing almost 140 clinical personnel, providing inpatient and outpatient orthopaedic, ENT and general surgical services. Following final contract agreement in 2004, we assigned a multi-skilled mobilisation team to work quickly to ensure the facility was fully furnished, equipped and staffed, ready to open on time in May 2005. Our philosophy is to deliver outstanding healthcare in a clean and professional environment, enabling our patients, many of whom are very elderly, to enjoy a full and healthy retirement. In its first year of operation, we expect to carry out in excess of 8,000 procedures.

6. Our innovative approach, using mobile units, provides additional capacity and an independent solution in areas where local units do not exist or cannot be justified. This has been supported by the early use of an IT solution, “Choose and Book”, a system which allows patients to choose our facilities and select a date convenient to them via their GP practice.

Q3 What contribution have ISTCs made to the reduction of waiting times and waiting lists?

7. Waiting times are managed through specific care pathways for high volume surgery. Once patients are referred to Netcare, the average waiting times have been as follows:

- Orthopaedic services—4 weeks.
- Cataract procedures—9 weeks.

We understand that this represents a significant improvement to the conditions that were in place prior to the start of the two contracts. This has been made possible by committing significant investment in the development of an efficient IM&T solution for bookings, which is fully compliant with the NHS’ National Programme for IT (NPfIT), and is seen as a pathfinder.

Q5 Does the operation of ISTCs have an adverse effect on the NHS service in their areas?

8. We have not detected any adverse impact upon other NHS service in any of the regions in which we operate. Our projects are complementary to the existing resource, and as an example, we have added 10% infrastructure at one of our locations but are contributing to an additional 20% activity. So that our activity can be seen in context, less than 3% of all NHS cataract treatments are currently performed by our mobile units.

Q6 What arrangements are made for patient follow-up and the management of complications?

9. All patients are followed up by Netcare. This can be up to one year after the procedure, for example with joint replacements. Complications, if clinically safe, can be treated by Netcare within the ISTC. Others are referred to NHS facilities under a service level agreement. To date less than 0.17% of patients have been referred to NHS facilities for treatment. Service level agreements provide access to, for example, critical care networks.

10. Complications are taken extremely seriously, and immediately referred to one of our medical directors to determine the appropriate course of action. Further treatment can include regular follow-up, surgery by the treating consultant or referral to a specialist within the NHS itself. On the rare occasions that a full review is merited, there will be a Joint Service Investigation undertaken by a panel chaired by an official from the commissioning authority and involving a distinguished independent clinician.

Q9 Are ISTCs providing care of the same or higher standard as that provided by the NHS?

11. We collect 280 data items related to cataract surgery, and these include all intra-operative and post-operative complications: final visual acuity compared with pre-operative visual acuity; and details of co-morbidities such as glaucoma, diabetic retinopathy, macular degeneration and amblyopia. The data is analysed on a daily basis to ensure that our outcomes are within agreed clinical parameters. In addition, 26 key performance indicators are presented to the Department of Health, many on a daily basis, and this information is used for measurement purposes. At our Greater Manchester ISTC, as part of our commitment to high standards, every orthopaedic patient is registered on the National Joint Registry. Based on these activities, we believe that our experience is in line with, or higher than, previous reported series, and that it is possible to provide a comparable service whilst delivering productivity gains and bringing new techniques and innovation to the NHS.

12. As well as clinical outcomes, we also monitor patient satisfaction closely, and ask every patient we treat to complete a detailed questionnaire. Based upon responses received, the weighted satisfaction with our ophthalmic service has been 97.3%. Questions include satisfaction with nursing attitudes, doctor attitudes, our pre-operative pathways, and the overall customer experience.
CONCLUSIONS

13. Based on our experience, our conclusion is that the government’s early stage ISTC initiatives have demonstrated that the NHS can successfully partner with the independent sector to the benefit of patients, without compromising its core values. We support the continuing rollout of the programme, including the transfer of risk to the independent sector through reductions in guaranteed referrals. Moreover, the government’s medium-term financial strategy suggests that the rate of increase in NHS funding will slow significantly beyond 2008. One implication of this is that it will be difficult to drive continuing improvement in capacity or waiting times by resources alone. This is likely to focus attention on innovative structural reforms, including patient choice, and partnerships with the independent sector for the provision of a variety of treatment services.

14. We would be delighted to welcome members of the Select Committee to view any of our operations. Please do not hesitate to contact me if this would be of interest.

Mark Adams
Chief Executive Officer
Netcare
13 February 2006

Evidence submitted by the NHS Alliance (ISTC 41)

1. INTRODUCTION

1.1 The NHS Alliance is recognised as the principal independent representative organisation for primary care. Its membership includes primary care organisations in the UK and GP practices, while individual membership is fully multi-professional, including NHS chief executives and other managers, doctors, nurses, allied health professionals, pharmacists and other primary care professionals together with PCT board chairs and non-executives. In particular it reflects the critical partnership between lay people, managers and clinicians in planning, securing and evaluating efforts to improve the health of local populations. It is in regular and close contact with Ministers and the Department of Health.

1.2 Its 12 professional networks have a growing role in sharing good practice and informing strategy and policy at a national level. In addition, the NHS Alliance is unique in bringing together practices and primary care trusts in planning, securing and evaluating local health services.

1.3 The NHS Alliance is committed to values of fairness, equity and collaborative working within a structure that is mutually supportive and accountable. Both national and local organisations have an important role to play in delivering those values.

1.4 This Memorandum of Evidence is provided on behalf of NHS Alliance members.

2. THE CURRENT EXPERIENCE OF INDEPENDENT SECTOR TREATMENT CENTRES

2.1 NHS Alliance members are more than willing to work in co-operation with the private sector. We have identified none who object to the principle of private sector involvement with the NHS. However primary care trust PEC chairs (clinical chairs) and senior managers report mixed experiences of Independent Sector Treatment Centres (ISTCs). Some have seen improved access, reduced waiting times and good quality services while others have experienced few benefits. Those areas where there was good engagement with local GPs and acute trust consultants at the planning stage are more likely to report positive outcomes.

2.2 ISTCs’ access times for patients are generally good and this is very welcome. However a relatively small proportion of patients benefit. The services provided by ISTCs are limited to specific surgical procedures within a given speciality (as defined by the ISTC’s local clinical criteria) and only those patients who fall within this definition are treated. There is not a general benefit to all patients.

2.3 The ISTC first wave contracts were negotiated on a national basis. PCTs have been committed to these block contracts that provide guaranteed payments to the ISTC—via their Strategic Health Authority’s share of the national contract—regardless of work done (the “Minimum Take”) and at a higher price than the national NHS tariff. At least some of these contracts are due to run for five or seven years. PCTs are required to “find” patients to take up their share of the activity within the ISTCs. For a variety of reasons, in some cases that has proved impossible, resulting in a financial loss to the PCT. Understandably, those PCTs that are managing deficits are particularly anxious about the consequent impact on patient care in clinical areas not served by an ISTC. Examples are described in the annex to this document.

55 See www.nhsalliance.org
2.4 Even where decisions were imposed by SHAs, many ISTCs are working well. Often this has depended on the active involvement of primary care trust PEC chairs. For example, in Somerset the system is working close to capacity and is popular with patients while North Bradford has cut waiting times for day surgery to four weeks. Elsewhere the experience is less happy and patients as well as professionals have rejected ISTC services.

2.5 The lack of widespread clinical engagement with local GPs and NHS hospital consultants has been a significant failure of the first wave of ISTC procurement. In some areas, the Department of Health’s national implementation team did visit local communities where an ISTC was being developed, staying in the local area and talking to local health professionals. This type of good practice is helpful. However, it would appear not to have been the standard in every area. As a result, local clinicians in both primary and secondary care have felt disengaged and angered by the lack of meaningful dialogue regarding local clinical issues and their interest, commitment or willingness to work with the ISTCs.

2.6 There is a perception that the first wave contracts were politically driven regardless of whether the impact on patient care would be positive or negative, and at any cost. Some members have expressed concerns about clinical quality or that contracts are too inflexible to meet local needs. In one case—Barnet—that has resulted in the curious problem that a PCT that wishes to use local independent sector providers is prevented from doing so.

3. The Future: Changes Government should make in its Policy Towards ISTCs

3.1 There are significant conflicts between current ISTC policies and both Payment by Results and Practice Based Commissioning. If PCTs are locked into national contracts, what ability will practice commissioners have to commission services they select—or to redesign to deliver more cost effective services in primary care? How can practice based commissioners achieve savings where their PCT is locked into a long term block contract? How can Payment by Results operate fairly and effectively where there are first wave ISTCs that have advantageous financial arrangements? These conflicts must be resolved if NHS reforms are to deliver real improvements.

3.2 The NHS Alliance believes that the IS Procurement Programme should be undertaken on a “call off” basis, with PCTs able to access activity as and when required, paying only for activity that is actually used. Whilst the principle of paying only for activity when utilised has now been recognised within the current 2nd Wave Programme, presently out to tender—and this is to be welcomed—the NHS is still paying for under-utilised IS contracts because they have been unattractive to local patients for a host of reasons.

3.3 That implies that existing contracts with 1st Wave ISTCs should be re-negotiated.

3.4 It also implies that future procurement should depend upon the decision by each primary care trust, agreed with its practice based commissioners, that there is local requirement for the service. It is clear that Value for Money is dependent upon procuring and paying for only those services that are needed, that practice based commissioners are content to commission, and that patients are willing to use.

3.5 Genuine clinical engagement within both primary and secondary care is critical within any IS programme. Effective local clinical pathways, suiting the needs of local patients, are essential if clinicians and the public care to have confidence in the health system. There has been some recognition of this within the 2nd Wave Programme, but it needs to be a fundamental requirement of any negotiated IS contract.

4. Additional Information

4.1 Further information is provided in the attached annex to this document by NHS Alliance members with direct frontline experience of ISTCs.

NHS Alliance
15 February 2006

Annex

Independent Sector Treatment Centres: Messages from members of the NHS Alliance

The NHS Alliance members quoted below include primary care trust clinical (PEC) chairs and NHS managers from across England. All have direct experience of Independent Sector Treatment Centres. Comments were received during January 2006. Should the Committee wish to do so, any or all of these contributors can be contacted via the NHS Alliance head office.
**DR A, PCT PEC Chair**

*Do you have experience of Independent Sector procurement?*

Yes. ISTC started up last year.

*What specialties does it affect?*

Orthopaedics, General Surgery, Ophthalmology

*What is the role of your SHA in this?*

They made the decision. The PCTs were informed that they had committed five years to the project.

*How involved are local GPs and healthcare professionals with Independent Sector (IS) commissioning in your locality?*

With some difficulty, because the resourcing of the project studiously avoided including remuneration for primary care input. Thus it was all left to the PEC Chairs. It was successful but dependent on the PEC Chairs alone to devise the clinical pathways and to sell the concept to their partners.

*Is it popular with local residents?*

Yes—because it reduced waiting times.

*How much of your commissioning does this constitute?*

Between 3–15%

*Do you have local care pathways agreed with the independent sector?*

Yes but because of the lack of resource commitment to securing the Primary Care input locally into the devising of these pathways, they are fragile and incomplete. Thus the managers blame the GP for “not referring enough” and the GPs blame the managers for not making it clear enough in the pathways. The system is working close to capacity only because of the fact that we have a very well developed Referral Management Centre — again something that was devised locally without central support.

*How has it affected relationships with your local NHS providers?*

It has certainly been helpful in beginning to break down the stranglehold of the NHS Trust providers locally. It has allowed us to begin discussion with them about service improvement in other areas because of the fact that they are now aware that there are other ways in which we can secure provision of services. On the negative side, it has created a degree of separation where the cultural of division and criticism can be allowed to creep in.

*How do you anticipate this policy will progress in the future?*

I suspect that the lessons learned will be widened considerably, including into Primary Care.

*What impact will practice based commissioning have on this policy?*

It will control the potential excesses of these projects. If PBC is genuinely left to practices then local capacity such as ISTC will be correctly utilised—patients will be matched to capacity in the early stages and it will then develop into a system where the capacity is matched to the patient.

However there is much scepticism about whether the PCT managers will allow PBC to flourish or whether they will insist on grand localities in order that they can maintain control on the commissioning budget.

*Does IS procurement work for you?*

Yes. More importantly it has worked for our patients by freeing up the local health community to allow services to be developed without one or other group having a monopoly on the system. It is beginning to allow Hospitals to concentrate on the more complex cases and let other cases be done in more appropriate (less complex and costly) surroundings.
The ISTCs work only if they are developed as part of the local health community and not in isolation from on high. This means that the importance of resourcing Primary Care clinicians to lead the projects locally is the main determinant of their success or failure.

**Dr B, PEC CHAIR**

We have two ISTCs with which we have contracts, one which is open and does orthopaedic surgery at an isolated site and a second which will do a wide range of outpatient and daycase clinics and treatment. They are quite different schemes and I will deal with them separately:

**ISTC one**

This was not welcomed by clinicians or clinical leads from the outset and was identified as being a high risk to the PCTs by the PEC Chairs. Three factors caused concern:

1. The geographical isolation from acute hospital support which limits the types of patients with co-morbidities that can be treated,
2. The type of fixed-volume contract for which the NHS is paying whether or not the work is done,
3. The use of overseas staff for whom we needed reassurance concerning qualifications and language.

All three issues have proved to be real: We have found that the ISTC excludes so many patients that it is difficult to find patients fit enough for them to treat. The geographical isolation has also deterred patients from choosing the ISTC because of the traveling distances involved both for patients and visitors.

Because of the difficulty in finding patients to go there we have not been able to fill the contract and the NHS is regularly wasting money that could have been spent on treating patients in a more suitable setting.

The clinical leaders pointed this out in no uncertain terms at the contract negotiation stage and were overruled by the SHA and National Negotiating teams. There have been isolated issues around communication and different specialist qualifications especially in the early stages of the scheme although these do appear to have been sorted out now. As PCTs, the Boards and CEOs were put under considerable pressure to sign up to the scheme despite major misgivings—it was made very clear that refusal to sign up was not an option. It is important to note that as a clinical leader I am not against the wider use of the Independent Sector; nor am I against innovative ways of working to act as a catalyst for change in the NHS. Our criticisms of this scheme were practical ones concerning the geographical isolation and the ridiculous nature of the contract that we were letting ourselves into. This was clearly driven centrally to make this happen at any cost.

**ISTC two**

This has been in many ways a different project in that much of the clinical staffing will be provided by the NHS and services will transfer redesign of clinical pathways are an integral part of the scheme and the issues of geographical isolation and travel are clearly not present in this scheme.

We were still forced into signing a fixed volume contract against our better judgement and this runs the risk of compromising the flexibility available to future commissioners for many years to come. It was somewhat galling that as clinicians we kept saying how stupid it was to sign such a contract only to find that after it had been signed the Secretary of State announced that future schemes would not be subjected to such restrictions! Because we are in the early waves with two ISTCs we are left penalised for many years to come with nationally agreed (and now discredited) fixed volume contracts. We have asked on many occasions what happens to those areas with pre-existing fixed volume contracts but no answer has been forthcoming. Nottingham will not be a good place to Implement Practice Based Commissioning with two major fixed contracts, which will run for the next five to seven years. Payment by results cannot function effectively in such a contractual straightjacket, which is very frustrating.

Looking to the future we need to ensure that there is a level playing field for independent providers. That needs to work both ways—the NHS mustn’t be disadvantaged by preferential fixed volume contracts being given to the independent sector, but equally we need to include these new providers as partners in our planning and redesign work so that they become a fully integrated part of the local health system. At the moment it still feels very much “them and us” in part because of the poorly thought out contractual arrangements we were pushed into signing.

**Dr C, PEC CHAIR**

I write to support all the comments that Dr B has already sent you. The impending ISTC two (see above) has added complication that although it was sold to the Health Community as a solution to the capacity problems that will hold back our achievement of the waiting list targets, specifically the 18/52 referral to treatment one. The problem is that as it does not come on stream until December 2007 we will have to do much of the work getting the waits down before we can actually use the solution. In the meantime we cannot afford to do that at National Tariff and in a rational world we would be hoping to redesign pathways and
provide many services in the community, utilising the brand new and extensive LIFT facilities that are currently coming on stream, (another major financial drain on our resources if they are not used to their maximum), and the burgeoning skills of Practitioners with Special Interest. (Rather as we presume the White Paper will be telling us when it eventually emerges). This will require an investment of finances, but also crucially, clinician engagement and demonstration of commitment for a long-term career path. Then all of a sudden over 2008–09 we will find ourselves increasingly committed to paying for the same work to be done at the new ISTC, at National Tariff.

This will mean we either will have to pay for unused TC capacity or empty LIFT premises and telling our GP/PwSIs to go back to their day jobs. We won’t be able to pay for both.

The underlying problem is the Minimum Take heavy-handedly imposed upon local PCTs by the National team using the performance management clout of the SHA. As Stephen says it is especially rankling that the Secretary of State was able to achieve such kudos by grandly announcing a “level playing field” at the NHS Confederation conference last summer. In Nottingham having fallen foul to two consecutive extremely “Unlevel” situations our patients will be suffering from these financial disasters for the next seven years.

I am not against the principle of ISTCs and I do see that there will be a general raising of standards in clinical processes as a consequence, although we do have a greater challenge in engaging hospital physicians to look at the community alternatives in patient pathways as a consequence to the ISTC’s being very hospital based.

Dr D, PEC CHAIR

Dr B and Dr C have effectively summarised the local situation.

It is difficult to understand how Payment By Results, Choice, and Practice Based Commissioning are going to work in a health community where a great deal of resource is tied up in “Minimum Take” contracts. The NHS Alliance would do many areas a great service if it could bring influence to bear to produce a level playing field—at minimum scrapping the ludicrous and unfair “Minimum Take” arrangements.

The advent of the Orthopaedic ISTC has strained relations with local orthopaedic surgeons, who have publicly expressed their displeasure. ISTC two will be utilising local clinical resource so we are more optimistic that true service integration may happen though, as Dr C says, too late to help us hit the 18/52 targets.

There is certainly widespread evidence of “cherry-picking” by the Orthopaedic ISTC—leaving the NHS to pick up the more challenging cases, as well as all the teaching/training/medical complications. There are anecdotal reports of adverse clinical outcomes, but this has not been objectively substantiated.

Finally, I should be interested to learn how much the DH spent, through the offices of the National Implementation Team (NIT), on the procurement of the first wave ISTCs? If you total the cost of procurement with the money continuing to be lost through unfilled “minimum take” contracts across England I think you are likely to come up with a very large number.

Dr E, PEC CHAIR

Contract was negotiated centrally and does not reflect local need.

This contract is valued at £1.5 million, in a county with deficit of approx £20 million.

ISTC is a five year contract providing routine orthopaedics procedures only.

This process has disengaged primary and secondary care. Local NHS trust consultants very irritated and relations have been damaged as a result.

Good points: good quality of care, good waiting times, patient experience good and promptness of response.

Overall perception is that it is not a completely unsuccessful venture but seemingly a mess.
F, Senior Portfolio Manager—Care Pathways

Do you have experience of Independent Sector procurement?

Yes we have used the IS when there has been a lack of capacity in our local NHS providers in order to meet waiting time targets. This has been planned throughout the year not spot purchases of capacity.

What specialties does it affect?

Orthopaedics, Plastics mainly.

What is the role of your SHA in this?

Little—only that ensuring our commissioning plans are robust.

How involved are local GPs and healthcare professionals with IS commissioning in your locality?

Little or no involvement although they are interested when their patients go to the IS.

Is it popular with local residents?

Yes as long as the IS provider is local.

How much of your commissioning does this constitute?

A small amount—less than 3%.

Do you have local care pathways agreed with the independent sector?

Yes but high level.

How has it affected relationships with your local NHS providers?

It has been welcomed.

How do you anticipate this policy will progress in the future?

No doubt NHS will be the provider of preference but as costs level out between the NHS and IS I’ve no doubt that practices may well choose to commission activity through the IS when it is quicker more convenient and the costs are the same.

What impact will practice based commissioning have on this policy?

As previous.

Does IS procurement work for you?

Yes.

G, PCC Chair

We have recently commissioned retinal screening from an independent provider and this has certainly caused a problem with our local providers. The way services are delivered/VFM and clinical pathways are not generally all considered at the commissioning end when pressure to deliver VFM is seen as paramount in a deficit situation. Costings are generally not always on a like for like basis. Whilst every effort has been made to make the clinical pathway smooth for users the great asset of multi disciplinary teams is shattered and skills are lost from within the team and for patients there is fragmentation. Against this is the increased standards expected from all teams to deliver what is currently commissioned—the failure to do this is the
signal for re-tendering. More user and PC involvement in the process of commissioning must go hand in hand with patient education and personally directed care. Lots to learn. Objectives to be absolutely clear and clearly linked to performance monitoring.

**DR H, CLINICAL DIRECTOR**

The ISTC procurement process in our area was highly politically driven—little clinical input from primary or secondary care. Present case mix is probably unsustainable and only recently have we been allowed to have direct discussions with provider.

The financial risk to PCTs is considerable.

Includes some minor surgery for dermatology, endoscopy, cataract extractions, hernias as well as diagnostics [Xray and USS] + WIC and minor injuries.

Concept of alternative provision is not a problem and with better clinical input initially we may have developed a better contract mix.

Only opened at Christmas so experience of patients difficult to judge.

WIC/MIU likely to be popular—but expensive as may be taking patients out of primary care rather than secondary care.

Diagnostics likely to be popular as quicker reporting times than acute trust.

Elective care is unknown as yet.

**DR I, PEC CHAIR**

We have spent the last four years in our area, planning and are now building a PFI Hospital which will provide both a diagnostic and treatment centre and acute medical beds as well as step down and rehab beds. We have also spent the last 12 months developing a clinical service strategy for the Hospital.

We have now been informed that the whole Hospital is to be put out to tender to ISTC!! This begs a number of questions:

— How will the staffing be arranged, as the services at present are largely integrated with pathways across primary and secondary care?
— Who will supply junior staff and the training input required?
— In the light of the impending white paper, how will we be able to break the barriers between primary and secondary care if the ISTC sits outside integrated care management.
— Early discussions with DOH suggest that they are uncertain how an ISTC is to approach the provision of acute medical services as opposed to the traditional cherry picking, production line elective care.
— The SHA has made the decision as far as I can see, on financial grounds without any meaningful discussion about the clinical impact.

Whilst on the subject we also locally have a first wave orthopaedic ISTC which employs largely overseas staff, which has been pretty divisive. There is virtually no co-operation between them and local NHS consultants which has led to gaming, arguments about post operative problems, and competency disputes. There are a number of anecdotes floating about but perhaps it would be best if I didn’t put them on paper.

More positively I suspect that a new perspective on this process that envisaged integrated service providers, associated with the localities emerging from PBC could be very exciting. Such an organisation would be largely clinically led, would sit outside both Primary and Secondary care and would be responsible for ensuring best care for a specific organisation. This would mean that the onus would be for best care not best profit.
Dr J, PEC Chair

Reply below after discussion with our Commissioning Director:

This request would appear to relate to the nationally procured activity rather than any locally procured IS services. For us that relates to cataracts, a small number of hips and knee replacements under what is known as GSuPP and very recently the use of an MRI service provided by Alliance Medical. In respect of the questions asked:

- Specialties are ophthalmology and orthopaedics plus MRI.
- The SHA have been leading the process on our behalf.
- I suspect that GPs are not very involved or aware of the ISTC services.
- The cataract service gets good patient feedback. The location isn’t ideal especially in the winter but patients have been offered and accepted another option.
- It currently represents a very small amount of our commissioning. Obviously this will increase when the Wave 2 programming comes in to force late next year.
- All referrals are processed via the RMC. Care pathways are in place particularly for cataracts. There have been problems in the past regarding follow up OP reappointments for GSuPP as the contract only include one f/u and not the six or 12 month review for joint replacements. The SHA is currently negotiating on our behalf with this years GSuPP provider to carry out these appointments but the PCT will need to pay.
- I would say that the local NHS provider accepts that they don’t have the capacity to meet demand and achieve access targets and so accepts the presence of these services.
- Given the Wave 2 programme this policy is obviously progressing and will include more activity and services including CATS (locally procured IS services). This will radically change the way patients access services and impact on the type of work the acute Trusts will need to provide.
- My understanding re PBC is that the localities will need to make use of any nationally procured services the PCT has commissioned. For this to work I believe that the IS services need to be provided in an accessible location for patients and dovetail with local NHS services.

Dr K, PEC Chair

Do you have experience of Independent Sector procurement?

Yes.

What specialties does it affect?

Mainly orthopaedics but also plastic surgery.

What is the role of your SHA in this?

Have taken the lead.

How involved are local GPs and healthcare professionals with IS commissioning in your locality?

Not at all.

Is it popular with local residents?

No—usually because they already have an arrangement following an OPD appointment and have a relationship with a consultant—they then don’t want to change

How much of your commissioning does this constitute?

Not sure—.

Do you have local care pathways agreed with the independent sector?

Not really.

How has it affected relationships with your local NHS providers?

Has not yet.
How do you anticipate this policy will progress in the future?

Would be better if it was a choice of referral from the outset but practice based commissioners will not use it if they have to pay above tariff.

What impact will practice based commissioning have on this policy?

As above.

Does IS procurement work for you?

Not at present.

**DR L, MEDICAL DIRECTOR**

As medical director, I had no direct experience of IS procurement but I certainly heard about its effects. We had Medical Alliance procured by the government on our behalf for MRI scans. I believe that over half of the scans performed had to be re-reported by our local hospital’s own staff as they were of such a poor quality.

When MA were procured again, they were only able to carry out half the number of MRI scans that they were commissioned to do, so setting back our plans for achieving the 26 week wait for diagnostics. In our local health economy, we have the equipment for diagnostics standing idle as we can’t afford the revenue to staff the equipment. We would have preferred to have the money that was ring fenced for IS procurement to use within our own health economy.

**DR M, PEC CHAIR**

In our PCT there is an orthopaedic ISTC operating, and has done so for a couple of years. There has been intense irritation locally that budgets have been top sliced and given to the ISTC whether or not there has been full activity. The reason for a shortfall in the number of patients attending the ISTC is predominantly due to patient choice, ie to go elsewhere. This will change with PBR, as presumably budgets are not top sliced from the PCT anymore.

All GP referrals go via a triage system manned by extended scope physiotherapy practitioners and GPs with a special interest, and it is at this point that choice takes place. There has been a slow increase of referrals to the ISTC since its conception. Their waiting times are shorter which is popular with patients, but the actual care and follow up and satisfaction appears very similar to local NHS hospitals.

The SHA are obviously aware of the development of the ISTC. Local GPs and health professionals are consulted about the ISTC and encouraged to use it/advise their patients to use it, but they are not involved with the commissioning process itself. The care pathways are similar to the NHS ones. The local hospital is anxious about the ISTC cherry picking all the easier patients, and themselves being left with the complex cases with co morbidities, but only being paid the same tariff. Practice based commissioning may well alter the referral patterns, but it is still in infancy locally.

**DR N, GP/PEC CHAIR**

We managed to escape—narrowly—in our area after amazing bullying tactics against all CEOs involved and wasting months of planning and clinical time and £££s in project management.

Final escape was as the acute trust was FT—and Monitor won the day on non-affordability!!

**DR O, PEC CHAIR**

We have three local private hospitals with in 30 mile radius. I’ve contacted all three to ask for help with practice based commissioning to purchase cheaper than tariff appointments, mainly thinking of one off consultant opinions eg first gen med o/p appt local acute trust £540, (admittedly including x-ray, bloods, scans etc) at private hospital (no tests just opinion) £120. Two of the hospitals are working so close to capacity with more lucrative surgical stuff they can convert to operations, they can’t really help us. The more isolated one is being more helpful as its o/p capacity is only running at 30% full. However, actually pinning down the nitty gritty of how we could make it work is being quite tricky so far. They are offering us a broader menu of options including investigations of varying complexity for more money. We have not sent an actual patient yet but I live in hope!

I have been upfront with our local acute trust about this work as I do not wish to sour relationships with them.

Not much help I know but all I have.
The local ISTC project commenced in early 2003 with the aim of developing a primary care facing treatment centre—those main aim was to dramatically improve access to diagnostics, by delivering one stop diagnoses, and direct access to day surgery without always needing an outpatient appointment prior to being listed. This was highlighted in the early days of the PCT by patients and GPs as a key priority.

The treatment centre was put out to tender as part of the wave one ISTC bids and the contract was awarded to an American company. The diagnostic element of this service is subcontracted and provided by an Australian company.

The contract provides the PCT with direct access to:

- MRI;
- CT;
- fluoroscopy;
- plain film;
- ultrasound;
- endoscopy;
- colonoscopy;
- general surgery;
- urology;
- ENT;
- ophthalmology;
- plastic surgery;
- gynaecology;
- oral surgery;
- orthopaedics.

The project was PCT led, with help and support from the National Implementation Team (part of the DOH), and legal support.

**Key objectives**

The key objectives were to:

- Improve access to diagnostics and reduce reporting times.
- Provide one stop diagnosis so that patients could get a definitive diagnosis and treatment plan prior to leaving the TC in one visit (including referral into a cancer MDT where appropriate) and stop the patient “ping ponging” between different clinical professions prior to getting a diagnosis.
- Provide direct access to day surgery using protocol driven referrals to reduce the need for consultant outpatient appointments prior to surgery and enable patients to just have pre-op then surgery.
- Deliver reduced waiting times for day surgery.

**New ground**

- Already providing one stop diagnosis and we have examples of patients who have referred routinely by the GP, something suspicious has been identified, and the patient has had a plain film, ultrasound, and MRI in one visit and then been referred straight through to a cancer MDT.
- Delivering one week maximum waits for urgent diagnostic referrals and two week maximum waits for routine diagnostic referrals.
- Delivering all reports back to GPs within 48 hours of the patient being seen (at the local NHS Trust reporting is taking about six weeks for routine referrals).
- Producing dramatically reduced need for consultant outpatient appointments as GPs can refer direct without going through consultants.
- Delivering maximum four week waits for day surgery for direct referrals.
- Reducing the need for outpatients prior to day surgery.
- Using new pathways from referral to treatment for:
  - rectal bleeding/ change in bowel habit;
  - headache;
  - hoarseness and other ENT;
— dyspepsia;
— inguinal swelling;
— right upper quadrant pain; and
— haemoptysis.

Delivering a hugely improved service to patients who have better, more local access, with less time when they don’t know what is happening (usually due to slow reporting—and the need to book an outpatient appointment to get results—GPs are now determining next steps).

Outcomes

1. Dramatically reduced wait from referral to diagnosis and treatment for those patients who have a definitive diagnosis

A report from the on-site Radiologist is attached:

“We have had multiple new malignant diagnoses some of which have been follow-ups of other examinations performed elsewhere although many also very unexpected. We have had lung, renal, pancreas, ovarian, a skull base lesion and an acoustic neuroma and almost certainly others.

One patient, a late middle aged man presented with vague abdominal symptoms from his GP for an ultrasound. This revealed an abnormality in the epigastric region which we were able to investigate immediately with CT and this proved to be a pancreatic tumour.

A middle aged man with sciatic symptoms had multiple metastatic lesions in the lumbar spine on MRI with no known primary lesion.

Another man who had metastatic disease to brain and liver on initial examinations (MR brain and ultrasound abdomen) also had an abnormal chest x-ray and was referred back for further imaging (CT chest abdomen and pelvis) after the GP had consulted with a consultant oncologist at BRI.

A lady with a liver lesion on ultrasound and a past history of malignancy was assessed with CT and the lesion found to be a large haemangioma rather than metastasis.

A full time onsite radiologist means that the radiographers have direct access to the radiologist so that examinations can be specifically tailored to the patient and additional or substitute examinations performed with the patient in the department.

We have been able to substitute more appropriate examinations. A lady with a history of loin pain had been imaged elsewhere with a KUB showing a possible right renal calculus and was referred to us for an IVU. I thought that the appearance was unusual for a calculus and we substituted at CT which revealed calcification in a renal artery aneurysm on a background of probable bilateral renal artery fibromuscular dysplasia as the final diagnosis. Today we followed an IVU study showing a poorly functioning left kidney with a CT scan and this revealed a final diagnosis of renal vein thrombosis.

Patients with abnormal plain film or ultrasound findings proceed immediately to another investigation (usually CT or MRI) and some with abnormalities which have not been prospectively identified by the radiographer at the time of the examination have been recalled for further imaging rather than issuing a report to the GP simply recommending another test.

GPs have been pleased with the prompt service we are able to offer their patients and their direct access to a comprehensive radiology service. We have also fielded calls from GPs regarding appropriate ordering and have been happy to talk with them to promote appropriate referral patterns and ultimately better patient care.”

2. Vastly improved access—maximum two weeks for diagnostics and four weeks for day surgery.

3. Fantastic patient and GP feedback.

4. Reduced need for consultant outpatient appointments—so reducing waiting times, and costs (via PBR).

Note: This project was the winner of the service re-design category in the 2005 NHS Alliance Acorn Awards.

Q, DIRECTOR OF MODERNISATION AND COMMISSIONING

Thank you for giving me the opportunity to brief you on ISTC Policy.

Historically, our PCT has commissioned very little from the private sector. There are no independent private providers located within the PCT. The nearest are 15–20 miles away. Our local ISTC is considerably further and inaccessible to our local population and certainly further to travel than would be clinically recommended for a day case, so the ISTC policy is not very accessible for our residents.
Our more general experience of nationally procured diagnostic and other activity (not specifically at ISTCs) would be that the contracts are insufficiently flexible to accommodate local circumstances, and they allow providers to “cherry pick” or refuse patients who don’t meet certain criteria—usually patients are “too ill”. This does not endear the independent provider to local NHS services and often the smooth running of the IS service is dependant upon relationships with local NHS services. The IS providers are certainly seen as being favoured with the choice to refuse to treat NHS patients with NHS services having to treat all comers.

Sorry not a very positive experience to date, hope these comments can be conveyed. If you require further detail please give me a call.

DR R, PEC CHAIR

At this time there is no local ITC, but a site has been identified for one of two surgicentres to be built in the county.

Contracts have just been finalised and building is due to start early 2006.

Examination of the finances and the effects it will have on the local acute trust are somewhat surprising.

Firstly in contrast to elsewhere the contract is a block for a fixed amount of work, and this has been agreed without any clear understanding of how much work will actually go there—it is all dependent on patient choice and if they choose elsewhere than we could easily be paying twice for surgery.

Secondly for the amount of work contracted (all the cold and day surgery), the current local provider is being left with emergency and majors, and calculations suggest the income to the acute trust is so diminished that it becomes unviable. There is some mixed feeling in primary care about this but I am sure the local population won’t be mixed in their feelings. I suppose this might have lead to some sharpening of the minds of acute staff but it does not seem to have done.

Generally the understanding of the applications of PBC has bypassed most hospital docs who are busy trying to impose their wills still.

S, ACTING DIRECTOR OF COMMISSIONING

Our experience of having an ISTC on the patch has been varied. On one hand we have experienced frustration over lack of clarity of type of patients to be referred for treatment, yet the contestability on the patch has encouraged our local NHS provider to reduce its waiting times for diagnostic and daycase surgery.

Ensuring consistent quality has been the most difficult aspect. We are fortunate that the local diagnostic services deliver exceptional, quality reports which currently cannot be mirrored by the ISTC, although plans are in hand to overcome this difficulty by increasing the access of the ISTC to “specialist” consultants.

In the future, it should be “quality” that drives the contract not cost.

T, ASSISTANT DIRECTOR OF COMMISSIONING—SERVICE REDESIGN

I am writing this letter on behalf of the Joint Executive Committee Chairs for my PCT, as part of your request in respect of the above.

We have involvement with two TCs.

Both TC’s have allocated DoH contracts managers, who support the local sponsors and provide a facilitation role. Our patients who choose a TC, are supported by a patient care advisor as part of the PCT choose and book centre team.

Feedback from the majority of patients is good, particularly shorter waits for assessment and surgery, but there have been some teething difficulties at the start.

All pathways have been agreed via DoH colleagues, and there is regular discussion with local NHS colleagues, particularly clinicians, but this usually happens if something goes wrong.

Probably the biggest issue with the current TC policy is the requirement of a PCT “minimum take” ie you pay whether you use or not. This cuts across the whole patient choice agenda. Also due to the somewhat inflexible casemix of the legally binding contracts it does cause some friction, because after assessment the patients requires a particular treatment regime which is not covered by the contract.

It is too early to guess the impact on practice based commissioning because WLPCT is only just starting it’s thinking, but in summary personally I think the ISTC capacity has helped achieve the shorter waiting lists etc, but the process is very restrictive.

If you wish to discuss further please do not hesitate to contact me.
Dr U, PEC Chair

Our PCT has commissioned a private provider for cataract surgery from 1 April 2006. The PEC clinicians, GP clinical director and optometrist assisted in assessing the unit, visiting it and supporting commissioning managers in setting the specification for the service. We plan to use the same mechanism to assess all our providers in due course, both NHS and private.

Patients are already asking GPs for alternative private providers. Some have experienced these through GSUP. We ran into some problems with follow-up with these providers which has helped us with the specification for eye service. I have asked V, Director of commissioning to give you any further details.

V, Director of Commissioning

This is a sore point with me highlighting how the central NHS bureaucracy limits local innovation and responsiveness to local market conditions/capabilities. Our PEC Chair has already replied to you separately with our position. I just want to emphasise some points that need to be made out of our local experience.

The demographics in our area have allowed a flourishing private health market to be established. Approximately 30% of all elective inpatient, daycase and outpatient care is conducted in the private sector. Of course with the information systems in place this activity is almost impossible to map with accuracy—we have relied on surveying our local GPs. The volume of customers has meant that there is a rich diversity and quantity of providers—approximately 20 alternative hospitals and clinics providing private care on a mainly daycase basis. Most of these providers are small independents although the large corporates such as BUPA, HCA, BMI and Nuffield also operate.

This range should mean that we are an ideal location to measure the impact of choice on patient behaviour. It is also an ideal set of market circumstances to drive up quality and reduce price. Sadly we are really struggling to set a framework up locally because of the NHS centre central contract and the plurality of provider issues slipping down the priority list after Commissioning a Patient Led NHS issues and setting up PbC.

A national procurement was issued last year for private providers to bid for. Fine if you are large but most of our providers are small one-centre sites and were unaware of the invite and tender obligations. Many have struggled to understand the Choose and Book requirements which are essential for entering the NHS Choice menu and therefore the PCT is actively assisting them with this.

Due to the national contract I will not be allowed to use the local small providers from next year, which is detrimental to our patients locally and removes a potential big win for PbC. I want to do everything I can to enable the small providers to be able to play a part in providing care to the local NHS population.

We have tried to initiate contract for cataracts with three local small providers and orthopaedics with two large providers—BUPA and HCA. These have become enmeshed in the arguments over complexity and the market forces factor—of which more later.

The difficulty for me as Director of Commissioning is that I could use the local private provider market to (a) influence quality and (b) drive down price. It also would allow us to give access to excellent private care to all NHS patients as well as private. I am being denied this capability. For practices entering PbC for example—the private providers are able to carry out cataract procedures £200 below the standard national tariff and pay the optometrists a referral fee as well. This would save the average practice approximately £4,000 per annum on a typical referral pattern. Similar savings levels are achievable with other elective surgical procedures.

To overcome the cherry picking argument—private providers only taking the least complicated cases—it must be remembered that the NHS providers receive a market forces factor (MFF) top up to cover cost of living differences. Locally this is 22%. The private providers are only paid by the PCT at the Standard Rate ie 22% less than the NHS trusts to allow for complexity differences. If a private provider relaxes the admissions criteria we would want to add a varying % to the base tariff to cover the increased complexity.

Unfortunately, the central financial rules for next year seem to have failed to address the cherry picking argument again despite them being told on numerous occasions about the problems. The PCT’s budget for next year has had the MFF top sliced from its budgets and handed directly over to the NHS providers who have historically provided the activity. The PCT is therefore not able to withdraw this funding from the NHS Trusts even if private providers carry out the activity for us. In other words for private providers to do the activity they have to do it for the base tariff without any MFF. This is fine if it is for the base activity but if we want them to do more complex activity they deserve some of the MFF top up. The PCT will be unable to fund this as it has already been allocated out to NHS providers and we can't get this back.

We also would wish the private sector and NHS to work collaboratively to further junior medical staff education. Our private units carry out procedures to a very high level of skill and efficiency—in most cases conducted by Consultants who work in the local NHS Hospitals. Training of juniors should therefore be possible to arrange to the benefit of all parties.
To ensure quality the PCT carries out an inspection of all providers who wish to join our menu of choice. The reports are presented back to the PEC meeting for opinion and agreement. The inspection uses the Healthcare Commission evidence as a start but goes further in measuring consumer satisfaction, Health and Safety and risk management procedures.

**Dr W, PEC Chair**

Contract provides for 11,500 procedures over a five-year duration. This provides daycases and outpatients in orthopaedics, general surgery, ophthalmology and endoscopy. The ISTC team is operated by a team from America.

The facility is a 34-bed unit with MRI facilities.

Clinical exclusion criteria have been agreed locally.

24/7 medical and anaesthetic cover is in place at the unit.

Good clinical results being achieved.

Generally working well now with good clinical outcomes.

However, GPs were not initially involved in contract discussions or the set up arrangements—this created much angst. Tensions were also in evidence with the local NHS consultants and acute trust. Our local press made much of this tension at the time but seems to have settled down now.

**Dr X, PEC Chair**

Some patients are already using an IS provider for orthopaedics and we believe this has added choice and has helped relieve some of the waiting list pressures on orthopaedics. However, our major experience with IS is just beginning with the opening of a new IS centre that will accept patients from our trust.

Initially we have been impressed and the new building that will soon receive patients is impressive. We have negotiated hard to ensure that local staff are not cherry picked and we do not believe this has happened. We have also negotiated a bundle of procedures to be offered. The IS has been quite prescriptive in what they have wanted in that bundle and I cannot say we have got everything we would have liked.

We now need to carefully manage activity through the IS to ensure that we fulfil the required quota we are paying for. We shall have to manage patient choice accordingly because if patients choose other providers and the IS does not receive quota, we shall in effect be paying twice. I sense local GP engagement has been positive—but the jury is out until we start to get details of the quality of outcomes both in terms of patient satisfaction and clinical result.

I believe that our commissioning team are now looking at the next wave IS to focus on diagnostics. I think that this will be well appreciated by local GPs if key diagnostic services can be accessed more easily than at present. The local acute trust provider considers that that additional resource should be given them to expand, but competition is probably preferable.

I do not have more information to hand but I hope this generally favourable response is helpful.

**Evidence submitted by the NHS Confederation (ISTC 32)**

**Introduction**

1. The NHS Confederation welcomes the Committee’s inquiry into the use of independent sector treatment centres (ISTCs) and welcomes the opportunity to present evidence.

2. The NHS Confederation is a membership body that represents over 93% of all statutory NHS organisations across the UK. Our role is to provide a voice for the management of the NHS and represent the interests of NHS organisations. We are independent of the UK Government although we work closely with the Department of Health and the devolved administrations. We also have a significant number of independent sector providers of healthcare as affiliate members.

3. This evidence has been put together with members from across the NHS Confederation including foundation trust hospitals, affiliate members (some of which are ISTC providers), NHS acute trusts, primary care trusts, mental health trusts and ambulance trusts. It also incorporates views on behalf of NHS Employers.

*What is the main function of ISTCs?*

4. The Confederation was closely involved in the development of this policy. In our view the main purpose was to:
   - Create additional physical surgical capacity
— Create a route to bring in additional surgical staff to increase the capacity of the system and put a downward pressure on very high private sector fees in some surgical specialties

In addition, the policy has acquired two additional functions:
— To facilitate the provision of choice as part of the new reform programme
— To create competitive pressure on NHS and other providers

What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

5. There is limited data on both these questions. The additionality rule which prevents ISTCs from employing NHS staff unless they have not worked in the NHS for six months, has meant that there has been a significant impact on capacity from ISTCs. The waiting list targets and the prospect of ISTC competition has also encouraged NHS providers to become more productive and create additional capacity. There appears to have been some innovation in terms of the organisation of work but the claims for very much greater productivity and lower lengths of stay in ISTCs need to be handled with caution as there may have been differences in the cases selected by commissioners and the stand alone nature of ISTCs means that some cases are not appropriate for this type of service because of their anaesthetic risk. Our ISTC provider members consider that they have achieved significant innovation in design to enhance productivity and in equipping to support remote teaching.

6. There is a question about how far this will be continued if there is a relaxation of the additionality rule. Some providers consider that this is far too restrictive and may be unsustainable. However, whether or not this rule persists commissioners and other responsible for procurement will need to ensure that new investment does add to capacity. This means that all providers will need to participate in local workforce planning and be open in sharing information.

7. NHS Employers (part of the NHS Confederation) has been working with the Department of Health and staff unions to address concerns over the workforce impact of ISTCs including on their ability to recruit existing NHS staff and the pay and conditions they offer. NHS Employers agreed the Human Resource Framework for the wave one of the ISTC programme with the Department of Health.

8. The Retention of Employment Model has been applied to those NHS staff seconded to the ISTC and this also appears to be working well. It does need to be kept under review. ISTC partners also appear happy with current arrangements.

9. There is currently a review of these arrangements in readiness for wave 2 of the ISTC programme which will include a change in the rules on additionality. It is important that acute providers in the NHS are kept communicated with and involved in plans for wave 2 of this programme so that the impact on services and staff are identified in advance.

Are ISTCs providing value for money?

10. The programme has paid a significant premium to support new providers to enter the market and has underwritten volumes which does create the prospect that capacity will not be used. This obviously has significant implications for value for money and efficiency. A detailed econometric study is required to establish whether the under-use of NHS or ISTC capacity is compensated for by possible productivity gains from encouraging changes in existing providers who have been improving their efficiency—though distinguishing the impact of the ISTC programme on productivity gains will be difficult. It is possible that the arrival of ISTCs was of help in creating a pressure to do this. It is also worth pointing out that new NHS providers would incur high start up costs associated with new buildings, recruitment and running in and so some sort of premium may have been unavoidable.

Does the operation of ISTCs have an adverse effect on NHS services in their areas?

11. There has been a significant concern about this. Although the total volume of work transferred to ISTCs is small relative to the total of NHS work the impact on individual specialties can be very considerable. The nature of ISTCs and some NHS Treatment Centres is that they have to carefully select patients to ensure that they will not need the backup of a hospital. Commissioners have required this for safety reasons. This means that in some specialties NHS providers run the risk of being left with emergency and high risk cases only. At present the way the tariff is set (based on the average cost of a group of procedures) means that hospitals can lose out if their patients are more costly than average because the less sick or simpler cases have been channelled elsewhere.
What arrangements are made for patient follow-up and the management of complications?

12. We have a number of anecdotes that patients with problems arising in treatment centres (both NHS and independent) have had to be followed up elsewhere. However, this may be a teething problem associated with a new model. ISTC providers have to follow up patients until they are fit for discharge back to the care of their GP. If a patient develops complications there is a requirement that these are dealt with by the ISTC. If the complications require transfer to an NHS provider, the patient is rapidly transferred and the ISTC covers the costs.

What role have ISTCs played and should they play in training medical staff?

13. In wave one of the ISTC the training of junior medical staff has been under a Schedule of Agreement within the contracts. In advance of wave two this has been strengthened which we strongly support.

14. Our Foundation Trust members report that there is emerging anecdotal evidence from the Deaneries that there are still difficulties in ensuring training is effectively provided, with instances of long delays before trainees are able to start work. Effective teaching and learning arrangements for medical staff are essential to the long term sustainability and refreshment of the system. We need mechanisms to ensure fair reimbursement for those providers who take on the kind of case mix that makes high quality teaching possible. There should be some caution in too rapid a transfer of training responsibilities until there is certainty that the responsibilities to do so will be met.

Are the accreditation and appointment procedures for ISTC medical staff appropriate?

15. All medical staff in ISTCs are recruited and accredited under procedures approved and monitored by the Healthcare Commission which we believe is working well.

Are ISTCs providing care of the same or higher standard as that provided by the NHS?

16. It is too early to tell, but it is possible that with well defined patient pathways, systematic care and high quality audit that ISTCs could achieve very high standards of outcomes. It will be important for both the NHS and ISTCs to develop rigorous outcome measures that will allow these comparisons to be made.

What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

17. The programme has been criticised for a lack of transparency. In time however, as the ISTCs move to a level playing field and are required to meet the NHS tariff then the main requirement will be for them to demonstrate that they are producing the outcomes required, that they meet key quality standards and that they are not selecting patients or where patient selection is necessary that the costs of this are properly recognised for both Treatment Centres and the hospitals that treat the remaining patients that do not meet the selection criteria.

What changes should the Government make to its policy towards ISTCs in the light of experience to date?

We would suggest the following:

18. The current Wave 2 ISTC procurement programme has been dogged by a lack transparency in the selection criteria which has caused real concern, particularly amongst foundation trusts.

19. Despite assurances from the Department of Health that a level playing field was in place, many foundation trusts that wanted to put in a bid did not do so because they were working to early signals that suggested they would be prohibited from involvement. The failure to make the selection criteria explicit has also meant that a number of foundation trusts have been rejected from the shortlist either without being given adequate reason or being given reasons that have not been consistently been applied to them on other bids. It would appear that the primary policy objective has been market creation rather than the establishment of a level playing field, but this too has lacked transparency.

20. It is essential that in future there is a genuine level playing field in these procurement exercises with transparent selection criteria in the public domain from the outset. NHS providers should be permitted to bid to provide these services as long as they can demonstrate that there is a real addition to capacity and that are prepared to accept the same contract terms and risks as the Independent sector.

21. The tariff should be examined to avoid cross-subsidisation within Healthcare Resource Groups which would unfairly advantage or disadvantage providers where it is necessary for Treatment Centres to select patients due to risk or safety criteria.

22. As capacity gaps are addressed it will become important to be fairly rewarded for business and casemix strategies capable of addressing health inequalities—the number one priority in the system rules for 06/07.
What criteria should be used in evaluating the bids for the Second Wave of ISTCs?

23. The position, as we now understand it, is that there is to be a level playing field with all potential providers able to bid, either alone or in joint ventures, provided that they can demonstrate that there is no state aid attached to their bid and that it does not constrain contestability.

24. A key criterion needs to be the views of the local practice based commissioners and the level of waiting, capacity and demand in the local health economy.

25. The key lesson from the procurement processes conducted so far is the importance of these criteria being transparent, as stressed in point 17.

What factors have been and should be taken into account when deciding the location of ISTCs?

See above.

How many ISTCs should there be?

We do not have a view on this issue.

Other comments

Further work is required to ensure that ISTCs contribute effectively to NHS research programmes. If ISTCs focus predominantly on simple cases this will distort the evidence base collected within the NHS. NHS teaching trusts have obligations to provide input into research and ISTCs should have similar obligations to contribute to epidemiological and other research work.

Nigel Edwards
Director of Policy
NHS Confederation
13 February 2006

Evidence submitted by NHS Partners Network (ISTC 29)

Key Points

— The NHS Partners Network is an alliance of independent healthcare organisations—private and not-for-profit—which provide diagnosis, treatment and care for NHS patients through the Department of Health’s procurement programmes.

— Our centres have performed almost 100,000 elective and diagnostic procedures for the NHS since the Government launched its programme in 2003.

— The main function of ISTCs is to provide high quality diagnostic and elective surgery procedures for NHS patients and, by increasing available capacity, provide greater choice for NHS patients.

— ISTCs have played a significant direct and indirect role in increasing capacity and choice and stimulating innovation.

— ISTCs have made and continue to make a significant contribution to reducing waiting times and waiting lists across the NHS.

— ISTCs are providing value for money for the NHS.

— The operation of ISTCs has a positive effect on local NHS services.

— Our members operate strict patient follow-up procedures and undertake to deal with complaints quickly and diligently to resolve problems.

— Our members are keen to become more involved and better integrated in the training of NHS staff.

— All our medical staff are employed and accredited under protocols approved by the Department of Health in consultation with the relevant Medical Royal Colleges and the General Medical Council.

— ISTC providers are subject to a more robust clinical quality regime than conventional NHS 4 providers.

— The health needs of local NHS patients should be the determining factor with regards the number of ISTCs that should be put in place as well as the availability of capacity to reduce waiting times and the necessity of extending plurality of provision to support greater patient choice.
Introduction

1. The NHS Partners Network is an alliance of independent healthcare organisations—private and not-for-profit—which provide diagnosis, treatment and care for NHS patients through the Department of Health’s procurement programmes.

2. Our members are as follows: Alliance Medical, BMI Healthcare, BUPA, Capio, Clinicenta, Mercury Health, Nations Healthcare, Netcare UK, Nuffield Hospitals, Partnership Health Group and UK Specialist Hospitals (UKSH). We are all leading national and international independent sector healthcare companies, with extensive experience of managing elective surgical centres and diagnostic facilities.

3. Our centres have performed almost 100,000 elective and diagnostic procedures for the NHS since the Government launched its procurement programme in 2003.

4. Our aim is to ensure that patients, doctors and the public have a better understanding of how new and traditional healthcare providers are working together in partnership for the benefit of NHS patients.

5. We support the NHS, in principle and in practice, and believe that the principles behind the government’s reform programme—extending patient choice, encouraging innovation and stimulating competition—are integral to the development of higher quality NHS provision into the future.

What is the main function of ISTCs?

6. The main function of ISTCs is to provide high quality diagnostics and elective surgery procedures for NHS patients and, by increasing available capacity, extend greater choice to NHS patients. Treatment centres deliver high volumes of activity in a range of routine treatments and diagnostics. They serve to separate emergency from elective procedures which reduces the number of cancelled operations.

What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

7. ISTCs have played a significant direct and indirect role in increasing capacity and choice and stimulating innovation. At the end of 2005, 20 facilities were in place as part of the Government’s ISTC programme. We anticipate a further 11 ISTCs opening in 2006/07 with the combined total treating over 170,000 NHS patients a year.

8. So far our centres have carried out almost 100,000 procedures (both surgical and diagnostic) including cataract removal, hip and knee replacements and MRI scans since the programme was launched.

9. We provide patients with pre-booked appointment times with many procedures carried out as day case procedures, enabling patients to return home the same day, freeing up hospital beds for other NHS patients.

10. ISTCs underpin the Government’s patient choice policy, through which NHS patients can now choose from different providers for hospital treatment procedures. Since December 2005, under Department of Health policy, NHS patients have been able to choose from a menu of 4-5 different providers when their GP decides that they need to be referred for hospital treatment or diagnostic procedures. As well as NHS Treatment Centres, in some cases these choices include an independent sector provider.

11. We also offer NHS patients additional choice—in terms of where their procedure is carried out, often close to home; and when their initial appointment and procedure takes place. Patients therefore have a real choice about where and when they are treated.

12. Increased choice encourages providers, including those in the traditional NHS, to develop more innovative working practices and patient-centred facilities. We are having a positive impact on the local health economy. Our centres offer the most innovative working practices and procedures including: use of regional rather than general anaesthetic for primary joint replacement to lower patient risk and reduce length of stay; stocking smaller ranges of prostheses allowing theatre staff to become more proficient and productive; more effective pain management techniques; double reading of post-operative test results.

What contribution have ISTCs made to the reduction of waiting times and waiting lists?

13. NHS waiting times and waiting lists have reduced considerably since the introduction of the ISTC programme in 2003. ISTCs do not claim to be the sole reason for this reduction but we have made and continue to make a significant contribution to reducing waiting times and waiting lists across the NHS. Since 2003, ISTCs have carried out almost 100,000 elective and diagnostic procedures. Our patients wait less time for many routine operations and diagnostic procedures than in conventional NHS facilities and are less likely to have their operations cancelled for non-clinical reasons because of the separation of elective procedures from emergency cases. We have performed almost 100,000 procedures in our centres so far and, by providing additional local capacity, we have also assisted NHS facilities to meet their own 6 month waiting times targets.
Are ISTCs providing value for money?

14. We believe that, on a like for like basis, our costs are comparable with NHS Trusts and represent value for money.

15. The September 2005 Laing and Buisson Market Review 2005–06 claims that the introduction of ISTCs is already exerting a downward pressure on specialists fees.

Does the operation of ISTCs have an adverse effect on NHS services in their areas?

16. The operation of ISTCs has a positive effect on local NHS services. A local ISTC provides additional capacity and choice for local NHS patients and encourages conventional NHS providers to adopt efficiency and productivity improvements.

What arrangements are made for patient follow-up and the management of complications?

17. All our member organisations operate strict patient follow-up procedures. The contracts we have with the Department of Health specify the details of the “patient pathway” from GP referral, through conclusion of the treatment to the method and quality of post-discharge patient care. The contract sets out clearly that patients should normally be treated for post-operative and post-discharge complications in the ISTC.

18. The Department of Health operates a performance management process including a patient complaint procedure, monitoring of post-operation visit rates, and liaison with local conventional NHS providers.

19. In the event of complications or adverse incidents, or if a patient is dissatisfied with the standard of care they receive, all our members undertake to deal with complaints quickly and diligently to resolve problems, learn from mistakes and avoid repetition. Redress is provided to patients who feel their experience was not as it should have been.

20. All our patients receive a comprehensive patient information pack on arrival which includes information on the provider, the patient care pathway including follow-up and complaints. This information is explained in more detail in advance of any procedure.

What role have ISTCs played and should they play in the training of medical staff?

21. Junior doctor training is provided in some of the Wave 1 ISTC projects. The facilities and training programmes replicate those available in traditional NHS providers.

22. The facilities, equipment and innovative practices allow medical staff to train and experience new ways of working, new procedures and techniques as well as management of care pathways.

23. The ISTC providers who form the NHS Partners Network wish to place on record our enthusiasm to be more involved and better integrated in the training of NHS staff.

Are the accreditation and appointment procedures for ISTC medical staff appropriate?

24. All ISTC medical staff are employed and accredited under protocols approved by the Department of Health in consultation with the relevant Medical Royal Colleges and the General Medical Council.

25. ISTCs meet a higher standard of medical accreditation than conventional NHS providers as only doctors who are listed on the specialist register for their specialty can practise in ISTCs. Traditional NHS providers can and do also employ doctors to perform procedures who are not trained or qualified to this level.

Are ISTCs providing care of the same or higher standard as that provided by the MIS?

26. The highest standards of clinical care for patients are our first priority. ISTC providers are subject to a more robust clinical quality regime than conventional NHS providers.

27. Our contracts with the Department of Health require that we have robust clinical governance arrangements in place. Clinical pathways and standards are defined during the contract negotiations and monitored through Key Performance Indicators as part of the contract management. ISTCs are subject to independent, external review at least once a year by the Healthcare Commission and quarterly by a Joint Service Review Board.
28. The Preliminary Overview report, published in October 2005, by the National Centre for Health Outcomes Development concluded that “there is a robust quality assurance system in place, more ambitious and demanding than that for the National Health Service organisations” and that the KPI data to be collected and provided by the ISTCs “extends beyond that used by the NHS.”

29. We carry out detailed patient satisfaction surveys; the findings have been very positive to date and patients are supportive of being treated by an independent provider.

**What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?**

30. Commercial confidentiality requirements are necessary to protect commercial sensitivities of each provider and to allow a fair and proper public procurement process. The Freedom of Information Act allows for information to be released, subject to exemption provisions. ISTC cost assumptions are transparent and publicly available throughout the procurement process.

**What changes should the government make to its policy towards ISTCs in the light of experience to date?**

31. The NHS Partners Network does not take policy positions and it is therefore inappropriate for the Network to make recommendations about future government policy.

**What criteria should be used in evaluating the bids for the second wave of ISTCs?**

32. It is not appropriate for the NHS Partners Network to comment on the criteria which should be used to judge between competing bidders for future waves of ISTC.

**What factors have been and should be taken into account when deciding the location of ISTCs?**

33. It is not appropriate for the NHS Partners Network to comment on the decisions in relation to the location of individual ISTCs provided by our member organisations.

**How many ISTCs should there be?**

34. There should be no artificial cap on the number of ISTCs which are put in place to diagnose and treat NHS patients. The Government has a manifesto commitment to reduce waiting times from the door of the GP’s surgery to the door of the operating theatre to 18 weeks. The ISTC programme can make a major contribution to helping to meet this goal by treating more NHS patients, more quickly to the highest standards. The determining factor should not be a set total number of ISTCs but the health needs of NHS patients, the availability of capacity to reduce waiting times and the necessity of extending plurality of provision to support greater patient choice.

**Evidence submitted by the Postgraduate Medical Education and Training Board (ISTC 28)**

**Introduction**

1. PMETB welcomes the opportunity to provide evidence to the Select Committee’s inquiry into Independent Sector Treatment Centres (ISTCs). Whilst we support in principle the concept of ISTCs as a means of increasing service capacity in the NHS, particularly around elective surgery, the issue for PMETB is one of ensuring the system provides appropriate safeguards for specialist trainees deployed in ISTCs. For the reasons set out in this submission, PMETB believe it is important that the local decision making process, concerning training in ISTCs, has the necessary direction, framework and clear lines of accountability. PMETB is keen, therefore, to work closely with the Department of Health and Central Clinical Procurement Programme team to ensure these safeguards are in place and understood by all involved.

**Background to PMETB’s Role**

2. To set this in context, PMETB took up its statutory responsibilities on 30 September 2005. In doing so, it subsumed the functions of two Competent Authorities: The Specialist Training Authority of the medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP). PMETB responsibilities are UK-wide. We understand that the ISTC programme is restricted to England.
PMETB’s Legal Responsibilities

The principal functions of PMETB, as set out in the Statutory Instrument made on 8th May 2003—The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003—are to:

- Establish standards of postgraduate medical education and training.
- Secure those standards and requirements.
- Develop and promote postgraduate medical education and training in the UK.
- Accredit training in hospital and general practice to meet PMETB standards.
- Issue (or refuse) Certificates of Completion of Training or eligibility for specialist registration.

PMETB’s statutory objectives are to:

- Safeguard service users.
- Ensure the needs of those undertaking training are met.
- Ensure the needs of employers are met.

PMETB also has a statutory duty to cooperate with:

- The General Medical Council.
- Any other body that appears to it to be representative of the medical Royal Colleges in the UK.
- Any other body that may be specified by the Secretary of State.

ISTCs—Implications for PMETB

3. There are two questions posed by the Select Committee which are pertinent to PMETB’s interests:

What role have ISTCs played and should they play in training medical staff?

Are the accreditation and appointment procedures for ISTC medical staff appropriate?

4. In the statutory framework described in paragraphs 1 and 2 above, PMETB has a duty to ensure that training of specialist (including general) practice trainees—who are part of approved training programmes and posts—is carried out in compliance with our standards across the spectrum of training environments including ISTCs.

Trainees deployed in ISTCs must therefore be in an environment which meets PMETB training standards, protects and progresses their training and ensures appropriate levels of supervision and assessment and, in turn, ensures patient safety.

Any programmes or posts which trainees undertake in an ISTC environment must be approved. PMETB, only, has the legal authority to issue such approvals. To this end it works closely with the medical Royal Colleges and the Postgraduate Deans. The Deans are responsible for the delivery of training.

5. PMETB was encouraged in principle at the development, by the Department of Health, of the generic schedule of training. This was designed to formalise arrangements for the second-wave of ISTCs where trainees and consultants/trainers are transferred to ISTCs. The Governing Principles provide that the ISTC and Trust will, with support of Postgraduate Deaneries and higher education institutions, enable clinical training and research to take place at the facility in respect of transferred activities. PMETB hopes that the schedule of training will provide a clear basis on which trainees and trainers are transferred to ISTCs.

We wish to draw the Committee’s attention to two concerns in this respect.

- Local networks, referred to in paragraph 6, with the benefit of their local knowledge and expertise, must have sufficient scope and time to inform preparation and agreement of ISTC contracts in order to ensure that the integrity of training is protected. PMETB see it as an essential prerequisite that schedules of training are agreed by the key stakeholders before contracts are signed and trainees transferred.

- In the case of ISTC contracts, for activity deemed “additional” to that already carried out in the NHS, financial provision must be made for training to be transferred to the ISTC. If ISTCs take the “easy” cases leaving only the more complex cases in the NHS, trainees may lack the necessary opportunities for their basic specialty training.

Lines of Accountability and Local Networks

6. Clearly the Department of Health has set the overall policy framework for ISTCs. Beyond that there have been numerous structures and fora and lines of accountability have, arguably, been less than clear. To illustrate, in addition to the Department’s and indeed PMETB’s role, the following are the bodies which have been/are currently involved:

(a) The National Implementation Team (NIT): Set up by the Department of Health with a policy remit. This forum no longer exists.
(b) The Central Clinical Procurement Programme (CCPP): This superseded NIT. Although it has a specific remit for service and financial aspects of the ISTC programme, CCPP does not have a policy function.

(c) ISTC Training Working Party: Chaired by a senior DH official, the Working Party was intended as a forum for the main stakeholders in postgraduate medical education to have input to the development of training policy for ISTCs. We believe this has only met once since it was established in July 2005.

(d) Local Training Steering Groups (LTSGs): Local implementation issues are meant to be handled through LTSGs. They involve the Department of Health, Trust, College and Postgraduate Dean representatives. The LTSGs originally received guidance from the NIT but, since that was abolished, central guidance has been withdrawn, we believe on grounds of cost. Colleges and Deans now report difficulties with the LTSGs; specifically that there are insufficient resources to support the bodies, there has been no clear direction and insufficient time has been afforded to allow for the effective negotiation of the schedules of training; the key documents described in paragraph 5 above.

CONCLUSION

7. With the onset of the second wave of ISTCs and for the reasons set out in this submission, clearly, PMETB has a role to play in ensuring that the integrity of training and trainees is not compromised and that safeguards afforded by the legislation governing specialist training are effectively deployed. However, as the various levels of the framework in paragraph 6 illustrate, PMETB is only part of the process. PMETB is therefore clear that the various agencies must work in partnership together to give direction at local level in order to achieve the desired results within a clear framework and proper lines of accountability. At present, we are not convinced that this clarity exists nor that the local training schedule arrangements discussed in paragraph 5 are sufficiently robust.

8. PMETB representatives will shortly be meeting Department of Health officials to discuss how best PMETB can contribute to the developmental process. PMETB will also be seeking a meeting with the head of the Central Clinical Procurement Programme.

Postgraduate Medical Education and Training Board

13 February 2006

Evidence submitted by the Royal College of Anaesthetists (ISTC 8)

The Royal College of Anaesthetists is the official professional organisation representing all anaesthetists in the United Kingdom and has responsibility for anaesthesia, critical care and pain management. We have more than 13,000 Fellows, Members and Trainees.

We welcome the additional surgical capacity provided by Treatment Centres, be they independent or in the NHS. We believe their full benefit will be achieved when a partnership with local NHS providers is better formed.

Many of the perceived problems of ISTCs are caused by a veil of secrecy governing their workings, and by a failure to provide and publish systematic audit and assessment of outcome. The public therefore rely on press reports and unreferenced anecdotes; we too are constrained by this lack of evidence in our submission to the committee. We think that the public interest should prevail over “commercial confidentiality”. We also think the committee should satisfy itself that probity has not been breached by the relationships of those who were employed or retained to advise the DoH and the owners of ISTCs who on at least one occasion subsequently employed an adviser.

We ask if the speed of the placement of contracts took first place over the understanding of the full implications of what the delivery of services actually involved.

The overall shortage of consultants and the original arrangements that prevailed, barring recent NHS staff from working in ISTCs meant that overseas doctors were recruited by ISTCs, sometimes on short-term contracts. For these doctors, being listed on the UK Specialist Register is in itself not a guarantee of competency. In the interests of public safety, those providing NHS services should be subject to the more robust selection processes that apply in NHS hospitals.

To the extent that patients are treated in ISTCs, training of medical and other staff is at risk. This problem, which should be capable of solution, already affects orthopaedic surgery and is beginning to threaten our own service specialty. ISTCs should apply to the Postgraduate Medical Training and Education Board for recognition of suitability of their premises, and their specialist staff to the relevant Royal College for assessment of their ability to train. With these in place Postgraduate Deans would be enabled to place training contracts with ISTCs.
1. **What is the main function of ISTCs?**

The main function is to provide increased elective capacity to relatively fit patients on a site distinct from enough from a NHS DGH to prevent admission of patients with urgent medical conditions. This will become more important as the ageing population with less support from families makes increasing demands on acute hospitals.

2. **What roles have ISTCs played in increasing capacity and choice, and stimulating innovation?**

   **Capacity**

   Capacity has been increased, although it may in part be an alternative to “waiting list initiatives” by re-allocating funding. To an extent for orthopaedic surgery, ISTCs might be regarded as a return to the specialist hospitals of earlier decades, except that unless staffed by local consultants those operating may not have been trained to the standard of a NHS consultant. Some ISTCs operate below their capacity.

   **Choice**

   Patients want to be treated near their homes and articulate ones want to be guided to the best available consultant, normally by a well-informed general practitioner (GP). Increased choice of hospital is not increased choice of competent surgeon. We know little and can guarantee even less about the competence of doctors working in an ISTC.

   If services have been removed from a local hospital to an ISTC there is no net increase of choice. If established Trusts lose too much elective work to ISTCs, under Payment by Results (PbR), their deficits may force some to declare bankruptcy, and technically could be forced to shut. This would reduce choice.

   **Innovation**

   Apart not allowing the patient to use a GP’s guidance to select a surgeon, ISTCs are difficult to distinguish from private hospitals.

   If innovation can be measured by a degree of panic, in the established Trusts about how to implement PbR, Choose and Book and the increasing competition from ISTCs local to them it has happened. In ISTCs only operating on a day-care basis a drive to do more challenging operations may escalate use of alternative techniques to ensure patients can go home the same day. However, if innovation is taken to indicate research into new techniques, funding will need to be identified as it seems unlikely that this will occur because of the time taken to frame questions and obtain consent and make whatever recordings would be required.

3. **What contribution have ISTCs made to the reduction of waiting times and waiting lists?**

   We understand that waiting times have fallen, but cannot tell to what extent they were already doing so before ISTCs were developed; an example is the widely publicised fall for cataract surgery which may have been in part a consequence of an ophthalmology initiative. We presume that most of the monies from this have now gone to the ISTCs. However, it is clear from data from the Royal College of Ophthalmologists that despite all that is claimed more than 90% of all cataract operations still take place within the NHS and that this is where much of the credit should go for the reduction in waiting lists.

   Readmission rates, and the rates of “re-do” operations would possibly not show up on the waiting list figures, as these patients would have been “discharged from care” and have “completed consultant episodes” appended to their files.

4. **Are ISTCs providing value for money?**

   We have no evidence to answer this and do not know the details of the financial arrangements that pump primed ISTCS, nor to discuss the allegations that they are paid for operations they do not perform.

   Where new buildings are commissioned ISTCs are likely to start from a basis of cleanliness. This will compare favourably with NHS hospitals that have to finance the management of infected patients (including those that may have had their operation in an ISTC).

5. **Does the operation of ISTCs have an adverse effect on NHS services in their areas?**

   We do not know if viability of local NHS services was part of the strategic and tactical planning of the locations and the issuance of ISTCs’ contracts.

   We have already dealt with some of this (see Question 2—Choice). The reason for impact on the ability of the local trust to continue to provide health care for the area is obvious. Put simply, by ISTCs being able to “cherry pick”, the loss of “easy surgical cases” that under PbR will be the ones that bring in money to
the Trust and what the health care professions need for training of their beginner trainees are serious issues. In at least one location, we understand there is excess capacity for the fitter patients when the ISTC, the private and the DGH are considered together, but it will still be the NHS hospital in which there is pressure to operate on the iller patients. This in turn puts pressure on the availability of Intensive Care beds.

There will be increased average real cost for those patients rejected by an ISTC who will need to seek care from their NHS hospital. The financial stream identified for these schemes (£500 million) would ensure many NHS trusts could comfortably deliver the demanded increase in provision, although we concede it would not encourage their becoming more efficient.

A further, but important issue is emerging with the relaxation of the “rules” governing the secondment of NHS consultant staff to work in ISTC’s, particularly when transferred activity, rather than additionality is involved. While the consultant anaesthetic staff are sent to the remote ISTC to anaesthetise fit patients, their juniors are left at the base hospital to look after the sicker patients remaining within the NHS. Put another way, the supervising consultant has to leave the trainees relatively unsupervised by others. This has resulted in serious issues over continued training approval in at least one Trust.

6. What arrangements are made for patient follow-up and the management of complications?

We only know of anecdotes and press reports of complications being handled by local NHS hospitals after the operating surgeon has left the country. These are widespread, and there seems to be no organised audit of this. Arrangements cannot be expected to be robust if the operating surgeon was an overseas doctors who worked as a “holiday locum” in an ISTC.

Follow up must mean long term assessment of results, not just the short term objective of whether or not “an operation” was performed within some defined time frame.

We refer the Committee to the Royal College of Ophthalmology (website: www.rcophth.ac.uk) for its President’s letter to Lord Warner.

7. What role have ISTCs played and should they play in training medical staff?

If substantial amounts of elective surgery are transferred to ISTCs, it will be essential for elective anaesthesia for these procedures to be taught in the ISTC’s. This has already happened in the case of transfer of orthopaedic work from the Royal Sussex County Hospital (Brighton) to a TC. It seems that nobody planned in advance how to continue to offer training to orthopaedic surgeons. The same might apply if the South West London Orthopaedic Centre is sold to a private concern; this would affect anaesthetic trainees because this centre provides orthopaedic services for five surrounding trusts; were it just one it might be possible to gain the training elsewhere in the NHS. Training in anaesthesia is competency-based and involves core requirements of every trainee. Although these are being met currently there is no guarantee that the future workforce will be suitably trained in anaesthesia for operations largely carried out in ISTCs.

The replenishment of clinical and nursing staff depends on well organised training schemes working within accredited processes. This is embedded in the NHS, including Foundation Trusts, but is a costly add-on for ISTCs. If funding is provided for one but not the other this may have a profound influence on the way hard-pressed Trusts view training (of all staff).

Training slows throughput and costs money. We see no reason why Private Health Care Companies should take any “hit” on throughput. Therefore there is no reason to expect them as “for-profit” suppliers to want trainees, unless out-of-hours cover was provided by them. If they (or any other NHS staff members are seconded to the treatment centres “following the patients”) clearly forward planning over money is urgently needed.

With proper forethought and organisation ISTCs could provide valuable training but standards for training must be in accordance with those expected by the Postgraduate Medical Education and Training Board, the competent body and delivered by the Postgraduate Dean in accordance with the curricula set by the Royal Colleges. This includes assurance that trainers are capable of delivering the relevant curriculum and taking part in assessment processes.

8. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

The issue is one of patient safety

It is the often misunderstood difference between being on the Specialist Register and being safe and competent to do the job, that NHS hospitals are keen to not fall foul of, in the interests of long term safety of patients. It is quite possible for overseas doctors used to working in more sheltered environments than an ISTC to gain access to the Specialist Register. Were appointments subject to the current DoH Guidance

56 We have prepared our own document for recognition of suitably qualified trainers.
to Advisory Appointment Committees an additional layer of discernment would exist. Our evidence is that even Foundation Trusts, although not obliged to follow this guidance are almost always doing so. Overall many NHS hospitals will leave a post unfilled, rather than make an unsuitable appointment.

For ISTCs the procedures appear to be variable, and therefore unsafe.

9. *Are ISTCs providing care of the same or higher standard as that provided by the NHS?*

We know of no audit evidence that supports this; audit seems sparse, but we suppose it might exist. We have learnt of a deal struck by one provider with the manufacturers of one particular prosthesis leading to local NHS surgeons if not overseas ones declining to operate on patients in whose interest they do not think it is to use such a prosthesis. On the other hand, we ask if audit might reveal what we guess might be the case—a reduction in infective complications as a result of segregation of elective surgical patients from other acutely ill patients.

Back-up facilities (on-call teams, ICU/HDU, proximity of laboratory services) are needed for the safety of an ISTC. We do not think these are uniformly provided.

Properly managed, many of these problems should be easily resolved. It may be that after the contracts with ISTCs were struck the necessary details were only later thought of.

10. *What implication does commercial confidentiality have for access to information and public accountability with regard to ISTCs?*

The current financial cloud of secrecy under the guise of commercial confidentiality is in our view unacceptable when dealing with public funds. We question the probity of a system which immediately after being set up employs the initiating staff within the providers.

Unless a proper external audit of ISTCs is performed, without constraint and limitations on the data provided, it will be impossible to properly assess the standards of care provided and also be impossible to identify any “problem” surgeons or anaesthetists, (some of whom will have returned to their country of origin at the end of their contracts).

Commercial confidentiality should not take priority over public accountability, especially when the public purse is being used to pay for the services provided.

11. *What changes should the Government make its policy towards ISTCs in the light of experience to date?*

We suggest lifting the veil of secrecy, arranging robust audit of performance, employment procedures that ensure competence of staff, placing of training contracts by the Postgraduate Deans and arrangement of financial matters that do not penalise NHS trusts.

12. *What criteria should be used in evaluating the bids for the Second Wave of ISTCs?*

We suggest:

— Locale and staffing issues need to be better controlled.
— Access to ISTCs accredited by PMETB as adequate for training of junior doctors and with College recognised trainers be used by Postgraduate Deans.
— While micromanagement by the government should be avoided in “centres for profit” there should also be agreed rules about who can staff run the centres.
— Appropriate appointment and accreditation standards.
— Openness of the management structure and access to management.
— Collection of data from the centres in an open manner with public debate. And with data made available to the press.
— A willingness of the health care company to work with the local trust and medical staff, not just with PCTs.
— Track record and performance figures of the companies being considered.
— Mutual waiting lists if not with equity of case mix then with financial penalty for those not willing or able to accept “difficult” surgery.
— Public scrutiny of contracts for all staff not just clinicians.
— External review of performance by the healthcare commission.
— Local lay and professional membership of the ISTC boards.
13. **What factors have been and should be taken into account when deciding the location of ISTCs?**

We do not know what has been taken into account and are told of siting of ISTCS that appear to be haphazard. We suggest:
- Waiting lists, and medical overload of surgical beds.  
- The proximity of the local DGH.  
- Ability and ease of access to proper backup in the event of a critical incident/medical catastrophe.  
- How well the local Tertiary care Trust is performing and whether or not it is meeting its targets.

14. **How many ISTCs should there be?**

We accept the drive to privatise care for elective surgery and degenerative medical conditions is an imperative for this (and probably a future) government. The number depends on their size, the overall need of surgical facilities and the density of the local populations that should be served.

*Dr Peter Simpson*  
Royal College of Anaesthetists  
12 January 2006  

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**Evidence submitted by the Royal College of Nursing (ISTC 22)**

**SUMMARY**

- The RCN supports the need for all patients to access good quality care that is delivered within NHS principles. Whilst the Independent Sector Treatment Centre (ISTC) programme seems to adhere to these principles we are concerned that the lack of transparency in relation to key information such as capacity, criteria for selection and financial implications makes it impossible for us to hold an informed position in relation to this procurement.  
- There is no evidence to suggest that there was any consultation or evaluation of the impact this service might have on the whole health economy.  
- ISTCs cannot be seen or evaluated in isolation but rather as one element of complex healthcare delivery. Any evaluation of these services must include an impact audit of both NHS acute and community services.  
- We are concerned that with no commitment to introducing Agenda for Change and access to NHS pensions, financial targets will be achieved by less advantageous terms and conditions for staff. We believe good health services are based on a strong workforce that is engaged, consulted and which receives proper investment and fair reward.

**INTRODUCTION**

The Royal College of Nursing has a membership of over 380,000 registered nurses, midwives, and health visitors, nursing students, health care assistants and nurse cadets. The organisation is the voice of nursing across the United Kingdom and the largest professional union of nursing staff in the world. The RCN promotes quality patient care and nursing interests on a wide range of issues by working closely with government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. Approximately 27% of our membership work within the independent sector.

Whilst the RCN has been invited to discuss some aspects of the independent sector treatment centre programme, a lack of transparency and clear information has prohibited us from making a fully informed contribution.

The RCN supports the continued development of a strategically planned, properly funded, effectively delivered and joined up health service. This is key to improving the health of the nation, enhancing productivity and promoting social inclusion.

1. **What is the main function of ISTCs?**

1.1 The Department of Health describes Treatment Centres as dedicated units that offer safe, fast, pre-booked day and short stay surgery and diagnostic procedures in a range of surgical specialties. Whilst there is sufficient evidence to demonstrate that separating elective surgery from emergency surgery provides a more efficient service by reducing the risk of cancellation for non-clinical reasons, providing a service in this way is not unique to an ISTC programme. Alternative ways of achieving this include NHS treatment centres, day surgery units and five-day wards.
2. **What role have ISTCs played in increasing capacity and choice, and stimulating innovation?**

2.1 The initial aim of the ISTC programme was to purchase additional capacity for elective surgery. Strategic Health Authorities in conjunction with local clinicians were asked to identify gaps in capacity by speciality. It is not clear as to the level of involvement local clinicians including nurses have had in the capacity planning process. During the procurement process a number of changes were introduced. These include an additional contract for 250,000 cases and an agreement to transfer existing activity from NHS Trusts to the ISTC. This raises questions as to the robustness of the initial capacity planning.

2.2 The Department of Health also introduced an additionality policy, which prevented staff who either worked in the NHS, or had worked in the NHS in the last six months from working in an ISTC. The policy was introduced without any consultation and elements of it were unworkable; for example the restriction of agency staff from moving between the NHS and an ISTC. The Department of Health intends to amend the additionality policy for the phase two procurement. These amendments relate to excluding some clinical staff from the policy. There is little evidence to suggest that these decisions have been made on an informed basis. In particular the Department of Health has very limited data in respect of nursing shortages. As a result the RCN has raised concerns about the vulnerability of NHS services if ISTCs are able to poach key staff.

2.3 Whilst acknowledging that innovation might exist to date we have no evidence to suggest that there has been any sharing of innovative practice.

3. **What contribution have ISTCs made to the reduction of waiting times and waiting lists?**

3.1 There is evidence to support the reduction in waiting lists, waiting times and some published data in respect of procedures undertaken. However, it would be difficult to make any direct link to any single service initiative in terms of the impact that it has had. This is particularly true for ISTCs as there are currently a limited number in operation. In addition, we are only just now seeing the conclusion of the General Supplementary contracts and NHS Trust internal initiatives to improve management of waiting lists.

4. **Are ISTCs providing value for money?**

4.1 Given the lack of transparency we are unable to assess whether the ISTCs are providing value for money. However we are concerned that poor uptake has resulted in some ISTCs being paid for episodes of care they have not undertaken.

5. **Does the operation of ISTCs have an adverse effect on NHS services in their areas?**

5.1 The ISTC programme has been introduced to provide additional capacity and through this to contribute towards achieving waiting list targets. Any increase in activity will have an impact on supporting services, in particular community services. These services will see an increase in both the number of patients requiring support and an increase in dependency given the reduced lengths of stay for patients in the ISTC. It is unclear how this has been incorporated in local service planning.

5.2 The ISTC contracts stipulate an agreed case mix which excludes patients with multiple pathology or who require more complex surgery. As a consequence more complex surgery and patients requiring higher levels of care will be treated in the NHS Trusts. This will have significant implications for staffing levels.

5.3 There are also impacts associated with shared services—some of the ISTCs are contracting with NHS providers for allied professional services and it is unclear what impact there will be on NHS services as a result of these new contractual arrangements (especially if there is a contractually binding priority system for ISTC work).

6. **What arrangements are made for patient follow-up and the management of complications?**

6.1 The Department of Health has given assurances that arrangements for follow up and the management of complications is included in the service contract. This includes financial penalties where the complication rate exceeds an agreed level. The management and frequency of complications is also a Key Performance Indicator within the performance management framework. Given the limited number of schemes that are operational and access to only one performance management report, it is not possible to comment on the effectiveness of the arrangements.

7. **What role have ISTCs played and should they play in training medical staff?**

7.1 We were surprised that provision of training was not included in Wave 1 of the ISTC programme. There is some work being undertaken within the Department of Health, but we are unclear as to how training issues will be implemented or incorporated within ISTC contracts. Our concerns focus on the potential reduction of clinical placements within the NHS; appropriate budgets being in place for Continuing Professional Development (for both seconded NHS and substantive ISTC posts); and sufficient
support for adaptation nurses—ISTCs currently depend on international recruitment, yet it is unclear if the providers and the Department of Health have considered access to adaptation courses which are mandatory for all overseas nurses requiring registration with the Nursing and Midwifery Council.

8. *Are the accreditation and appointment procedures for ISTC medical staff appropriate?*

   This issue is outside of our expertise and we are therefore unable to comment.

9. *Are ISTCs providing care of the same or higher standard as that provided by the NHS?*

   9.1 ISTCs are currently regulated as part of the independent sector. As such they are inspected and regulated by the Healthcare Commission and are required to meet the requirements of the Care Standards Act 2000. In addition they need to meet a contractually binding Performance Management Framework, which incorporates a range of Key Performance Indicators (KPIs). Twenty-three of these are clinical Key Performance Indicators. We are concerned that these KPIs were not consulted on these measures and they contain no nursing KPIs.

   9.2 We are also aware that there are no human resources KPIs and we believe that without these, the performance management system is unlikely to offer a robust assessment of the service being delivered. Organisations which do not have effective staff management systems in place are less likely to be delivering quality services. Given the infancy of this programme the effectiveness of the performance Management Framework has not been tested.

10. *What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?*

    10.1 The RCN has been working with the Department of Health and NHS employers on a number of professional and employment issues, but this has generally been occurring in an environment where information sharing has been limited, eg the NHS trade union stakeholders have been asked to work with the Department of Health on developing a list of shortage professions for phase two schemes. This discussion, however, has been happening with trade unions having no knowledge of phase two schemes—we do not know what is being contracted, where the schemes are geographically located, what services are being delivered, or what volume is being contracted. The Department of Health has refused to share information on the basis of commercial confidentiality.

11. *What changes should the Government make to its policy towards ISTCs in the light of experience to date?*

    11.1 The Government needs to ensure that there is a level playing field—this means the removal of a two-tier workforce. The RCN is arguing for Agenda for Change and access to NHS pensions for all staff (whether seconded from the NHS or substantively employed by the ISTC). This will ensure that ISTCs do not meet the NHS tariff by simply cutting staff terms and conditions.

    11.2 Contractual arrangements with ISTC providers should also incorporate an obligation on their part to participate in national workforce planning—through Workforce Review Team activity and through the SHAs.

12. *What criteria should be used in evaluating the bids for the Second Wave of ISTCs?*

    12.1 Given the absence of any confirmation of the criteria used to evaluate wave one or the current procurement for phase two, we are unable to comment on the existing system. However, we would consider that any evaluation criteria should address the following; clinical standards, value for money, patient access and choice, governance frameworks, human resources standards, evidence of clinical leadership, a training and development strategy and evidence based innovation.

13. *What factors have been and should be taken into account when deciding the location of ISTCs?*

    13.1 Lack of information due to commercial confidentiality means that we are unclear as to how decisions on location are made.
14. **How many ISTCs should there be?**

14.1 We might ask ourselves another question and ask if there should be ISTCs? There has been no consultation on the ISTC programme and we are concerned that decisions are being made on how to make a success of ISTCs, which are isolated from wider healthcare reform and healthcare priorities.

*Emma McKinney*
Royal College of Nursing
*February 2006*

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**Evidence from the Royal College of Obstetricians and Gynaecologists (ISTC 5)**

**Introduction**

1. The Royal College of Obstetricians and Gynaecologists (RCOG) received its Royal Charter in 1947. Its role is to encourage the study and the advancement of the science and practice of obstetrics and gynaecology. The RCOG, to this end, oversees standards of clinical practice and training in all aspects of obstetrics and gynaecology.

2. The RCOG supports improvement and modernisation of service delivery within the NHS. It is keen to see new models of clinical care, which lead to improved, efficient and quality services.

3. So far the RCOG is unaware of any significant impact of ISTCs on gynaecological practice, however, we share many of the concerns that have been expressed in the past, particularly those relating to staffing, clinical governance, training and payment tariffs.

**Medical Staffing**

4. It is essential that the quality and expertise of staff employed in ISTCs is of the highest calibre. There is not a surplus of doctors and the staffing of ISTCs will either come from overseas, competition from Trusts, or by sharing staff with Trusts. To date, we believe that employment has been on short-term contract and the majority of the staff have come from overseas. The ability to quality assure clinical staff has not been proven and there is concern that doctors employed by ISTCs on short term contracts may not have the appropriate skills and abilities.

**Clinical Governance**

5. It is essential that the work of ISTCs has encompassing methods of audit and governance. The quality of care delivered in ISTCs must be monitored very carefully. Although it may be difficult to compare complication rates with Trusts, particularly as the more simple cases will be selected by ISTCs, one would expect better outcomes and lower complication rates.

6. The RCOG is particularly concerned that its close liaison with departments of obstetrics and gynaecology in Trust hospitals will not exist with ISTCs. The RCOG issues guidelines and recommendations which its Members and Fellows implement and audit in clinical practice in Trust hospitals.

**Case Selection**

7. It is not clear who will select cases for ISTCs. It is important to identify means and mechanisms of referral. Pros and cons of direct primary care and/or involvement of NHS Trust clinicians should be considered. It is imperative that the correct specialist is identified so as to give most appropriate treatment for the patient’s condition. It is not clear how primary care will achieve this particularly when choice means that the selection options are even greater.

8. It is essential that continuity of patient care is maintained at ISTCs, as they have the potential to interfere with continuity and lead to fragmentation. Should complications of treatment in an ISTC arise, then it is essential that these are dealt with promptly. If medical problems occur on site in an ISTC, there must be clear mechanisms as to how these emergencies can be resolved.

**Continuity of Care**

9. The complexities of arranging confidential patient clinical notes to be available for the clinician at the right time in the right place are considerable. Will clinical notes travel with the patient or be sent in advance? What happens when there is a complication and how will the notes be available to the doctor who may be dealing with the complication in another hospital? Maintaining confidentiality through this process will be very difficult.
TRAINING

10. It is essential that training opportunities are available throughout NHS clinical practice. In particular the more simple and straightforward surgical operations that are planned to be performed in ISTCs are ideal training opportunities. Those clinicians working in ISTCs must be trained to deliver training as part of their role. Such training must meet the standards set by the Postgraduate Medical Education and Training Board (PMETB) and the Royal Colleges.

IMPACT ON TRUSTS

11. The selection of simple cases for ISTCs lead to an imbalance in case-mix. Difficult cases, often with the same payment tariff, will remain in NHS Trust hospitals.

12. It will be difficult to develop new techniques and innovations when efficiency and costs are so paramount. Many new procedures are initially expensive and take surgeons longer to perform before the full benefits to the NHS and patients are realised.

13. We are concerned that with shortages across all the medical professions, ISTCs will compete for valuable human resources. With less acute work and more structured hours of employment, ISTCs may well attract staff from hard-pressed Trusts!

14. It is unlikely that the simple tariff rates will be able to discern between the simple cases selected for ISTCs and those that are left at the Trust.

CONCLUSION

15. The RCOG welcomes service improvements, which lead to higher standards of care and improved access and efficiency. We endorse processes that lead to modernisation and productivity. However, we have major concerns that there are conflicts between ISTCs and healthcare delivery in Trusts. Consideration must be given to all these issues if ISTCs are to lead an overall enhancement of NHS Service.

Richard Warren
Honorary Secretary
Royal College of Obstetricians and Gynaecologists
7 February 2006

Evidence submitted by the Royal College of Ophthalmologists (ISTC 4)

EXECUTIVE SUMMARY

The Royal College of Ophthalmologists (the College) wishes to thank the Select Committee for this opportunity to contribute to the Committee’s Inquiry into ISTCs. The College welcomes extra investment in healthcare by Government but we favour investment in local integrated NHS ophthalmic services, including in NHS Treatment Centres, rather than in ISTCs. We believe such investment will reap long term gains which are presently being undermined by the current focus on ISTCs in England at the expense of local NHS departments.

In summary the College has concerns about:
— Adverse clinical or patient safety incidents in the ISTCs.
— Adverse impact of ISTCs on the finances or services at local NHS eye units.
— Adverse impact of ISTCs on local NHS clinical staff morale.
— Adverse impact of ISTCs on local NHS clinical training.
— Destabilisation of clinical manpower planning by ISTCs.

The College’s response to the questions follows in the order the questions were posed.

1. What is the main function of ISTCs?

To increase capacity, often for a single procedure, such as cataract surgery. The separation of planned elective care (often called cold surgery, eg cataract extraction) in ring-fenced beds or treatment areas away from the pressures of providing emergency care is of considerable merit in healthcare. It makes good operational management and safe clinical sense. In National Health Service (NHS) hospitals this is provided in dedicated day treatment or day care areas on the site of existing acute hospital services. Ophthalmologists in English NHS care have long been leaders in this field. The College has encouraged such innovations along with NHS managers, nursing and paramedical colleagues for some years.
2. What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

2.1 Capacity. ISTCs have resulted in a small increase of capacity of around 7%. To increase capacity, the College favoured expansion and upgrading of local NHS hospital eye service (HES) units. Excellent progress has been made with the commissioning of dedicated day-care cataract facilities within the Action on Cataracts scheme (2000), an initiative undertaken long before the introduction of ISTCs. Over 300,000 cataract operations were performed by the NHS in England in 2005, an increase from 175,000 in 2000. Only 20,000 cataract operations have been performed in ISTCs cumulatively to date.

2.2 Choice. While having more providers inevitably gives more choice, in reality, in ophthalmology, patients have chosen their established NHS eye service. In many areas it has been necessary for PCTs to direct patients to ISTCs and, despite this and local advertising campaigns, capacity at the ISTCs has not been utilised.

2.3 Innovation. We are unaware of any innovation relevant to ophthalmology from either the mobile or static ISTCs to date. We do have evidence of some outdated practices with adverse incidents to patients. ISTC procedures by overseas visiting teams have had to be raised to UK standards. Participation in research, clinical audit and peer-reviewed presentations are vital for quality assurance and innovation in healthcare but are not compatible with the short term nature of rotating (overseas) teams in ISTCs. There is also a complete lack of training in any ophthalmic ISTC.

3. What contribution have ISTCs made to the reduction of waiting times and waiting lists?

Very little as waiting times for cataract surgery in England came down before the cataract ISTCs became operational.

4. Are ISTCs providing value for money?

We do not know. The evidence suggests that ISTCs select the more straightforward cases and exclude those with co-morbidity (for example poor mobility) but receive the same funding or tariff per case while NHS hospitals accommodate all patients including a significant proportion with severe or multiple co-morbidities such as dementia without any supplement. ISTCs do not provide holistic care. We understand ISTCs received additional start-up funding at the outset. Furthermore the ISTCs are paid for block contracts of work regardless if this work is ever undertaken or not.

5. Does the operation of ISTCs have an adverse effect on NHS services in their areas?

Yes. The diversion of funds away from NHS hospital eye services to ISTCs is threatening the provision of comprehensive ophthalmic care for whole communities—emergency care for injuries or retinal detachments, the management of chronic blinding conditions such as diabetic retinopathy, glaucoma, macular degeneration, children’s eye problems etc. Some NHS eye units are contracting (not replacing ophthalmologists who retire) and may become inviable, requiring patients, mainly children, the elderly and visually impaired people, to travel further for care. The local hospital is also accommodating patients who suffer adverse incidents at the ISTCs often requiring months of ongoing care and sometimes further surgery to prevent blindness.

6. What arrangements are made for patient follow-up and the management of complications?

6.1 Patient safety in the ISTCs is a concern in ophthalmology and in other specialities. College guidance on prudent steps to take in advance of commissioning cataract surgery was largely ignored by sponsors.

6.2 Several examples of poor care arrangements have been made known to the College in correspondence from patients and ophthalmologists. This correspondence has been shared by the College with the Healthcare Commission. Patients following surgery at mobile units have been told by the ISTC “Help Line” service to travel considerable distances for urgent follow up. The use of brief standardised letters by ISTCs to general practitioners has lead to a breakdown in communications and a total lack of information accompanying the patient with complications who arrives at their local NHS unit. Service Level Agreements said to have been made by ISTCs with Trusts have not been communicated to NHS clinicians who actually deliver the back up care.

6.3 The College is concerned that the National Patient Safety Agency (NPSA) will not be made aware of patient safety incidents in ISTCs as their remit is currently restricted to NHS providers. We are not aware of any risk assessment being made in advance of the mobile ISTC deployment.
7. What role have ISTCs played and should they play in training medical staff?

No training has been provided to ophthalmic medical, nursing or paramedical staff in the ISTCs that we are aware of. In order to offer high volume surgery, ISTCs are not a suitable location for training as trainees in all clinical professions require time and are encouraged to practice holistic care, not usually provided in single-procedure settings. However the “cherry-picking” of the straightforward surgical procedures to ISTCs has implications for surgical training, as NHS units are left with more complex cases, which are less suitable for the training of junior surgeons. There is an ethos of training among all clinicians in NHS units which is not found in ISTCs.

8. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

8.1 There are concerns about the uncertain appointments of ISTC specialists compared with the robust NHS Advisory Appointment Committees for consultants in the NHS. Staff employed by the NHS in any clinical capacity within the previous 6 months have been specifically excluded from working in Wave 1 ISTCs. This “additionality” rule had the effect of favouring overseas bidders for ISTC work, employing overseas doctors working in their vacations. Although registered as specialists with the GMC, overseas doctors have not been subject to NHS appraisal and clinical governance systems long familiar to UK clinicians.

8.2 We are aware of concerns from both the Healthcare Commission and from the Department of Health with regard to inconsistencies in appointments to ISTCs. The inconsistencies that have been listed by Marney Prouse, (Clinical Governance Lead for the ISTC programme at Central Contract Management Unit (CCMU) in 2005) to Royal Colleges at the Royal College Leads/National Implementation Team meeting include variations in:

- Recruitment agency practices.
- English language assessment.
- Testing mechanisms.
- Communicating under stress.
- Medical education in country of origin.
- Working practices in country of origin.
- Availability of suitably qualified personnel.
- Interviews and practice privileges awards.
- Short term contracts.
- Assessment techniques by providers.
- Induction for new staff.
- Use of Alert Letters.

9. Are ISTCs providing care of the same or higher standard as that provided by the NHS?

9.1 We find no evidence that ISTCs provide cataract surgery of higher standards than that provided by NHS units. There is evidence that co-existent problems such as diabetic retinopathy or glaucoma in the patient’s same eye are ignored. Treating patients as individuals with an integrated multidisciplinary holistic care approach for both acute and chronic eye conditions locally is preferred. The current ISTCs can only receive the most straightforward patients for surgery and exclude wheelchair patients, deaf patients, patients requiring general anaesthesia, children etc from the mobile cataract units. (Netcare Principals Document, Netcare UK).

9.2 There is also no coordination with services for blind and partially sighted individuals and the patient groups and charities that represent them. There is a risk of fragmentation of existing comprehensive NHS ophthalmic services.

9.3 We share the reservations of the National Centre for Health Outcomes Development concerning the monitoring of quality, especially clinical outcomes, from the ISTC schemes. A recent survey of PCTs revealing little or no robust monitoring of the quality of cataract care commissioned by most Primary Care Trusts is important and a further worry.

10. What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

The true costs of ISTC care are unknown and are protected by “commercial confidentiality considerations” from scrutiny. NHS units are readily accessible for accountability and are subject to the Freedom of Information Act. As overseas providers are based in other countries, their activities are remote from UK investigation including the Audit Commission.
11. **What changes should the Government make to its policy towards ISTCs in the light of experience to date?**

While we welcome the additional investment by Government in healthcare we believe it should be directed to expanding local NHS hospitals. Treatment centres should be run in co-ordination with established units (as NHS Treatment centres are) to ensure quality and equality of patient care, integrated services available to all patients and training opportunities for our future healthcare professionals. Medical staff would be subject to more robust regulation procedures and clinical governance issues would be open to scrutiny.

12. **What criteria should be used in evaluating the bids for the Second Wave of ISTCs?**

12.1 Little or no clinical or local NHS management or informed public engagement occurred in wave 1 commissioning. We see the same errors repeating in Wave 2 bids. The lack of discussion and engagement with local clinicians is allegedly for reasons of commercial sensitivities.

12.2 The College has written to Dr Bruce Websdale, Clinical Director, detailing which specialist ophthalmic operations should NOT be commissioned/purchased from ISTCs as they are invariably part of a long term treatment plan for the patient and require multidisciplinary team care for optimal results.

12.3 Some ophthalmic treatments may be suitable for treatment centres, such as (ie low clinical risk) high volume day care cataract care, minor eyelid surgery while other more complex cases, which are part of a continuum of care, are not.

13. **What factors have been and should be taken into account when deciding the location of ISTCs?**

Where there is a documented need for an increase in routine surgery expansion should be considered. Any such expansion should be fully integrated into the existing NHS services, as occurs with NHS Treatment Centres, even if geographically distinct, to ensure continuity of care for the patients and good communications with other clinicians and support services involved. This would have the added benefit of accommodating the training of new healthcare professionals at all levels and ensure innovation and research is continued in a controlled environment.

With the piecemeal roll out of ISTCs without local clinical and managerial engagement we risk destabilising existing world-class NHS hospital eye services. This will be at the peril of future generations' eyecare.

14. **How many ISTCs should there be?**

We favour NHS Treatment Centres, rather than ISTCs, integrated into existing local NHS services, possibly in a hub and spoke model. Examples exist and function very effectively with the operational benefits of single procedure surgical lists but with the guaranteed quality and patient safety associated with an established, well-governed NHS eye unit.

The Royal College of Ophthalmologists

*10 February 2006*

**REFERENCES**


## Annex A

### SUMMARY OF LETTERS RECEIVED FROM COLLEGE MEMBERS REGARDING CONCERNS ABOUT INDEPENDENT SECTOR TREATMENT CENTRES

<table>
<thead>
<tr>
<th>Date of letter</th>
<th>County</th>
<th>Patient’s DOB</th>
<th>Patient’s Gender</th>
<th>Issues raised about ISTC</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/01/06</td>
<td>Buckinghamshire</td>
<td>31/08/50</td>
<td>F</td>
<td>Unsatisfactory follow-up arrangements. Poor communication.</td>
</tr>
<tr>
<td>03/01/06</td>
<td>Somerset</td>
<td>16/02/71</td>
<td>F</td>
<td>Inadequate explanation to patient about the reason for surgery, concerns about the treatment itself, and inadequate information provided to NHS unit providing treatment of complications that developed.</td>
</tr>
<tr>
<td>15/12/05</td>
<td>Dorset</td>
<td>16/07/29</td>
<td>M</td>
<td>Lack of follow-up care for patient suffering complications. Patient lost sight of eye.</td>
</tr>
<tr>
<td>11/12/05</td>
<td>Merseyside</td>
<td>27/02/61</td>
<td>M</td>
<td>Concern regarding complications following cataract surgery.</td>
</tr>
<tr>
<td>02/12/05</td>
<td>Northern Ireland</td>
<td>Not given</td>
<td>Not given</td>
<td>General concerns regarding communication and administration errors over contract and arrangements for post-operative review.</td>
</tr>
<tr>
<td>05/10/05</td>
<td>Essex</td>
<td>Not given</td>
<td>Not given</td>
<td>Concern regarding lack of consultation over removal of patients from NHS to ISTC and lack of follow-up arrangements.</td>
</tr>
<tr>
<td>05/09/05</td>
<td>Hampshire</td>
<td>12/07/22</td>
<td>F</td>
<td>Concern regarding erroneous and inadequate information on discharge summary and patient’s record notes. Inadequate follow-up. Development of complications.</td>
</tr>
<tr>
<td>16/06/05</td>
<td>Devon</td>
<td>18/08/19</td>
<td>F</td>
<td>Erroneous diagnosis causing unnecessary anxiety to patient. Problem was already well documented in patient’s notes.</td>
</tr>
<tr>
<td>03/06/05</td>
<td>Wirral</td>
<td>Not given</td>
<td>M</td>
<td>Inadequate follow-up and communication with patient.</td>
</tr>
<tr>
<td>09/05/05</td>
<td>Somerset</td>
<td>17/01/40</td>
<td>M</td>
<td>Misdiagnosis of corneal lesion leading to postponement of operation and transfer back to NHS list. Also general observation that ISTC is having adverse effect on local NHS service.</td>
</tr>
<tr>
<td>18/04/05</td>
<td>Devon</td>
<td>Not given</td>
<td>Not given</td>
<td>Concerns regarding several cases referred to ISTC. Inadequate follow-up arrangements. Development of complications. Poor communication. Erroneous information on discharge summaries.</td>
</tr>
<tr>
<td>Undated (received on 20/04/05)</td>
<td>Wirral</td>
<td>Not given</td>
<td>F</td>
<td>Inadequate counselling of patient prior to operation. Concern regarding management of complications.</td>
</tr>
<tr>
<td>11/04/05</td>
<td>Berkshire</td>
<td>04/07/21</td>
<td>M</td>
<td>Lack of follow-up arrangements.</td>
</tr>
<tr>
<td>18/03/05</td>
<td>Devon</td>
<td>Not given</td>
<td>Not given</td>
<td>Concern regarding 26 patients turned down for surgery. Unsatisfactory reasons given and inadequate preoperative preparation.</td>
</tr>
<tr>
<td>28/02/05</td>
<td>Berkshire</td>
<td>14/02/42</td>
<td>M</td>
<td>Patient turned down for surgery due to patient’s preference for general anaesthetic.</td>
</tr>
<tr>
<td>22/12/04</td>
<td>Lancashire</td>
<td>27/12/25</td>
<td>M</td>
<td>Concern regarding follow-up arrangements.</td>
</tr>
<tr>
<td>Date of letter</td>
<td>County</td>
<td>Patient’s DOB</td>
<td>Patient’s Gender</td>
<td>Issues raised about ISTC</td>
</tr>
<tr>
<td>---------------</td>
<td>------------</td>
<td>---------------</td>
<td>------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>15/12/04</td>
<td>London</td>
<td>08/08/34</td>
<td>M</td>
<td>Concern regarding follow-up arrangements. Development of complications following surgery.</td>
</tr>
<tr>
<td>26/11/04</td>
<td>Northants</td>
<td>24/12/29</td>
<td>F</td>
<td>Concern regarding follow-up arrangements.</td>
</tr>
<tr>
<td>25/11/04</td>
<td>Northants</td>
<td>Not given</td>
<td>F</td>
<td>Concern over management of complications.</td>
</tr>
<tr>
<td>28/10/04</td>
<td>Lancashire</td>
<td>27/10/31</td>
<td>M</td>
<td>Concerns regarding postoperative management.</td>
</tr>
<tr>
<td>24/09/04</td>
<td>Wirral</td>
<td>Not given</td>
<td>F</td>
<td>Patient turned down for surgery due to requirement to have general anaesthetic. Concern that choice is being offered indiscriminately to all patients.</td>
</tr>
<tr>
<td>14/09/04</td>
<td>Devon</td>
<td>29/08/22</td>
<td>M</td>
<td>Misdiagnosis of advanced hypertensive retinopathy.</td>
</tr>
<tr>
<td>14/09/04</td>
<td>Devon</td>
<td>18/11/21</td>
<td>F</td>
<td>Patient turned down for surgery without explanation.</td>
</tr>
<tr>
<td>09/09/04</td>
<td>Merseyside</td>
<td>12/01/13</td>
<td>F</td>
<td>Concern regarding complications following surgery.</td>
</tr>
<tr>
<td>09/09/04</td>
<td>Wirral</td>
<td>Not given</td>
<td>F</td>
<td>Concern regarding complications following surgery.</td>
</tr>
<tr>
<td>25/08/04</td>
<td>Lancashire</td>
<td>16/04/26</td>
<td>M</td>
<td>Concern regarding diagnosis and erroneous information documented.</td>
</tr>
<tr>
<td>23/08/04</td>
<td>Lancashire</td>
<td>Not given</td>
<td>Not given</td>
<td>Concern regarding reasons given by ISTC for regarding patients as unsuitable for surgery.</td>
</tr>
<tr>
<td>02/08/04</td>
<td>Lancashire</td>
<td>17/03/19</td>
<td>F</td>
<td>Patient turned down for surgery. Unsatisfactory explanation given.</td>
</tr>
<tr>
<td>29/06/04</td>
<td>Devon</td>
<td>29/12/16</td>
<td>F</td>
<td>Erroneous information on discharge summary indicating surgery was uneventful. ISTC subsequently referred patient back to NHS for complications secondary to complication cataract surgery.</td>
</tr>
<tr>
<td>28/05/04</td>
<td>Lancashire</td>
<td>02/07/09</td>
<td>F</td>
<td>Lack of provision of follow-up care following development of complications.</td>
</tr>
<tr>
<td>27/05/04</td>
<td>Lancashire</td>
<td>Not given</td>
<td>Not given</td>
<td>Letter from patient’s son complaining of poor communication and follow-up development of complications.</td>
</tr>
<tr>
<td>25/05/04</td>
<td>Lancashire</td>
<td>Not given</td>
<td>Not given</td>
<td>Lack of provision of follow-up care following development of complications.</td>
</tr>
</tbody>
</table>

Annex B

ASSESSING THE IMPACT OF ISTCs: A REPORT OF TWO RELATED SURVEYS BY THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

BACKGROUND

Over the course of the last 18 months the government has introduced changes to aspects of the way patients receive their treatment for cataract extraction including the introduction of independent sector treatment centres (ISTCs) in England.

This reorganisation may have contributed to the shortening of waiting times for cataract surgery but clinicians have expressed concern that, thus far, there has been no formal assessment of the affects on patient safety and the continuity of care or of the impact on training and the viability of local units.
In response to anecdotal reports detailing difficulties with the introduction of ISTCs, the Royal College of Ophthalmologists have undertaken two questionnaire surveys in England to assess the impact on training, and obtain information upon the affects on patient safety, the continuity of care and the viability of local units. This report details the preliminary findings from these surveys. It is the intention of the Royal College of Ophthalmologists to provide a more comprehensive report prior to the end of February 2006.

The Royal College of Ophthalmologists conducted two complimentary postal surveys.

A SURVEY OF OPHTHALMOLOGY CLINICAL DIRECTORS IN ENGLAND

A postal questionnaire was sent to all clinical directors or lead consultant ophthalmologists of NHS eye units in England, as named on the database of the Royal College of Ophthalmologists. The questionnaire sought information on staff recruitment and provision for operating lists, surgical provision for trainees, cataract waiting times, surgical volume and the presentation of complication following surgery provided by other centres. The existence of an ISTC within the catchment area was also recorded.

All non-responders were sent a reminder and replacement questionnaire after one month.

RESULTS

107/128 questionnaires were returned (84%), the number of units reporting an ISTC within their catchment’s area are:

<table>
<thead>
<tr>
<th>EXISTENCE OF ISTC</th>
<th></th>
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<tbody>
<tr>
<td>Static ISTC</td>
<td>29</td>
</tr>
<tr>
<td>Mobile ISTC</td>
<td>18</td>
</tr>
<tr>
<td>No ISTC</td>
<td>56</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
</tr>
</tbody>
</table>

CANCELLATIONS OF LIST DUE TO STAFF SHORTAGE OR LACK OF SUITABLE TRAINING CASES

These data have been divided by the number of lists conducted per week to provide a comparative figure for each unit. A comparison of the mean cancellations per year per list conducted for units affected by an ISTC and units not affected by ISTCS was undertaken using a normal test (null hypothesis = no difference).

The number of lists cancelled because of inadequate staffing levels in units with no ISTC was 0.660 compared with 0.824 in units with ISTCs. This suggests that there is no significant difference in the current experiences of units with an ISTC and those without.

The mean number of protected training lists cancelled in each group was 0.3718 and 0.6286 P (No difference) = 0.14, which again suggests no difference in current practice between units with ISTC and those without.

STAFF RECRUITMENT

Chi-squared test has been used to establish if both sets of responses come from the same or separate populations.

<table>
<thead>
<tr>
<th></th>
<th>Harder</th>
<th>No diff or easier</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISTC</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>No ISTC</td>
<td>19</td>
<td>34</td>
</tr>
</tbody>
</table>

χ² = 2.15 d.f = 1 p = 0.143

There is no significant difference between the two groups.
**Reported Waiting Times**

Mean waiting times for the two groups are detailed. The mean waiting times between the two groups have been compared, ISTC 2.67 months vs No ISTC, 2.47 months P (no difference) = 0.08. Although the P value is small the size of effect is less than one week, with waiting times longer in units with ISTCs and any difference may be accounted for by rounding up or down of actual waiting times by respondents.

**Reported Complications**

Chi-squared test has been used to establish if both sets of responses come from the same or separate populations.

<table>
<thead>
<tr>
<th></th>
<th>More presentations</th>
<th>No diff or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISTC</td>
<td>28</td>
<td>11</td>
</tr>
<tr>
<td>No ISTC</td>
<td>6</td>
<td>47</td>
</tr>
</tbody>
</table>

χ² = 35.26 d.f. = 1 p < 0.0001

Areas with ISTCs report a greater increase in complications presenting following surgery outside the unit.

Without a clinical study assessing the true differences and evaluating any differences in outcome for patients it is hard to quantify the implications of this statistic.

**A Training Audit of Ophthalmology Senior House Officers**

A questionnaire was distributed via College tutors to each ophthalmology senior house Officer (SHO) in England. 202 questionnaires were returned equating to an estimated response rate of 58%.

The objective of this survey was to compare the levels of training provision in hospitals with an ISTC operating in their traditional catchment area with the levels of provision in training units without an ISTC. Data from the clinical directors’ survey was used to categorise each unit.

The survey employed the questionnaire used in a previously published nationwide ophthalmology training audit. Information on surgical training activity, including number of theatre lists, procedures observed, and part and full procedures undertaken, in the previous two weeks was sought. In addition the questionnaire collected demographic data and details of previous ophthalmology experience and medical education.

In order to ensure that responses represented the true situation all data was provided anonymously. This reduced the likelihood of response bias; however it simultaneously removed the possibility of distributing reminders, which will have reduced the final response rate.

**Results**

Ophthalmology SHOs training in units with an ISTC within their catchment area attended fewer theatre lists (mean 2.9 vs 3.7) than SHOs in units not affected an ISTC in the two weeks prior to completing the questionnaire. This resulted in a mean reduction in exposure to 6.25 procedures (19.5 vs 13.25). Furthermore SHOs in units affected by ISTCs performed a mean of 1 less part phako cataract extraction procedure and 1.3 full phako cataract extraction procedures (0.9 vs. 1.9 and 1.7 vs. 2.0) during the survey period.

SHOs in units not affected by ISTCs were more likely to have access to protected training cases on their theatre operating lists.

<table>
<thead>
<tr>
<th></th>
<th>All or Some cases protected</th>
<th>No protected training cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISTC with catchment</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>No ISTC within catchment</td>
<td>120</td>
<td>36</td>
</tr>
</tbody>
</table>

χ² = 23.1 d.f. = 1 p < 0.0001

Although in this preliminary analysis no attempt has been made to control for potential influencing factors such as hospital type or previous experience, the data detailed does denote the possibility of a divergence between the training provisions between these two groups. This could indicate an association between the existence of an ISTC operating within the traditional catchment area of an NHS training eye unit and the levels of surgical exposure SHOs receive.
CONCLUSIONS

Whilst in the survey of Clinical Directors and lead clinicians little adverse impact yet of ISTCs on the hospital eye service was identified, impact over the longer term is possible. A repeat survey could provide further clarification and consistency of findings with the subsequent training audit. The reported increase in complications could be partially due to the increase in local cataract surgery being undertaken outside the hospital eye service. However, this finding highlights the importance of assessing patient outcomes in ISTCs, similar to the audit and clinical governance activity that is undertaken in NHS units to ensure that quality of care is equitable for all NHS patients.

The more detailed study into the effect on training through the survey of SHOs has identified the possibility of a negative impact upon training activity, although not necessarily overall efficacy of training. Further analysis to control for potential confounders and comparison with The Royal College of Ophthalmologists training standards will provide a more complete representation.

In addition to the quantitative data, a qualitative analysis of free text comments from both clinical directors and SHOs in areas with an ISTC identified the difficulty of providing sufficient numbers of suitable cases for training as a recurring theme. This was attributed to the ISTC only selecting straightforward cases, leaving the NHS unit with a more complex case mix. This prevalent observation supports the implications of the initial analysis of the SHO training audit and the likelihood that ISTCs are having an impact upon the training of ophthalmologists in England.

Evidence submitted by the Royal College of Physicians (ISTC 9)

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence.

We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

We believe that Independent Sector Treatment Centres (ISTCs) can play their part in providing high quality patient care in a convenient location for patients but that there are some practical issues which must be addressed. We have consulted our joint speciality committees and we have outlined below those specific areas that could be improved.

1. Are ISTCs providing value for money?

   1.1 ISTCs currently have financial protection and support that is not provided to services within the NHS. We believe that tariffs need to be much more sophisticated and applied equally to all service providers.

2. Does the operation of ISTCs have an adverse effect on NHS services in their areas?

   2.1 We feel that ISTCs are destabilising some local NHS units both through the reduction of funding to their local units and through reducing their service and therefore potentially threatening critical mass. This can have adverse consequences for maintaining other clinical services including emergency cover as well as in the provision of training within the NHS.

   2.2 For example, the economic running of an endoscopy service in an acute trust, which needs to cover not only routine work but urgent out-of-hours endoscopy, is likely to become very difficult if the core of the service and associated income stream (straightforward diagnostic endoscopy) is diverted elsewhere.

3. What arrangements are made for patient follow-up and the management of complications?

   3.1 We are concerned that work that is performed outside a NHS setting does not have the specialist backup that would be available in a large hospital. Consequently ISTCs will still require the management of complications to be supported by NHS hospitals.

   3.2 One approach to the management of patients across organisations is the example that comes from renal dialysis, where there has been significant provision from the private sector for many years. Here clinical supervision has always remained within the NHS although part of the resource delivery is within a separate private unit.
4. What role have ISTCs played and should they play in training medical staff?

4.1 Generally ISTCs have not had a formal training requirement. The shift of some service can have a negative effect on training, which is of considerable concern to the College.

4.2 For example, a major activity of the specialties that perform endoscopy has been ensuring that staff are adequately trained before they endoscope independently, and trainees are adequately supervised. Training must now follow rigorously defined guidelines and assessment of competence requires direct observation by multiple trainers overseen by a Joint Advisory Committee on Gastrointestinal Endoscopy. We are concerned whether there are guarantees that operatives in the ISTCs will be certified to a similar level.

5. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

5.1 There are legal requirements for the appointment of consultants and senior medical staff within the NHS; this College actively supports these requirements. We believe that these standards of accreditation and appointment should be applied to ISTC medical staff.

6. Are ISTCs providing care of the same or higher standards as that provided by the NHS?

6.1 We would like to have reassurance that the same standards are being applied to the NHS and ISTCs and that they are subject to the same level of inspection and regulation. For example we understand that ISTCs do not currently have Directors of Infection Control, with the increasing occurrences of hospital-acquired infections this should be monitored closely.

The Royal College of Physicians
9 February 2006

Evidence submitted by the Royal College of Surgeons of England (ISTC 39)

INTRODUCTION

1. The Royal College of Surgeons of England (RCSEng) welcomed the announcement of the inquiry into ISTCs on 12 January 2006. It wishes to thank the Health Committee for the opportunity of submitting this memorandum of evidence. The College would value the opportunity to present additional oral evidence should the Committee feel that this would be of assistance.

2. For ease of reference, the College’s responses to the specific questions posed in the Committee’s terms of reference are set out immediately below but these should be read in the context of the subsequent sections that provide a background from the College’s point of view.

RESPONSES TO QUESTIONS RAISED UNDER THE TERMS OF REFERENCE

3. What is the main function of ISTCs?

The stated aim in Growing Capacity: a New Role for External Healthcare Providers in England was to develop plurality and diversity in the delivery of health services designed to meet the ambitious targets for reducing waiting times for treatment set out in Delivering the NHS Plan. This included the use of clinical teams in existing NHS provider organisations both to support existing services and to help staff new NHS-managed developments as well as the development of an international establishment of providers to set up and run healthcare units in this country. The NHS units have a strong track record which is achieved largely by the separation of elective surgery from the competing demands of emergency care provision.

4. What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

Capacity

There is developing a progressive increase in capacity but sadly, although initially designed to provide this in areas with the greatest target gap, imbalances are occurring with destabilisation of existing NHS facilities.

58 Delivering the NHS Plan; next steps on investment, next steps on reform. Department of Health. April 2002.
Choice

Although patient choice is extended, the reality is that in the majority of cases they prefer to opt for existing NHS facilities. In addition, general practitioners who have traditionally referred patients to local NHS consultants are, with transfer to ISTCs, losing direct contact with a known and trusted service.

Stimulation of Innovation

So far there has been no evidence of innovative technical advance in the ISTCs established in the First Wave programme. In addition, both the profession and wider public await solid evidence that the projected more efficient ways of working are providing sustained safe and quality surgical care for patients.

5. What contribution have ISTCs made to the reduction of waiting times and waiting lists?

Although there is the evidence that in certain areas waiting times for certain procedures have diminished, it is unclear whether, in the light of experience, this will be sustained and whether the provision of care in a balanced manner across the health economy can be ensured.

6. Are ISTCs providing value for money?

Unfortunately, there is clear evidence that this is not the case and that a number of Primary Care Trusts (PCTs) have expended significant sums of public money in the advance purchase of surgical procedures which have not been taken up.

It is difficult to assess the benefits objectively as there are no outcome data available to evaluate procedures performed.

7. Does the operation of ISTCs have an adverse effect on NHS services in their areas?

There is clear evidence from a number of areas that triaging arrangements have diverted patients into ISTCs leaving existing NHS facilities under-utilised with a concurrent deleterious effect on fragile NHS Trust financial balances. There is also evidence to show that training of surgeons in adjacent NHS hospitals has suffered. (Personal Communication—SAC Report Southampton)

8. What arrangements are made for patient follow-up and the management of complications?

Unfortunately, there is increasing evidence of a relatively high level of complications for example in patients undergoing major orthopaedic surgery where the ISTC has been unable to manage these with consequent transfer to existing NHS facilities and on occasions to the consultant to whom the patient was initially referred. Documented examples have been made available to the National Clinical Governance Support Unit.

9. What role have ISTCs played and should they play in training medical staff?

So far there has been no surgical training provided in the First Wave of ISTCs and the College has recently been working with the Conference of Postgraduate Medical Deans (COPMeD), the Central Clinical Procurement Unit, the Central Clinical Management Team and educational colleagues in the Department of Health in an endeavour to resolve this. There is concern that lack of central guidance is impeding the work of Local Training Steering Groups. The College is anxious to assist in any way that it is able on this issue.

10. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

The College has from the outset been concerned that this is not the case and at an early stage set down a set of guidelines which have been disseminated to surgical colleagues at the local level and made available to the Department of Health.59

11. Are ISTCs providing care of the same or higher standard as that provided by the NHS?

Although patient satisfaction surveys reported by the Department of Health show 80% satisfaction rates, reports received by the College and specialist surgical societies have suggested that care provided by ISTCs is often of an inferior standard to that provided by NHS staff in NHS facilities. It is recognised however that

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there may well be examples of good practice and that these have not been highlighted. The outcome of
detailed patient satisfaction surveys is awaited with interest.

It is unfortunate that College lead representatives have encountered difficulty in identifying those involved
at the local level with the Joint Service Review (JSR) process.

In this context the College welcomes the establishment of a Clinical Reference Group.

12. What implications does commercial confidentiality have for access to information and public accountability
with regard to ISTCs?

Clearly, the work of the College in assisting the establishment of quality standards for patient care,
surgical training and continuing professional development of surgeons employed in ISTCs has been
impeded by commercial confidentiality in the procurement process of both First Wave and Second Wave
programmes.

13. What changes should the Government make to its policy towards ISTCs in the light of experience to date?

Effect on Service in the NHS

It can be seen that First Wave of ISTCs has had a great impact on the NHS dependent on the geographical
location of the ISTCs.

There is a significant body of evidence of ISTCs “cherry picking” the more straightforward cases. Furthermore, as previously stated there is increasing evidence of a relatively high level of complications and
there is no real evidence of the ISTCs being able to provide all the necessary post operative care. In these
cases patients are referred back to the existing NHS services.

The existing ISTCs are adversely affecting training and skewing the case mix. Furthermore, because in
the First Wave activities were considered to be additional, no provision was made for transfer of activity.
Problems have been highlighted in Bradford, Portsmouth and Maidenhead. There is evidence that the
movement of healthy patients with few anaesthetic complications eg ASA grade I has had an adverse impact,
increasing the number of high risk patients with co-morbidity in the adjacent NHS hospital. For
orthopaedic patients, the number of ASA I patients has fallen from 33% to 8% while the number of ASA
III patients has risen from 15% to 25%.

Training in ISTCs

In the first instance, the issue of training in ISTCs had not been considered by central government as the
priority was service development/“productivity” and the philosophy of “additionality” was a further
complicating factor.

The Department of Health had originally indicated that training in ISTCs should be cost neutral with no
impact on the training provider. In fact it has been very difficult to manipulate this to remain cost neutral
and to identify alternative funding streams.

Further information about the effects that ISTCs have had on training in individual cases is available from
the College and from the Joint Committee on Higher Surgical Training. In particular, there have been
reports of the effect that ISTCs are having in trauma and orthopaedics.

It is now implicit in discussions that training will be taking place in the Second Wave of ISTCs. Phase 2 of
the invitation to negotiate (ITN) has been completed although there is still debate about whether the training
schedule would be applied to all at this stage. The expectation is that training will now take place as a result
of transferred activity rather than additionality.

Mechanisms for the Set Up of ISTCs

The College has major concerns about the mechanisms for the set up of ISTCs. The National
Implementation Team no longer exists and has been replaced by the Central Clinical Procurement
Programme (CCPP) and the Central Contract Management Unit (CCMU). The main concern is that there
is a disconnection between the Department of Health Dept of Education and the CCPP/CCMU (ie the
implementation arm).

Furthermore, most of the work involved with training in ISTCs has been devolved to Local Training
Steering Groups (LTSGs). The concerns here are that no one knows about the composition and experience
of these groups and there does not seem to be any uniform structure for them. Undoubtedly there is
significant willingness locally but not always the experience and understanding of training and education,
particularly in view of the changing environment and the introduction of Modernising Medical Careers.
14. **What criteria should be used in evaluating the bids for the Second Wave of ISTCs?**

The original guidance set down by the College remains valid.\(^{60}\) The College is supportive of any initiative designed to improve the access for patients to high quality surgical care and has provided guidance for Fellows involved in assessing bids, selecting preferred providers and determining contracts for surgical services in ISTCs. It is anxious to ensure that careful monitoring of the skills and capabilities of the surgical teams takes place before the contracts begin and that arrangements are put in place to ensure a high level of clinical governance. The College is also keen to ensure that opportunities for training are introduced. Modular training will be required to allow trainees to spend time in the treatment centres working with consultants who are recognised by the College as trainers.

However, there is increasing anxiety that the geographical location of some facilities within the Second Wave may have increasing deleterious effects as a result of inaccurate or unbalanced projections. NHS Treatment Centres benefit from being able to separate the elective from the emergency work thus avoiding the cancellation of routine elective work.

15. **What factors have been and should be taken into account when deciding the location of ISTCs?**

Unfortunately commercial confidentiality has clouded information shared with the Royal Colleges and their representatives on this issue.

Reference to this was made in the provision of evidence by the College to the recent Gateway Review of ISTCs. Second Wave ISTCs are best located in private hospitals which are readily accessible to consultants in neighbouring NHS hospitals.

16. **How many ISTCs should there be?**

The College has consistently stated that the underlying concept of ISTCs lacks long term consistency and that it favoured a progressive advance in the development of NHS facilities underpinned by high quality as initially set out at the commencement of the current government administration during 1997 in *The New NHS: Modern Dependable*.\(^{61}\) An enhanced NHS Treatment Centre programme would in the view of the College have rendered the ISTC project redundant. Consideration should be given to expanding the number of NHS Treatment Centres.

**BACKGROUND**

17. The RCSEng welcomes any initiative to enhance the quality, safety and additional provision of surgical care for patients in line with the stated aims for the National Health Service in the introductions by the Prime Minister in *The New NHS: Modern Dependable* and *The NHS Plan: a plan for investment, a plan for reform*\(^{62}\) and by a former Secretary of State for Health in *A First Class Service: Quality in the new NHS*.\(^{63}\) Indeed the clearly stated intentions to “replace the former internal market with integrated care” and to provide “fair, prompt access to modern and dependable treatment delivered with courtesy and a real understanding of patients fears and worries” were laudable.

18. Clearly the stated intentions for the provision of additional staff and facilities and for the reduction within a limited timeframe of waiting times for treatment as extra staff were recruited were ambitious and it was evident that the targets were unlikely to be met. It was therefore with this background that further initiatives were introduced including:

- *Extending Choice*\(^{64}\) in which patients were able be treated in a wider range of NHS facilities, private facilities or abroad.
- *An International recruitment campaign* with a programme of International Fellowships and recruitment from targeted nations including Spain and Germany.
- *Overseas Clinical Teams*\(^{65}\) a scheme in which clinical teams from France, Germany, Belgium, South Africa, Spain and Scandinavia were introduced into NHS hospitals in England.
- *Growing Capacity; a new role for external healthcare providers in England*\(^{66}\) which set the foundation for the establishment of Independent Diagnosis and Treatment Centres.

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\(^{65}\) *Overseas Clinical Teams*. Department of Health. 2002.

19. The College had been aware of the introduction sometimes covertly of overseas surgical teams into NHS hospitals and had concerns that basic standards of clinical governance, *Good Medical Practice*\(^{67}\) and *Good Surgical Practice*\(^{68}\) were being transgressed. Indeed, following an emergency meeting convened by the President with officials of the Department of Health, an agreed set of guidance\(^{69}\) was published. This was subsequently reiterated in the RCSEng response to a consultation exercise *Overseas Clinical Teams: Code of Practice and Guidance*.\(^{70}\)

20. The responsibilities of the College are to:
- set and help to maintain the highest standards of surgical practice and patient care;
- develop the potential of the profession by education, training and research;
- provide strong leadership and support in all matters relating to practise throughout a practitioner’s career; and
- ensure that patient needs are at the centre of all activities.

21. Set against this background, the College from the earliest stages has consistently stated that, while it welcomes additional investment in the NHS generally, it does not support the employment of an overseas workforce of this type, preferring investment to be made in the infrastructure for surgical resources required for the sustained benefit of NHS patients.\(^{71}\)

22. With the continued introduction of a programme of Independent Sector Treatment Centres (ISTCs), formerly Independent Sector Diagnosis and Treatment Centres, the College set down recommendations for the training, qualifications and experience of surgeons to be employed as well as for their standards of practice.\(^{72}\)

23. In addition, from the outset the RCSEng has repeatedly raised concerns about the consequential effects of the introduction of ISTCs, for example:
- The loss of training for the next generation of surgeons as patients are transferred out of NHS units.
- The effects of “cherry picking” of patients with low co-morbidity (ASA I).
- The balance between elective and emergency care provided by NHS hospitals in the locality—any shift of elective work increases the percentage of emergency work done. General surgery and trauma and orthopaedics, emergencies make up 50% of the total work done. Increasing the percentage of emergency is likely to place more stress on the staff in these hospitals.
- Arrangements for the management of complications and the provision of secure follow-up and continuity for patients.
- The risk of destabilisation of local NHS healthcare provision with the introduction of *Payment by Results*.\(^{73}\)

24. It is clear that the initial concerns raised had significant foundation and that the realities have come to light in that the political pressure to advance the ISTCs programme is having an adverse effect on existing NHS services and on surgical training as well as on planned developments, even though they have so far treated a relatively low number of patients (we understand around 16,000) in contrast we believe to over 106,000 by the generally well integrated NHS Treatment Centres. It was indeed unfortunate that in *Treatment Centres: Delivering Faster, Quality Care and Choice for NHS Patients*\(^{74}\) a statement by the former Secretary of State for Health inferred that ISTCs operate far more efficiently than units in NHS hospitals.

25. Although it has been agreed that surgical training will be encouraged in the ISTCs, there are still a number of hurdles to be overcome and there is, to the knowledge of the College, only a single example of a pilot scheme for surgical training so far with further programmes unlikely to be implemented before 2007. However, the College was heartened to note the announcement of five NHS centres as leaders in the field of innovation and training in short stay elective care with funding of £1.5 million per year for the next three years.\(^{75}\) It is anticipated that they will act as models of good practice in day surgery and short stay elective care and we welcome this.

26. Although the initial stated intention was that ISTCs would be sited in areas where the gap between waiting times and targets was greatest, it is understood that an orthopaedic unit in a major university teaching hospital with a track record of well controlled waiting lists has lost at least 50% (2,000 patients) of

70 Overseas visiting surgical teams: Royal College of Surgeons of England July 2002.
its elective work with resulting closure of a ward. In addition, ophthalmological surgeons have reported patients transferred to ISTCs with the consequence that finance has been identified for only one-third of 30 planned new consultant appointments.

27. The College is also aware that at least two ISTC orthopaedic programmes have not attracted the predicted number of patients under the Choice initiative and that PCTs are concerned that the planned surgical procedures for which they have paid £2 million in advance are not being carried out. General practitioners have also confirmed that patients are being selectively transferred (“cherry-picked”) although the company operating one of the centres has pointed out that it was contracted to undertake elective cases on a fast-track basis.

28. The College has also been very concerned to hear reports of complications in patients treated in a number of ISTCs with poor arrangements for their management. Although stringent clinical governance measures must be put in place by the contracted providers, we remain anxious that the monitoring of these currently leaves much to be desired as does compliance with clinical audit. Furthermore interim arrangements with two independent providers under the G Supp 1 contracts are even less well controlled as they largely fall outside the control and principles set down by the National Implementation Team (Central Contract Purchasing Unit and Central Contract Management Unit). Clearly therefore there is much to do to try to ensure that the quality of care and safety of patients as well as the training of tomorrow’s surgeons is preserved.

The Royal College of Surgeons of England: A way forward:
— The College would like to see central guidance provided to the Local Training Steering Groups and would welcome the opportunity to assist in this process.
— The College wishes to see a central position on education and training in the IS which should come from the Department of Health. Common principles should be devised at a national level. Again the College would like to contribute.
— The College calls for greater awareness at the NIT/CCPU of issues surrounding training in particular the impact of training on service delivery.
— The College would like to see a link between the Department of Health Dept of Education and the NIT/CCPU.
— The College welcomes the establishment of a Clinical Reference Group in view of the difficulties that the College has found in identifying those involved at the local level with the Joint Service Review (JSR) process.
— While the College understands that the NHS does not currently see NHS DTCs as a way forward, the College would like still to commend the model offered by the NHS DTCs. This model provides an effective means for the separation of elective from emergency work on the same site.

Bernard Ribeiro CBE
President
The Royal College of Surgeons of England

14 February 2006

Evidence submitted by the Society and College of Radiographers (ISTC 16)

1. The Society and College of Radiographers (SCoR) represents more than 18,000 Radiographers and Assistants employed in all forms of imaging, including ultrasound, MRI and in Radiotherapy. As a trade union and professional body our aims are to protect the interests of our members and to promote high standards of professional practice and safety for patients and public. We are not opposed to any initiative to improve the service delivery to patients; however, we question the effectiveness of the ISTC programme which we feel was introduced without a full examination of alternative means to improve services within current health care provision and without full consultation with our members, many of whom are leaders in their respective fields. Further, it is our view that whilst there is evidence that waiting times have improved there has been insufficient examination of the knock on effect on NHS workloads in support of the ISTCs.

2. MRI facilities provide a key role in the diagnosis and management of cancer care and without sufficient or robust planning any reduction or failure of this service will have an immediate impact on the delivery of other policy initiatives. We are concerned that the forecast for MRI provision by 2007–08 expects that the Independent Sector (IS) will provide 20% activity and as such we would query the intention for service provision once the life of the current contracts expire. It appears that a dependency upon private sector provision is being deliberately and unnecessarily created at the expense of investment in NHS services.

Not all of the terms of reference of the inquiry are of direct relevance to the SCoR and only items of primary relevance will be addressed in this submission. Our submission focuses upon radiography services conducted within ISTCs.

Q3. What contribution have ISTCs made to the reduction of waiting times and waiting lists?

3.1 The ISTCs have undoubtedly impacted upon waiting times but it is our belief that any reduction would have occurred if the same level of investment (finance and infrastructure) had been channelled directly in to NHS facilities. Our view is that the benchmark was superficial in that a reduction in waiting times was the measurement of success but there was no account taken of the wider impact of the introduction of ISTC, such as the knock on effects within the NHS.

3.2 The ISTCs are not innovative they have merely increased capacity and therefore helped to reduce waiting times for specific procedures. Undoubtedly, had capacity, staff numbers and equipment within the NHS been increased waiting times would have been similarly reduced and consistency of care and treatment maintained. In 2005 the SCoR conducted research into the impact upon NHS units of IS MRI provision. The consensus was that that the work of the ISTC could have been done more efficiently by the NHS units.

Quote: “We have the ability to perform these scans by extending the working at a much lesser cost. The figures were submitted to the SHA but the decision to use mobiles was made.”

Quote: “We costed it to do some Saturday lists, less than half the price, including all radiologist fees etc”

Quote: “For the cost of no more than 10 hours per week support staff (Health Care Assistant) wages, we could eliminate our waiting list completely.”

Quote: “The patients would have been fed through the system in a more controlled manner, resulting in less administration time by the NHS being spent on the organisation of the scans and the reports getting to clinicians.”

Q4. Are ISTCs providing value for money?

4.1 Whether or not the ISTC programme is value for money is unclear. Most requests for clarification as to the costs associated with ISTCs (including saving per procedure compared to within the NHS) are declined due to “commercial confidentiality”. However, in the MRI survey 85% of respondents agreed that the IS arrangements had resulted in a direct additional cost to their Trust.

Quote: “Many hours of administrative work are required from clinical staff prior to each visit, that would not be required if the work was done in-house. Not to mention costs of linen, lockers, reception staffing—all extra to normal practice”

Q5. Does the operation of ISTCs have an adverse effect on NHS services in their areas?

5.1 Our research found that NHS radiographers believed that IS provision has an adverse effect upon local NHS services. For example, it was found that NHS staff and capacity was diverted to the time consuming task of identifying suitable cases for the IS. Additional NHS time was then spent on follow up work where the IS failed to conduct the relevant examination or was unable to produce sufficient clarity of image to produce a satisfactory medical report. Members further advise us that some examinations had to be repeated in the NHS because overseas radiologists employed by the IS and ISTCs to report images from a remote location, failed to produce reports with sufficient clarity to determine further treatment. Many of these problems could have been resolved had the entire procedure been conducted within the NHS unit with the reporting radiologist on hand to resolve any ambiguities.

Q6. What arrangements are made for patient follow-up and the management of complications?

6.1 The lack of evidence to assess the impact of the scheme has hindered any realistic or in depth examination of how the programme has been effective or not. We would welcome some information to assess the effectiveness of treatment to examination and the degree of follow up imaging required.

Q7. What role have ISTCs played and should they play in training medical staff?

7.1 We are concerned that there has been an emphasis on the training of medical staff. ISTCs employ a range of staff including our members. It is our view that an assessment of the effectiveness on role development and training should apply to all sections of the workforce.

7.2 A number of universities already use private providers for clinical placements of pre-registration level radiography students. Additionally, for post-registration competence based programmes, there is already private sector provision, either because they provide the placements required to support necessary post-registration education and training programmes for their own employees undergoing development, or because they provide specific experience that isn’t readily available in the NHS (an example is where an NHS organisation has outsourced its ‘routine’ MRI but has a radiographer undertaking an MRI PgDip/MSc—that radiographer may well be seconded out to the private provider to enable him/her to gain the required experience and undergo the relevant clinical assessments). The SCoR is in the process of developing a good practice guide, which sets out our expectations of ISTC/private sector placement providers.
7.3 One important issue highlighted in our MRI unit survey was the negative impact upon Continuing Professional Development time for NHS staff. By having to deal with urgent and complex cases, since the ISTC siphon the routine cases, means that staff has less time to train new entrants.

Quote: “Pressure on unit is so great that although we train new members of staff we cannot allow more scanning time on patients to teach these individuals. There is no extra time allocated to CPD”

Q8. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

8.1 We are concerned that the role of the AHP is consistently overlooked in favour of medical staff. In recognition of the fact that radiography is a shortage profession, and is likely to remain so for the foreseeable future, the Government has restricted employment of radiographers in ISTCs and the Society supports this policy of additionality. Any radiographer practising within the UK, wherever they gained their qualification, must comply with the Health Professions Council standards and therefore this must be the minimum requirement for employment in or for an ISTC. To date few of our members have been in direct employment in ISTCs. It is our view that the focus for all employment must be the NHS to encourage new recruits retain key skills and to access national terms and conditions and national pension entitlement. It is our view that the failures in workforce planning will only serve to deepen divisions within the health care environment.

Q9. What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

9.1 Commercial confidentiality has been a barrier to understanding the true cost benefit of ISTCs and so they have been judged on the impact upon waiting times and thereby judged a success. A fuller assessment needs to be undertaken.

Q10. What changes should the Government make to its policy towards ISTCs in the light of experience to date?

10.1:
— The government should require that all image reporting in ISTCs be done on site or in real time so that any ambiguity can be swiftly resolved and not become a burden subsequently shifted to NHS sites for resolution.
— We would expect that any ISTC would employ staff on terms no less than AFC and provide access to the NHS pension scheme.
— All ISTC providers should have, as a condition of engagement, recognition of trade union and professional bodies. There should be a requirement to support and actively work with the appropriate professional body to introduce role extension and development.
— We recognise that increasingly there will be a reliance on teleradiology as a standard practice for reporting on images. Until then we would advocate caution. Certainly before there is further implementation, there must be full evaluation of the effectiveness and consistency with this form of reporting.
— There should be a full assessment of workforce needs for the foreseeable future with full engagement with all stakeholders.

Q11. What criteria should be used in evaluating the bids for the Second Wave of ISTCs?

11.1 We would expect that at the very least, there would be evaluation of effectiveness of service provision and standards, evaluation of the levels of training and development and the effectiveness of patient access and standards of care.

Q12. What factors have been and should be taken into account when deciding the location of ISTCs?

12.1 There must be an evaluation of the current provision and transparent evidence to justify the use of an ISTC or IS facility to provide additional capacity or choice.

Yvonne Reihill
The Society of Radiographers
10 February 2006

Evidence submitted by Sunderland Local Medical Committee (ISTC 14)

1. May we take the opportunity to congratulate the Select Committee on its choice of Terms of Reference. They provide an excellent framework for respondents to address the key areas of debate.
2. Our response is based on our experience in with the “Capio” scheme based in North Tyneside.
3. We understand Capio have been provided with a contract for a fixed number of procedures over a period of five years. The fees are apparently guaranteed whether the procedures are performed or not. The average cost of many of those procedures is well in excess of that paid to other providers, eg GPs for minor skin procedures. We therefore do not believe this is providing value for money.

4. We understand that Capio’s contract allows them not to accept referrals for patients who have significant co-existent disease. In cases where there may be significant unexpected post-operative complications these are referred to neighbouring NHS Hospitals to deal with. This demonstrates a process of “cherry-picking” easier cases, and yet not taking full responsibility for adverse outcomes. We believe this inevitably has an adverse effect on local NHS services.

5. We understand that Capio has no role in the training of junior medical staff. Indeed there may even be an adverse effect insomuch that the minor cases they are doing are the “bread and butter” cases necessary for junior staff in both Hospital and General Practice to gain valuable surgical experience. In Sunderland many practices have reached their “ceiling” on the number of surgical procedures the PCT will resource. Those practices have been advised to refer those patients elsewhere for their surgery and this includes the Capio Centre. A significant number of teaching practices are involved and thus training opportunities have been lost.

6. We do not believe the public understand the preferential contracts that have been awarded to ISTCs. It is therefore difficult to understand how there can be proper public accountability.

7. We assume that the accreditation and appointment procedures for medical staff are consistent with proper guidelines. However, the surgeon working in North Tyneside is an experienced pancreatic surgeon from Hungary. Surgeons with that degree of expertise are rare even in the UK. This begs the question whether it is proper for the NHS to appoint personnel to perform minor procedures and thus deprive their own health services of valuable personnel.

8. The North Tyneside scheme is located a significant distance from Sunderland. In our view it is entirely inappropriate to expect patients to travel a large distance when the same service can be offered by the local Hospital or their own GP.

9. The provision of an ISTC has clearly increased “choice”. But the issue is whether that is an appropriate and necessary choice. We believe not.

10. The increase in capacity is relatively small and as we point out earlier, that capacity is available within the NHS at a lesser price and more convenient locations.

11. We are not certain of the role of ISTCs in the light of the DoH’s enthusiasm for Practice Based Commissioning and the movement of services from Hospital to locality-based providers as envisaged in the recently published White Paper.

Dr Roger N Ford
Local Medical Committee, Sunderland
10 February 2006

Memorandum submitted by Surrey and Sussex Healthcare NHS Trust (ISTC 34)

1. What is the main function of ISTCs?

The BUPA run Diagnostics and Treatment Centre in Redhill works in partnership with Surrey & Sussex Healthcare NHS Trust. Like other ISTCs its primary objective is to provide additional capacity for surgery and endoscopy procedures that will enable the NH to improve access to services in the locality. As the unit operates without the pressures associated with emergency admissions it is able to provide an improved level of productivity and efficiency. The Unit offers an additional choice to patients.

2. What role have ISTCs played in increasing capacity and choice, and stimulating innovation?

Redwood DTC is planning to treat around 14,000 patients in 2006 which represents a significant increase in capacity. Its introduction has widened the choice of hospitals available to our patients. NH and BUPA staff work closely together to deliver continuous improvements in quality and efficiency. For example, we have recently introduced a direct access service for patients requiring hernia repair, which means that patients do not have to attend for an initial outpatient appointment.

3. What contribution have ISTCs made to the reduction of waiting times and waiting lists?

Redwood DTC played a major role in helping the local health economy to achieve a six month maximum wait time for inpatient and day case admission at the end of December. This is the lowest recorded level for
the Trust. We work closely with the Redwood DTC team to ensure that waiting times targets for patients with suspected cancer are achieved in endoscopy and breast surgery. We also hope to achieve colorectal cancer screening unit status in September 2006.

4. Are ISTCs providing value for money?

I understand that the financial arrangements indicate that services are provided at close to NH tariff. It is also important to recognise the high level of satisfaction the unit delivers to patients and the consultants who undertake their NH commitments in the Unit.

5. Does the operation of ISTCs have an adverse effect on NHS services in their areas?

No, the additional ring fenced surgical and endoscopy capacity has clearly been beneficial in improving access to services but also in freeing up beds in the acute Trust for emergency patients. Also, continuity of care for patients has been maintained and the approach to clinical governance strengthened. Crucially, the way in which we operate also delivers a good training environment for junior doctors.

6. What arrangements are made for patient follow up and the management of complications?

The service provided to patients at the DTC is fully integrated with services provided in the acute hospital. This ensures that we provide a comprehensive service to patients in the most appropriate environment. For example, patients having their surgery in the DTC will have any routine follow up in the Trust. The arrangement we have ensures that services are not duplicated across 2 sites.

The DTC and the Trust work closely to ensure appropriate medical cover is provided and the DTC in its annexed position to the Trust is part of the on call arrangements in the main hospital. There are very few transfers to the Trust as a result of a patient’s medical condition and formal transfer arrangements have been agreed.

7. What role have the ISTCs played and should they play in training medical staff?

It is vital that ISTCs are able to provide a training environment for medical staff, as they are likely to be providing a large proportion of routine surgery. As NH consultants undertake part of their NHS commitments in the Redwood DTC it provides good opportunities for all doctors in training to receive appropriate surgical and endoscopic training.

8. Are the accreditation and appointment procedures for ISTC medical staff appropriate?

Only NH staff from Surrey & Sussex Healthcare NH Trust work in the DTC. They are all subject to the NHS appointment process. In addition to this each member of staff undergoes rigorous assessment for practising privileges at the DTC and this includes a Criminal Records Bureau Disclosure check. There is a formal link between the appraisal processes in the DTC and the Trust to ensure a whole practice review. A Consultant from the Trust chairs the DTC’s Clinical Governance Committee and the Medical Advisory Committee made up of specialty representatives oversees medical practice.

9. Are ISTCs providing care of the same or higher standard as that provided by the NHS?

It is very difficult to make meaningful comparisons, as there are no objective measures. Redwood DTC performs extremely well in stakeholder satisfaction surveys and in any comparisons with national indicators.

10. What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?

No comment.

11. What changes should the government make to its policy toward ISTCs in the light of experience to date?

ISTCs should be jointly provided by the NH and the independent sector and be co-located on NHS sites to optimise the benefits of partnership such as improving efficiency, encouraging innovation and sharing best practice.
12. What criteria should be used in evaluating bids for the second wave of ISTCs?

Value for money, improved stakeholder satisfaction and plans for training junior doctors.

13. What factors have been taken and should be taken into account when deciding the location of ISTCs?

Co-location on a NH site optimises the integration of the ISTC with the NHS to enable a comprehensive and seamless service for patients. The obvious advantages are ensuring high quality clinical governance arrangements and the on-going training for junior staff to protect future services.

14. How many ISTCs should there be?

This will depend on the requirements of individual local health economics.

Mr Gordon-Wright and Mr Grabham
Surrey and Sussex Healthcare NHS Trust
10 February 2006

Evidence submitted by UNISON (ISTC 42)

1 INTRODUCTION

1.1 UNISON is the largest trade union in the UK, with 1.3 million members. We have 450,000 members working within the health service and across the whole range of healthcare provision. We have been instrumental in helping to develop health policy and are pleased to have the opportunity of submitting evidence to the select committee on Independent Sector Treatment Centres (ISTCs).

1.2 As the largest trade union and the voice of the healthcare team, we are instrumental in influencing policy at regional, national and international level. We work with Government and other international unions to shape healthcare. UNISON has a long history of working with a range of stakeholders and members to develop education pathways and frameworks, which meet the career aspirations of all health workers, we hope that some of our expertise will aid the Committee’s deliberations.

1.3 We have sought to work in partnership with a number of other organisations in sharing views and concerns relating to the current provision of ISTC’s. We work closely and effectively with a number of trade unions and professional associations including the British Medical Association. Since the introduction of ISTC’s we have sought to work in partnership with the Department of Health on a range of issues but paying particular attention to the human resources agenda.

1.4 We hope that the Committee will take into account the weight of UNISON’s views and evidence as a major stakeholder. We would also wish to put on record our appreciation for the extension to the submission; this enabled us to take a strategic analysis of our evidence. We are grateful for the Committee’s support in this.

1.5 The Committee in gathering its evidence has posed a series of questions, whilst we have tried to cover all of them, UNISON has particular expertise in a number of areas and we have sought to cover these in as much detail as possible.

2 EXECUTIVE SUMMARY

2.1 UNISON has serious concerns regarding the continued use of the private sector in the development of ISTC’s, the NHS has additional capacity which could be and is being used reduce the waiting lists. What they lack is the funding, as this is currently being handed over to the private sector.

2.2 Looking at Government documents, almost £5 billion will be handed over to the private sector over the next five years. In wave one we have seen Primary Care Trusts financially compromised, as ISTCs have had to be paid in full irrespective of contract delivery.

2.3 UNISON firmly believes that the financial pressures that the ISTCs will place on the NHS, will inevitably lead to local services being cut or closed. Particularly in light of the current primary care re-configuration it will be difficult to bring back services once they are lost to the NHS and thus furthering the fragmentation of the service and widening the marketisation agenda.

2.4 Whilst UNISON understands that there may be issues of commercial sensitivity, we believe that these are being applied too vigorously and seriously impacting on local accountability and public scrutiny.
2.5 The innovation and expertise in training and development of staff that the NHS provides will be lost as currently, despite the claims, ISTCs are not held to the same standards as the NHS. The weakening of the additivity clause in effect means that we will be relying on the “goodwill” of the private sector not to poach NHS staff whole scale. It has long been recognised that the NHS’s most valuable commodity is its staff, what future it might have if they are lost or enticed from it.

3 BACKGROUND

3.1 UNISON has not opposed the separating of elective and complex surgery by using specialists treatment centres in the attempts to reduce waiting times, but did express concerns over the impact of these centres on the existing NHS resources.\(^77\) Indeed it became common practice since the introduction of waiting list targets for NHS organisations to be provided with additional funding in the final quarter of the financial year to clear the 48 month and 18 month patient waiting times. This coupled with other measures had already started to make a significant impact on the surgical waiting lists. However, the plurality of provision in this untested manner is alarming, the government did not consult on the establishment of independent ISTCs and there has been no research to assess whether this should be the direction of travel.\(^78\)

3.2 UNISON has not been ideologically opposed to Treatment Centres—our opposition has been in the provision, with large amounts of work being handed over to the private sector without assessing the true long term impact on the NHS, its patients, staff and the viability of future service. UNISON is particularly concerned that, due to the lack of evidence based on vigorous audit it is impossible to properly assess the quality of service or ensure new providers offer value for money. No comparison has ever been drawn from the 36 NHS Treatment Centres.

3.3 UNISON represents health workers who currently work within ISTCs, we have been actively involved at a local level in the contractual negotiations in a number of the wave one sites. We have recruited new members within ISTC’s by working with them to resolve issues. We have national and local recognition agreements with a number of organisations and have actively sought to assist in the process. We have been working very closely with a number of members working for one ISTC provider after they expressed concern about patient safety and questioned a range of employment practices. We are currently seeking a ministerial meeting with Lord Warner and have drawn these concerns to the attention of the regulators.\(^79\)

4. What is the main function of ISTCs?

4.1 ISTCs were originally announced by the Prime Minister on the 30 July 2003 and were introduced to provide additional capacity for the NHS\(^80\) to reduce the existing waiting times. However, many NHS organisations had already made significant progress on this issue by looking at the patient journey and planning more effectively manageable surgical lists. Previously the Government had sought to use the private sector to reduce the waiting lists, but while this proved popular with the sector, the irony was that many patients were operated on by the same team including NHS staff, the location simply becoming geographic. If the argument of additional capacity was a key driver, it is surprising that a full assessment was never made to assess the true requirement of the NHS to clearly identify what they could provide and where. This would have given an emerging picture, to enable additional capacity to be sought, where necessary.

4.2 In the recent adjournment debate in the Houses of Parliament Kevan Jones, MP for North Durham,\(^81\) cited a letter that he had received from the Chief Executive of University Hospital North Durham in which he stated “The MRI scanner at University Hospital North Durham is considerably under employed and had been for some time, and it is the case that had the “Alliance Medical” money been direct to us, at the University Hospital North Durham we would have been able to put on a large number of scanning clinics, which would have almost eliminated in total our waiting times and waiting number”. He went on to say, “It was a disappointment for us when the Department of Health said that providing individual hospitals with additional resources was not an option, the additional resources had to be made available to the private sector.” Considering this example it is difficult to see how, in this case, the system provided value for money for the health service, or reflected the needs and capacity of the local NHS trusts.

4.3 Elective surgery is easier to manage as there are predicable levels and the ability to assess and choose cases. However, this also increases the burden on the NHS, who undertake the more complex procedures or care for patients with other underlying medical conditions.\(^82\) In addition ISTCs do not have to compete with increasing demands and unpredictable admissions, for example it is highly possible that the admission of a complex road traffic accident needing surgical intervention, could impact in a number of ways. They

\(^77\) UNISON Bargaining Support paper—June 2005.
\(^78\) Operating for Profits An examination of the UK government’s policy of promoting “Independent Sector Treatment Centres” Dr John Lister September 2005.
\(^79\) UNISON letter to Lord Warner 13 February 2006.
\(^80\) In the Interests of Patients? Examining the impact of the creation of a competitive commercial market in the provision of NHS care—UNISON September 2005.
\(^81\) HC Deb, 19 October 2005, Col 270WH.
\(^82\) Private outcomes data “misleading” Hospital Doctor 6 October 2005.
could, for example, need lengthy theatre time, more than one surgical team could be involved or perhaps they may need an ITU bed. The NHS is used to dealing with these competing demands and prioritise accordingly, hence we have seen the increased use of day surgical units, five day surgical wards, a dedicated emergency theatre available 24/7 and innovation in home care.

4.4 UNISON would seriously question the introduction of phase two sites as there is no analysis to demonstrate that wave one has been any more effective than the NHS. Indeed we would strongly argue that they do not provide value for money. In the future patient choice will become an old catch phrase, the reality is that patients would, we firmly believe, choose to have the surgical procedure performed at their local hospital. UNISON contends that the future of ISTCs is about a sustainable market for the private sector and not what is in the best interests of patients or the public purse. The NHS will achieve an 18 week waiting time if it were not for a Governmental push requiring PCTs to contract from ISTCs. What future would ISTCs and their shareholders have when waiting lists become a historical fact?

5. What role have ISTCs played in increasing capacity and choice and stimulating innovation?

5.1 UNISON has seen little evidence to clearly demonstrate that ISTCs have effectively contributed to the reduction in NHS waiting lists. Indeed a number of wave one sites are still not operational. While they have been heralded by the Department of Health, many have questioned the statistical examples given in Ophthalmology services. In a letter to Hospital Doctor magazine Mr Simon Kelly consultant ophthalmic surgeon, stated, “it is the efforts of NHS ophthalmology teams who perform over 300,000 cataract operations annually in England that have brought down cataract waiting times.”

5.2 It has been stated that ISTCs are discharging hip replacements earlier than the NHS as a result of their innovative practice. Most NHS organisations, including NHS treatment centres have moved to or are moving towards a four–five day discharge approach. Within the NHS this has been developed for a variety of procedures using a patient care pathway approach (PCP). The NHS has developed a multidisciplinary approach to their design, which commences with the surgical assessment. At this stage patients are referred to a community team who can assess the patient at home and identify what additional care or resources they may need. This coupled with improved communications, often means that on the day a patient is discharged their equipment is either already there or being delivered. A single document used by all members of the team caring for the patient ensures a consistent and seamless approach to care.

5.3 We have received complaints from staff in one ISTC provider who stated that medical instructions not to discharge a patient have been overridden by others; this was cited in the case of a post-operative patient following a hip replacement whose wound was oozing. A patient presenting with this would be at risk of infection and we would argue that in the NHS this particular patient would not have been discharged.

5.4 A number of the current ISTC providers are replacing NHS provision, but we cannot assume that this is improving overall capacity in the NHS. Indeed a number of PCTs have come under increasing pressure to commission services from an ISTC irrespective of their local circumstances. A PCT in Oxford had very early misgivings when first made aware of the planned initiatives in January 2003 and the lack of transparent information surrounding ISTCs. The board members expressed concern and consistently opposed the contract as they did not believe it was in the interests of the local population. They argued that waiting lists were being met by the local NHS and that they had been awarded Beacon status for excellence and also had additional capacity in the NHS.

5.5 Innovation has been best developed where it is complimented by research and teaching and has often evolved through service development. However we could not identify any specific innovative practice which had been developed as a direct result of ISTCs.

5.6 UNISON acknowledged early on the role that diagnostic treatment centres and subsequently NHS ISTCs could have in service delivery within elective work. However we strongly argue that there is little long term justification for the extension of this within the private sector.

6. What contribution have ISTCs made to the reduction of waiting times and waiting lists?

6.1 Only a small number of the wave one ISTCs are currently operational, so we believe it is difficult to assess what impact they have made on the reduction of waiting lists. The situation is even more complex as there are no mechanisms to identify lists which have altered as a result of the numerous other NHS initiatives to tackle this challenging issue. However, we believe that improvements in the way the NHS manages surgical cases, the establishment of waiting list targets, role re-design and the modernisation agenda have contributed more effectively to delivering the current reduction than the ISTCs.

83 Letter to Hospital Doctor 6 October 2005 Mr Simon Kelly.
6.2 The question must also be seen in the context of patient safety and standards of care. 70 NHS patients had to be returned to theatre after having orthopaedic surgery at treatment centres run by Partnership Health. In 15 months 70 patients had to go back into theatre—more than 2% of the 3,253 patients treated, compared with the five other providers measured who reported between 0–0.4% of patients returning. 85

6.3 Staff working in outpatients for Partnership Healthcare report being expected to care for 50 patients while undertaking the preadmission procedures. While UNISON has fully supported the modernisation agenda we are deeply concerned that some staff have been observed with stop watches. A significant number of patients presenting for elective orthopaedic replacements are elderly. It is impossible to say that every patient will only take 10–15 minutes to complete their assessment. Every patient should be treated equally and to ensure that this can be done, each must have their own needs taken into account and have sufficient time for their questions and fears to be addressed.

6.4 Elsewhere in the evidence we have presented examples of where capacity has not been additional but has utilised the spare capacity that the NHS already has. At Middlesbrough, Kidderminster, Tyne and Wear, and Oxford the patient numbers that the ISTCs have treated would have been manageable within the NHS and without the huge sums of money that are paid to the private provider.

7. Are ISTCs providing value for money?

7.1 Along with the additional capacity that the ISTC programme was supposed to provide to the NHS the added claims that they would provide value for money was another attraction highlighted by supporters. However, among the initial concerns expressed one of the main areas of contention was the cost of private sector involvement and the effects on the NHS having to pick up the bill. The contract signed by 28 PCTs in Trent and South Yorkshire for the services of Partnership Health Group Limited (PHG) at both its interim sites at Bassetlaw and Ilkeston and then its purpose-built £7.5 million site at Barlborough felt a huge financial burden in its first year of contract. The value of which for 2004–05 was £13.4 million with the actual uptake being worth £10.1 million. This shows a loss of £3.3 million for operations that PHG never performed. Nottingham City PCT was one of the biggest losers to the tune of £800,000. Additional documents obtained by a local newspaper revealed the government made £5 million available to local health authorities to offset losses and encourage more use of the centre and GPs were being asked to “cold call” patients on waiting lists. 86

7.2 At a meeting of the Maidstone & Tunbridge Wells NHS Trust Board, their Chief Executive, commenting on their ISTC project, said “The ISTC has been reviewed. The project is now costing at 125% of National Tariff. This means that £3.1 million is likely to be released to the Trust this financial year. Locally there will still be affordability issues for the project that will have to be addressed”. 87 Exactly what impact this would have on other NHS services in the area is not clearly documented.

7.3 Papers from a presentation given to Central Manchester PCT highlight the financial risk that they were facing. The paper states that “Latest figures from the contract management team suggest that the ISTC contract overall is being under utilised and if this continues then the PCT would be liable to pay under the risk sharing agreement. This is a matter of some concern to the PCT… the maximum risks that the PCT will be exposed to is £500k and the working assumption is a £250K overspend”. 88 With 14 contracting PCTs signed up to the ISTC based at Trafford this figure could well be replicated as they all suffer due to poor uptake of planned activity. The private provider profits whether or not they complete scheduled numbers of operations.

7.4 As mentioned elsewhere in this evidence, Oxfordshire and the contract with Netcare has provided numerous examples of concern. A six month review 89 of the contract highlighted the financial impact on the local health economy. Netcare were contracted to provide 800 cataracts a year in North and South Oxfordshire from April 2005 for four years. South Oxfordshire was contracted to take on average 456 cataract operations and 593 pre-operative assessments per year. The review showed that in the first six months of the contract despite only £40k of work being carried out, Netcare were paid £255k and the contract honoured irrespective of the volume of completed activity. The review concluded that the population commonly requiring cataract surgery is elderly and Oxford Radcliffe Hospitals had such a strong reputation and short waiting lists that local people preferred the NHS to the new ISTC. This merely echoed previous concerns expressed by local PCTs when assessing the accountability to local people and the cost of the scheme that the NHS would have to bear.

7.5 The Cobalt ISTC on North Tyneside, run by Capio Healthcare UK, has a contract value that is worth £6.5 million to provide 2,000 day-case procedures a year for five years, including minor skin procedures, endoscopies and surgery for hernias and varicose veins. Yet over the first three months of the contract most referrals were for minor skin procedures such as epidermal cysts. Tyne and Wear GP Dr Sam Misherki was quoted as saying “The whole thing is a farce. They gave a five-year contract that wasn’t even needed.

85 National Centre for Health Outcomes Development (NCHOD) 11 November 2005.
86 Chris Locke, Chief Executive of Notts Local Medical Committee.
87 Maidstone & Tunbridge Wells PCT board papers.
88 Central Manchester PCT board presentation.
89 South West Oxfordshire PCT board papers and UNISON report.
Certainly for minor surgery we would not refer. Almost every GP is capable of doing that. It is ironic that, at some stage, there were thoughts of training non-medical staff to carry out less complex surgical procedures to cut the costs, and here we find taxpayers’ money is being spent to pay a private clinic that employs a consultant surgeon to do epidermal cysts. 7.6 When assessing the contract values of other schemes and comparing them with examples already given, it is clear that there is alarming potential for contracting PCTs, particularly those already in debt, to face financial meltdown and be forced to utilise ISTCs at the expense of the NHS. Worrying figures of contract values that could present problems include the following: Burton-upon-Trent—Nations Healthcare Limited—contract value £77 million, North West—Interhealth Canada—contract value £146 million, Halton—Nuffield—contract value £120 million, Kidderminster—Interhealth Canada—contract value £26 million.

8. Does the operation of ISTCs have an adverse effect on NHS services in their area?

8.1 The NHS Treatment Centre at Kidderminster in Worcestershire offers a broad range of services for short stay and day cases in areas such as ophthalmology, general surgery, orthopaedics and radiology. A £14 million purpose built site that saw early success in reducing waiting lists could perform 15,000 procedures a year. Yet despite operating well below capacity (3,000 procedures in its first year) a new ISTC run by Interhealth Canada was set up within the existing NHS site to provide additional capacity that bizarrely already existed. General Manager David Evans at the time stated, “The whole issue in losing out to the private sector is that it is hard to compete on a level playing field with the independent sector.” Other fears that orthopaedic activity undertaken at neighbouring Evesham Hospital would be transferred to the ISTC in Kidderminster were strongly expressed, particularly as funding had already been committed for a pre-determined level of service. The effects on the local NHS services could be disastrous as activity is lost and costs increase. Also the fear of loss of services force patients to travel long distances for treatment, becomes a real factor.

8.2 It is frightening to consider what could be the long-term impact of ISTCs on the NHS. We could end up with a fragmented service, with funding being ring fenced and directed to the private sector. Department of Health figures show that wave one and phase two will cost the NHS almost five billion. It’s not hard to imagine how the NHS could have utilised that funding to clear the waiting lists and how many nurses, healthcare assistants, theatre staff, surgeons and anaesthetists could be employed. There is evidence that the NHS has the capacity to deliver the agenda, what they appear to lack is the funding.

8.3 The weakening of the additionality statement will enable the private sector to actively recruit from the NHS. While some posts will be protected, large numbers will not. The ISTCs are exempt from implementing the new pay system Agenda for Change, so in effect there will be a two tier system within the health economy and also within the site itself. The additionality clause in wave one prevented ISTCs from recruiting anyone who had worked for the NHS in the last year. The statement will now only protect specific staff. Some staff may be seconded over to the ISTC, on their NHS terms and conditions, while others will be directly employed by the ISTC on varying terms and conditions and no NHS pension rights. This level of inequity will, we believe, lead to instability within the local health economy.

9. What arrangements are made for patient follow up and the management of complications?

9.1 The importance of post operative care cannot be underestimated. The need for re-admission following hip replacements is a real possibility given that patients are at a higher risk of dislocation within the first 12 weeks of surgery. In the NHS multi-disciplinary discussions take place within and between teams and there is close liaison with community services for home care, often starting months before surgery with a home assessment.

9.2 Re-admissions following surgery are often an emergency, so patients would normally be taken to their nearest A&E department. The only data that we have been able to source on the subject of re-admission was published by the National Centre for Health Outcomes Development on 11 November 2005. The report appeared to identify a higher rate of re-admission for patients who had been operated on within PHG. 9.3 As a result of commercial sensitivity we cannot ascertain the number of complications or critical incidents which have occurred within ISTCs as they are not required to report incidents to the National Patient Agency (NPA) While they are expected to have governance arrangements in place we have not been able to examine them. So we cannot assess whether they are sufficiently robust to protect patient safety, nor can we compare their management to that of the NHS. The NHS uses a multi-disciplinary process to locally assess all adverse clinical incidents and are required to document and investigate where appropriate to ensure that all possible lessons are learnt to prevent, where possible, the same thing happening again.

90 UNISON health group research document.
91 Public Finance article—December 2004.
92 National Centre for Health Outcomes Development 11 November 2005.
9.4 ISTCs will have the indemnity protection of the NHS under the clinical negligence systems so are expected to comply with appropriate risk management. They are not however, required to share any information about their systems.

9.5 The loss of critical skills as a result of the elective/complex split could mean that staff will become deskilled. We have yet to see evidence that training systems are in place at a vigorous standard in order to avoid this. We have seen cases within the private sector of patients being transferred back to the NHS as they were too ill to be cared for within that sector.

10. What role have ISTCs played and should they play in training medical staff?

10.1 The importance of training and development that the ISTCs should be required to provide in the ways the NHS does is highlighted by the orthopaedic case mix at Southampton University Hospitals NHS Trust (SUHNT). This is too skewed to meet training needs because the healthiest patients are going to an ISTC. This leaves future doctors’ training and service in turmoil, unless contracts between PCTs and private providers are renegotiated. In fact the Chief Executive of SUHNT, Mark Hackett, asked the specialist advisory committee (SAC) in orthopaedics to visit Southampton because he was so concerned at the situation. Since the ISTC run by Capio opened, the trust has treated 25% fewer healthy patients (ASA grade 1) and 10% more complex (ASA grade 3) patients. The SAC report ordered the contract be “reworked” and that failure to do so “would lead to the SAC advising the competent authority of the need to withdraw training”. Matt Freudmann, British Orthopaedic Trainees’ Association Chair, said that “the rising age of the UK population is causing ever-increasing demands for orthopaedic surgery. It is vital the surgeons who will perform these operations are properly trained”.

10.2 Evidence that UNISON has gathered over several months’ extensive research at the ISTC in Barlborough, run by Partnership Health Group Limited (PHG) provides alarming examples of the lack of training being offered, including basic health and safety training as well as clinical training. Only a handful of staff have received training on what action to take in the event of a fire or a patient having a cardiac arrest. In the NHS this would be considered mandatory and every member of staff is expected to have annual training on this. One member of staff who was also a fire bleep holder described an event where the alarm had gone off but no one, including them, knew what to do. Another member of staff received an electric shock from trailing cables which highlights a level of neglect from the private provider. Staff have had little or no training in the use of equipment, some staff have been expected to work as anaesthetic assistants, where their roles included checking the anaesthetic machine, preparing anaesthetic agents, assisting in intubation of patients for their procedures and positioning the patient appropriately without having received any specific training. In the UK this is recommended as a highly specialised role. The recommended standard, which is supported by the Royal College of Anaesthetists, is that staff should have either a post basic anaesthetic qualification or have studied for a course in surgery and anaesthesia such as Operating Department Practice.

10.3 Lack of fundamental training in health and safety, fire and resuscitation has resulted in incidents unacceptable in the NHS. In conjunction with this there is poor access to courses and no set pattern for developmental reviews. More worryingly is where staff have been asked to work within anaesthetics and were doing so without either proper training or supervision.

11. Are ISTCs providing care of the same or higher standard as that provided by the NHS?

11.1 The standard of care that the ISTCs offer is meant to be measured by the high clinical standards that the NHS is governed by. UNISON has, during the course of research into experiences from wave 1 sites, uncovered specific examples where the level of care offered by certain ISTC providers has been significantly lower than their contracts. One reason highlighted early on was the fact that there was no requirement for a private provider to be registered with the regulatory watchdogs of the NHS. A private clinic that carried out thousands of cataract operations for the NHS was one such provider not registered with the Healthcare Commission, Levent Clinics, which performed around 4,000 cataract operations in Nottingham and Derbyshire in 2003–04, was in fact never registered and openly admitted that they were not required to do so. A Trent Strategic Health Authority (SHA) spokesperson talked of “extensive advice” taken from the Department of Health and assurance given that they could operate without having to be registered. This must surely be a minimum requirement in ensuring that the private sector meets the same standards as the NHS. Local ophthalmologists highlighted concern with both the Commission and the Royal College of Ophthalmologists over patients with co-morbidity whose cataracts were treated by Levent. Patients with problems such as glaucoma were allegedly released following operations without onward referral for treatment and the NHS was left with the more costly follow up treatment.

11.2 The issues that we have presented from evidence at Barlborough, run by Partnership Health Group Limited (PHG), have covered virtually the whole range of concerns that UNISON has with the ISTC programme. We have sought on several occasions to raise these issues with PHG, but sadly they have declined at every stage. We also raised the issue of trade union recognition, as a means of using our expertise...
to resolve some of the clinical issues that staff were concerned about in partnership, every positive step we
sought to take has been resisted. Our concerns included examples of swab count policies (routine for the
NHS) not being included in existing clinical policies and procedures and thus not followed. We believe that
this has resulted in serious breaches of the clinical governance. One case in particular was where a pin was
left in place following an operation and this was missed at the swab and post operative assessment meaning
either no x-ray was taken, or if it was, it was incorrectly cleared. This was only diagnosed when the patient
presented to their GP in pain and the pin was felt upon examination.\textsuperscript{94} In the NHS three swab counts are
taken, (close of cavity, muscle and skin) all equipment, pins, needles and swabs used are counted by two
persons and the accuracy of the count would be reported to the surgeon. Following all joint replacements
xrays are taken post operatively to check the position of the prosthesis and to assess the surgery, this is
checked and assessed by a competent person.

12. What implications does commercial confidentiality have for access to Information and public
accountability with regard to ISTCs?

12.1 Public accountability and access to information is vital to encourage local scrutiny in any area of
the public and private sector. Many of the private providers claim high rates of patient satisfaction and
operational success rates yet this information has proved impossible to obtain. A recent Freedom of
Information (FOI) request to Nottingham City PCT revealed that the commercial interests of the private
provider are placed before the public interest. When asked to provide a list of the number of recorded
complaints at the local ISTC and audit figures to show how patient satisfaction rates were constructed and
measured, both were refused on the grounds that, “This information is withheld as likely to prejudice the
commercial interests of the provider under Section 43 (2) of the Act…In assessing the balance of public
interest, it is important to be able to compare these to audit figures for other units of a similar nature. As
these are not available it is not considered in the public interest to release them”.\textsuperscript{95} Therefore, the private
provider can publicise approval rates of 97%, as Partnership Health Group Limited have done, and yet not
have to justify this in the interests of commercial sensitivity.

12.2 The government and the previous Secretary of State, John Reid MP, consistently provided
assurances that the final decision over the acceptance of an ISTC contract lay with the PCTs and their
respective boards.\textsuperscript{96} As the case in Oxfordshire concerning the Netcare contract highlights, this method of
accountability and scrutiny was completely bypassed. Decisions made at local level by South West
Oxfordshire PCT and Cherwell Vale PCT in opposition to the contract was based on the belief that it was
not deemed beneficial for the local population. The local NHS trust, Oxford Radcliffe Hospitals, was
already meeting its waiting list targets and the proposed ISTC seriously risked undermining the quality of
training and therefore in the long term, the standard of clinical expertise. The fragmentation of local services
and the financial pressures on the PCTs were also cited. The decision to approve the contract came after
months of constant pressure at SHA and government level with members of the respective PCT boards even
being removed from office to secure a positive vote. Accountability to the local people was taken out of the
hands of the PCTs and despite the opaque business case that was put before them the five year contract was
approved.

12.3 The ability to scrutinise the role of the private sector and in particular the private providers, from
contract details to patient satisfaction rates, is not only a real worry but grounded in fact when looking at
another area of the government’s modernisation agenda. Foundation Trusts in their autonomy have
frequently declined to provide information, hiding behind their new-found independence from the rest of
the NHS. This lack of accountability will prevail with the ISTCs for as long their business interests are
protected.

13. What changes should the Government make to its policy towards ISTCs in light of experiences to date?

13.1 We believe that information is too limited at the moment to assess any impact that ISTCs may have
had on NHS waiting lists. However, we would contend that Phase two of the ISTC programme should be
halted until such time as a full assessment has been undertaken, the scope of which should include
governance, patient safety and whether they are delivering value for money.

13.2 We recognise that patients want a faster and more responsive service, we also believe that they do
not wish to travel 40 miles to receive this treatment if they can access it locally. The NHS has already done
so much to improve services; health workers have always, and will continue to deliver, high standards of
care. Unless we make a true measure of need we cannot assess capacity or demand effectively, we are rather
playing with figures and, in our opinion, wasting public money by handing millions over to the private
sector.

\textsuperscript{94} Unpublished UNISON research—2005–06.
\textsuperscript{95} Notts City PCT response to FOI request—November 2005.
\textsuperscript{96} Parliamentary response to questions—December 2003.
13.3 We believe that the current ISTC programmes will undermine the future of the NHS and this, coupled with the current financial situation within the service, makes a worrying picture. There is a real risk to the NHS and local services; an example of this exists in the Brighton ISTC. Our members there have reported fears from staff regarding the future of the Princess Alice site at Haywards Heath. At this ISTC Mercury have been commissioned in Wave one to provide elective orthopaedic surgery, complex cases will be undertaken at Brighton University Hospital. However, questions now appear to have emerged regarding whether they need to retain an ITU at the Princes Alice site. If ITU goes in the future, the site will not be able to receive certain cases as they would not have the capacity to care for them. The staff remain concerned that as a result of the ISTC centre being on the site, coupled with the £18 million overspend their future could be bleak. The cost of this ISTC could wipe out the Trust’s current deficit.

13.4 No real assessment has been made of the possible long term risks of ISTCs on the remaining health economy. What can we be sure of is that, without the long term commitment that the government is giving to the private sector, we would not have ISTCs. Where else would we find an organisation that was paid irrespective of what work it undertook? What incentive does this give any organisation to deliver on targets? We can hardly argue a level playing field when NHS trusts who fail to meet government targets are labelled as poorly performing and those ISTCs who do not meet the case numbers are still paid and heralded as reducing NHS patient waits.

13.5 The use of commercial sensitivity affects all parties’ ability to assess the full picture and scope of ISTCs and undermines the level of accountability that we should all be held to. How are we to make informed decisions if we cannot effectively question organisations and systems? While we recognise that there may be issues with commercial sensitivity, it appears to currently cover even the most bizarre elements, such as how many cases an organisation is contracted to perform and how many they have done. If the objective of ISTCs was to reduce the waiting lists, surely this information should be transparent to ensure it delivers on its objective.

14. What criteria should be used in evaluating the bids for the second wave of ISTCs?

14.1 There is a need for a real debate on the use of ISTCs. A clear criteria from the outset was capacity, however we can find little evidence that the schemes we have looked at have added capacity. In the main they are taking over existing areas of work and not increasing capacity at all. This will impact on the future of the local economy.

14.2 Currently the government requires work to be commissioned from ISTCs up to a maximum of 15%, however this does not appear to be monitored, so how will they prevent more than 15% being commissioned? As there is no partnership involved in the selection process we believe that there is also no transparency. While the trade unions have been involved in some of the human resource discussions, we have been denied access to commercially sensitive information in the same manner as everyone else.

14.3 The Department of Health has, in a number of documents, stressed the need to ensure effective governance and training. The NHS treatment centres appear to be integrated into the local health economy and work effectively in partnership. The orthopaedic centre in South West London has been highlighted by staff as having excellent nurse/clinical leadership. However, despite contributing to the waiting list work, it is threatened with being handed over to the private sector.

14.4 We believe that the evaluation of bids must start at a much earlier stage with local consultation and discussion on their appropriateness. This would allow the local area to assess, in a much more informed manner, what is required and whether they have the capacity to deliver it. We would wish to see NHS centres considered first and we can clearly see the merit in exploring different ways of delivering healthcare. However, we would argue that these ways should be seamless, local, affordable and deliver high standards of care.

14.5 A number of other factors should also be taken into account and the local service should be able to judge each and ever bid in a consistent transparent manner. We would wish to see trade unions and professional organisations involved at all levels, as they are with other contracts. Governance must be more vigorously tested, it is not good enough for an organisation to state that they will have systems in place, they must demonstrate that they are and must be consistent with the NHS system. Organisation must be able to stand up to scrutiny.

14.6 We would also wish to see the following included in any evaluation:
- closer working relations as part of the local healthcare unit;
- commitment to Agenda for Change;
- value for money;
- delivering additional capacity not replacing existing services;
- training, in a consistent manner;
- regulation;
— local and national workforce planning;
— compliance with clinical governance frameworks;
— transparency at all levels of the process;
— accountability;
— future partnership working with trade unions;
— trade union recognition.

15. What factors have been and should be taken into account when deciding the location of ISTCs?

15.1 There has been a cloud of secrecy surrounding the selection of wave one sites and this continues with the process for phase two. We do not know who the short listed bidders are, we cannot therefore judge their ability to work effectively within the NHS nor their ability to deliver the contract on time. There will continue to be little or no accountability to stakeholders as they are not required to publish statistics in the same manner as the NHS and will, we believe, continue to use commercial sensitivity and their independence as a means to keep information private.

15.2 We have found it alarming that no review or comparison of NHS centres has been undertaken to assess what additional capacity they may have or whether they can provide more services. Without this information we cannot assess what, if any, involvement the private sector may need to provide.

15.3 There is no logic in a patient having to travel 50 miles for a scan when the local hospital, the University of Durham, has one available but not funded. We have already seen NHS hospitals closing wards because of transferred activity to the ISTCs and this is only from the few ISTCs currently operational in wave one. If this pattern were to continue, the impact of phase two could be catastrophic.

16. How many ISTCs should there be?

16.1 UNISON believes that the money which is currently being handed over to the private sector could be better spent enabling the NHS to increase its capacity. UNISON is not opposed to the role that treatment centres could play, however if they are to be truly effective and deliver not just on waiting lists, but on the modernisation agenda, they must be retained by the local NHS services. The local NHS should have greater control over what is required within the local health economy.

17. Conclusions

17.1 The ISTC programme was originally designed to provide additional capacity to the NHS and drive down waiting lists while offering patient choice. However, the creation of the market within the NHS has had the opposite effect.

17.2 Patients are treated as consumers and in cases highlighted earlier, the ISTC becomes a conveyor belt treating these consumers. Patient care, particularly around complications, takes second place to maximising profit. The market itself requires competition and as the Department of Health’s own independently commissioned Sustainability Analysis stated, three or four big companies are needed to create and control the market to allow the private sector to survive in the public sector domain. It also states that the market has to be big enough and robust enough to maintain this market which will no doubt raise questions over Lord Warner’s assertion that “...I guarantee that by 2008 the independent sector will not account for more than 10% of NHS work...”

Due to the nature of this market no one organisation will develop an overview of understanding of what the local community needs.

17.3 UNISON believes that ISTCs ultimately fail because:
— the private sector failing to deliver the required standards;
— abuse of monopoly power;
— unequal distribution of information;
— resorting to maximising profits first;
— they do not stand up to public scrutiny;
— we do not believe that they deliver value for money, any NHS organisation with empty theatres and scanners cannot be justified;
— we have seen little evidence of training and development in the ISTC’s wave one sites;
— ISTCs are cherry picking the cases, this leaves the NHS with the more complicated cases but without receiving any additional funding to cover this patient mix.

98 Lord Warner at the UNISON breakfast seminar 18 January 2006.
17.4 The evidence in wave 1 is still being assessed and evaluated. The relaxation of the “Additionality Clause” that previously prevented anyone who had worked in the NHS within the last six months from working in an ISTC presents further problems and risks adding to the fragmentation of the NHS.

17.5 The research so far has shown that ISTCs do not provide value for money, but instead place further strain on already demanding PCT budgets. Local decision making and accountability is threatened with PCTs being forced to sign up to potentially damaging contracts that are under utilised and sometimes in places where the NHS has spare capacity itself.

17.6 Workforce issues (including lack of training and development of staff) and patient care are being threatened by autocratic management who refuse to work closely with other stakeholders, including trade unions, and wilfully protest about “partnership working”. The government mantra of patient choice and value for money are overridden by serious doubts about any choice at all, particularly where GPs are incentivised to send patients to the ISTC. As for cost, there is a real risk of the ISTC programme becoming the white elephant of the NHS.

UNISON
13 February 2006

Annex 1

Letter from Karen Jennings, UNISON, to Lord Warner, Minister of State, Department of Health

I am writing to you as the Minister with responsibility for Workforce Development to inform you of the serious concerns that have been expressed to us by staff working for Partnership Health Group Limited (PHG) who are running the Independent Sector Treatment Centres in Lincolnshire and Plymouth.

We have written to Partnership Health Group Limited on four separate occasions since 25 November 2005 with regards to one site in particular at Barlborough. In each of the letters we outlined our serious concerns and our commitment to working with them to find a suitable resolution. The issues raised have been both clinical and employment related and includes the following:

— Lack of basic training and development.
— Poor clinical governance policies.
— Concerns over patient safety and standards of care.
— Management’s use of stopwatches during pre-op assessments.
— Bullying and intimidation.
— Work / Life balance.
— Cross site working.
— Working Time Regulations.
— Neglect of partnership working.

We sought an immediate meeting to discuss these concerns with PHG but despite repeated requests no meeting has so far been arranged. Furthermore, a meeting between staff and management was cancelled due to PHG management refusing to allow a UNISON representative to participate. At all stages we have been approached by staff who have sought our assistance in finding a resolution to their concerns and at all times we would have preferred to do this in partnership with PHG.

We have worked with the staff over a number of weeks to re-assure them that their complaints are justified and need to be investigated and that they have been right to raise them with us. Nevertheless, a culture of fear seems to exist within this organisation and this needs to be investigated thoroughly.

We do not believe that these incidents are isolated to one site as the experiences of staff appear to be similar throughout the organisation and its other sites.

During this time we have collated their information and will be advising the Nursing & Midwifery Council and the Healthcare Commission of our concerns.

We would welcome the opportunity to meet with you to discuss these issues, and still remain committed to working with Partnership Health Group. We have sought to gain recognition with them with no positive outcome and sadly are now considering making an application under the Union and Labour Relations (Consolidation) Act 1992.

I am sure you will agree that there is a need for independent sector organisations that are commissioned to perform work for the NHS, to mirror the good practices that are currently available throughout the NHS. In fact we know that the Department of Health recognises that this is an essential part of the modernisation agenda. There are already a number of independent sector organisations who we have good working relationships with. This partnership working with trade unions and ensuring the provision for union recognition is an important step towards facilitating this process.

I look forward to hearing your views on this serious matter.

13 February 2006
1. **Introduction**

1.1 I have been a hospital consultant for 22 years. I have been a Clinical Tutor and Associate Medical Director at my hospital, and care for the hospital’s archives. In addition to my NHS post I undertake a small amount of private practice. I have served my specialist society, the British Society for Rheumatology, in various roles and am currently President-Elect, assuming office in May 2006. I have previously submitted written evidence to the Health Committee.\(^99\) I have also written of my concerns about NHS expenditure for the visit of Mr John Oughton of the NHS Commerce Unit to my hospital.\(^100\)

This is an entirely personal view. I have no conflict of interest to declare.

2. **Preamble**

2.1 The latest organisational paper from the Department of Health (DoH) “The NHS in England: The operating framework 2006–07”\(^101\) sets three conditions in the preamble: “The NHS must deliver improved services for patients; it must press forward with reform to deliver substantial and lasting improvements for the future; and it must return to robust financial health.” In the main document financial health is the first priority. It is therefore surprising to find that two major initiatives—the development of ISTCs and the latest White Paper on reform—threaten this.

2.2 Currently a large number of hospital Trusts and Primary Care Trusts are in serious financial difficulties, and “turn-around teams” have been sent into many of them. The development of ISTCs (and to some extent community hospitals) will require the withdrawal of funds from acute Trusts, and will require substantial investment that may duplicate existing facilities while threatening the very existence of them—a fear for which some evidence exists. Indeed in a response to my paper above, Lord Warner writes “…to maintain overall balance any organisation that overspends requires another organisation to underspend”.\(^102\)

The creation of new facilities will inevitably therefore, in a constrained financial envelope, reduce the funding available for existing units.

2.3 If the total NHS budget is constrained then any and all developments must be cost-effective. It does not make any sense, therefore, to propose developments that are more expensive than they need to be. Further, it makes no sense to demoralise staff within the NHS by piling “reform” on “reform” when there has been no time or opportunity to make current initiatives work properly. The cases of “Choose & Book” and of the introduction of a new Care Records System (CRS) are classic—both are expensive, unwieldy, use outdated IT software and are insecure—but have resulted in enormous staff stress at a time when they already feel threatened by the local financial situation and talk of job losses.

2.4 The prospect for clinicians of yet more initiatives of dubious value, either economically or in terms of patient suitability, have resulted in a catastrophic fall in morale within the NHS. It is time to call a halt, remembering one very simple financial principle—a Rolls-Royce and a Ford Fiesta will both transport someone from A to B, but if you cannot afford to run a Rolls-Royce you will put up with something slightly less perfect. The government speaks with forked tongue. On the one hand it exhorts us, the professionals, to save, save, save and on the other it promotes expensive, unaffordable choices. It cannot do both at once.

2.5 There are two myths that have coloured attitudes to the NHS, both of which have poisoned thinking within government. The first is that there is some sort of Chinese wall between hospitals and the communities they serve. While there are areas of the country where the main hospital may be distant, it nevertheless remains within its community. The second myth is that doctors and other health professionals are trying to protect their empires and the status quo and are unwilling to countenance change. Most advances in medical care delivery have actually been driven by those within the service, and for three reasons—first, they speak on behalf of their patients (and in my case, rehabilitation patients who are severely disabled may need an informed advocate); second, they know what they would like if they were patients themselves; and third, they actually run the services. To dismiss the concerns and comments of doctors (or exclude them from using new systems, as with the records database at our hospital) is quite simply madness.

2.6 I have been involved in NHS politics and management since 1976. I have seen initiatives, managers and politicians come and go. I have seen some failed initiatives revisited by those who are unaware that they have been tried before. While I have questioned many so-called advances, I have been personally involved in attempts to make many of them work. However I have never encountered such a depth of professional despair as is current. Indeed this is so profound that many who would say “I told you so” after some new initiative had failed cannot any more be bothered even to do that. Such is the climate of impotence among NHS professionals.


\(^{100}\) Bamji AN. *NHSMoney and the Front Line: A Clinician’s Perspective* (2005)—Not printed here.


\(^{102}\) Letter from Lord Warner to Michael Fallon MP, 6 February 2006.
3. **What are ISTCs for?**

3.1 The establishment of ISTCs appears to have been driven by a wish to reduce surgical waiting lists and to improve cost-efficiency in the NHS. To some extent this has succeeded, but there are hidden problems which lead, from a professional viewpoint, to serious concerns about the whole principle. It should be noted that some specialties, and operations, may be more suited to the system than others; thus cataract surgery (often used as an exemplar for schemes) is a simple patient pathway—GP makes diagnosis, patient is seen by ophthalmologist, relatively simple operation is done, patient is discharged and no follow-up is required. However other surgical procedures are not so straightforward; thus a patient with RA who requires joint replacement surgery may have poor bone stock, other medical conditions, a drug regime and mobility problems that make the operation difficult. Follow-up rehabilitation may be essential in such cases. Thus while ISTCs may be an ideal practical model for simple “one-stop” surgery they do not do well with complex conditions that require continuing care.

3.2 In any event, if the issue is a capacity one, what is wrong with expanding facilities on NHS sites? Clinicians faced with swinging service cuts to meet unrealistic financial targets (faced also with expenditure increases that do not match NHS inflation—thus the tariff price for episodes is to rise by 1.5% in hospitals next year against a projected NHS inflation rate of 4.5%) do not see any benefit in withdrawing money to reduplicate facilities on additional sites. The benefits of an ISTC that can share expensive capital facilities with an NHS institution are manifest.

4. **The Costs of ISTCs**

4.1 In establishing an ISTC (or indeed any other new health facility) it has become necessary to use private finance. This is, within the NHS, raised under the Private Finance Initiative (PFI) scheme and outside it by a profits payback system identical to current private sector provision. Experience of PFIs proves that while they allow capital projects to proceed, the revenue consequences are substantial and indeed unsustainable. They are, in effect, a mortgage for which repayment is at a high rate of interest (typically 1–2% over the base rate) and which therefore provides the supporting financial institution with a profit at no ongoing benefit to the NHS for that expenditure on interest. It is thus inevitable that any facilities of this type will be more expensive than a not-for-profit development. This could be offset by lower cost-per-case prices, but this is not achievable if a “level playing field” for tariffs under Payment by Results (PbR) is set for NHS and other facilities. However, by propping up such schemes that run into trouble (the Queen Elizabeth Hospital, Woolwich cannot presently service its PFI interest payments and is projected to have a £100 million deficit on its PFI loan by 2010) the government is obliged to claw back money from PCTs and other Trusts. It should be noted that the proposed redevelopment of the Royal London/St Bartholomew’s hospitals has a PFI consequence of over £100 million per year—more than the entire annual budget of my own hospital.

4.2 As noted above a proposal has surfaced recently to develop an ISTC for musculoskeletal conditions in the North-West. Quite apart from the extraordinary failure to consult local providers it appears that some £3.5m would be withdrawn yearly from the existing facilities to enable the development. As outlined below (5.2.7) this could have a catastrophic effect on current provision, destroying an established and respected service in the name of untested dogma.

4.3 The capital and revenue costs of an ISTC, if developed as a stand-alone unit, must necessarily cover the provision of diagnostic equipment and critical care facilities. These are very expensive and there is rarely a case where duplication of such facilities is either practical (there is a shortage of fully trained staff in these areas, both medical and non-medical) or cost-effective (running two MRI scanners with a capacity of less than 100% is inefficient).

4.4 It has recently been suggested that diagnostic ISTCs should be established. The rationale for this is quite inexplicable. Any acute hospital is obliged to provide a 24-hour pathology and radiology service so the establishment of a separate ISTC cannot replace this—there will be delays in transporting samples, and it is impractical to transport sick patients. Thus such services will duplicate existing facilities but must be funded from existing allocations. Neither is there any requirement at present for such centres to meet current accreditation standards. One could, therefore, take the cynical view that the forcing through of diagnostic ISTCs is a deliberate attempt to break up and destabilise the NHS.

4.5 Furthermore the standard of service from such centres is (or could be) suspect. In the case of pathology the raw results returned from a laboratory may need clinical interpretation by a specialist—a haematologist, microbiologist or chemical pathologist. At present such interpretation is often supplied at source when a result is sent out; however it is common for a GP, or specialist, to wish to speak to the relevant pathologist. Such clinical backup is a sine qua non in the NHS but appears to be absent from private sector establishments—and to try and get interpretation from elsewhere, when the test methods and normal ranges may be different, will prove problematic and even risky.

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103 £3.5 million funds diversion sparks fury. Hospital Doctor, 2 February 2006.
4.6 This concern is exemplified by the MRI service provided in South London. This service relies on radiologists based abroad of uncertain expertise. It is impossible to discuss a scan with a radiologist in Belgium if there is a difference of opinion over interpretation. Within the NHS it is easy to walk round to the Imaging department with a set of films and ask questions in the clinical context. This is especially important for specialised scans, such as in neurosurgery, where neuroradiologists can provide a level of service over and above that of a “standard” radiologist and work very closely with their clinical colleagues. The private sector scans that have been produced for the neuroscience service at King’s College Hospital have been inadequate and in many cases required a repeat scan—to the point where the private service has been abandoned. Just as with pathology a test may require interpretation; just as with surgery there is a need to ensure that expertise is matched to complexity. There is little point in setting up a service that can only do “easy” scans—and even less point if access to it is so widened that costs escalate from inappropriate referrals. But independent centres will be under pressure to enhance their profits by doing as much work as possible, whether or not it is clinically relevant or necessary. As an example there is a widespread view in general practice that back pain can, and should, be “diagnosed” by an MRI scan. It cannot; the indications for scans are quite tight. But if ISTCs are allowed to offer unrestricted scans to GPs the costs will go through the roof—for no clinical benefit at all.

4.7 In any case there is little point in investing in equipment if currently available equipment is underutilised. The capital and revenue costs of a new scanner cannot be justified if the cost of extending opening hours of existing scanners (which will be an insignificant proportion, comprising overtime rates for staff) is sensible.

5. EFFECTIVENESS OF ISTCS

5.1 The ISTC “principle” has been predicated on three major assumptions—that ISTC provision reduces waiting lists, that it is cost-effective and that it increases patient choice. However there has to my knowledge been no systematic analysis of current schemes to test any of these hypotheses. Indeed there are both theoretical and real-life examples of why ISTCs may provide a poor quality of service, even if they appear to be effective in quantitative measures.

5.2 It is of course true that one major problem of acute hospitals—infection—is lower in private centres and ISTCs. This is a result of patient selection as well as better standards of infection control, but the advantages may be outweighed by the disadvantages, which are as follows:

5.2.1 Successful management is based on short lengths of stay. While there is no reason to condone excessive hospital stays the pressure to conform to norms, particularly when financial targets are at stake, places undue pressure on units to discharge patients early and there is often a loss of flexibility (and common sense) as a result. Patients are treated as packages, or products, not as individuals whose needs may vary. An elderly patient may require a package of care to be set up or re-established at home before discharge; failure or delay can prolong a stay, and as it is quite easy to predict which patients will fall into this group it is very easy to exclude them from an ISTC.

5.2.2 To conform to patterns, as in (5.2.1) above, it is tempting for units to refuse patients whose care may be complex and result in a longer length of stay or require prolonged rehabilitation. Our local experience has been exactly that. My hospital has been doing work for East Surrey PCT, but the cases we have taken have been those turned down by a local ISTC as too difficult. Thus the marketplace is distorted as ISTCs “cream off” the easy cases, leaving the difficult ones to the NHS. If reimbursement under Payment by Results (PbR) is on a fixed cost-per-case tariff then the NHS institutions will be penalised for their complex casemix, while ISTCs and private facilities can make a profit out of routine and easy operations. If, as suggested above (4.2) the ISTC has only been developed by removing funding from the NHS acute Trust then NHS hospitals will face meltdown.

5.2.3 Many NHS hospitals and departments have developed effective multi-disciplinary teams to manage the rehabilitation of post-operative and other patients. These patients may be seen for several weeks following discharge. ISTCs do not provide multidisciplinary teams; thus, by definition, they do not provide a complete care package and do not have to bear the financial consequences of aftercare. This clearly has both monetary and clinical implications.

5.2.4 Patients not infrequently develop post-discharge complications. Those treated in an ISTC which may be distant from the patient’s home find that the ISTC has neither the capacity nor the inclination to pick up these cases when things go wrong. Thus any complications (which will be expensive to manage) will often have to be managed by NHS clinicians who have never met the patient before.

5.2.5 There are no acceptable controls on the quality of staff employed in ISTCs. Surgical units are run by surgeons who come from overseas, have different standards of training, have unknown experience and have no accountability when things go wrong; this is a quite deliberate policy designed to add manpower capacity rather than move it. However such a policy has risks. A surgeon is a surgeon is a surgeon, it is often assumed; this is not so. Within the NHS there are variations in quality and experience but for full patient choice a potential candidate for surgery should have some knowledge of the team that will operate upon them. Let us take the example of patients with rheumatic disease again. A local GP or consultant rheumatologist will refer to an orthopaedic surgeon who “fits the bill”—they have the correct specialist
interest, the “right” personality to suit the patient (and vice-versa), an established record of good management etc. Sending a patient to an ISTC where none of these are known is absurd. The analogy of hairdressing is apt; one may decide on a particular salon, but will learn from experience, or from others who report theirs, which hairdresser to go to within that salon. This “horses for courses” approach is standard consumer practice which the ISTC principle, with its reliance on generic referral, completely negates. To place a patient in the hands of an unknown surgeon in a unit of uncertain reputation is hardly ethical. Specialist surgery is more than operations; and a patient who returns to their consultant rheumatologist whose choice, with them, of a particular surgeon has been subverted by such a generic referral places that consultant in considerable difficulty if things have gone badly. I have encountered this dilemma myself.

5.2.6 This problem has already been faced in Hampshire in relation to eye surgery. In that case the Care Trust and the local providers expressed extreme and well argued reservations about an independent provider, but were overruled from the centre. This was exposed in a BBC “File on Four” documentary. Such bullying in the face of well-reasoned arguments seriously damages the prospects of sensible local decision-making.

5.2.7 There are existing proposals for ISTCs that appear to be deliberately provocative. An example is that proposed (see 4.2 above) in Cumbria to provide a musculoskeletal service. It appears that some ersatz arrangement is being considered with the employment of, effectively, partly trained “musculoskeletal” doctors who have no formal accreditation in either rheumatology or orthopaedics. If the consequence of developing an ISTC is not only that it provides a substandard clinical service, but in so doing it pulls money from established and accredited services, then it is no more than a cheap “dumbing-down” of care which cannot be in patients’ interests. Furthermore it destabilises existing services which may have an excellent reputation—in the case quoted, the senior rheumatologist in the area was “Hospital Doctor of the Year” in 2002. It is hardly surprising that medical morale is nose-diving when this sort of behaviour is condoned, indeed encouraged.

5.2.8 An example of an ISTC that may also be a financial liability is the “award-winning” Westwood Park Diagnostic & Treatment Centre, Bradford. This apparently cost £6–9 million to develop, has 20 5-day beds and 2 scanners. It is largely staffed by special interest GPs (at a yearly cost of £10k per session—which is higher than a consultant salary) but is currently underused, partly because patients are exercising their choice and refusing to go there. At present therefore it is offering its local purchasers “loss-leader” prices, while any shortfall in expected income due to the parent (US) company will apparently be topped up by a direct grant. Unfortunately it is not possible from local PCT information in the public domain to disaggregate the costs of the Unit. Such financial arrangements that are not made public in detail are unacceptable. On the other hand the Birmingham Orthopaedic Hospital is now running theatre sessions from 8 am to 8 pm—thus expanding throughput without any initial capital cost—and an individual surgeon in East Anglia has reported a similar initiative. The economies of scale make it impossible to justify either the capital or revenue cost of an ISTC when there are financially prudent and practical alternatives. In a financially constrained system it is in my view the duty of government to encourage such good practice. In fact its “reforms” may do the opposite; in my own hospital our Back pain Triage system (which had the benefit of reducing unnecessary waiting times to treatment and directed patients more accurately to the right professional) has been almost completely destroyed by the Choose & Book system.

5.2.9 If it is eventually proposed to staff ISTCs with NHS staff who will work across sites (allowing that staff shortages make this difficult to visualise in the short term) then staff will find that they may have to supervise, and be responsible for, patients when they are not on site. There is no virtue in this whatever. Indeed such divisions of effort have already resulted in doctors being taken before the General Medical Council. Neither may it be possible for staff to meet and plan effectively. Having started my consultant career in four hospitals (with two GP outreach clinics on top) I know at first hand the need for clinicians to use their time efficiently by being in one place, and the trouble caused when important meetings in one hospital are always scheduled for a time when you are at another. If current rules continue and staff must be recruited from outside the NHS, then it must be said that satisfactory clinical governance arrangements are not in place and will have a substantial cost to implement.

5.2.10 There are significant emergency risks in centres that do not have immediate access to full critical care facilities. It is only the very largest private hospitals that have fully staffed intensive care beds. Most private hospitals (and ISTCs) will have an arrangement with a local NHS hospital to ship out a patient who suddenly needs such facilities. This is a fragile system, but re-providing critical care to duplicate NHS units (most of which are under-resourced) will simply cause damage to those where, as outlined, the underlying risks are greater.

5.2.11 It is generally believed among the public that private practitioners, whether from overseas or not, are superior to “ordinary” NHS ones. This is a dangerous and often incorrect assumption. While there are undoubtedly many doctors practicing wholly within the private sector who are excellent, there are others who are not. Some, indeed, are there because they have repeatedly failed to obtain an NHS consultant post in open competition. There have already been cases of practitioners in ISTCs who have been found to be substandard.

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104 Transcript of BBC Radio “File on Four” transmitted Tuesday 1 June 2004. Programme 04 vy 3022LHO (Appendix 3)—Not printed here.
wanting\(^{105}\) (see attached appendix 2). While of course that is itself a generalisation it is important to remember that there is not necessarily any formal arrangement, or requirement for, ISTC practitioners to do audit, to have regular appraisals and job plan reviews, or to have educational updates. Setting up such systems is essential—but then simply duplicates what is already available (at considerable cost in time) in NHS hospitals—another example, therefore, of duplication. Worse still, an overseas practitioner who gets into trouble can simply decamp and there is no recourse for the patient.

5.2.12 To continue this theme—medical professionalism dictates that practitioners do more than just provide a service role. Audit, continuing professional development, research and time for reflection are all important aspects enshrined in any NHS post. So far this is not the case for ISTCs and most planning, and costing, has been designed to cover service only. The clinical governance and medicolegal implications of this require careful analysis before further progress can or should be made.

5.2.13 An example of the deleterious effect on training is that of the orthopaedic service at Southampton. Cases were diverted to an ISTC, with resources, as a result of which orthopaedic beds were closed—in a teaching hospital with an excellent reputation. The effects on training of this sort of move can be disastrous. Training is an enormous issue. It is expensive and essentially, in service terms, unproductive. Thus it is not in the interests of ISTCs to provide it. However it seems unlikely that trainees can get proper experience if their training is confined to NHS institutions from which the easy “bread and butter” work has been removed to the ISTCs. There is already concern among trainees that the European Working Time Directive (EWTD) has diminished their opportunities for hands-on experience and surgeons do not spring, like Athene, fully armed from Zeus’ breast. Because of this the level at which practitioners become familiar with practical procedures is rising alarmingly; it is the specialist registrars who are learning to do chest drains and appendicectomies while years ago the house doctors, or even the students, were seeing enough to get opportunities themselves. If our current generation of trainees is to get appropriate experience across the board then ISTCs will have to provide training and all the backup that entails—which will be an enormously costly, even prohibitive exercise in duplication.

5.2.14 Professionals will often need to seek second opinions. As an example, I offer a recent experience; one of my surgical colleagues, doing an outpatient clinic around the corner from me, popped in to ask my opinion of a patient whose backache was worrying. Had he been working in an ISTC the opportunity for me to offer that opinion (let alone see the X-rays and patient) would not have occurred. Likewise if I see a patient with an acute orthopaedic problem (and I have had two such in the last month) I can call a colleague out of clinic, or roll the patient round in a wheelchair, to get an instant opinion. Working in large hospitals is thus a positive advantage to a clinician—and to their patients. A “one-stop” service provides patient satisfaction; when that patient can possibly get the opinion of two, or three consultants at a single visit it is highly satisfying for all concerned.

6. SUMMARY

6.1 While ISTCs have been proved to supply capacity to reduce waiting times for surgery there is no evidence that they do any more than this, but there is significant concern that they may provide a substandard service. Costs can be kept down but the superstructure of NHS provision (in terms of education, training and research) is not accounted for, and there is already evidence that ISTCs will turn away difficult, and therefore expensive, cases. On a standard tariff this means that they can make a profit because their throughput is high (easy cases, short lengths of stay) while an NHS institution on the same tariff (which is at present the case) will make a loss because difficult cases reduce productivity and consume other resources, such as critical care and training time, that count as excess overheads.

6.2 The “conveyor-belt” attitude to surgical procedures removes the opportunities for patients and their doctors to choose their specialist—which results in a loss of professionalism. To offer patients a choice between unknowns is unsatisfying and ethically suspect. Thus the development of ISTCs will damage morale within the NHS.

6.3 Some high-cost, low volume work will be seriously threatened if already scarce resources are split between the NHS and ISTCs, especially where the work is excluded from tariffs (for example, rehabilitation). Division of work will encourage private facilities, whether these are private hospitals or ISTCs, to provide low cost, high volume work which will seriously distort casemix and leave NHS institutions dealing with expensive and difficult cases. This distortion will threaten medical and surgical training.

6.4 In a situation where nearly one-half of acute Trusts are in serious financial imbalance it is senseless to develop new facilities where the overhead costs, be these PFI interest repayments or the duplication of diagnostic facilities, are both high and unnecessary. It is even more dangerous to destabilise existing NHS facilities by withdrawing money from them to establish ISTCs.

6.5 To remove large chunks of “loss-making” work from NHS institutions for financial reasons alone will potentially destroy acute care; for example, it is not safe to run an A&E department without on-call general and orthopaedic surgeons. If, by taking away either the staff (or the money to pay them) to set up

an elective unit on a separate site, then emergency care is damaged there are serious consequences which will play out in the courts or elsewhere. The Kidderminster question illustrates the potential political liability of unsound decisions.

6.6 No evidence of quality assessments, complication rates, outcomes or casemix analysis in ISTCs—all the things required to make a balanced analysis—have ever been submitted for public scrutiny. Neither have any of the concerns raised by doctors over duplication, funding reallocation, clinical governance or training issues been treated seriously. I hope that the Committee will redress this.

6.7 Another example of money thrown away on political initiatives, while peripheral to a discussion on ISTCs, serves to illustrate the risks of planning by dogma and underpins the concerns of clinicians that money is being squandered in the NHS. The government has decreed that a network of “Community Matrons” be established. As a result, a team has been established in Salford with a rolling 5 year budget at a staff cost of approximately £0.5 million per year. The newly established team sought a meeting with local clinicians who asked them to define and explain their role. The team did not know. It became apparent that they had had no direction and were therefore thrown back on inventing their own role.

When rehabilitation units like mine have had to close beds because they are not allowed to recruit sufficient nursing staff to cover them, and when those same units cannot advertise their services because of a shortage of therapists (because of a lack of funding for new posts)—and when some 60% of physiotherapist graduates in the South-East will not get a job for at least a year because of a shortage of posts, the development of role-less community teams, and of ISTCs that are under-used, becomes not an embarrassment but a scandal.

6.8 If the NHS is short of capacity it makes sense to increase it. However, if funding is not available to do this, the provision of new facilities will inevitably draw money from existing ones, causing a serious, even catastrophic, failure of many NHS hospitals. Given the government’s decision to “return” care to community settings (whatever that may mean—hospitals are in their communities), such financial transfers will ensure failure. A desire to offer a “Rolls-Royce” service cannot be fulfilled if it is unaffordable. Not only are ISTCs unsafe but they are unaffordable.

I will be happy to make myself available for interview if required.

Dr Andrew Bamji, FRCP
Consultant Rheumatologist and Director
Emstead Rehabilitation Unit, Queen Mary’s Hospital

10 February 2006

Evidence submitted by Robert Johnston (ISTC 11)

I am the first author of the largest survey of cataract surgery in the UK since 1997. The first paper was published in the medical journal Eye in July 2005. Previous national surveys of cataract surgery have taken place in 1997 and 1991. This paper therefore documents the enormous quality and quantitative improvements that have taken place since 1997.

I was an advisor to the winning Netcare bid for the chain of ISTCs. This gave me an interesting incite into the multiple changes of policy by the department of health and their determination to have a particular model of healthcare delivery (mobile units and foreign personnel). I turned down the medical director job for Netcare (and a vast salary) because I do not think that here today gone tomorrow surgeons are a good way of practicing medicine. This model was adopted at the insistence of the DoH.

1. Factual Conclusions of My Studies and Experience

At present government policy is based on inadequate evidence (waiting times, waiting lists and percentage day case or local anaesthetic only).

The government policy should be based on “need” (how bad vision is before surgery) and quality of care data. It is vital for you to understand that there is no absolute cut off of patients that would benefit from cataract surgery, but each time the threshold for surgery falls the potential pool of patients increases enormously.

This data does exist for cataract surgery.

The evidence that I have collected shows that the UK is now bordering on overprovision of cataract surgery, for those that present with cataracts to their optometrists or GPs. For example in the 1997 survey of cataract surgery in the UK a visual outcome of 6/12 (approximately driving vision) was used as a measure.

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of a “good” outcome after cataract surgery. In my study in 2003 almost 50% of patients had this level of visual acuity before cataract surgery and reviewing data from centres that use my software in January 2006 this has risen to 55–60%.

Good research has shown that there is still significant visual impairment from cataracts in patients who do not present to health professionals (those in nursing homes, deprived communities, ethnic minorities etc).

Waits for cataract surgery have been eliminated throughout England (not Wales) due to the increased productivity of NHS departments. The contribution to the reduced waits by ISTCs is insignificant in terms of numbers of cases performed and their limited geographic spread.

At many locations where ISTCs operate the local NHS departments no longer have enough cataract cases to perform.

As a result of the ISTC programme and the forced recruitment of overseas surgeons the number of consultant ophthalmology jobs in the UK has fallen very dramatically over the last few years. There are now numerous highly qualified surgeons unable to find a consultant job.

ISTCs are frequently being paid for operations that they do not perform. You should confirm exactly what this number is.

Patients are not really given the “choice” of where to have their surgery. PCTs have been forced by the DoH to pay for capacity at ISTCs regardless of whether the operations are performed and therefore coerce patients to go there. There are already examples of PCTs selling off this capacity to other PCTs at a significant loss.

The tariff paid to ISTCs and the subsidies for their start up costs makes surgery in these facilities more expensive than in current NHS departments.

The tariff for cataract surgery in NHS departments subsidises other areas of healthcare (in ophthalmology and other specialties) that are not the subject of government targets.

2. Opinion

A system that pays optometrists to refer patients with cataracts and then pays private organisations to perform surgery, regardless of real need, will have one result—MORE SURGERY. The government has therefore set up a treadmill of ever increasing expenditure on cataract surgery with ever more marginal patient benefit.

There is no doubt that other areas of ophthalmology are now more desperately in need of funding (eg the most common blinding condition—age related macular degeneration) and yet because this does not appear on waiting lists etc it is not prioritised.

Demand limitation needs to be implemented now.

ISTC type facilities can be very efficient and NHS departments have little or no incentive to be efficient.

In my view the most effective way to deliver healthcare with incentives for efficiency and high quality is an HMO model. Pay efficient private sector groups a capitation fee to deliver comprehensive eye care for a population and define the quality benchmarks that must be met. Groups of UK surgeons would jump at the chance to show what dramatic improvements would result. The organisations can have incentives by sharing any money they do not spend.

Rob Johnston
Consultant Ophthalmologist

9 February 2006

Evidence submitted by Dennis McDonald (ISTC 2)

1. I write as a private individual fully committed to the values and principles of the NHS. I wish to express deep concern about the current direction of NHS policy in relation to the procurement of services from independent treatment centres. I also wish to demonstrate the inherent risks to the long-term public finances and existing NHS structures by making reference to a contract negotiated in 2005 between my local SHA Northumberland, Tyne and Wear and Capio UK to procure elective diagnostic treatment.

2. In May 2005 I wrote to the Chairman of the SHA (Annex 1) to voice my concerns about this contract which is to carry out 2,000 minor procedures a year over the next five years at a cost of £1.2 million per annum. The funding formula for the contract means that each of the six PCTs across the SHA patch pays a fixed monthly amount, which is an equal share of the cost.
3. My concerns were initially triggered by the fact that despite assurances from the SHA that they had sufficient capacity within local NHS structures to meet the 18-week target they were overruled by the DOH, a clear case of dogma over pragmatism. Additionally, I raised the issues of equity, monitoring the quality of care and the value for money offered to taxpayers. The Chairman of the SHA replied on 19 May 2005 (Annex 2). His response was non-committal and dismissive.

4. Undeterred, I monitored the activity and financial risk implications of this contract until early autumn when it became apparent that on these assessments this contract should have been a matter of deep concern to those charged with overseeing the health economy within Northumberland and Tyne and Wear. In mid-November I wrote an open letter to my local newspaper107 inviting Sunderland Teaching Primary Care Trust to comment on certain aspects of the contract and the concerns being expressed by local GPs.108 The Chair of Sunderland TPCT replied on 22 November 2005 (Annex 3). Her reply requires no further comment.

5. I also enclose the updated activity as at 19 January 2006 (Annex 4). The discrepancies in activity across the six PCTs seems to indicate an alarming state of affairs in relation to equity and the financial risk to the public purse. The cost of a minor procedure is seven times higher in Sunderland than it is in North Tyneside. How can this be value for money to taxpayers in Sunderland, one of the poorest health economies in the UK?

6. It may sound that I am opposed to all current policies relating to private treatment centres. This is not the case but the absolute fixity and inflexibility of this contract contradicts the goal of good universal provision to the whole population.

Dennis McDonald
22 January 2006

Annex 1

Letter from Dennis McDonald to Peter Carr, Chair, Northumberland, Tyne and Wear SHA

Dear Mr Carr

It was my intention to attend your board meeting on 12 May 2005 to comment on two of the published agenda items. However, I was unable to do so. Nevertheless, I wish to submit my comments in writing as a member of the public, service user and taxpayer.

INDEPENDENT SECTOR PHASE 2 ELECTIVE DIAGNOSTIC PROCUREMENT

It is interesting to note that the DH overruled the SHA’s position that it could meet the 18 week target without independent sector provision, clearly an example of ideology overruling pragmatism. I would support the argument that rather than providing patients with a choice that includes private sector providers, we should be focusing our limited time and money improving the standard of locally available services.

According to “pure” market economics those who “purchase” or choose services should ideally have complete knowledge, eg about quality and value for money. I am not convinced that most GPs—never mind the patients—have a true idea of the quality of care different secondary care providers supply, other than anything beyond waiting times, anecdotal accounts and experiences of good or bad care and disputed star ratings. I do believe, however, that we should have access to indicators of proven value (ie they accurately and reliably measure important aspects of care). The DH has developed a draft range of such indicators under the “Better Metrics” project. I would suggest that GPs and patients should have access to these data about local services, in addition to waiting times.

Assuming that independent sector provision goes ahead the next most important thing is how we measure the quality of care and value for money they offer. These measures need to be robust enough so that they cannot be tampered with. Of course, it could also be argued that staff pay and conditions should form one of the quality measures. The other problem about PEI is its inflexibility, ie once bought into it is difficult to alter the service according to changing needs. On the other hand, the NTIS as it stands also suffers from a similar problem with inertia.

LOCAL DELIVERY PLAN (DRAFT) 2005–08

Overall, this strategy does acknowledge some real problems (eg waits for cancer treatments, mental health service capacity) and recognises the need to address these health service issues in long term planning. Several of the public health initiatives are also welcome, especially plans to reduce smoking.

Section 2, page 5: How exactly will the SHA and others really listen to the local voices of patients, carers and the public? Will this be via surveys, focus groups or committees, etc? However, the key issue is how much these voices can meaningfully influence health and health care planning.

107www.sunderland-echo.co.uk, Friday 4 November 2005.
Section 4: The progress on waiting times looks impressive, although they have come at some cost. But there are many other more important ways to measure the quality of care.

Section 5: There has been a recent *British Medical Journal* paper which pointed out how the health gap between the least and most affluent has continued to grow in the past decade. One national target is “by 2010 to reduce by at least 10% the gap [in infant mortality and life expectancy] between the fifth of areas with the worst health and deprivation indicators and the population as a whole. However, this does not actually measure the gap between the most and least affluent.

Section 5.4: As has undoubtedly been raised and debated before, there must be some concern that the proposal to allow “money to follow the patient” may actually undermine choice and accessibility in the long term. For example, a reduction in income resulting from fewer referrals may destabilise (particularly smaller) NHS Trusts, potentially resulting in closures of services. Such closures may affect those patients without good access to transport. How will this risk be managed? (This issue is at least acknowledged in Section 5.21.) In my own locality I have grave concerns about the future viability of City Hospital Sunderland.

Section 5.7: Will the plans to allow PCTs to commission dental care services eventually result in greater access to NHS dentistry?

Section 5.11: I would welcome moves to reduce waits for diagnostic services—the issue (also as identified before) is how to finance this.

Sections 5.12 and 5.14: As acknowledged, there are problems with existing capacity of mental health services, the “crisis intervention” service is under continuous pressure, and the waiting time for clinical psychology services is about a year in some areas.

15 May 2005

Annex 2

*Letter from Peter Carr to Dennis McDonald*

I am responding to your letter about two reports discussed at our public board meeting on 12 May.

Your comments on the increased use of the independent sector are noted, as are your comments about the local delivery plan.

You asked how will the strategic health authority and others listen to the views of patients, carers and the public. This is already done in all of the ways you mention as well as involving them in discussions about possible service changes and about plans for new developments. Our staff are also involved in discussion at all levels. Our strategy is, in fact, shaped by all of these discussions. Across the NHS there is much greater emphasis on seeking the views of patients, carers and the public. Indeed there is legislation (section 8 and 11 of the *Health and Social Care Act 2001*) that we must adhere to. Also, I agree with you that it is important we ensure that comments do meaningfully influence health and health care planning and this is something we are working with local NHS organisations about.

You also asked about how risk will be managed in the new payment by results financial system. This is currently being addressed by all local NHS organisations, including the strategic health authority which will be closely monitoring the implementation of this system.

Finally, you asked if the plans to allow primary care trusts to commission dental services will result in greater access to NHS dentistry. It is expected that this will happen.

Thank you for taking the time to send your comments to me.

19 May 2005

Annex 3

*Letter from Sue Winfield, Chair, Sunderland Teaching Primary Care Trust*

I am replying privately to your recent letter in the *Sunderland Echo* as I would find it very difficult to respond publicly. As a regular attendee at the TPCT Board meetings, your questions are always measures and challenging, and this latest one is no exception.

I can confirm that Capio UK is contracted by the NHS to carry out approximately 2,000 procedures a year for the next five years at the Cobalt Treatment Centre in North Tyneside. The contract was not negotiated locally by Sunderland Teaching Primary Care Trust. The funding arrangements at present mean that the TPCT pays a fixed monthly amount, which is an equal share across the six PCTs in Northumberland, Tyne and Wear Strategic Health Authority. The centre accepts referral from GPs across the area for a range of procedures—hernias, varicose veins, minor skin procedures, endoscopies and colonoscopies. GPs can, therefore, offer more choice and flexibility provided in a hospital setting.

I am sorry, but I do not feel able to respond to you concerning Capio’s comments.
I appreciate that there is always a need to strike a balance between local commissioning and working together with other primary care organisations to ensure a co-ordinated approach. This facility is now in place and it is our role to ensure that as the contract progresses, we can influence the case mix to meet local needs and thereby ensure that Sunderland patients benefit from the choice it provides.

22 November 2005

Annex 4

Number of Procedures carried out at Capio’s Treatment Centre, North Tyneside as at 19 January 2006 supplied by Northumberland, Tyne and Wear SHA

<table>
<thead>
<tr>
<th>Location</th>
<th>Oesophagus—Diagnostic</th>
<th>Colonoscopy/Sigmoidoscopy</th>
<th>Hernia</th>
<th>Minor Skin</th>
<th>Varicose Vein</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>NEWCASTLE PCT</td>
<td>90</td>
<td>32</td>
<td>9</td>
<td>191</td>
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<td>336</td>
</tr>
<tr>
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Each of the PCTs is required, by the terms of the contract, to pay an equal share of £200,000 pa for the next five years. This document sets out the massive disparity that exists in relation to the cost of each procedure on a Trust by Trust basis. Hence my reference to the comparative costs between Sunderland and North Tyneside.

Evidence submitted by Dr Sally Ruane (ISTC 46)

I am writing as an academic with a research interest in public-private partnerships. The views expressed here are based on the study of academic analyses and news reports within general and specialist publications.

1. Independent Sector Treatment Centres (ISTCs) threaten to undermine long standing NHS hospitals partly because they divert resources away from the NHS units and partly because of the terms of their contracts and the consequences these have. The survey of over 100 NHS chief executives conducted by the Health Service Journal (and reported in January 2005) identified a number of perceived concerns. These included significant numbers of respondents claiming that ISTCs represented poor value for money for the NHS; that they threatened the viability of NHS units (particularly in relation to elective work and training but also in relation to emergency services) by taking work and therefore income which previously would have accrued to the NHS; that they undermined their ability to increase NHS capacity; and that the programme was being enforced through “bullying”; making a mockery of local choice. The combination of waiting list targets and the official commitment to increasing private sector provision to up to 15% by 2008 is having the effect of transferring significant amounts of NHS work to private sector operators; the impact is likely to fall unevenly across NHS specialties, placing some seriously at risk. Notably, the weakening of surgical skills through lost elective work could damage quality in accident and emergency. Numerous complaints and concerns about the threat to training have been published in the British Medical Journal.

2. The imposition of centrally negotiated schemes in locations, determined perhaps by the preferences of the commercial operator regardless of local performance and capacity, with potential to damage the local health economy has attracted vehement criticism from PCTs, Trust chief executives, NHS Elect and the NHS Confederation. The events surrounding the alleged imposition of a Netcare scheme specialising in cataract work in Oxfordshire and its impact upon the viability of the local highly regarded NHS eye unit, compounded by the subsequent failure of Netcare to perform contracted procedures, have attracted widespread critical press coverage and been the cause of scandal. The “macho” style of the Department’s commercial directorate has also been criticised. None of this can enhance the confidence of the public in the NHS. The Department needs to signal that it does not intend to permit damage to long-standing NHS units to satisfy the ambitions of commercial providers.

3. The advantageous terms of ISTC contracts in comparison with the rules governing NHS units within the new pluralistic environment have the potential to undermine further the NHS. The fact that income is guaranteed for ISTCs regardless of performance places additional pressure on local PCTs and GPs, given severe budget constraints, to encourage patients to “choose” to have their care from them, at the expense of possibly otherwise more popular NHS units. The NHS units then face loss of income and redundant facilities (reported, for instance, in both Nottingham and Oxford). The higher prices paid to ISTCs for procedures adds to the perception that they do not represent good value for money and draws attention to the health care foregone by NHS patients which results. The distorting terms enjoyed by the commercial treatment centres has contributed to the failure of some NHS DTCs, some of which now face privatisation of their management. For instance, Ravenscourt Park Hospital, set up at a cost of £14 million in 2002, is predicted to incur losses of £37 million by 2010 because of high running costs and low numbers of referred patients as a result of cash shortages at local PCTs.

4. The involvement of ISTCs in the context of the new market in health can be expected to lead to inefficiencies and wasted resources. Markets create disequilibrium and instability. Facilities and amenities will be redundant when work is transferred to a rival provider; hoping to regain the work and conscious that facilities and equipment once lost would be hugely costly to replace at a later date, non-performing units will seek to hold onto their idle equipment and facilities for as long as possible.

5. The transfer of individuals from sensitive positions within the NHS, the Department of Health, Downing Street or the Cabinet to companies which go on to secure contracts for providing health services in the UK undermines the confidence the public can have in the propriety of those who make and implement policy. If news reports in the specialist press are accurate, Mr Tom Mann, formerly Department of Health civil servant who had been involved in securing the first large scale deals with the private sector, left the

NORTHUMBERLAND CARE TRUST

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Department to set up his own consultancy firm which then advised the commercial directorate of the Department; he was named in summer 2005 as the Chief Executive of Capio Healthcare UK, an ISTC provider in the UK. Such moves raise the prospect of Capio using Mr Mann’s insider knowledge of the Department to secure advantageous terms in subsequent contracts, at the public expense and potentially subverting the competitive process and undermining public confidence in the integrity of the Department’s affairs. Similar concerns can be raised in relation to the signing up of Mr Alan Milburn by Bridgeport Capital’s advisory committee, the parent company of Alliance Medical; Mr Simon Stevens, former health advisor to the Prime Minister, by the European arm of UnitedHealth Group; Mr Mark Smith, former NHS hospital Trust chief executive by Mercury Health as managing director. These firms have won contracts with the Department of Health and it is not unreasonable for observers to consider that these individuals have been employed by these companies precisely because they are seen as possessing insider knowledge useful in the negotiating process in both social and technical respects. The threats to public confidence posed by these developments are deepened by the confidentiality surrounding the terms of contracts. This secrecy has contributed to the belief that ISTCs are more costly than the NHS and do not represent value for money. Considerations of public accountability should override any wish for commercial confidentiality. Where businesses wish to do business with the state, contracts should be in the public domain, along with clear and accurate summaries.

6. It is difficult to draw firm conclusions at this stage about the comparative quality of care offered by ISTCs and NHS units. Evidence from reviews of comparative public/private health care provision conducted in Canada and the United States suggests that private providers perform relatively poorly on criteria such as mortality rates, access, quality, cost-effectiveness and administrative costs. The tendency of private companies to ‘go through’ as many patients as possible and to cherry pick the most straightforward (ie low cost) patients has not only been identified in such reviews but has also been attributed to the UK ISTCs. The National Centre for Health Outcomes Development’s Preliminary Overview Report (2005) provides some evidence for partially satisfactory performance among the ISTC schemes reviewed but concluded that the findings must be tempered by the need to refine the performance indicators and to improve data collection. ISTCs may suffer a number of built-in disadvantages: if they are to fulfil their avowed objective of adding to capacity, they are likely to be hiring overseas clinicians whose familiarity with the health care system within which they are working is limited; they often lack on-site back-up and emergency facilities; they may be mobile creating problems of continuity of care, particularly where complications arise. A report by Channel 4 News in December 2005 which, whilst based on a small number of cases managed to convey the lived patient experience, identified a number of serious quality concerns which require further investigation. These included the burden placed upon patients whose care has not had a satisfactory outcome when ISTCs operate on a mobile basis; the potential risk to patients where complications set in but no back-up facilities are available; the possibility that recruitment and vetting procedures for clinicians may be less rigorous than those used by the NHS resulting in the hiring of inferior clinicians; and the use of risky procedures for the rapid reduction of blood pressure in order to avoid clinical cancellation, where unit managers are applying pressure to maintain high “throughput”.

7. ISTCs have a disintegrating effect because they pull apart activities and processes which were previously interdependent. In doing this, they undermine a number of government policy goals such as (ironically) choice at a local level, effective and efficient use of available resources and high quality health care throughout the system. The contribution of ISTCs to reducing waiting lists is disputed since they have been implemented not in a policy vacuum but alongside other waiting list reduction strategies. IS-TCs should be phased out and public funding used to enhance NHS capacity. The concept of fast-track units is not inherently flawed since these may permit undisrupted care at a high quality given the focus upon a small number of procedures and the development of NHS DTCs, with emergency facilities close by, may be a way forward. The problem with ISTCs has not merely been one of implementation: it is integral to their conception that they provide for a flow of public funds out of the NHS. Their purpose has shifted from supplementing capacity to maintenance of the market. Departmental announcements over the past few months regarding NHS deficits which total the best part of £1 billion suggest the bottleneck operating to create waiting lists has reverted from capacity constraints to funding limitations.

8. Despite the best efforts of policy makers to harness commercial investment and skills to the public interest, businesses place profit interests ahead of other considerations. This is inherent in their nature since their legal status as corporations requires them to maximise the return to shareholders. Thus, they will seek to maximise what they can secure from the public purse when engaging with the state and its agencies and they will seek to extend the scope of their involvement for this purpose: that is, they will seek to occupy a wider area of state activity. They have demonstrated their ability to negotiate deals on unjustifiably advantageous terms at the public expense on numerous occasions: guaranteed income among ISTCs and refinancing deals reflecting exaggerated risk transfer and excessive unitary repayments under PFI are two examples which demonstrate the losses borne by the health economy. These losses can be calculated and translated into health care foregone by the public the NHS is meant to serve.

Dr Sally Ruane
De Montfort University

February 2006
Evidence submitted by Ruth Salisbury (ISTC 18)

I would like to submit the following points for consideration by the Inquiry Panel—Independent Sector Treatment Centres.

Whilst the profound concerns I have about the interface between NHS and private hospitals began following my husband's orthopaedic operation under the outsourcing scheme to reduce NHS waiting lists, the issues that I raised with my local health authority, my MP, the Nuffield Hospital and eventually with the Independent Sector Treatment Centre programme, CCMU, Department of Health had a much wider remit than a personal case and challenged several procedures and processes that resulted in a full joint service investigation led by Marney Prouse: CCMU Clinical Risk Advisor on 17th May 2005.

I would urge panel members to read the minutes of the meeting on May 17th—particularly the first section of the report—submitted under (i) of two sections that deals with policy and strategic issues regarding elements raised in my letter dated 25th February 2005.

I note from the press notice regarding the ISTC Inquiry that a short memorandum is invited. The minutes of the meeting held on 17 May 2005 are succinct and both outline and address my concerns and therefore I would like to submit these minutes to the panel for their consideration. The concerns I raised in my letter of February 25th 2005 included:

- PCT Patient Care Advisors (PCA) and lack of information on the initiative, post operative care and availability of care from the private hospital, Surgeon’s track records and trends, the closure of the Nuffield Hospital over the Christmas period, staffing issues resulting in no surgeon during the first week and a half in January 2005, medical advisory issues, induction for new Nuffield Consultants, communication channels between NHS and private hospital, referral to GP’s, GSup2 contracts, Gap analysis research project dealing with the interface between foreign medical practice and British medical practice, doctor’s CV’s and reference checking procedures for foreign doctors. In all of the areas I have outlined above there were moderate to serious concerns noted in the outcome of the investigation (17 May 2005) regarding private sector processes/procedures and a lack of practical interface between private providers and the NHS.

The cost to the NHS—due to a lack of real forethought and planning on the part of the NHS to have in place a rigorous check on the qualifications of doctors employed by private hospitals who undertake operations on behalf of the NHS is absolutely outrageous. The splendid team of orthopaedic NHS surgeons in my local Health Authority have been monitoring the number of patients that return to NHS care to have corrective surgery following private treatment and hold extensive records for their area. I am extremely worried about the way such information appears to have been covered up or denied by NHS managers and urge the Inquiry members to approach the surgeons rather than the managers for their views on the ISTCP.

I am happy to supply a copy of the minutes I have referred to.

Ruth Salisbury
13 February 2006

Evidence submitted by Dr David Sowden (ISTC 19)

Introduction

In 2002, the Government announced the Independent Sector programme. More recently the new NHS improvement plan clearly heralded increasing pluralism in the provision of NHS funded healthcare, driven by patient choice. The development of Independent Sector Treatment Centres is designed to both enhance patient choice and to harness the skills and capacity within the private sector to meet patient demand for diagnostic services and treatment.

During the initial phase of the development of Independent Sector Treatment Centres (ISTCs) (wave 1) the principle was very much one of additionality, i.e that these facilities would provide services for those patients currently on waiting lists or whose needs could not easily be met by existing service provision within the local NHS.

At this time it was hoped that the first wave ISTCs would be able to contribute to the educational and training environment within the NHS by providing access to innovative practice with particular regard to surgery. Such innovation would include organisation, administration, team working and in particular new approaches to the management of patient care with consequent opportunities to improve productivity within the NHS.

Early experience with ISTCs has suggested that the initial focus on additionality was somewhat misleading. There is now mounting evidence to suggest that, for a number of reasons, ISTCs attract a significant proportion of cases transferring from existing NHS waiting lists who would previously have been managed within NHS facilities. As a result the case mix in many ISTCs is having an impact on the case mix available for medical education and training within the NHS. In particular patients who are relatively young, have limited co-morbidity and are unlikely to require high dependency or intensive care form the
majority of ISTC patient throughput. In contra-distinction the population increasingly being treated by a number of NHS facilities, where local ISTCs have been established, reflect a pattern of increasing comorbidity, high dependency, and an increased requirement for intensive care. Linked to this, probably causatively, is an increase in patient stay.

The impact on postgraduate medical education, particularly within the surgical and craft specialties, has been an identifiable trend in the reduction of the availability of relatively straightforward cases necessary to provide an appropriate educational environment for trainees in the early and intermediate stages of specialty training in certain surgical or craft specialties and to a lesser extent in anaesthetics.

As a direct result ISTCs are increasingly seen as being required not only to enhance training opportunities but to maintain existing training opportunities for surgical and craft specialties, and to establish appropriate educational opportunities to deliver the aspirations of Modernising Medical Careers (MMC).

The announcement of wave 2 IS developments, representing upwards of 1.5 million first finished consultant episodes (FFCEs) per annum across treatment and diagnostic facilities, emphasises the need to ensure education and training features in all planning and implementation discussions.

**CURRENT PROVISION**

There are currently three types of service provision that could be used to provide training opportunities outside NHS Trusts:

- NHS work in Independent Sector Treatment Centres (ISTCs)
- NHS work in private hospitals
- Private work in private hospitals

Unfortunately because of the need to alter College, and hence specialty, curricular as a result of the implementation of Modernising Medical Careers (MMC) it is not possible to provide comprehensive data pertaining to the precise case mix and training activity that trainees in each specialty should achieve at different stages of their training, nor therefore an indication of how precisely post MMC training will be affected by the transfer of elective surgery outside the NHS. However, early indications are that to fulfil the requirements of MMC, specialty trainees will require more access to elective surgery in the earlier stages of training than is currently the case; especially during specialty training years 1 and 2 (ST1 and 2).

The following issues will need to be addressed before training is transferred outside existing NHS service provision:

1. **Training opportunities**

   First of all the ISTC must be undertaking activity which is relevant to the education and training needs of trainee doctors within local specialty training programmes.

   Secondly the ISTC must be in a position to support postgraduate medical education and training, and this is related to both facilities and trainer issues (see below).

   If the ISTC is equipped to provide training opportunities then consideration needs to be given to the following factors:

   - The unit is genuinely providing only additional activity (and no resulting alteration in local NHS casemix)
   - The unit is providing a mixture of transferred and additional activity
   - The unit is predominantly providing transferred activity

   In the first case (and experience to date suggests this will be uncommon) the utilisation of facilities within the ISTC is predominantly optional where education, if provided, relates to educational innovation and added value. However, in the second two cases it is highly likely that the sustainability of local training programmes in certain specialties will be dependent upon access to the ISTC training opportunities already identified.

   It is important to emphasise that, in future, it will be usual for most medical specialist trainees to train in a combination of NHS and IS settings as part of a planned programme of training. The balance depending on local and specialty factors.

2. **Trainer issues**

   The training undertaken within the ISTC must be to at least the same standards as that within the NHS. In particular the quality of educational supervision, feedback and assessment must match and link in with existing and post MMC training structures within the NHS and local specialty training programmes.

   To that effect it would be ideal if trainees were accompanied by existing NHS trainers who already are involved in their clinical and educational supervision within the NHS.
If this is not possible then the trainers within the ISTC must meet Postgraduate Medical Education and Training Board (PMETB) standards and must also liaise closely with the local training programme and its educational supervisors. They will also require access to and time to be trained in the developing MMC assessment arrangements and systems for appraisal, and report into local record of in training assessment (RITA) arrangements.

3. ISTC Issues

The facility itself will need to be recognised by both the Healthcare Commission and the relevant College, and will be the subject of continuing quality assurance as part of the local training programme by PMETB.

For the ISTC to be utilised as a training centre for postgraduate medical trainees it must clearly meet the Health Commission and PMETB standards for trainers or supervisors which are linked to Collegiate curricula requirements for specialty training. In addition, particularly in early years training, the operative methods utilised will need to be similar to or the same as that used in the local NHS.

4. Contractual issues

The contractual status of the trainees needs to be clear, and so does that of the trainers if they are undertaking work on a transfer or secondment basis.

Further consideration needs to be given as to the employment status of the trainees and other non-consultant staff whilst working in an ISTC (see later re other consequences).

5. Indemnity and Insurance issues

Presently it is stated that postgraduate trainee doctors and trainers working within ISTCs will be covered by NHS indemnity. This position needs to be confirmed at the point at which any trainee or trainer trains/works within an ISTC environment.

6. Resource and funding implications

Whilst there are no long term studies there are good reasons, and some evidence, to suggest that trainees will impact on productivity rates in surgical and anaesthetic practice, and the reductions in productivity are most notable amongst the most junior trainees. The exception to this is when such trainees are merely observing procedures

At a Senior House Officer equivalent level (ST1 and 2), for example, general surgical trainees can reduce productivity by 50% or so, falling to 25% in the first few years of SpR training but seldom reaching the same levels of productivity as consultants even as they approach their completion of training date.

It is clear that this impact on productivity has significant resource implications for ISTCs who are working to specific contracts of activity. Therefore there is an identifiable cost to the training of postgraduate medical trainees within ISTCs. Against this needs to be balanced potential productivity gains in, for example, outpatient settings.

Further ISTCs who are involved in the training of postgraduate medical trainees will require significant advance warning of their presence within units so that they can alter the number of patients operated on within a particular session.

This will have a very particular impact on rostering arrangements at the trainee’s NHS base. It seems a reasonable assumption that it would not be acceptable for the trainee to fail to attend an operating session (whether as a surgical or anaesthetic trainee) since the costs associated with that session will already have been borne by the ISTC provider, and the training would form a requisite component of that trainee’s postgraduate medical educational opportunities and education plan.

Thus the Trust at which the trainee is employed will need to guarantee the release of the trainee (or an alternate at a similar stage of training) to the planned sessions. In many Trusts this will cause problems because of the lack of doctors on existing rosters within particular departments—at present the absence of an individual doctor from a middle grade roster in many hospitals requires the doctors already on the rotation to alter their working pattern at short notice or for the Trust concerned to employ a locum (at additional cost). This situation is liable to be exacerbated when trainees utilise ISTC facilities.

In addition, at present, trainees are frequently dual rostered within the NHS ie they are both rostered to work in an Outpatient clinic or operating theatre and to provide cover on the ward. Within the geographic confines of the Trust such an arrangement will work to some extent even if the educational outcomes are less than ideal. Such an arrangement cannot work when an ISTC is at a significant geographic distance from the Trust in which the trainee is originally employed. In these circumstances once the trainee leaves the Trust or is rostered for a session within an ISTC the Trust will have no practical call on that trainee’s time or availability during the course of the planned session. This will also apply to anything other than phone advice for seconded trainers. There is little doubt that this has the potential to impact on the ability of Trusts
to manage acute admissions, cases on the wards and ultimately to sustain the four hour wait limit within Accident and Emergency departments. The situation will probably be exacerbated by the European Working Time Directive (EWTD) requirements for 2009.

7. Other Issues

Whilst it will be predominantly postgraduate medical trainees in surgical and craft specialties at both an SHO equivalent (ST1 and ST2—MMC levels) and Specialist Registrar level there is little doubt that ISTCs will need to be utilised for the training of other professions, undergraduate medical students and pre-registration students in nursing and some allied health professions. As stated above, all such groups would benefit from an exposure to innovative practice but also to the different culture operating within an ISTC environment as their preparation for plurality of provision within their subsequent professional lives, especially as the implementation of the patient led NHS proceeds.

However, in some ISTCs the extent of transfer of care will make the availability of training for this group of staff or students a vital part of their training environment and educational opportunities.

In medical training the new focus on the development of IS diagnostic facilities may well extend significantly the range of specialty trainees affected by IS provision in a locality.

CONCLUSION

ISTCs offer a new environment in which valuable educational opportunities can be provided for postgraduate medical trainees and others. In some instances such opportunities are limited to access to innovative practice and a different culture which will help prepare the trainees for the diversity of healthcare provision within the new NHS.

In others the educational opportunities provided within ISTCs form an integral and vital element of the local health economy’s capacity to support the existing and developing specialist trainee workforce. In such circumstances the failure to provide opportunities within ISTCs will result in certain training programmes becoming unsustainable with a knock on impact to local service provision and workforce planning.

However, there remain a number of outstanding issues that need resolution before either type of training opportunity can be realised. In the meantime some trainees have experienced a significant reduction in educational opportunity and this, over time, threatens the viability of some local speciality training programmes.

Dr D S Sowden
University of Nottingham
13 February 2006

Evidence submitted by Mr Z (ISTC 44)

My points are as follows:

1. The introduction of ISTCs was too hasty and did not accurately take account of the expanding capacity of the existing NHS.

2. A great deal of unnecessary anxiety and bad blood has been caused by the Department of Health’s requirement that up to 15% of a Trust’s patients should be treated privately. PCTs and Trusts all too often have no say in the matter.

3. In the case of Southampton, the orthopaedic ward is virtually empty, the PCT having required patients to go to the local ISTC. Consultants who demur are threatened with disciplinary action according to the magazine “Hospital Doctor”.

4. Where patients are required to go to ISTCs, they are always the easiest patients, thus leaving behind in the Trust the more difficult ones, whose care costs more. The resulting average costs of the parent Trust are therefore higher. At a time of tariff and PBR, the Trust will therefore be doubly penalised and may have to make further patient savings elsewhere, not on account of anything which the Trust has done, but on account of DOH pressure. The impression of inefficiency is forced on them by the presence of the ISTCs. (All this is false anyway, for the NHS has no idea at all of its own costs, nor how to apportion common costs across services. Tariff is purely notional.)

5. The ISTC will be here today and gone tomorrow. In the meantime, the service will have been fragmented.

6. There is considerable concern about the quality of the Doctors who come from abroad. The medical director of Netcare resigned following the publication of adverse orthopaedic results.
7. I suggest that you watch the Channel 4 News programme on Netcare which was broadcast at 1900 hours on 7 December 2005. This shows you what can go wrong if the emphasis is always on throughput rather than all-round quality. (Although this may not be strictly relevant to your enquiry, you may also wish to look at another by-product of the target culture; at Kingston Hospital the appointment of a foot surgeon was so very popular with the public that there were instantly long waiting lists. The only way for Kingston to escape from the DOH constant criticism about failure to meet the waiting list targets was to cancel the service. The foot surgeon now works wholly privately.)

8. All too often, ISTCs have been paid for work which they have not done. In its rush to entice additional provision to the UK, the first round of Contracts involved payment not according that which was actually done, but that which was contractually stated. While this has changed with the second wave, there are still first wave ISTCs which receive money, I believe for work not actually done.

9. Sheffield is a case in point. Patients were required to go to the ISTC in Derby. Many refused to do so. The ISTC was paid, nevertheless, for the agreed volumes and the PCT at Sheffield had either to put the poor patient on the bottom of the list—because he had “refused” treatment—or had to pay for it a second time. The amount of money received by ISTCs in the area for treatment not given is in the region of £4.5 million.

10. The South West London Elective Orthopaedic Centre (SWLEOC) in Epsom started life as a NHS ISTC. It is to become an ISTC, with ownership very probably passing to the Hospital for Special Surgery in New York. The HSS is reported to be getting cold feet as the NHS TC was not able to cover its costs. The Queen opened the NHS TC; history does not relate what she thinks about it being sold off to the HSS!

11. There are no doctors on the wards at SWLEOC, as these cannot be spared from the surrounding Trusts. Instead there is an arrangement whereby Consultant Intensivists are paid £2,000 per night to stay over night. This is not popular with the Trusts as they are depleted of intensivists.

12. Where things go wrong, patients tend to be shipped back from the ISTC to the Trust. This is not a good service for patients.

13. Arrangements are made directly between an ISTC provider and the Department for Health. The DOH then requires, with no consultation with the PCTs or the Trust, that a given number of patients should be sent straight from the waiting list to the ISTC; this causes many problems for the Trust and the PCT, both budgetary and operational.

14. In some cases, it is not possible to find a local consultant or trained doctor to perform the procedure. Colonoscopy lists have been performed by doctors who have been brought out of retirement or have been imported from Germany. As the caecum has not always been reached—the Clinical governance point—a second procedure sometimes has to be performed on return to the parent Trust. This is bad for the patient and wasteful of resources.

15. The ground rules keep changing. In order to justify the importing of overseas doctors, there has been a prohibition on UK doctors who have worked in the NHS working in the ISTCs. The principle of “additionality” however, is increasingly being jettisoned, not officially, but by default. There appear to be no longer any “rules”, as the Government changes tack incessantly.

16. Undergraduate medical education is suffering; with the emphasis on throughput, ISTCs have little time to devote to education. Nor, as far, as I can gather, is the government insistent, in every case, that the new provider takes students. Where they do, the education is of course only for the simplest of procedures. This involves another shift in resources—this time for training—away from the permanent Trust to the ephemeral ISTC.

17. A similar lack of clarity surrounds ISTCs from the regulation point of view. They should be regulated under the Care Standards Act and should be subject to regular inspection by the Health Care Commission. I do not believe that this is the case, by any means.

18. I hope this is of some use. By all means use this material, but I should be grateful if it is used anonymously.

10 February 2006