



House of Commons
Health Committee

Independent Sector Treatment Centres

Fourth Report of Session 2005–06

Volume I



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Report, together with formal minutes

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The Health Committee

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

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, which can be found in Volume III (HC 934-III). Written evidence is cited by reference in the form 'Ev' followed by the page number and the Volume Number, either Volume II (HC 934-II) or Volume III (HC 934-III).

Contents

| Report | <i>Page</i> |
|-------------------------------------------------|-------------|
| Summary | 3 |
| 1 Introduction | 7 |
| 2 History | 9 |
| NHS Treatment Centres | 9 |
| BUPA at Redwood | 10 |
| ISTCs: Phase 1 | 10 |
| General Supplementary Contracts | 13 |
| ISTCs: Phase 2 | 14 |
| 3 Assessment of Phase 1 | 16 |
| Objectives | 16 |
| Capacity | 16 |
| Spot purchase price in the private sector | 19 |
| Choice | 20 |
| Best practice and innovation | 21 |
| The challenge from ISTCs: the effect on the NHS | 24 |
| Concerns | 26 |
| Additionality | 26 |
| Quality of care | 27 |
| Integration | 31 |
| Training | 33 |
| Effect on pay and conditions | 33 |
| Effect on NHS finances | 34 |
| Value for Money | 36 |
| 4 Phase 2 | 39 |
| Improvements in Phase 2 | 40 |
| Integration | 40 |
| Training | 42 |
| Assessment of Phase 2 bids | 43 |
| Local plans | 43 |
| The Department's assessment of Phase 2 | 45 |
| Other models of care | 46 |
| Annex | 48 |
| NHS Treatment Centres | 48 |
| Glossary of Terms | 50 |
| Conclusions and recommendations | 52 |

| | |
|-----------------------------------------------|-----------|
| Formal minutes | 56 |
| Witnesses | 57 |
| List of written evidence in Volume III | 59 |
| List of written evidence in Volume II | 59 |
| Reports from the Health Committee | 62 |

Summary

Since the early 1990s, clinicians in the NHS have been advocating the separation of elective from emergency surgical procedures in order to improve productivity and relieve pressure on the acute sector. In 1999, the first treatment centre in England dedicated to elective procedures was opened at the Central Middlesex Hospital. In 2002, the Department of Health announced that it was creating a programme of similar NHS Treatment Centres as a systematic approach to the issue.

At the end of 2002, the Government decided to commission a number of independent sector treatment centres (ISTCs) to treat NHS patients who required relatively straightforward elective or diagnostic procedures. Several objectives were ascribed to the ISTC programme, including:

- Increasing elective capacity available to the NHS in order to reduce waiting lists and times;
- Reducing the spot purchase price in the private sector;
- Increasing patient choice within the NHS;
- Encouraging best practice and innovation;
- Stimulating reform within the NHS through competition.

Many of the ISTCs are stand-alone sites, physically removed from local acute hospitals, and their contracts included a stipulation of ‘additionality’; the independent providers were prohibited from employing anyone who had worked for the NHS in the previous six months. Partly as a result of this, they were overwhelmingly staffed by overseas clinicians. The contracts also contained financial guarantees, the so-called ‘take or pay’ element, whereby they were assured of a certain level of income, irrespective of how many procedures they performed for the NHS. The Department of Health justified this by arguing that it was necessary to introduce new providers into the health economy.

Our inquiry examined whether the objectives of the programme had been met. We concluded that ISTCs had not made a major direct contribution to increasing capacity. The Department of Health has admitted that the number of procedures performed by ISTCs is a tiny fraction of the NHS’s total capacity. ISTCs have had a significant effect on the spot purchase price and increased patient choice, offering more locations and earlier treatments. However, without information relating to clinical quality, patients are not offered an informed choice. We found that ISTCs have embodied good practice and introduced innovative techniques, but good practice and innovation can also be found in NHS Treatment Centres and other parts of the NHS. ISTCs are not necessarily more efficient than NHS Treatment Centres. The Department claims that ISTCs drive the adoption of good practice and innovation in the NHS, but we received no convincing evidence which proved that NHS facilities are adopting in any systematic way techniques pioneered in ISTCs.

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

A number of concerns were raised about the ISTC programme by the professional medical bodies and others. There were concerns that ISTCs were poorly integrated into the NHS and that they were not training doctors. These concerns are well-founded. The additionality policy was felt by many to have hindered integration between ISTCs and their local NHS facilities, while the reliance on overseas staff which additionality had necessitated raised concerns about clinical quality and continuity of care. We concluded that there was no hard, quantifiable evidence to prove that standards in ISTCs differed from those in the NHS; however, there are failings in the quality of data collection by both NHS and IS providers. We recommend that comparable and standardised data be collected. We welcome the forthcoming inquiry into the quality of care in ISTCs which the Chief Medical Officer, Professor Sir Liam Donaldson, has asked the Healthcare Commission to undertake.

We also received evidence about the effect of ISTCs on the finances of the NHS. The ISTC programme is intended eventually to provide about half a million procedures per year at a cost of over £5 billion in total. This could clearly affect the viability of many existing NHS providers over the next five years and possibly beyond. Moreover, as the quantity of ISTC activity is not evenly spread across the country, the impact on the budgets of different local health economies is likely to vary. The Phase 1 contracts, including the 'take or pay' elements, give ISTCs a significant advantage over NHS Treatment Centres and other NHS facilities. In the longer term, there are good reasons for thinking that ISTCs could have a more significant effect on the finances of NHS hospitals. We do not know how big that effect might be or how great the dangers might be. The Department of Health has carried out analysis of the possible effects of the ISTC programme on NHS facilities, but it has refused to disclose the analysis to us. Phase 2 ISTCs may lead to unpopular hospital closures under 'reconfiguration' schemes.

There was also considerable scepticism about whether the ISTC programme represented value for money. We found it difficult to make an assessment since the Department would not provide us with detailed figures on the grounds of commercial confidentiality. We have some evidence about the potential benefits. It is hard to see that the decision to commission Phase 1 could have been justified in terms of the need for additional capacity alone. The other major potential benefit, the galvanising effect of competition on the NHS, was not and probably could not be quantified when the decision to go ahead with Phase 1 of the ISTC programme was made. It is claimed that this decision was a leap in the dark in the hope that the 'challenge' of ISTCs would improve efficiency in the NHS. We agree. In view of the high degree of uncertainty about ISTCs' wider benefits and costs of the ISTC programme, we recommend that the NAO investigate them, in particular the extent to

which the challenge of ISTCs has led to higher productivity in the NHS.

In March 2005 the Department announced that it would commission a second wave (“Phase 2”) of ISTCs. Phase 2 is to consist of an elective and a diagnostic element. £2.75 billion is to be spent on the former, £1 billion on the latter. There was a degree of confusion over the scale and nature of Phase 2. 17 elective and 7 diagnostic schemes are likely to go ahead. 7 other schemes are not in the end to go ahead, but the SHAs affected by these cancellations are nonetheless to be obliged to make independent provision available to NHS patients through other means.

The Department acknowledged some of the anxieties which Phase 1 had created and promised to address them in Phase 2: additionality would be restricted to increase the involvement of NHS staff in ISTCs and improve integration; and all ISTCs would be obliged to offer training provision for NHS staff if required by local needs. We support these moves. The Department also proposes to allow NHS consultants to work non-contracted hours in ISTCs. We welcome this and recommend that, in addition, the Department should ensure that Phase 2 contracts encourage NHS staff to be seconded to treatment centres. We also recommend that consultants be allowed to hold sessions of NHS planned activities in ISTCs where this would be thought appropriate for local service needs and to aid integration. Consultants working non-contract hours should do so at NHS contract rates.

In Phase 2, ISTCs are not only to be built where local plans show the capacity is needed but they are also to be used as part of ‘reconfiguration’ plans. This could mean that major hospitals would be closed and the elective services they provide be undertaken by ISTCs. We were told that ISTCs would only go ahead where local health communities considered them appropriate, but there is concern about the pressure put on such communities by the Department. The second stage of the evaluation of Phase 2 is the Department’s assessment of whether the ISTCs represent value for money. However, we were not given any detailed figures which would enable us to check this assessment. We found it difficult, therefore, to assess the current state of Phase 2 of the ISTC programme, or the rationale behind it. The Department of Health and the Secretary of State have, over the course of our inquiry, given answers which have shifted in both fact and emphasis as time has gone by, and the statement of the current position by the Secretary of State leaves several important questions unanswered. The decision to maintain the commitment to spend £550 million per year despite changing circumstances has not been explained, and seems to sit uncomfortably with the Secretary of State’s admission that “in other [areas] it has become clear that the level of capacity required by the local NHS does not justify new ISTC schemes”. It is not clear whether this represents simply a failure coherently to articulate the situation or a more profound incoherence in terms of policy as opposed to presentation. There are also real concerns that the expansion of the ISTC programme will destabilise local NHS trusts, especially those with financial deficits.

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

1 Introduction

We from the college and specialist associations have for the last 10, 12, 15 years been talking about separating emergency from elective work. Currently some 64% of consultant general surgeons are on call for emergencies when they are doing elective work. The NHS has to deal with emergencies at the same time as it does its elective work [...] if you separate elective from emergency you will get good treatment.¹

(Mr Bernard Ribeiro, President of the Royal College of Surgeons of England)

1. The separation of elective from emergency care by establishing treatment centres has been promoted by clinicians in England since the early 1990s. The first treatment centre in England opened in 1999. In April 2002, the Department of Health announced a programme of NHS Treatment Centres to create additional elective surgery and relieve pressure on the acute sector. This was followed in December 2002 by a decision to commission a number of independent sector treatment centres (ISTCs) to treat NHS patients for relatively simple, high-volume surgical procedures. The first ISTC began operating in 2003.

2. In March 2005, the Government announced that it was launching a second and substantial phase of procurement of additional elective surgery and diagnostic capacity from the independent sector. This was contentious for a number of reasons: for example, several professional groups had been concerned about the quality of care provided by the ISTCs and there were doubts as to whether the ISTCs provided value for money. In January 2006, we announced an inquiry into ISTCs. In addition to examining public concerns about the programme, we were keen to see what lessons should be learned from Phase 1 and applied to Phase 2, and what the long-term future of ISTCs should be. Our terms of reference were:

- What is the main function of ISTCs?
- What role have ISTCs played in increasing capacity and choice, and stimulating innovation?
- What contribution have ISTCs made to the reduction of waiting times and waiting lists?
- Are ISTCs providing value for money?
- Does the operation of ISTCs have an adverse effect on NHS services in their areas?
- What arrangements are made for patient follow-up and the management of complications?
- What role have ISTCs played and should they play in training medical staff?

- Are the accreditation and appointment procedures for ISTC medical staff appropriate?
- Are ISTCs providing care of the same or higher standard as that provided by the NHS?
- What implications does commercial confidentiality have for access to information and public accountability with regard to ISTCs?
- 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?
- How many ISTCs should there be?

3. We held four evidence sessions between 9 March and 26 April 2006, hearing from independent healthcare providers, medical professional groups including several Royal Colleges, trades unions, regulatory bodies and academics, as well as the Secretary of State for Health, the Rt Hon Patricia Hewitt MP, and officials from the Department of Health. To clarify the progress being made on Phase 2 of the ISTC Programme we held a fifth evidence session on 28 June.

4. We visited three treatment centres in April 2006, representing three different models: Redwood Diagnostic and Treatment Centre, run by BUPA in partnership with the local NHS and using a mixture of BUPA and seconded NHS staff; the Will Adams NHS Treatment Centre at Gillingham, a conventional Phase 1 ISTC operated by Mercury Health; and the Woodland NHS Treatment Centre at Darent Valley Hospital, an NHS-run treatment centre. In addition, members of the Committee visited ISTCs in or near their constituencies. In March 2006 we visited St Görans Hospital in Stockholm which is run by Capio Healthcare, an independent healthcare company, and provides a full range of services to state-funded patients.

5. We are extremely grateful to our specialist advisers; Professor Nick Bosanquet, Professor of Health Policy at Imperial College, London; Seán Boyle, Senior Research Fellow at the LSE Health and Social Care research centre, London School of Economics; and Professor Sir Ara Darzi, Clinical Professor at the Division of Surgery, Oncology, Reproductive Biology and Anaesthetics at Imperial College, London, for their very helpful advice and support during this inquiry.

2 History

July 1999—ACAD, Europe’s first dedicated elective treatment centre, opened at Central Middlesex Hospital

April 2002—NHS Treatment Centre programme announced in *Delivering the NHS Plan: next steps on investment, next steps on reform*

December 2002—ISTC programme announced in *Growing Capacity: Independent Sector Diagnosis and Treatment Centres*

September 2003—first ISTC contracts signed

October 2003—first ISTC opened at Daventry (Birkdale Ltd)

March 2005—second phase of ISTCs announced

6. The reasons for separating elective and emergency care were vividly brought to our attention by the President of the Royal College of Surgeons. He described a situation in which he had been scheduled to perform three hernia operations and two laparoscopic cholecystectomies in an afternoon, while supervising trainees, but the admission of an emergency case had required the use of the operating theatre in which he had been scheduled to work. The hernia patients had to be sent home.²

NHS Treatment Centres

7. Various ways of ‘ring-fencing’ elective procedures have been attempted, including setting aside beds in wards specifically for this purpose. Such measures were unsuccessful because the beds were often needed by emergency patients. Treatment centres have the great advantage that they cannot be used for emergency care.³

8. Following a decade’s pressure from many leading members of the medical profession to establish treatment centres, ACAD (the Ambulatory Care and Diagnostic Centre) was opened at the Central Middlesex Hospital in 1999. A further 15 schemes were introduced before a systematic programme of treatment centres was announced in 2002.

9. In April of that year, the Department of Health published *Delivering the NHS Plan: next steps on investment, next steps on reform*. One of the innovations contained in the document was the establishment of NHS Treatment Centres to perform a high volume of relatively straightforward elective procedures in a predictable flow. These centres, originally referred to as Diagnostic and Treatment Centres (DTCs), were intended “to help meet NHS waiting time reductions and provide more rapid, convenient and improved outpatient and diagnostic services in the community [...] diversify service provision and,

2 Q 108 (Mr Ribeiro)

3 Ev 136 Volume II

once again, relieve pressure on mainstream NHS hospitals”.⁴ The treatment centres which already existed were absorbed into the NHS Treatment Centre programme.

10. The original NHS Treatment Centre programme comprised 46 treatment centres.⁵ Many of the larger centres were intended, in part, to facilitate the achievement of NHS Plan targets and were accordingly designed to have spare capacity. The business cases for these treatment centres assumed that they would perform additional work for Trusts other than their hosts. However, all NHS Treatment Centres received and continue to receive funding solely on the basis of number of patients seen.⁶

11. In 2002, a group of NHS chief executives and clinicians, some from the NHS Treatment Centres, established NHS Elect to promote innovation and deliver a high standard of care. NHS Elect “currently supports 18 elective care providers as part of the formal infrastructure of support provided to the NHS by the Department of Health Short-Stay Elective Care Programme”.⁷ It is funded by the Department of Health and by a small subscription from the sponsoring NHS Trusts.⁸

BUPA at Redwood

12. In addition to the NHS Treatment Centre programme, and predating the ISTC programme, an independent diagnostic and treatment centre was opened at Redwood in Surrey in December 2002 by BUPA, in partnership with the local NHS trust. The centre, which we visited, employs both dedicated BUPA staff and NHS employees on secondment, and is based on the same site as an NHS hospital, the East Surrey Hospital, with a physical link to that facility, thereby, we were told, fostering a spirit of co-operation.

ISTCs: Phase 1

13. In December 2002, eight months after announcing its programme of NHS Treatment Centres, the Department of Health published *Growing Capacity: Independent Sector Diagnosis and Treatment Centres*, which launched a procurement exercise to acquire from the independent sector additional capacity beyond that provided by the NHS.⁹ The total cost of Phase 1 will be £1.7 billion. The Department has referred to two main and distinct purposes, which have often and misleadingly been conflated: to increase the surgical capacity available to the NHS; and to involve the independent sector in an increasingly mixed health economy with all the benefits the Department claims this will bring.¹⁰

14. In its memorandum to the Committee, the Department claimed that the exercise was undertaken in response to local capacity analyses.¹¹ This claim was much disputed (see

4 Department of Health, *Delivering the NHS Plan: next steps on investment, next steps on reform*, April 2002, p 26

5 A list of NHS Treatment Centres can be found in the attached Annex on p 48

6 Ev 207 Volume III

7 NHS Elect members are identified in the Annex on p 48

8 For more information on NHS Elect see www.nhselect.org.uk

9 Department of Health, *Growing Capacity: Independent Sector Diagnosis and Treatment Centres*, December 2002

10 See para 51

11 Ev 1 Volume II

paragraph 34 below). We were told that the analyses were conducted by Strategic Health Authorities (SHAs), in consultation with their Primary Care Trusts (PCTs), in which the SHAs had identified any anticipated gaps in their capacity required to achieve the waiting time targets laid down for 2005.¹²

15. We asked the Secretary of State for Health, the Rt Hon Patricia Hewitt MP, why the additional capacity which SHAs had identified as being required could not be provided by further investment in the NHS Treatment Centre programme and NHS services more generally. She told us:

We needed very rapidly to bring new capacity into the NHS, and my predecessors, I think quite rightly, made the decision to do that, first of all, by expanding capacity within the NHS itself, secondly to expand capacity through the ISTC programme.¹³

16. The Secretary of State continued:

It was [...] through the ISTC programme that we challenged the exceptionally high prices of the private sector in the United Kingdom, got those prices down, brought the prices down for the spot purchasing (thus increasing value for money) [...] challenging the incumbents (uncomfortably for them, perhaps) within the UK private sector and introduced a new element of dynamism into the NHS but, more broadly, into the health care system.

The precise objectives behind the introduction of the ISTC programme, and the way in which they developed and changed over time, are dealt with in greater detail in Chapter 3.

17. The Department informed us that once local studies had established the need for new capacity, it followed the process described below. The programme was advertised in December 2002, attracting expressions of interest from 147 companies, to whom Pre-Qualification Questionnaires (PQQs) and Memoranda of Information (MOIs) were then issued. The responses to the PQQs were received by the Department in February 2003 and pre-qualification was decided by assessing the technical and financial capability and capacity of potential bidders. A short-list was then drawn up and those companies were issued with Invitations to Negotiate (ITNs) in April 2003, to be returned during the following two months.¹⁴

18. Once the responses to the ITNs had been received by the Department of Health, the Bid Evaluation Phase began, consisting of six stages:

- Stage 1: Bid Receipt;
- Stage 2: Evaluation;
- Stage 3: Clarification;
- Stage 4: Bidder Convergence;

12 Q 4

13 Q 537

14 Ev 148 Volume III

- Stage 5: Final Evaluation, and
- Stage 6: Preferred Bidder Selection.

After the Preferred Bidder (and, where appropriate, a Reserve Bidder) had been selected, negotiations began to finalise the details of the contract.¹⁵

19. The preferred bidders for most of the ISTC contracts were announced in September 2003. The Department of Health’s memorandum to the Committee stated that the bidders had to “meet the core clinical standards required by the NHS, provide high standards of patient care [...] and provide good value for money to NHS commissioners”.¹⁶ The contracts had a number of noteworthy features, including the ‘additionality’ provision and the ‘take or pay’ elements.¹⁷ There was no requirement to train staff.

20. The table below lists the 29 Phase 1 ISTCs which are currently or will shortly be operating:

| Treatment Centre | Operational Status | Casemix |
|-------------------------------------------------|--------------------|------------------------------------------------------------------------------------------|
| Ophthalmic Chain | Full Service | Ophthalmology |
| East Cornwall | Full Service | Ophthalmology, General Surgery, Gastroenterology, Gynaecology, Urology |
| East Lincolnshire | Full Service | Ophthalmology, Urology, Hernias, Varicose Veins, Colonoscopies and Minor Skin |
| West Lincolnshire | Full Service | Ophthalmology, Gastroscopies, Colonoscopies, Orthopaedics, Urology and Minor Skin |
| North Oxford (Horton) | Full Service | Orthopaedics |
| North and East Yorkshire and North Lincolnshire | Full Service | General Surgery, Trauma and Orthopaedics |
| Southampton | Full Service | Orthopaedics |
| Northumberland | Full Service | Upper GI Scopes, Hernias, Varicose Veins, Minor Skin |
| TV3500 | Full Service | General Surgery, Urology, Trauma and Orthopaedics, Dermatology, Gynaecology |
| Kidderminster | Full Service | Orthopaedics |
| Wycombe | Full Service | Diagnostics |
| Medway | Full Service | General Surgery, Gastroenterology, ENT, Orthopaedics, Urology, Oral Surgery, Endoscopies |
| Portsmouth | Full Service | Walk-In Centre/Minor Injuries Unit, Day Surgery, Ophthalmology, Diagnostics |

15 *ibid.*

16 Ev 1 Volume II

17 See Glossary of Terms on p 50

| Treatment Centre | Operational Status | Casemix |
|--------------------------------|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|
| Bradford | Full Service | General Surgery, Gastroenterology, ENT, Gynaecology, Ophthalmology, Orthopaedics, Plastic Surgery, Urology, Oral Surgery, Diagnostics |
| Trent & South Yorkshire | Full Service | Orthopaedics |
| Daventry | Full Service | Ophthalmology, Orthopaedics, Plastic Surgery, Oral Surgery, Upper GI Endoscopies |
| Shepton Mallet | Full Service | Orthopaedics, Ophthalmology, General Surgery and Endoscopies |
| Greater Manchester | Full Service | Orthopaedics, General Surgery and ENT |
| Plymouth | Full Service | Orthopaedics |
| Cheshire & Merseyside | Mobilisation | Orthopaedics |
| Nottingham | Mobilisation | Orthopaedics, Gynaecology, General Surgery, Dermatology, Endoscopies, Oral and Maxillofacial Surgery, Vascular Surgery, Chronic Pain and Diagnostics |
| Maidstone | Mobilisation | Chemotherapy, Minor Surgery and Diagnostics |
| Outer North–East London (BHRT) | Mobilisation | Ophthalmology, Orthopaedics, ENT, Oral Surgery, General Surgery and Urology |
| Brighton | Mobilisation | Orthopaedics |
| Burton | Mobilisation | General Surgery, ENT, Gynaecology, Ophthalmology, Orthopaedics, Plastic Surgery, Urology, Oral Surgery, Rheumatology, Pain Procedures |
| GC4 West Surrey | Under Negotiation | Orthopaedics |
| Lister Surgi Centre | Under Negotiation | Paediatrics, ENT, Endoscopies, Urology, Ophthalmology, Gynaecology and Other Specialities |
| Hemel Hempstead Surgi Centre | Under Negotiation | Paediatrics, ENT, Endoscopies, Urology, Ophthalmology, Gynaecology and Other Specialities |
| Havant | Not Operational | Diagnostics |

Data from Department of Health, see Ev 16 Volume II¹⁸

General Supplementary Contracts

21. Separate from the ISTC programme was another system of private sector–provided NHS elective care, the so–called General Supplementary Contracts (GSup). Under GSup–1 in 2005, Nuffield and Capio provided extra activity in ear, nose and throat (ENT), general

¹⁸ We are concerned by the inaccuracies in evidence concerning Kidderminster provided by the Department of Health at Ev 26, Volume II, lines 2–4, which are incorrect or out–of–date and therefore misleading.

surgery, urology and orthopaedics, in areas with especially long waiting times. GSup-2, a six-month contract beginning in July 2005, concentrated on orthopaedics.

ISTCs: Phase 2

22. In March 2005, the Department of Health announced a substantial second wave of procurement from the independent sector. Phase 2 was to consist of diagnostic and elective work, including an Extended Choice Network (ECN) of independent sector providers to deliver procedures on an *ad hoc* basis. £2.75 billion is to be spent on the elective element and £1 billion on the diagnostics.¹⁹ The procedures will be performed in a variety of settings, including existing ISTCs, new-build facilities, refurbishments and NHS sites. The same process for choosing bidders was used for Phase 2 as in Phase 1.

23. There has been confusion about the scale and nature of Phase 2. When the Secretary of State gave oral evidence on 26 April 2006, she told us that ITNs had been issued for 12 elective schemes, in two tranches, and that responses had been received for five of those bids.²⁰ However, the *Health Service Journal* reported the next day that Phase 2 had originally comprised 24 schemes, of which seven had subsequently been scrapped, with only 17 proceeding (perhaps with some delay).²¹ The Secretary of State conceded in a letter to the Committee that Phase 2 would indeed probably consist of 17 schemes.²² We were eventually able to clarify the situation in a further evidence session with the Commercial Director: the Secretary of State had referred on 26 April to 12 schemes for which ITNs had been issued, but there were a further 12 schemes which, at that time, were under consideration within the Department. Following that consideration, it was decided not to proceed with seven of them, but the other five were still being assessed. Subsequently, the Department sent us a supplementary memorandum indicating why the seven schemes were not going ahead. Therefore, Phase 2 is likely to consist of 17 elective schemes. In addition, there will be seven regional diagnostic schemes.²³

24. The Department told the seven failed bidders:

It was necessary to review the resulting, more detailed makeup of these schemes against its objectives, the changing situation in health economies, and commercial criteria. As a result of this review, Ministers have decided that these particular schemes will not go ahead.

Nevertheless, all SHAs affected by the cancellation of these seven schemes would be obliged by the Department to make more independent sector provision available to their NHS patients in a variety of ways.²⁴ The Department of Health remains committed to investing £550 million each year in procurement from the independent sector, seemingly regardless

19 Ev 1 Volume II

20 Q 585

21 Helen Mooney, "Treatment centre programme in disarray as contracts axed", *Health Service Journal*, 27 April 2006, p 5

22 Ev 150 Volume III

23 Qq 617-19

24 Ev 150 Volume III

of the what local health economies decide they need.²⁵ The total budget for Phase 2 over five years will therefore remain £2.75 billion for the elective component and £1 billion for diagnostics.²⁶ The apparent contradiction between leaving it to local health economies to decide on Phase 2 schemes and the determination to spend almost £3 billion on independent provision is considered in Chapter 4.

25 *ibid.*

26 Ev 1 Volume II

3 Assessment of Phase 1

25. In this chapter we first consider the Government's objectives and whether they have been met. Secondly, we look at the main concerns raised by witnesses.

Objectives

26. The ISTC programme has had a number of objectives, but it has proved surprisingly difficult to identify them or establish the weight given to each of them since a different emphasis has been placed on different objectives at different times. The Government's broad goals seem to have been to use the ISTC programme to:

- Increase capacity;
- Reduce spot purchase prices in the private sector;
- Increase choice;
- Introduce best practice and innovation and diffuse these through the NHS, and
- Through the challenge of competition from ISTCs, stimulate reform and improve efficiency in the NHS (the 'grit in the oyster' argument).

These we consider below as well as examining witnesses' doubts as to whether the goals have been achieved. In our final evidence session with Department of Health officials we were told of another objective for the ISTC scheme:

- to assist reconfiguration; for example, existing hospitals might be closed and some of the facilities replaced by an ISTC.

Since this is a feature of Phase 2, it is discussed in the next chapter.

Capacity

27. A fundamental objective at the genesis of the ISTC programme was to increase the capacity available to perform elective surgical and diagnostic procedures on NHS patients. The Commercial Director of the Department of Health confirmed to us that "the primary objective was the capacity issue".²⁷ To ensure that there was a genuine increase in capacity the Department insisted that staff and buildings used in the ISTC programme were additional to those used in the NHS.²⁸

28. The Department stressed that the need for increased capacity was assessed locally in capacity plans. Indeed, the Department's Commercial Director, Mr Ken Anderson, was at pains to point out that it would not have been possible to generate the plans at a national level. He told us:

27 Q 3

28 Q 12 (Mr Anderson)

The capacity planning was done at a local economy level. It was not for us to try to determine at our level. We would not have had the capability because we do not have the granularity of data to go out and make those decisions for a local health economy.²⁹

He added:

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

Mr Anderson explained that, in accordance with these capacity plans, Phase 1 ISTCs were located in areas which had a lack of capacity or long waiting lists.³⁰

29. The Department of Health made much of the contribution of ISTCs to bringing down waiting lists and times. The Department pointed out that 250,000 patients had been treated or diagnosed in the independent sector by the end of 2005,³¹ although only a minority of these—50,000—were treated in the mainstream ISTC programme, the rest representing independent provision of procedures not in the ISTC programme such as MRI scans.³² The record on cataract operations was, we were told, particularly impressive. The Secretary of State told the Committee on 26 April:

If you look at the number of additional operations (for cataracts) that had to be done to get those waiting times down to a maximum of just three months, around a third, I think, of those additional operations were done by the ISTCs—not the majority but nonetheless a significant contribution.³³

30. This view was fiercely disputed by the Royal College of Ophthalmologists. In written evidence, the College described the contribution of ISTCs to reducing waiting lists and times as “very little as waiting times for cataract surgery in England came down before the cataract ISTCs became operational”.³⁴ The Royal College informed us that the ISTCs had led to an increase in capacity of about 7% to date (March 2006); only 20,000 cataracts had been performed in ISTCs.³⁵ The College’s representative, Mr Simon Kelly, told us that “we [NHS providers] are able to do the same amount of cataract surgery as the independent sector do in the schemes”.³⁶

29 Q 7 (Mr Anderson)

30 Q 6

31 Department of Health, *Independent Sector Treatment Centres, A Report from Ken Anderson to the Secretary of State for Health*, 16 February 2006

32 Q 554

33 Q 568

34 Ev 128 Volume II

35 *ibid.*

36 Q 91

31. In general, the additional capacity has been modest in size: as of December 2005, ISTCs had performed 44,000 elective surgical procedures and 9,000 diagnostic procedures, with Phase 1 centres expected to perform an average of 170,000 Finished Consultant Episodes (FCEs) each year over a five-year period.³⁷ By contrast, the NHS as a whole performs around 5.6 million elective FCEs each year.³⁸

32. It is not entirely clear how necessary the additional capacity provided by the ISTCs was. A number of ISTCs are operating significantly below capacity, a point which the Secretary of State conceded.³⁹ We visited the Will Adams NHS Treatment Centre in Gillingham, a facility operated by Mercury Health, where we were told that the centre was operating at around 50% of its capacity.⁴⁰ In oral evidence, we heard a similar story from the NHS Alliance and others. It was claimed that one of the reasons for unused capacity was a reluctance on the part of some GPs and, indeed, some patients to use ISTCs.⁴¹ The fact that there is substantial unused capacity within the ISTC programme casts doubt on the assertion that ISTCs were necessary to increase capacity.

33. If there had been a severe shortage of capacity, the ISTC programme should have had little effect on capacity utilisation of NHS facilities. This has not been the case; according to NHS Elect, the introduction of ISTCs has led to under-utilisation of NHS Treatment Centres (because of the ‘take or pay’ contract⁴²).

34. We heard evidence that, in one part of the country at least, ISTCs were not established in accordance with local capacity plans, which had been agreed with local health providers, as the Department of Health had assured us was the case. Ms Jane Hanna, a former Non-Executive Director of South-West Oxfordshire Primary Care Trust, told us that in Oxfordshire, independent provision was imposed on local NHS providers against their wishes. She told us that the PCT Board voted not to approve a contract with Netcare UK for a private cataract unit. The Board believed it was not in the interests of the local population, since it would involve the transfer of work away from an NHS facility with an excellent reputation, which was already due to meet the Department of Health’s six-month waiting time target. Subsequently, Ms Hanna alleges, the Board was placed under pressure by the Department to change its mind, and “policy was imposed through private, informal methods which included threats and bullying”.⁴³ Although Mr Anderson of the Department of Health claimed that he had no evidence that such bullying took place,⁴⁴ nevertheless, Ms Hanna’s allegations cast serious doubts on the degree to which local autonomy was respected, and therefore calls into question a central plank of the Department of Health’s argument in favour of the locating of ISTCs.

37 Ev 1 Volume II

38 Q 9; Written evidence to the Health Committee, *Public Expenditure on Health and Personal Social Services 2005*, HC 736, Ev 184

39 Qq 552, 560

40 See also Ev 158 Volume III

41 Q 432, Q 435 (Ms Easey)

42 See Glossary of Terms on p 50

43 Ev 201 Volume III

44 Qq 630, 647

35. In evidence to the Committee, the Department of Health conceded that ISTCs have not made a major contribution to capacity or reducing waiting lists; Mr Bob Ricketts, Head of Demand Side Reform and initially responsible for the NHS Treatment Centre programme, said:

I have been very clear that the majority of the contribution even in cataracts was from the NHS [...] I would certainly want to go on record as saying that, in terms of delivering three months for cataracts, the NHS did it because at the time the majority of the facilities were NHS facilities.⁴⁵

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

36. There is also concern that figures relating to the ISTC programme and its productivity have been subject to a degree of misrepresentation, witting or unwitting, in some of the Department of Health's public statements. It has not always been made clear whether such figures include the results from BUPA Redwood, which has treated nearly 40,000 patients to date. BUPA Redwood was established before the ISTC programme was commissioned, and, according to the Acting Chief Executive of the NHS, Sir Ian Carruthers, "it is viewed as a prototype ISTC and, actually, it is therefore different".⁴⁶ However, it has been far and away the most productive of the treatment centres to date, and its turnover seems to have been conflated in some situations with that of the mainstream ISTC programme, unrealistically boosting the figures for ISTCs. The Secretary of State was asked what part of the figure of 60,000 patients treated by ISTCs per year was taken from BUPA Redwood. She admitted, "I am not sure. About 35,000 elective patients treated so far."⁴⁷ **We are concerned that the Department has attempted to misrepresent the situation by presenting the BUPA Redwood figures as procedures performed by the mainstream ISTC programme.**

Spot purchase price in the private sector

37. Before the introduction of ISTCs, the NHS had made use of the independent sector on an *ad hoc* basis for some years. Patients were treated by independent providers at the NHS's expense when extra capacity was required to meet targets or speed up treatment; this is known as spot purchasing. The Secretary of State explained:

We mobilised spare capacity that was sitting around in the private sector of the kind that was made visible to patients when they were told, as they so often were, "Well, of course, if you have it done on the NHS you will have to wait 12, 15 or 18 months (whatever it was) but if you would like to go private we can do it for you next week". We said, quite rightly: "If they can do it next week they can do it on the NHS".⁴⁸

45 Q 52

46 Q 558

47 Q 555

48 Q 537

38. Inevitably, a more systematised engagement between the NHS and the independent sector has altered this relationship. Traditionally, the NHS paid independent sector providers a premium of 40–100% over reference costs. Following the announcement of the introduction of the ISTC programme, the healthcare sector has seen a downward trend in spot prices. We also heard that the ISTC programme has acted to drive down prices in the wider private healthcare sector. Mr Robin Smith, Chief Executive of Mendip PCT claimed that fees for some operations had fallen by as much as 50% as a result of the existence of ISTCs.⁴⁹ **ISTCs have had a significant effect on the spot purchase price in the private sector and on charges in the private sector more generally.**

39. Initially, following the introduction of ISTCs, more purchases were made from the private sector but reliance on spot purchasing has declined to a point that the Secretary of State now believes that: “there is no real need for the NHS to use spot purchasing at all.”⁵⁰ If this is the case, the level of the spot purchase price is no longer strictly relevant to the NHS. Moreover, spot purchasing was always regarded as a necessary evil to meet temporary capacity shortages rather than an integral part of NHS procurement, and the introduction of additional capacity would therefore inevitably lessen the need to rely on spot purchasing.

Choice

40. Another objective of the ISTC programme was the extension of patient choice. Mr Ricketts explained that this aim had been central to the programme from the outset.

Choice was at a very early stage of development. When Alan Milburn announced the first wave of the procurement in December 2002 he put the emphasis on cutting waiting times, but he also referred to an objective which was to increase patient choice clearly with a view that in three years’ time we would have to offer choice.⁵¹

The point was reiterated by Sir Ian Carruthers, who said that “ISTCs are [...] trying to break the monopoly [of the NHS] so that consumers can actually have choice”.⁵²

41. ISTCs do offer some patients the opportunity to receive treatment earlier than they would obtain it in an NHS hospital; they also provide a choice of location. On the other hand, witnesses pointed to a number of limitations. We were told that ISTCs might reduce choice in the long run if they led to the closure of NHS facilities.⁵³ It was also stressed that patients could not make an informed choice without proper, intelligible and comparable clinical data from ISTCs and NHS facilities.⁵⁴ The Department of Health conceded that data relating to complication rates and other measures of clinical quality are not available across the board of NHS facilities and ISTCs.⁵⁵ Mr Ricketts admitted that, under the circumstances, the patient would “not [be] making as informed a choice”.⁵⁶ **ISTCs have for**

49 Qq 383–85

50 Q 548

51 Q 8

52 Q 602

53 Ev 120 Volume II

54 Q 137 (Mr Leslie)

55 Qq 30–31

56 Q 32

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

Best practice and innovation

42. The Department of Health also maintained both that ISTCs embody best practice and innovative techniques and that innovation which occurs in ISTCs will be diffused more quickly through the NHS than innovation occurring in NHS Treatment Centres and other facilities.

43. It is argued that ISTCs are in a better position to innovate since they are new and not constrained by existing practices. Representatives of the independent providers told us that, while they were not unique in promoting innovation, they were driven to make it as widespread as possible because “if we do not provide that best practice in the way we set out, we will not exist. Our goal is to be a long-term player as part of the NHS. Therefore we live or fall by the implementation of our best practice.”⁵⁷ The Secretary of State stressed the unique role which ISTCs play:

It is actually much easier not just to innovate, but to embed every aspect of best practice in a total system if you are starting on a greenfield site and you do not have established ways of working [...] that is probably one of the main reasons why in 2002 in the very early stages of this the NHS Modernisation Agency reported that good practices that they identified at the time in the NHS treatment centres were not widespread, nor did any treatment centre embody more than a few of them, whereas actually a lot of the gains are to be found if you have every aspect of best practice in every aspect of care and you try to get the whole lot together.⁵⁸

44. The Department identified a number of examples of innovation at ISTCs, including:

- The use of mobile units to improve access to services for patients in remote areas;
- The construction of facilities based around patient flow;
- Streamlining the supply of prostheses so that a smaller range is used, allowing theatre staff to become more proficient and specialised in their use;
- Performing primary joint replacement under local⁵⁹ rather than general anaesthesia to reduce patient stay, and
- Blood conservancy and recycling techniques to reduce the need for transfusions.⁶⁰

Others claimed that most of these practices were already occurring in the NHS. The Department stressed that, as a result of the innovations, ISTCs were able to carry out considerably more procedures than the NHS. The Secretary of State told us that the best

57 Q 193 (Mr Parish)

58 Q 573

59 That is, procedures such as regional blocks or spinal anaesthesia.

60 Ev 3 Volume II

ISTCs were performing, for example, six to seven arthroscopies per day compared to only three or four in the NHS,⁶¹ while the mobile ophthalmology units operated by Netcare UK were delivering as many as 20 cases per day, compared to 12 to 15 in the NHS.⁶²

45. Several witnesses doubted that ISTCs were especially innovative. Mr Simon Kelly of the Royal College of Ophthalmologists told us that he saw no innovation in cataract surgery in Phase 1 of the ISTC programme that was not also practised within the NHS.⁶³ The President of the Royal College of Surgeons of England, Mr Bernard Ribeiro, conceded that the NHS could learn lessons from the independent sector—he identified the rationalisation of surgical equipment as an example—but countered that “the experiment had already been done” in NHS Treatment Centres, and was not a function of ISTCs’ independent status.⁶⁴ The President of the British Orthopaedic Association (BOA), Mr Ian Leslie, pointed out that the ‘innovative’ blood recycling techniques to which the Department of Health had referred had in fact been employed in the NHS for at least two years.⁶⁵ The Healthcare Commission supplied a supplementary memorandum which dealt with the issue of innovation and good practice. It pointed to similar examples as the Department of Health—the use of mobile facilities, blood conservancy and recycling techniques, greater use of local rather than general anaesthesia—but noted that these “are not exclusive to ISTCs”.⁶⁶

46. We were also told that, since ISTCs did no training and by their very nature undertook the simpler cases, it would be very surprising if they did not appear more ‘efficient’ than NHS facilities. The NHS Confederation warned that:

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.⁶⁷

47. Witnesses stressed that it was important to compare like with like. The Royal College of Surgeons informed us that, while ISTCs performed more procedures per day than the NHS in general, so did NHS Treatment Centres, “an effective means for the separation of elective from emergency work on the same site”.⁶⁸ Indeed, the Department’s own report on NHS Treatment Centres in January 2005 is very positive about their achievements. It praised the productivity and innovation of treatment centres, drawing attention to several examples from within the NHS Treatment Centre programme; for example, of the Nuffield Orthopaedic Centre in Oxford, it reported that “care pathways were written with primary care involvement resulting in a reduction in the length of stay from a range of twelve to fourteen days to just five days”, while it noted that, at Goole, the average length of stay in

61 Q 578

62 Ev 3 Volume II; Q 193 (Mr Adams)

63 Q 91 (Mr Kelly)

64 Q 96

65 Q 97 (Mr Leslie)

66 Ev 172 Volume III

67 Ev 112 Volume II

68 Ev 141 Volume II

orthopaedics had been reduced from twelve to five-and-a-half to six days thanks to new pre-operative assessment procedures.⁶⁹ The Woodland NHS Treatment Centre at Dartford which we visited was very efficient; for example, it had a theatre utilisation rate of 90%.

48. Innovation in ISTCs is largely a matter of better processes and clinical management rather than surgical techniques or technological advances. It is probable that it has been driven by the regular and consistent case-mix and stems from the 'elective surgery-only' status of all treatment centres rather than the independent sector's involvement in the treatment centre programme.

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

50. The Secretary of State also argued that ISTCs were driving the diffusion of best practice and innovation through the NHS; they were better at doing this than NHS Treatment Centres. She told us:

What the system, taken as a whole, has been very poor at doing is incentivising best practice [...] by putting more diversity and more competition into the NHS as a whole we are incentivising best practice and innovation throughout the whole service.⁷⁰

Asked to give examples of ways in which ISTCs were driving best practice in the NHS, the Secretary of State promised us a supplementary memorandum.⁷¹ While the memorandum cautioned that innovation and best practice could also be found in the NHS, it identified four areas in which ISTCs regularly exemplified such best practice and improved productivity:

- Efficient administration and working methods, for example in primary care screening, patient reminders and a 12-hour theatre day, six days a week;
- Maximising theatre usage, with admission and recovery areas close to theatre and minimised bed transfers;
- Minimising time spent by patients under the knife, for example through local rather than general anaesthesia, the streamlining of procedures through a limited range of prostheses and the repeat exposure of operating teams, leading to greater efficiency, and
- Speeding up recovery to reduce bed time, increase the facility's productivity and enhance the patient experience, including the use of chair-based post-operative recovery and a discharge lounge.⁷²

69 Department of Health, *Treatment Centres: Delivering Faster, Quality Care and Choice for NHS Patients*, January 2005, p 8

70 Q 569

71 Q 577

72 Ev 152-54 Volume III

51. The memorandum gives examples of good practice and efficiency in ISTCs but does not answer the question we posed about the effect of ISTC practice on the NHS. Indeed, we were not given the evidence to assess how, to what extent and how quickly best practice in the ISTCs was diffused through the NHS. A number of witnesses disputed the unique role of ISTCs in spreading best practice. Several argued that, where there had been change to working practices in the NHS, they were not related to the independent sector and denied that the ISTC programme had acted as a stimulus.⁷³ NHS Elect thought that the role of ISTCs in stimulating innovation had been “limited”, partly because locally-developed proposals for collaboration between ISTCs and NHS providers had found little support from the centre, representing a “lost opportunity for sharing of innovation and for the creative use of existing facilities”.⁷⁴ Equally, the BMA noted that “evidence of [the diffusion of best practice] is lacking” and argued that the lack of integration between ISTCs and the NHS could in fact hinder the spread of best practice.⁷⁵ **The Department claims that ISTCs drive the adoption of good practice and innovation in the NHS, but we received no convincing evidence which proved that NHS facilities were adopting in any systematic way techniques pioneered in ISTCs.**

The challenge from ISTCs: the effect on the NHS

52. The final objective of the ISTC programme is to stimulate the NHS to adopt more efficient practices through the threat of competition. To put it colloquially, the ISTCs act as the ‘grit in the oyster’. Sir Ian Carruthers told us that “the most important impact is the impact they [ISTCs] often have on the local NHS which is about how they improve their practice”.⁷⁶ Mr Robin Smith said that “the best way to improve performance is to introduce a degree of challenge”.⁷⁷ Part of the argument is theoretical: it is claimed that there is evidence across economies that competition provides for gains in speed and variety of service as compared to monopoly.⁷⁸ It was suggested that in Sweden greater pluralism had led to a reduction in waiting times.

53. The evidence that the NHS has responded to the challenge of ISTCs is set out below. First, the announcement of the ISTCs has at the very least coincided with unprecedented falls in waiting times for some procedures which had had the longest waiting lists for many years. It may be difficult to prove causation, but there has certainly been a coincidence in time, which means that some effect from the ISTCs cannot be ruled out. Secondly, the reductions in waiting times have been greater in procedures covered by the ISTCs than in elective procedures such as prolapse and hernia repair where the ISTCs have not offered much additional service.

54. The ISTCs were also starting against a background of long-running problems in increasing day surgery in the NHS. An Audit Commission report recorded some progress since 1998 but estimated that, with better management of the existing resources, there

73 For example, Q 479

74 Ev 208–209 Volume III

75 Ev 57 Volume II

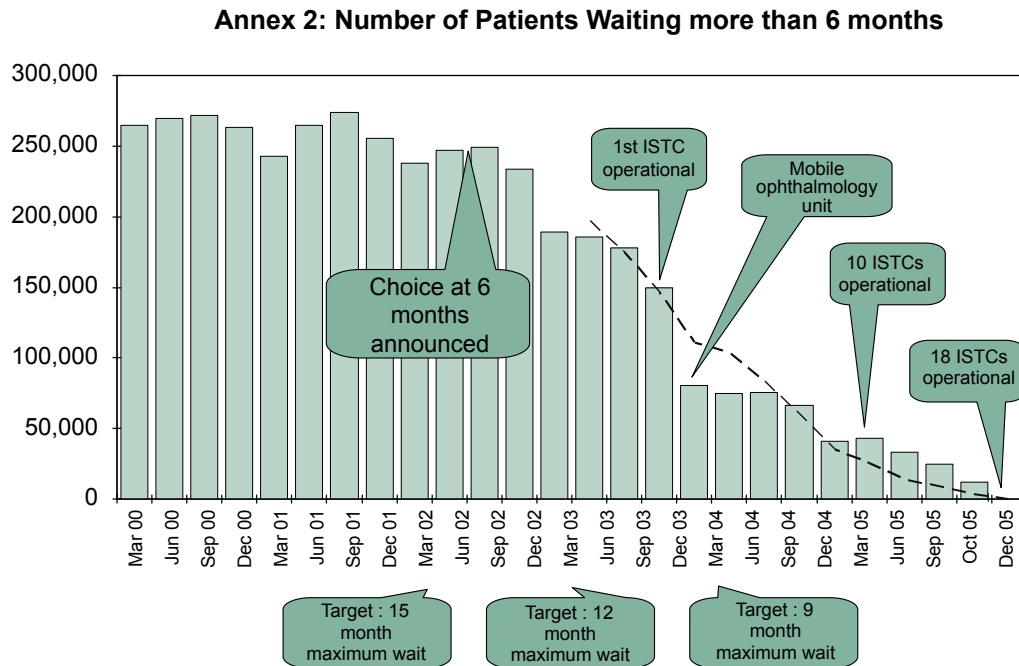
76 Q 572 (Sir Ian Carruthers)

77 Q 420

78 Q 573

could be 120,000 more treatments a year.⁷⁹ The NHS had not been able to deliver such treatments and many of the difficulties in using resources efficiently had persisted despite significant investment in day surgery.

55. To demonstrate the effect which the ISTC programme had had, the Secretary of State provided the graph below.



Provided to the Committee by the Department of Health

56. However, it could be argued that the graph indicates not a causal effect but a coincidence. Other factors have been more important than ISTCs in reducing waiting lists. The NHS Confederation told us that “the prospect of ISTC competition” had encouraged the NHS to become more productive, but that Government-imposed waiting list targets had also played a role in shaking up the NHS.⁸⁰ Waiting times for procedures covered by ISTCs have declined most quickly, but these are often the procedures which the NHS has been instructed to target. **The threat of competition from the ISTCs may have had a significant effect on the NHS. This factor may be the most important contribution made by the ISTC programme. However, the evidence is largely anecdotal. Waiting lists have declined since the introduction of ISTCs, but it is unclear how far this has happened because the NHS has changed in response to the ISTCs or because of additional NHS spending and the intense focus placed on waiting list targets over this period. We are surprised that the Department has made no attempt systematically to assess and quantify the effect of competition from ISTCs on the NHS. Given its importance, the Department should have ensured that this was done from the beginning of the ISTC programme in 2003.**

79 Audit Commission, *Day Surgery*, December 2001

80 Ev 112 Volume II

Concerns

57. A range of witnesses, from professional bodies and trades unions to patient groups and their representatives, voiced concerns about the ISTC programme. These concerns fell into the following broad categories:

- Additionality;
- Quality of care;
- Integration;
- Training;
- Effect on pay and conditions;
- Effect on NHS finances, and
- Value for money.

Additionality

58. In Phase 1, ISTCs were forbidden to employ anyone who worked for an NHS secondary care organisation, or who had worked for such an organisation within the previous six months. According to the Department of Health, the policy “was designed to prevent a draining of NHS human resource capacity” and to ensure that the new capacity was genuinely ‘additional’—hence the term the ‘additionality’ principle.⁸¹ Mr Anderson stressed:

As a country we did not have at our disposal the number of nurses and doctors that we needed to perform procedures and to bring the waiting lists down. It was a very specific part of policy that looked at ensuring bringing in that extra capacity both in terms of buildings, people and clinicians.⁸²

59. We received conflicting evidence about the value of the additionality principle. UNISON defended additionality as an important tool to prevent the poaching of NHS staff by the private sector.⁸³ Amicus agreed; its Health Sector Officer, Mr Barrie Brown, told us:

If you are increasing capacity one thing we do not want to see is the risk [...] of losing highly experienced qualified staff from the NHS to work in the ISTC where we are increasing capacity but losing part of the NHS at the same time.⁸⁴

The policy was also supported by Mr Mike Parish, Chief Executive Officer of Care UK, who said that “if additionality had not applied to date and if it did not apply going forwards

81 Ev 2 Volume II

82 Q 12

83 Ev 147 Volume II

84 Q 512

then we would be heavily criticised for causing a supply shortage problem within the NHS, which is quite possibly what could be the case”.⁸⁵

60. In contrast, the Chief Executive Officer of Mercury Health, Mr Peter Martin, told us that additionality had been a hindrance:

I do not think it is clinically the best solution [...] I think it has hindered developing close partnerships locally. It has hindered integration with the local health economy. I personally believe that the best overall solution for the Department and the NHS is by providing clinically robust solutions and high quality but on a cost-effective basis in this mixed economy where we have a mix of UK doctors and overseas doctors, and wave one did not allow us to do that.⁸⁶

Additionality has also been seen as having an adverse effect on the quality of care which we now discuss.

Quality of care

61. A significant number of witnesses, including patients and professional bodies, criticised the quality of care provided to patients in ISTCs. This was blamed by some on the use of foreign-trained clinicians (because of the additionality principle). Many foreign-trained doctors do currently work in the NHS and are integral to the workforce. However, they have been integrated into the system over a long period of time. By contrast, there are overseas surgeons employed in ISTCs who have no experience of working in the UK or in the NHS. They might be unfamiliar with processes within the NHS, surgical techniques or equipment, and might have language problems. Some surgeons working in ISTCs, albeit a decreasing number, have come to the UK to work for a weekend or a few weeks, and are therefore often unable to follow up, or even be aware of, complications.

62. ISTC providers stated that the level of complications and unexpected transfers back to NHS facilities were low; they provide care of the same or a higher standard than that provided by the NHS.

63. Many others disagree. In evidence to the Committee, the BOA claimed that orthopaedic surgeons working in the NHS had seen above-average revision and re-admission rates for patients who had been treated in ISTCs.⁸⁷ They claimed that there were revision rates of 2.3% in ISTCs, compared to only 0.7% in the NHS.⁸⁸ The organisation described stories of “overseas surgeons inserting unfamiliar prostheses, not cementing those designed to be cemented etc”.⁸⁹ The BOA added that the consequences of defective prosthesis and surgical error might not be apparent for two or three years. The Royal Colleges and the BMA also voiced concern about the quality of care in ISTCs. The Royal College of Surgeons of England told us of “increasing evidence” that ISTCs were unable to

85 Q 201

86 Q 196

87 Ev 62 Volume II

88 Q 129 (Mr Leslie)

89 Ev 64 Volume II

manage complications “with consequent transfer to existing NHS facilities and on occasions to the consultant to whom the patient was initially referred”.⁹⁰

64. However, most witnesses agreed that the evidence was not currently available to compare clinical standards such as complication rates in NHS Treatment Centres and ISTCs. The BOA conceded that its evidence was anecdotal, and argued for more rigorous auditing of the work done in ISTCs.⁹¹ Similarly, the BMA alluded to concerns about surgical standards, suggesting that service fragmentation and the introduction of competition could undermine the quality of clinical care, but admitted that there was not sufficient data to reach a satisfactory conclusion on the matter.⁹²

65. The ISTCs do collect a substantial body of data based on 26 Key Performance Indicators (KPIs), with a subset of nearly 100 overall indicators as part of their contractual obligations. The KPIs represent a broad range of performance indicators, from the logistical (KPI 1 records the percentage of procedures not performed because the patient did not attend) through the clinical (KPI 4 measures the percentage of patients who were returned to theatre unexpectedly) to measures of patient experience (KPI 18 demonstrates patient satisfaction by a monthly survey of 10% of all patients).⁹³ The measures pointed to extremely high rates of patient satisfaction.⁹⁴ Nevertheless, most of the KPIs are a measure of process rather than quality; for example, quality of life changes have not yet been evaluated. There are few clinical KPIs.

66. The ISTCs supplied the Committee with data which they collect. Mr Parish of Care UK explained that the data collected, based on the 26 KPIs stipulated in their contracts:

Is [...] audited locally by the PCT, and obviously the Healthcare Commission when they review it. It is made available within the unit to patients. We focus on continuing improvement and therefore each of those statistics is reviewed on an ongoing basis to seek improvement.⁹⁵

He was supported in this by Dr Thomas Mann, Chief Executive of Capio UK, who told us that:

The data is collected from all of us for our ISTC contract. Every month there is a review of the data and a scrutiny of the results of that data, which is jointly undertaken between the NHS and our own people in a group that has a majority from the NHS locally.⁹⁶

67. The independent providers were at pains to stress that these data sets were not collected simply because they were a contractual requirement, but also because they were a critical

90 Ev 137 Volume II

91 Ev 65 Volume II

92 Ev 59 Volume II

93 A full list of the KPIs can be found in Ev 115–16 Volume III

94 Ev 73, 89, 92, 97 Volume II

95 Q 149

96 Q 153 (Dr Mann)

part of the monitoring of clinical standards.⁹⁷ Furthermore, many providers make extensive use of patient satisfaction surveys.⁹⁸

68. There has been an overview study, conducted by the National Centre for Health Outcomes Development (NCHOD),⁹⁹ which compared ISTC data with similar data from the NHS. The preliminary report¹⁰⁰ in October 2005 based on the 26 contractual KPIs collected by four ISTC schemes found that:

There is no statistically significant difference in the proportion of patients readmitted [to a hospital after their initial procedures had been carried out] between patients treated in NHS hospitals and NHS patients treated by the independent sector.¹⁰¹

However, the report was unable to make comparisons across a wide range of quality measures.

69. Dr Foster Intelligence sent us evidence arguing that there was a good deal of comparable data. However, the organisation admitted that there were several important caveats which must attach to any comparisons. ISTCs are relatively recent creations and therefore the volumes of activity are not “at the necessary level for meaningful analysis”; in some cases, the coding of activity is poor; several ISTC providers operate a number of sites, requiring a high degree of accuracy of coding; and some data which is applicable to ISTCs may be collected by the trust which subcontracted the procedures to the independent sector.¹⁰² Coding is important: it needs to be identical for procedures in the NHS and ISTCs and currently is not.

70. Ms Anna Walker, the Chief Executive of the Healthcare Commission which is responsible for regulating standards within the independent sector, cautioned that comparisons between the ISTC programme and NHS facilities were difficult to make. For example, while reports of serious untoward incidents in ISTCs were made to the Healthcare Commission, similar reports about NHS facilities would be made to Strategic Health Authorities.¹⁰³ In written evidence, the Commission underlined this point, also suggesting that the short length of time the ISTC programme had been running made it doubly difficult to make a comparative assessment.¹⁰⁴ It summarised the problem:

Routine data and information reporting does not exist for the independent sector in the same way it does for the NHS [...] most NHS information is collected at institutional level, whereas ISTCs equate to sub-departments of hospitals.¹⁰⁵

97 Qq 155–56

98 See, for example, Ev 164 Volume III

99 An independent research centre based jointly at the London School of Hygiene and Tropical Medicine and the University of Oxford’s Department of Health

100 National Centre for Health Outcomes Development, *Report to the Department of Health: ISTC Performance Management Analysis Service—Preliminary Overview Report for Schemes GSUP1C, OC123, LP4 and LP5*, October 2005

101 Ev 195 Volume III

102 *ibid.*

103 Q 253

104 Ev 172 Volume III

105 Ev 173 Volume III

71. Our adviser, Professor Sir Ara Darzi, submitted a brief memorandum, stressing that NHS trusts and ISTCs should collect standardised data. He informed us:

There should be a standardised method of capturing data for all patients, regardless of their provider. Quality of life assessment should go beyond a standardised questionnaire—it needs to be multi-faceted, procedure- or disease-specific, and should be centrally collected. Given the narrow range of procedures performed in ISTCs, procedure-specific information should be captured and useful comparisons of case-mix should be possible (ideally, risk-adjusted outcomes should be assessed). This should be applied to both the NHS and ISTCs. In particular, coding needs to be identical in the NHS and in ISTCs for the same procedures, and this is not currently the case. Quality measures (ideally risk-adjusted, prospectively collected, procedure- and disease-specific) should be centrally collected in both NHS Treatment Centres and ISTCs.¹⁰⁶

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

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

74. There are also worries about the procedures for vetting foreign-trained doctors. Professor Sir Graeme Catto, President of the General Medical Council, explained that all doctors working in ISTCs are required to be registered with the GMC. However, he sounded a note of caution, adding that:

Being on the medical register does not mean that a doctor is necessarily entirely competent to work in all environments or is necessarily able to work unsupervised or even able to practise all of the procedures within their given speciality.¹⁰⁷

Sir Graeme went on to say that the GMC’s hands are to some extent tied because the European Commission’s directive on Mutual Recognition of Professional Qualifications requires doctors from the European Economic Area¹⁰⁸ who are accredited specialists in their own country to be accepted as such in the UK.¹⁰⁹ He was supported in this by

106 Ev 218 Volume III

107 Q 231

108 The European Economic Area was created on 1 January 2004 as a result of an agreement between the European Union and the European Free Trade Area (EFTA). Its membership consists of the 25 EU member states and three of the four non-EU members of EFTA, Iceland, Liechtenstein and Norway (Switzerland decided not to join after a referendum). The EEA is based on four core ‘freedoms’: free movement of goods, persons, services and capital.

109 Council Directive 2005/36/EC on the Recognition of Professional Qualifications (OJ No. L 255, 30.9.2005, p 22)

Professor Peter Rubin, the Chairman of the Postgraduate Medical Education and Training Board (PMETB) who told us:

Whatever the EU says about the equivalence, there may not be equivalence in terms of the culture in which a doctor worked and all sorts of differences may exist, so it is for the employer to look very carefully at what every individual doctor has done in their country of origin.¹¹⁰

75. Employers stressed that they took their responsibilities very seriously. Mercury Health claimed in its report to the HCC that its appointment procedures were the same if not more rigorous than those of the NHS. On the other hand, the BMA, BOA, RCP, RCOA and others were all critical of the procedures. Several witnesses argued for a more robust and transparent appointment procedure similar to those used in the NHS. The Royal College of Anaesthetists suggested that “were appointments [in ISTCs] subject to the current DoH Guidance to Advisory Appointment Committees an additional layer of discernment would exist”, and pointed to the example of Foundation Trusts, which were not obliged to follow the Department’s guidance, but many of which did.¹¹¹ The Healthcare Commission made a similar proposal, and noted that one independent provider operating under the GSup contract had already reviewed its recruitment procedures with a view to strengthening them.¹¹²

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

Integration

77. ISTCs are not well integrated into the NHS. According to the NHS Alliance, in Phase 1 of the ISTC programme, there had been a “lack of widespread clinical engagement with local GPs and NHS hospital consultants”, as a result of which “local clinicians in both primary and secondary care have felt disengaged and angered by the lack of a meaningful

110 Q 235 (Professor Rubin)

111 Ev 121–22 Volume II

112 Ev 85 Volume II

dialogue regarding local clinical issues and their interest, commitment or willingness to work with the ISTCs”.¹¹³ The BMA criticised a “lack of robust communication channels between ISTC clinicians in treatment centres and those in local NHS services”, and pointed to a survey of its members which demonstrated that nearly 75% of respondents were unable to discuss patient cases with ISTC staff, compared with only 20% for an NHS treatment centre.¹¹⁴

78. The problem is exacerbated by the physical separation of many ISTCs from the NHS. The President of the Royal College of Anaesthetists, Dr (now Sir) Peter Simpson, for example, explained that relatively straightforward surgical procedures sometimes required more complex anaesthesia, “A laparoscopy, keyhole surgery in the abdomen, is quite a complicated anaesthetic and therefore not necessarily transferable to remote sites all the time”.¹¹⁵

79. The ISTCs are also concerned about poor integration with the NHS. During our visit to the Will Adams Treatment Centre at Gillingham, staff told us that one of the reasons that it was operating significantly under capacity was the unwillingness of some local GPs to refer patients to an independent sector facility. Similar problems affected the ISTC in Nottingham.

80. In a supplementary memorandum, the Department of Health acknowledged some of the problems which had affected the Will Adams Treatment Centre. It explained that an executive group had been created including the Chief Executives of Medway PCT, the acute trust and senior representatives from Mercury Health, to focus on ways in which the centre could be more efficiently used and relationships between the centre and the local NHS could be improved.¹¹⁶

81. However, poor integration between ISTCs and the local NHS is not inevitable. The Chief Executive of Mendip PCT told us that there had been a high level of clinical engagement between the Shepton Mallet Treatment Centre and local NHS facilities within Mendip PCT.¹¹⁷ Mrs Pauline Quan Arrow, the Chair of Southampton PCT, was similarly positive about co-operation between the NHS and the independent sector.¹¹⁸ Even though the Will Adams Treatment Centre had difficulties with local GPs, it believed that it had a perfectly satisfactory relationship with the local NHS hospital which had signed a service agreement to handle any complications.

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

113 Ev 99 Volume II

114 Ev 58 Volume II

115 Q 100 (Dr Simpson)

116 Ev 219 Volume III

117 Qq 394, 399, 410, 412, 417

118 Qq 431, 435 (Mrs Quan Arrow), 439 (Mrs Quan Arrow)

Training

83. The Department of Health claimed that ISTCs “offer an ideal training environment over more traditional NHS settings” since they were predicated on regular and uninterrupted work flow and a high volume of procedures.¹¹⁹ Some training takes place; for example, the facility operated by Mercury Health at Haywards Heath will be able to train 20 junior doctors in elective orthopaedic surgery.¹²⁰ However, the Phase 1 contracts did not require ISTCs to train clinical staff and most ISTCs do not train doctors.

84. The professional medical bodies warned that the removal of a great deal of relatively straightforward elective surgery to an environment in which staff were not being trained resulted in clinicians being denied vital experience of so-called ‘bread-and-butter’ procedures during their training. The BOA described ISTCs as “depleting the competence of the next generation”,¹²¹ while the BMA expressed “serious concern” that “procedures most suited to training purposes are transferred to ISTCs”.¹²² The Royal College of Surgeons informed us that there was evidence to show that the training of surgeons in NHS hospitals adjacent to ISTCs had suffered.¹²³ **Even though Phase 1 ISTCs perform a relatively small number of procedures, there can be a significant local effect on the training of junior doctors.**

85. The Department accepts that ISTCs should offer training and has stated that in Phase 2 they will do so. It will be setting up a number of pilot schemes in Phase 1 ISTCs to inform Phase 2. The pilots will be established in order to assess whether the introduction of training provision in ISTCs would lead to a significant loss of productivity.¹²⁴ We look at the form training should take in the next chapter.

Effect on pay and conditions

86. One of the independent providers told us that productivity levels and cost advantages of ISTC depended on the ability to use non-NHS staff. Mr Mike Parish, Chief Executive Officer of Care UK, said, “Even if additionality was not required, we would still look to bring doctors in internationally because, frankly, the cost-base of UK doctors is not competitive; it is too high. That is evidenced in some of the pricing solutions we have been developing for the second wave.”¹²⁵

87. Lower pay rates in the ISTCs are already causing concern. In the NHS consultant anaesthetists are on the same salary scale as other consultants. This is not the case for anaesthetists working in ISTCs. We were informed by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) that a number of independent healthcare providers (Capio, Nuffield, BMI and BUPA) “have not been following the principle of equal pay for

119 Ev 6 Volume II

120 Ev 90 Volume II

121 Ev 61 Volume II

122 Ev 58 Volume II

123 Ev 137 Volume II

124 Q 674

125 Q 197

all consultants”, and instead have applied the practice commonly followed in private hospitals by which consultant surgeons are paid two-and-a-half times the fee per case that consultant anaesthetists receive.¹²⁶ The AAGBI maintained that, as the patients treated in ISTCs are NHS patients, this application of a practice used for private patients was unacceptable. It also argued that it represented a hidden discrimination on grounds of gender, as a much higher proportion of consultant anaesthetists are women (34%) compared to consultant surgeons (7%).

88. Perhaps more significantly, private providers do not match the pension provision made by the NHS. A Department of Health official explained that NHS providers benefited from “state aid” in a number of ways, which put them to some degree at a competitive advantage compared to independent providers, and “staff pension costs” was one of these advantages.¹²⁷

Effect on NHS finances

89. Several witnesses commented on the effect of ISTCs on the services provided by, and the finances of, existing NHS providers. We were informed of beneficial effects: if routine operations are sent to treatment centres, NHS hospitals are more able to deal with emergency patients; ISTCs could in the short term take the pressure off NHS hospitals striving to bring down waiting lists.¹²⁸

90. Most witnesses, however, stressed the negative effects. The ISTC programme is expected eventually to cost a considerable amount of money—£1.7 billion for Phase 1, £2.75 billion for Phase 2 elective procedures and £1 billion for Phase 2 diagnostics. It is likely that such substantial expenditure will have an effect on the NHS.

91. NHS Treatment Centres, in particular, seem to have suffered financially. Under the ‘take or pay’ aspect of the Phase 1 contracts, ISTCs have to be paid irrespective of how many procedures they actually carry out. As a result there is a powerful incentive to PCTs to encourage patients to use ISTCs rather than NHS Treatment Centres. NHS Elect claimed that the diversion of elective procedures to ISTCs was creating a problem of under-utilisation in NHS Treatment Centres. It pointed to five treatment centres which had substantial spare capacity:

126 Ev 46–47 Volume II

127 Q 689

128 For example, see Ev 100 Volume II

| Treatment Centre | Capacity currently used per annum (FCEs) | Spare capacity available per annum (FCEs) | Spare capacity as percentage of total |
|-----------------------------------------|------------------------------------------|-------------------------------------------|---------------------------------------|
| Ravenscourt Park Hospital | 6,000 | 6,000 | 50% |
| ACAD (Central Middlesex) ¹²⁹ | 8,000 | 3,000 | 27% |
| Kidderminster | 12,000 | 8,000 | 40% |
| Crewe | 8,400 | 6,000 | 42% |
| Birmingham City | 7,200 | 1,500 | 17% |

Data from NHS Elect, see Ev 208 Volume III

The fixed costs of these NHS Treatment Centres will inevitably be borne by the NHS, and unused capacity will raise the unit cost of the services provided. NHS Elect argued, therefore, that there was a hidden additional cost to the ISTC programme, as they are creating a financial penalty for their NHS counterparts as well as the cost they represent in terms of procurement.¹³⁰

92. Other organisations had concerns about the effect of the ISTC programme on other parts of the NHS. A BMA study of clinical directors found that over half of respondents reported a negative overall impact of a local treatment centre, including NHS Treatment Centres, on the facilities and services provided by their NHS trust with more than two-thirds reporting a negative impact from an ISTC. The BMA also highlighted the potential risks of NHS facilities being left with more complex procedures to which a premium would not attach under the Payment by Results system, but which would inevitably be more expensive to perform: “Current policy will see those conventional NHS centres reliant on routine work to cross subsidise large fixed overheads become increasingly vulnerable.”¹³¹

93. The threat of ISTCs is particularly worrying in view of some trusts’ high deficits. The Royal College of Surgeons of England told us:

Triaging arrangements have diverted patients into ISTCs leaving existing NHS facilities under-utilised with a concurrent deleterious effect on fragile NHS Trust financial balances.¹³²

Similar comments were made by the Royal College of Physicians and the Royal College of Nursing.¹³³

94. One clinical director, quoted in the NHS Alliance’s written evidence, noted that: “The financial risk to PCTs is considerable.”¹³⁴ The argument was put that the financial

129 It should be noted, however, that, even though ACAD was providing additional capacity to its local trust, the same trust continued to send elective surgery cases to the private sector at the same time, at a cost of nearly £500,000 (Report to North West London SHA, *Ambulatory Care and Diagnostic Centre at Central Middlesex Hospital North West London Hospitals Trust*, p 15).

130 Ev 208 Volume III

131 Ev 58 Volume II

132 Ev 137 Volume II

133 Ev 135 Volume II; Ev 124 Volume II

guarantee of the “minimum take”—ISTCs would be paid for a specified number of procedures, whether or not they were actually carried out—could be a significant burden on PCT finances. It was also put to us by a director of commissioning that some PCTs had had money top-sliced from their budgets and given to the NHS providers who had traditionally performed their elective surgery, and that this could not subsequently be recovered, even if the PCT then employed an ISTC to deliver that activity, thereby leaving the PCT effectively paying twice for some procedures to be performed.¹³⁵

95. The Department is aware that ISTCs might have an effect on the NHS. The Acting Chief Executive of the NHS told us that the Department had carried out analysis of the possible effects of the ISTC programme on NHS facilities, but the Department has refused to disclose the analysis to us.¹³⁶

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

97. In the Phase 2 programme, which we discuss in the next chapter, ISTCs are being used to assist ‘reconfiguration’. To put it more bluntly: major NHS hospitals will be closed and a proportion of elective services they provide will be performed in ISTCs.¹³⁷

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

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

Value for Money

100. Finally, there is concern about value for money (VfM). Two questions are involved:

- Was an adequate VfM assessment made before the bids were accepted;
- Has the ISTC programme in practice provided VfM?

134 Ev 104 Volume II

135 Ev 110 Volume II

136 Q 609 (Sir Ian Carruthers)

137 See paras 128 and 132

101. We asked the Department of Health how it had assessed whether the ISTCs would offer value for money. The Department supplied the Committee with a supplementary memorandum which set out the methodology which it had used. In the absence of an accepted public sector comparator for providing clinical services, VfM was assured by:

- The running of an open and competitive procurement;
- Selecting the best value (compliant) offer received, and
- Rejecting any scheme which was not significantly better value than prevailing spot-purchase rates.¹³⁸

102. In order to ensure that each scheme offered better value than the prevailing spot market, a benchmarking process was devised. An NHS Equivalent Cost was established for each scheme.¹³⁹ Since independent sector providers face costs which are not borne by the NHS, such as tax, they are paid more than the NHS Equivalent Cost. The Department set a maximum threshold that it would pay—considerably below ‘prevailing spot prices’.

103. We were informed that “the average is 11.2% [above the NHS Equivalent Cost] in comparison with historical “spot-purchasing” rates of in excess of 40% above NHS Tariff”.¹⁴⁰ However, we are unable to assess these figures because we have not been given the necessary information on the grounds of commercial confidentiality. The Department has declined to disclose the detailed figures which it used to establish the NHS Equivalent Cost on the grounds that “to release information on the detailed process would jeopardise the ability of the Department and the NHS to secure the best value for money in the next phase of procurement”.¹⁴¹ On the same grounds it has refused to provide us with the figures in any Business Case (although it did provide us with a redacted Business Case for one of the bids which had previously been obtained through a Freedom of Information request). An independent review of the VfM methodology used for Phase 1 was commissioned in October 2004. The purpose of the review was to establish whether the VfM methodology was being consistently and correctly applied. The review found that it was the case. This too has not been disclosed to the Committee.¹⁴²

104. Some witnesses thought that the use of spot-purchase prices as a benchmark was undemanding: it would be very surprising if the systematic, high-volume procurement of services from the independent sector through the ISTC programme was *not* better value than *ad hoc* arrangement by which procedures were paid for on an individual basis. On the other hand, DoH officials pointed out that independent sector providers had to meet costs which were not included in the tariff/Equivalent Cost such as provision for pensions. Nevertheless, they admitted that a premium over the NHS Equivalent Cost had been paid

138 Ev 146 Volume III

139 The NHS Equivalent Cost is a calculation of the amount of money that would be paid to an NHS provider for delivering a certain activity in the same location as the provider with the same care pathway. It is derived from the NHS tariff, with certain adjustments made to reflect the delivery model of the independent provider.

140 Ev 33 Volume II

141 Ev 146 Volume III

142 Ev 150 Volume III

and the financial guarantee of the ‘minimum take’ introduced to involve the private sector and get the additional benefits they would bring.¹⁴³

105. A number of witnesses also suspected that the Secretary of State in 2002 decided on an experiment to introduce private sector providers largely irrespective of any objective cost benefit analysis: it was a leap in the dark, based on a hunch that the advantages brought by the private sector were worth paying a significant premium for.¹⁴⁴ Only eight months had elapsed between the announcement of the NHS Treatment Centre programme and the announcement that substantial TC provision would be procured from the independent sector; this looked like unseemly haste. The fact that officials and ministers from the Department of Health have provided a range of changing objectives to explain the ISTC programme also suggested that the ISTC programme was not a carefully thought-out venture.

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

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

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

143 Q 574

144 For example, Q 574

4 Phase 2

109. By June 2006, the situation with regard to Phase 2 was as set out below:

Invitations to Negotiate (ITNs) have been issued for 12 schemes:

- Northumberland, Tyne and Wear;
- Cumbria and Lancashire (two schemes);
- Cheshire and Merseyside;
- Essex;
- West Midland South;
- Avon, Gloucestershire and Wiltshire;
- Greater Manchester (two schemes);
- South London;
- Hampshire and the Isle of Wight;
- Norfolk, Suffolk and Cambridgeshire.¹⁴⁵

The following seven schemes will not be proceeded with:

- West Yorkshire elective scheme;
- West Yorkshire plastic surgery scheme;
- South West Peninsula multi-specialty;
- South Yorkshire general surgery;
- South Yorkshire cardiology;
- County Durham and Tees Valley multi-speciality;
- Birmingham and Black Country.

In addition, five further elective schemes are likely to go ahead but we were told that no decisions had been made yet as to where they will be located.

145 HC Deb, 13 June 2006, col 1163W

Negotiations are underway with bidders for seven regional diagnostic schemes, in the following areas:

- London;
- The North East;
- The West Midlands;
- The North West;
- The South East;
- The South West;
- The East.

110. In the first evidence session of the inquiry, the Department announced that Phase 2 contracts would differ in a number of ways to take account of the concerns raised about Phase 1. The first section of this chapter considers those proposed changes. The second section considers the assessment of Phase 2 bids. Finally, we examine alternatives to ISTCs including the use of ‘Redwood’ model and NHS Treatment Centres.

Improvements in Phase 2

111. The Department has agreed that in Phase 2 there should be improvements in respect of:

- Integration of ISTCs with the local NHS, including a curtailment of additionality, and
- Training.

Integration

112. As we have seen, the failure to integrate satisfactorily a number of the ISTC schemes with the local NHS has caused difficulties for patients and the ISTCs. The Department has made a number of proposals to improve the situation, including:

- Better co-operation between ISTCs and the NHS;
- Locating ISTCs in or next to NHS hospitals;
- A curtailment of additionality;
- The use of NHS consultants in ISTCs, and
- Changes in respect of clinical appointments in ISTCs.

In addition, the provision of training in Phase 2 ISTCs will improve integration (see below).

113. The Department agrees that some SHAs, PCTs and ISTCs have failed to engage GPs and hospital consultants in the work of ISTCs, but it notes that where real efforts were made to involve local PCTs and NHS clinicians in the ISTC programme, as at Shepton Mallet, there were few problems of integration. Here, through widespread consultation, clear care pathways and co-ordinate referrals a high degree of integration between local PCTs, NHS staff and ISTCs can be achieved.¹⁴⁶ The Department proposes to build on best practice established here.

114. In addition to the Department's proposals to improve integration, other witnesses put forward other recommendations. The Healthcare Commission proposed that account be taken in locating new ISTCs of their proximity to local NHS providers and the "suitability of a 'host' site with a range of shared facilities".¹⁴⁷ The Royal College of Surgeons agreed that there was a need for ISTCs to be located close to larger facilities, though argued that "Second Wave ISTCs are best located in private hospitals which are readily accessible to consultants in neighbouring NHS hospitals".¹⁴⁸ As a general principle, however, witnesses thought it important that ISTCs were physically close to facilities which could provide both integration in terms of NHS staff and a full range of medical support.

115. Several witnesses who had supported additionality in Phase 1 thought that it should not be part of Phase 2. Capio Healthcare UK told us that the additionality principle had served an important purpose in bringing new clinicians into the NHS sphere, but that it should be relaxed for Phase 2 "to allow free movement of staff between providers, as is allowed in any other area of work".¹⁴⁹ This view was supported by Netcare UK.¹⁵⁰ The Royal College of Radiologists also suggested that the relaxation of the policy of additionality "would resolve the important issues related to clinical governance and allow integration of the independent sector provision with NHS services thus providing a seamless service for patients".¹⁵¹

116. The Department of Health, while believing that the additionality principle was useful for Phase 1, agreed that it had led to an over-reliance on overseas doctors and hindered integration. We were initially told that additionality would therefore be somewhat curtailed in Phase 2 and would only apply in certain limited circumstances where there are shortages of NHS staff.¹⁵² However, the Department subsequently told us that the curtailment of additionality would only apply to NHS staff's non-contracted hours—in effect, they will be free to work in ISTCs only over and above their NHS work, and will not be able simply to move from a position in the NHS to one with an independent provider.¹⁵³

117. Even in specialities where there are severe shortages of staff such as radiology, the disadvantages of additionality were thought by some witnesses to outweigh the advantages;

146 Qq 391, 394, 399, 410–13

147 Ev 86 Volume II

148 Ev 139 Volume II

149 Ev 74 Volume II

150 Q 142

151 Ev 182 Volume III

152 Qq 12–15

153 Q 658

for example, Professor Janet Husband, President of the Royal College of Radiologists, advocated the scrapping of additionality for Phase 2.¹⁵⁴

118. Secondments by NHS staff to ISTCs could also improve integration. At the Redwood Treatment Centre there is a mix of seconded staff and dedicated BUPA employees which has proved very effective.¹⁵⁵

119. The HCC thought that improvements could be brought about by changing procedures for appointing staff to ISTCs. It suggested that the recruitment procedures could be aligned with those in the NHS, including the introduction of an equivalent to the advisory appointment committee system.¹⁵⁶ The Royal College of Anaesthetists agreed with this proposal, arguing that it would add “an additional layer of discernment” to appointment procedures.¹⁵⁷

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

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

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

Training

123. Most witnesses agreed that it was essential for Phase 2 to provide training and the Department has agreed that Phase 2 schemes will be required to make training available to the Deans if they wish to commission it. Officials from the Department of Health explained that they had consulted with the professional medical bodies to establish what sort of training was required. The Deans were informed of Phase 2 contract volumes and case mix and have been left to decide what training they would wish to procure from ISTCs. The Department went on to tell us that bidders for Phase 2 schemes had been required to

154 Qq 95 and 140

155 Ev 66 Volume II

156 Ev 85 Volume II

157 Ev 121–22 Volume II

submit bid prices with and without training, and that a generic training schedule is being developed which will be incorporated into the final contracts.¹⁵⁸

124. We also heard assurances from the Department of Health that any training conducted in Phase 2 ISTCs would be in accordance with NHS requirements and standards and would be approved by the Deans. There has also been consultation with the Royal Colleges. An official told us that “those are the safeguards that ensure the training will be of the appropriate standard”.¹⁵⁹

125. The medical professional and regulatory bodies also stressed the need for training to be to the same standard as that provided by the NHS. It should be subject to rigorous regulation and inspection by the Postgraduate Medical Education and Training Board (PMETB), in order to protect and ensure the progress of trainees, guarantee appropriate levels of supervision and assessment and maintain patient safety.¹⁶⁰

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

Assessment of Phase 2 bids

127. There are two main aspects to the assessment of Phase 2:

- the decision about where to locate the ISTCs: the extent to which decisions will be genuinely taken locally; the criteria to be used, including the need for new capacity and the use of ISTC to ‘reconfigure’ local services, and
- once the decision about location has been taken in principle, how the Department assesses whether the bids are competitive.

Local plans

128. The Department informed us that Phase 2 ISTCs are to be established where there are capacity needs and, we heard for the first time at our final evidence in June, where they are part of local ‘reconfiguration’ plans.

129. The Department claims that decisions about whether to establish Phase 2 ISTCs are made by ‘local health economies’. Mr Ken Anderson described the process of consultation with local health providers. The NHS submitted Local Delivery Plans (LDPs) to the Department of Health, following which “we [the Department] map across what we feel the private sector component would look like”.¹⁶¹ If the consultation revealed that there was no need for additional capacity from the independent sector, the ISTC scheme would not go ahead, and it was after such consultation that some of the proposed schemes were

158 Q 664 (Mr Rees)

159 Q 672

160 For example, see Ev 118 Volume II

161 Q 618

withdrawn.¹⁶² Mr Anderson stressed that the consultations with local NHS providers had a significant role in shaping the sort of independent provision which was finally procured. The fact that seven Phase 2 Schemes have been withdrawn suggests that there is a degree of local influence.¹⁶³

130. He added that ISTCs could also be used as part of reconfiguration plans where local health economies considered this appropriate:

Health Economies used the independent sector treatment centre programme as a reconfiguration tool as well. There is capacity in the NHS that we pay for that is not necessarily applicable to today's type of health care [...] it takes a detailed conversation with the health economy around what does reconfiguration look like and what does 21st century healthcare look like.¹⁶⁴

131. However, others emphasised the pressure the Department exerts to get the right decision. There is evidence that this happened in Oxfordshire in Phase 1. It is clear that some local trusts do not want the proposed Phase 2 ISTCs and are very concerned about the consequences. Dr C, a PEC chair, informed us:

As it [Phase 2] 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 [Local Improvement Finance Trust] facilities that are currently coming on stream (another major financial drain on our resources if they are not used to their maximum) [...] 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.¹⁶⁵

132. In West Hertfordshire, the proposals for reconfiguration are causing considerable concern. The West Hertfordshire Hospitals NHS Trust currently has an accumulated deficit of around £43 million, has four separate sites and currently deals with four relatively small PCTs.¹⁶⁶ In addition, it suffers from a low capitation rate, and needs considerable investment. We were told that these problems have been exacerbated by proposals to site an ISTC in the area at Hemel Hempstead. The Chief Executive of the Trust, Mr David Law, told us that the introduction of the ISTC would cost the local NHS around £15 million in income and would necessitate the closure of its facility in St Albans, as it would become redundant.¹⁶⁷

133. If decisions are genuinely a local matter, it is hard to see why the Department is adamant that it will spend almost £3 billion over the next five years on private sector

162 Qq 618–19

163 Q 622

164 Q 632

165 Ev 101–02 Volume II

166 Uncorrected transcript of oral evidence taken before the Health Committee on 22 June 2006, HC (2005–06) 1024–i, Qq 160, 166, 169

167 *ibid.* Qq 175 (Mr Law), 179

provision. The commitment to “replace the activity withdrawn [...] with alternative schemes” is similarly difficult to understand. If the schemes which have been withdrawn were cancelled because there was no need for additional capacity, it seems *prima facie* a peculiar decision to make a commitment to replace the schemes with further independent sector capacity. Mr Anderson also noted:

We cancelled schemes in wave 1 which came back to the health economy but in a different guise with a different case mix. Maybe, instead of being a stand-alone scheme, it then became something that we did on a JV [joint venture] basis with another National Health Service Trust, or maybe it was a completely different package, where it was attached to a more community-based provision package.¹⁶⁸

134. The Department seems to be maintaining that, on the one hand, Phase 2 has been designed sympathetically to local capacity needs in the NHS, but that, on the other hand, the total value of Phase 2 schemes will remain the same, irrespective of local consultations.

The Department’s assessment of Phase 2

135. According to the Department, once the local health economy has decided on its needs, the Department will assess Phase 2 bids in much the same way that it used for Phase 1; for example, it will employ the same VfM methodology. However, it expects to receive more competitive bids. In addition, the ‘take or pay’ element of the contract is to be amended. In Phase 2 ‘take or pay’ will be ‘tapered’ (see Glossary).¹⁶⁹

136. Despite the changes, the Department will continue to pay more than the NHS Equivalent Cost for Phase 2 ISTCs. NHS providers stressed in their evidence that this was unacceptable. Bids should not be accepted unless they provided services more cheaply than the NHS equivalent. They wanted fair competition.¹⁷⁰ The supposed benefits of Phase 1 ISTCs in improving efficiency in the NHS were not sufficiently proven to continue to pay a substantial premium.

137. While the concept of fair competition seems sensible in principle, there is some difficulty in establishing what it means. Some witnesses argued that ISTC bids should be compared with the NHS tariff price. On the other hand, the Department argued that ‘tariff’ was not a fair comparison.¹⁷¹ The NHS Equivalent Cost would seem to be a fairer comparison, but the Department stated that there were factors of which even that did not take account.

138. An added difficulty is how to treat pensions and salaries. Should NHS costs take account of higher pension costs? Some ISTCs currently compete by paying lower salaries. If bids are compared including NHS pension costs, it is possible that, in future, independent providers will seem to be good value. In this case, the main effect of increasing the level of independent provision will be to ‘increase efficiency’ through lower salary and associated costs.

168 Q 622

169 Qq 588–89

170 For example, Q 125, Q 136 (Dr Simpson), Q 303 (Mr Johnson)

171 Q 689

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

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

Other models of care

141. While the Government has focused on the independent sector and the benefits which it has brought to NHS patients, witnesses claimed that here was a strong argument for the use of other mechanisms for providing more elective and diagnostic procedures. We were told that, while facilities dedicated to elective procedures were a valuable tool for improving efficiency, they would work best within the NHS, and linked closely to acute facilities in order to deal with complications as well as to foster greater integration and engagement.¹⁷²

142. The principal options are to establish:

- new NHS Treatment Centres;
- greater utilisation of existing NHS facilities out of hours, and
- local arrangements to involve the private sector in treatment centres on the model of Redwood.

Any of these options would provide better integration than ISTCs.

143. We questioned the Department of Health about these options. Mr Ricketts argued that there had indeed been some use of out of hours capacity, especially in terms of diagnostics.¹⁷³

144. In the subject of joint ventures on the model of BUPA Redwood, the Secretary of State said that "there is no reason why there should not be more joint ventures in the future".¹⁷⁴ However, she implied that these were not a high priority for the Department of Health. She noted that many foundation trusts had expressed interest in developing joint ventures, but stressed that one of the driving forces behind the ISTC programme had been "diversity and

172 Q 140 (Mr Ribeiro, Mr Leslie, Dr Simpson)

173 Q 22 (Mr Ricketts)

174 Q 598

an element of competition and challenge”.¹⁷⁵ Sir Ian Carruthers went on to explain that joint ventures had not been more fully utilised because:

Sometimes you have to go through this difficult phase of creating the infrastructure before you can then reintegrate, because if you start from the point of integrating, you quite often end up with replicas of the same organisation [...] once you have got an infrastructure in place, you can reposition how you do some of that for the common good.¹⁷⁶

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

¹⁷⁵ *ibid.*

¹⁷⁶ Q 602 (Sir Ian Carruthers)

Annex

NHS Treatment Centres

| Scheme | SHA (2006) | Fully Operational Capacity | Fully Operational Date |
|------------------------------------|------------------------|----------------------------|------------------------|
| ACAD* | London | 5,400 | April 2002 |
| University College London Hospital | London | 3,500 | November 2002 |
| Royal Berkshire & Battle | South Central | 4,116 | November 2002 |
| Weston* | South West | 4,600 | January 2003 |
| Moorfields | London | 4,800 | February 2003 |
| King's College Hospital | London | 3,000 | April 2003 |
| Royal Haslar Hospital | South Central | 2,150 | May 2003 |
| North Hampshire Phase 1 | South Central | 1,700 | July 2003 |
| Nuffield Orthopaedic* | South Central | 900 | August 2003 |
| Clatterbridge | North West | 1,040 | September 2003 |
| Newham PCT | London | 600 | November 2003 |
| Bromley Hospitals | London | 2,990 | November 2003 |
| Torbay | South West | 2,200 | January 2004 |
| Goole | Yorkshire & The Humber | 2,800 | April 2004 |
| Ravenscourt Park* | London | 7,000 | January 2004 |
| Bury St Edmunds | East of England | 1,820 | February 2004 |
| Dudley | West Midlands | 3,000 | February 2004 |
| South-West London Orthopaedic | London | 3,150 | April 2004 |
| Cannock | West Midlands | 4,400 | December 2004 |
| Erewash | East Midlands | 1,600 | April 2004 |
| Princess Alexandra Phases 1 & 2 | East of England | 5,100 | April 2004 |
| Kidderminster* | West Midlands | 4,500 | April 2004 |
| Bishop Auckland | North East | 1,281 | April 2004 |
| Aintree | North West | 4,115 | April 2004 |
| Wrightington | North West | 1,230 | April 2004 |

| | | | |
|----------------------------------------|------------------------|--------|----------------|
| Chase, Bordon | South Central | 700 | April 2004 |
| Royal Cornwall (Truro) | South West | 5,420 | May 2004 |
| Frimley Park | South East Coast | 7,622 | September 2004 |
| Southampton & Winchester* | South Central | 7,420 | October 2004 |
| Birmingham City Hospital* | West Midlands | 2,598 | December 2004 |
| Milton Keynes | South Central | 1,500 | December 2004 |
| Chelsea & Westminster | London | 3,670 | January 2005 |
| Good Hope | West Midlands | 2,666 | January 2005 |
| Southport & Ormskirk | North West | 3,400 | January 2005 |
| North Hampshire Phase 2 | South Central | 3,335 | March 2005 |
| Royal Orthopaedic Hospital, Birmingham | West Midlands | 2,000 | April 2005 |
| Pontefract | Yorkshire & The Humber | 1,882 | April 2005 |
| Withington | North West | 9,240 | April 2005 |
| Crewe* | North West | 3,386 | April 2005 |
| Dartford | South East Coast | 3,739 | April 2005 |
| Swindon* | South West | 6,588 | April 2005 |
| Newham Acute Hospital | London | 5,100 | June 2005 |
| Chichester* | South East Coast | 6,000 | July 2005 |
| Hinchingbrooke | East of England | 12,898 | December 2005 |
| Northumberland, Tyne & Wear | North East | 5,000 | January 2006 |
| Royal Liverpool & Broadgreen | North West | 2,585 | February 2006 |
| Kettering General | East Midlands | 3,941 | April 2006 |

* Denotes NHS Elect member

Glossary of Terms

AAGBI—Association of Anaesthetists of Great Britain

Additionality—a policy whereby ISTCs were prohibited from employing staff who been employed in the NHS in the previous six months

BMA—British Medical Association

BMJ—British Medical Journal

BOA—British Orthopaedic Association

DTC—Diagnostic and Treatment Centre

FCE—Finished Consultant Episode

GMC—General Medical Council

HCC—Healthcare Commission

HSJ—Health Service Journal

ISTC—Independent Sector Treatment Centre

ITN—Invitation to Negotiate

KPI—Key Performance Indicator

LDP—Local Delivery Plan

Minimum Take—see Take or Pay

MOI—Memorandum of Information

MRI—Magnetic Resonance Imaging

NHS Equivalent Cost—a calculation of the amount of money that would be paid to an NHS provider for delivering a certain activity in the same location as the provider with the same care pathway. It is derived from the NHS tariff, with certain adjustments made to reflect the delivery model of the independent provider

NHS Tariff—a centrally-calculated average cost for any given procedure within the NHS, generated by the Department of Health based on submissions from trusts

PbR—Payment by Results

PCT—Primary Care Trust

PEC—Professional Executive Committee

PMETB—Postgraduate Medical Education and Training Board

PQQ—Pre-Qualification Questionnaire

Revision rate—rate at which joint replacements have to be replaced a second time

RCN—Royal College of Nursing

RCoA—Royal College of Anaesthetists

RCOphth—Royal College of Ophthalmologists

RCP—Royal College of Physicians

RCR—Royal College of Radiologists

RCSEng—Royal College of Surgeons of England

SHA—Strategic Health Authority

Spot purchasing—the ad hoc use of the independent sector to treat NHS patients

Take or Pay—a contractual guarantee of minimum income, irrespective of how many procedures were performed

Tapered Take or Pay—a variant of take or pay whereby over the period of the contract there will be a reduction in the proportion of payment made regardless of whether the procedures are performed

VfM—Value for Money

Conclusions and recommendations

1. ISTCs have not made a major direct contribution to increasing capacity, as the Department of Health has admitted. It is far from obvious that the capacity provided by the ISTCs was needed in all the areas where Phase 1 ISTCs have been built, despite claims by the Department that capacity needs were assessed locally. (Paragraph 35)
2. We are concerned that the Department has attempted to misrepresent the situation by presenting the BUPA Redwood figures as procedures performed by the mainstream ISTC programme. (Paragraph 36)
3. ISTCs have had a significant effect on the spot purchase price in the private sector and on charges in the private sector more generally. (Paragraph 38)
4. ISTCs have for the present increased choice, offering more locations and earlier treatments. However, without information relating to clinical quality, patients are not offered an informed choice. (Paragraph 41)
5. ISTCs have embodied good practice and introduced innovative techniques, but good practice and innovation can also be found in NHS Treatment Centres and other parts of the NHS. ISTCs are not necessarily more efficient than NHS Treatment Centres such as Dartford. (Paragraph 49)
6. The Department claims that ISTCs drive the adoption of good practice and innovation in the NHS, but we received no convincing evidence which proved that NHS facilities were adopting in any systematic way techniques pioneered in ISTCs. (Paragraph 51)
7. The threat of competition from the ISTCs may have had a significant effect on the NHS. This factor may be the most important contribution made by the ISTC programme. However, the evidence is largely anecdotal. Waiting lists have declined since the introduction of ISTCs, but it is unclear how far this has happened because the NHS has changed in response to the ISTCs or because of additional NHS spending and the intense focus placed on waiting list targets over this period. We are surprised that the Department has made no attempt systematically to assess and quantify the effect of competition from ISTCs on the NHS. Given its importance, the Department should have ensured that this was done from the beginning of the ISTC programme in 2003. (Paragraph 56)
8. There are examples of poor care in ISTCs, as there are in the NHS. However, in the absence of the necessary comparable data from both NHS Treatment Centres and ISTCs, there is not the statistical evidence to suggest that standards are different. The Department should have ensured that such data were collected from both providers and published in order accurately to assess quality of care, complication rates and other quality measures. We are concerned that currently only eight of the 26 KPIs are clinical indicators. We welcome the Healthcare Commission's review of the quality of care in ISTCs which the Chief Medical Officer has requested. (Paragraph 72)

9. Given the difficulty in making comparisons, we are dismayed at the strident and alarmist tone of some criticisms of clinical standards in ISTCs on the basis of anecdotal evidence, highlighted by the BOA's questionable claim that there are revision rates of 2.3% in ISTCs (Paragraph 73)
10. As a result of the European legislation, the regulation of foreign-trained EEA clinicians, who make up the majority of doctors in ISTCs, is not as rigorous as it should be. The GMC made it clear to us that it had reservations about the robustness of the current regulatory system for doctors who qualified outside the UK. The fact that language tests cannot be imposed on doctors from the EEA (although they can be on international medical graduates) and that the GMC has no discretion in accepting clinicians from the EEA who are registered as specialists in their home country are causes of concern. As a result, scrutiny of a foreign-trained doctor's fitness to practise in a given set of circumstances is effectively passed on to the employers. In view of the limited role of the GMC in the accreditation of EU doctors, the appointment procedures used by ISTCs must be carefully monitored. It is essential that the Department stresses to those who employ EEA qualified doctors the responsibility they have to ensure that these doctors are proficient. As a safeguard we recommend that ISTCs use the same appointment procedures as the NHS. In addition, ISTC clinical appointments for overseas doctors should incorporate a standardised, independent assessment system based on competency. (Paragraph 76)
11. The Department admits that some ISTCs are poorly integrated into the NHS. In our view, too many fall into this category. We were informed of notable exceptions such as the Shepton Mallet Treatment Centre, which show that with the right approach it is possible to engage NHS doctors and other staff in the work of ISTCs. (Paragraph 82)
12. Even though Phase 1 ISTCs perform a relatively small number of procedures, there can be a significant local effect on the training of junior doctors. (Paragraph 84)
13. The ISTC programme is intended eventually to provide about half a million procedures per year at a cost of over £5 billion in total. This is close to 10% of the total elective workload of the NHS and would clearly affect the viability of many existing NHS providers over the next five years and possibly beyond. Moreover as the quantity of ISTC activity is not evenly balanced across the country, the impact on the budgets of different local health economies is likely to vary. (Paragraph 96)
14. The Phase 1 contracts, including the 'take or pay' elements, give ISTCs a significant advantage over NHS Treatment Centres and other NHS facilities. This is one of the reasons that several NHS Treatment Centres have spare capacity. (Paragraph 98)
15. In the longer term, there are good reasons for thinking that ISTCs could have a more significant effect on the finances of NHS hospitals. We do not know how big that effect might be or how great the dangers might be. The Department of Health has carried out analysis of the possible effects of the ISTC programme on NHS facilities, but it has refused to disclose the analysis to us. Phase 2 ISTCs may lead to unpopular hospital closures under 'reconfiguration' schemes. (Paragraph 99)

16. The cost of Phase 1 includes a premium over the NHS Equivalent Cost which was paid to the ISTC providers, but without access to the detailed figures we do not know how big this premium was. There were other costs of Phase 1, for example the effect on NHS finances. It is hard to see that this could have been justified in terms of the need for additional capacity alone. The other major potential benefit, the galvanising effect of competition on the NHS, was not and probably could not be quantified when the decision to go ahead with Phase 1 of the ISTC programme was made. It is claimed that this decision was a leap in the dark in the hope that the ‘challenge’ of ISTCs would improve efficiency in the NHS. We agree. (Paragraph 106)
17. Moreover, since we do not know the details of the contracts, what figure was used for the NHS Equivalent Cost or how it was arrived at, and since the benefits of ISTCs have not been quantified, it is also impossible to assess whether ISTC schemes have in practice proved good value for money. (Paragraph 107)
18. In view of the high degree of uncertainty about the wider benefits and costs of the ISTC programme, we recommend that the NAO investigate them, in particular the extent to which the challenge of ISTCs has led to higher productivity in the NHS. (Paragraph 108)
19. The Department has proposed a number of changes to ensure that Phase 2 ISTCs are better integrated into the NHS than those in Phase 1. We welcome the proposals to ensure better clinical engagement in all ISTCs. In addition, we recommend that Phase 2 ISTC facilities be sited in or near NHS hospitals. (Paragraph 120)
20. The Department has recognised that the additionality principle has hindered integration and proposes to restrict its application. It proposes to allow NHS consultants to work non-contracted hours in ISTCs. We welcome this and recommend that, in addition, the Department should ensure that Phase 2 contracts encourage NHS staff to be seconded to treatment centres. We also recommend that consultants be allowed to hold sessions of NHS planned activities in ISTCs where this would be thought appropriate for local service needs and to aid integration. Consultants working non-contracted hours in ISTCs should do so at NHS contract rates. (Paragraph 121)
21. If ISTCs are to be fully integrated into the NHS, the Department will need to address concerns about pay and conditions. Lower salaries and poorer pension provision in ISTCs are unlikely to assist integration. (Paragraph 122)
22. We support the Department’s decision to include the provision of training as a contractual obligation for Phase 2 of the ISTC programme. This will greatly help to break down barriers between ISTCs and the NHS. The standard of training in ISTCs should be of the same standard as in the NHS. (Paragraph 126)
23. It is difficult at present, therefore, to assess the current state of Phase 2 of the ISTC programme, or the rationale behind it. The Department of Health and the Secretary of State have, over the course of our inquiry, given answers which have shifted in both fact and emphasis as time has gone by, and the statement of the current position by the Secretary of State leaves several important questions unanswered. The decision to maintain the commitment to spend £550 million per year despite

changing circumstances has not been explained, and seems to sit uncomfortably with the Secretary of State's admission that "in other [areas] it has become clear that the level of capacity required by the local NHS does not justify new ISTC schemes". It is not clear whether this represents simply a failure coherently to articulate the situation or a more profound incoherence in terms of policy as opposed to presentation. (Paragraph 139)

24. There are real concerns that the expansion of the ISTC programme will destabilise local NHS trusts, especially those with financial deficits. ISTCs should only be built where there is a local need and after consultation with the local health community. (Paragraph 140)
25. There are major benefits from separating elective and emergency care in treatment centres. Such centres should continue to be built where there is a need and where the decision to build the centre has been agreed with the local health community following Section 11 consultation. We are not convinced that ISTCs provide better value for money than other options such as more NHS Treatment Centres, greater use of NHS facilities out-of-hours or partnership arrangements such as those at Redwood. All these options would more readily secure integration and may be cheaper. (Paragraph 145)

Formal minutes

Thursday 13 July 2006

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins

Mr Ronnie Campbell

Sandra Gidley

Dr Doug Naysmith

Mike Penning

Dr Howard Stoate

Dr Richard Taylor

The Committee considered the draft Report [Independent Sector Treatment Centres], proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 145 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Annex read and agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

Ordered, That several Memoranda are reported to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the Provisions of Standing Order No. 134.

[Adjourned till Thursday 20 July at 9.30 am

Witnesses

Thursday 9 March 2006

Page

Mr Ken Anderson, Commercial Director, and **Mr Bob Ricketts**, Head of Demand Side Reform, Department of Health Ev 1

Mr Bernard Ribeiro CBE, President, Royal College of Surgeons of England, **Mr Simon Kelly**, Bolton Hospitals NHS Trust, Royal College of Ophthalmologists, **Professor Janet Husband, OBE**, President, Royal College of Radiologists, **Dr Peter Simpson**, President, Royal College of Anaesthetists, and **Mr Ian Leslie**, President, British Orthopaedic Association Ev 13

Thursday 16 March 2006

Dr Thomas Mann, Chief Executive of Capio Healthcare UK, **Mr Mike Parish**, Chief Executive of Care UK and Director Partnership Health Group, **Mr Mark Adams**, Chief Executive Officer of Netcare UK, **Mr Peter Martin**, Chief Executive of Mercury Health, **Dr Ian Smith**, Chief Executive of General Health Care Group, and **Mr Alan Pilgrim**, Chief Executive of Alliance Medical Ev 26

Ms Anna Walker, Chief Executive, Healthcare Commission, **Professor Sir Graeme Catto**, President, General Medical Council, and **Professor Peter Rubin**, Chairman, Postgraduate Medical Education and Training Board (PMETB) Ev 39

Professor John Appleby, Chief Economist, The King's Fund, **Mr James Johnson**, Chairman, and **Dr Paul Miller**, Chairman of the Central Consultants and Specialist Committee, British Medical Association, **Dr Sally Ruane**, Senior Lecturer, Health Policy Research Unit, De Montfort University, and **Mr Daniel Eayres**, Public Health Information Specialist, National Centre for Health Outcomes Development Ev 47

Thursday 23 March 2006

Ms Jane Hanna, Former Non-Executive Director, South West Oxfordshire Primary Care Trust and **Mr Robin Smith**, Chief Executive, Mendip Primary Care Trust Ev 58

Ms Nicola Easey, Lead for the Modernisation & Commissioning Paired Leads Network, NHS Alliance, and **Mrs Pauline Quan Arrow**, Chair of Southampton City Primary Care Trust Ev 67

Dr Donal Hynes, Vice Chairman of the NHS Alliance, **Dr Tony Marsh**, Chairman of Gedling Primary Care Trust Professional Executive Committee, **Ms Valerie Smith**, Independent Sector Advisor, Royal College of Nursing, **Ms Gail Adams**, Head of Nursing, UNISON, and **Mr Barrie Brown**, Health Sector Officer, Amicus Ev 72

Wednesday 26 April 2006

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

Ev 86

Wednesday 28 June 2006

Mr Ken Anderson, Commercial Director, **Mr Bleddyn Rees**, General Counsel, Commercial Directorate, **Mr Geoff Searle**, ISTC Programme Lead, Department of Health

Ev 103

List of written evidence in Volume III

| | | |
|----|-----------------------------------------------------------------------|--------|
| 1 | Department of Health (ISTC 01C) | Ev 111 |
| 2 | Department of Health (ISTC 01D) | Ev 116 |
| 3 | Department of Health (ISTC 01E) | Ev 146 |
| 4 | Letter from Patricia Hewitt, Secretary of State for Health (ISTC 01G) | Ev 150 |
| 5 | Mercury Healthcare (ISTC 06A) | Ev 156 |
| 6 | Royal College of Nursing (ISTC 22A) | Ev 162 |
| 7 | Netcare Healthcare Ltd (ISTC 27A) | Ev 163 |
| 8 | British Medical Association (ISTC 33B) | Ev 171 |
| 9 | Healthcare Commission (ISTC 36A) | Ev 171 |
| 10 | Dr Sally Ruane (ISTC 46A) | Ev 175 |
| 11 | King's Fund (ISTC 50) | Ev 179 |
| 12 | Royal College of Radiologists (ISTC 51) | Ev 182 |
| 13 | Partnership Health Group (ISTC 52A) | Ev 186 |
| 14 | Partnership Health Group (ISTC 52B) | Ev 194 |
| 15 | National Centre for Health Outcomes Development (ISTC 53) | Ev 194 |
| 16 | Mendip Primary Care Trust (ISTC 54) | Ev 196 |
| 17 | Jane Hanna (ISTC 55) | Ev 201 |
| 18 | Dr Foster Intelligence (ISTC 57) | Ev 205 |
| 19 | NHS Elect (ISTC 58) | Ev 207 |
| 20 | BMI Healthcare (ISTC 59) | Ev 211 |
| 21 | UNISON (ISTC 42B) | Ev 213 |
| 22 | BUPA Hospitals (ISTC 60) | Ev 214 |
| 23 | Capio Healthcrae UK (ISTC 35A) | Ev 215 |
| 24 | Professor Sir Ara Darzi (ISTC 62) | Ev 218 |
| 25 | Department of Health (ISTC 01H) | Ev 219 |

List of written evidence in Volume II

| | | |
|----|---------------------------------------------------------------------|-------|
| 1 | Department of Health (ISTC 1) | Ev 1 |
| 2 | Action against Medical Accidents (ISTC 43) | Ev 35 |
| 3 | Amicus (ISTC 13) | Ev 39 |
| 4 | Association of Anaesthetists of Great Britain and Ireland (ISTC 40) | Ev 42 |
| 5 | British Association of Day Surgery (ISTC 26) | Ev 52 |
| 6 | British Geriatrics Society (ISTC 21) | Ev 53 |
| 7 | British Hip Society (ISTC 17) | Ev 54 |
| 8 | British Medical Association (ISTC 33) | Ev 55 |
| 9 | British Orthopaedic Association (ISTC 25) | Ev 61 |
| 10 | BUPA Hospitals (ISTC 23) | Ev 65 |
| 11 | Capio Healthcare UK (ISTC 35) | Ev 70 |

| | | |
|----|-------------------------------------------------------------|--------|
| 12 | Chartered Society of Physiotherapy (ISTC 7) | Ev 75 |
| 13 | Confederation of British Industry (ISTC 31) | Ev 77 |
| 14 | General Medical Council (ISTC 38) | Ev 80 |
| 15 | Healthcare Commission (ISTC 36) | Ev 81 |
| 16 | Hospital Management Trust (ISTC 30) | Ev 87 |
| 17 | Mercury Health (ISTC 6) | Ev 89 |
| 18 | Nations Healthcare (ISTC 24) | Ev 91 |
| 19 | Netcare Healthcare UK (ISTC 27) | Ev 96 |
| 20 | NHS Alliance (ISTC 41) | Ev 98 |
| 21 | NHS Confederation (ISTC 32) | Ev 111 |
| 22 | NHS Partners Network (ISTC 29) | Ev 114 |
| 23 | Postgraduate Medical Education and Training Board (ISTC 28) | Ev 117 |
| 24 | Royal College of Anaesthetists (ISTC 8) | Ev 119 |
| 25 | Royal College of Nursing (ISTC 22) | Ev 123 |
| 26 | Royal College of Obstetricians and Gynaecologists (ISTC 5) | Ev 126 |
| 27 | Royal College of Ophthalmologists (ISTC 4) | Ev 127 |
| 28 | Royal College of Physicians (ISTC 9) | Ev 135 |
| 29 | Royal College of Surgeons of England (ISTC 39) | Ev 136 |
| 30 | Society and College of Radiographers (ISTC 16) | Ev 141 |
| 31 | Sunderland Local Medical Committee (ISTC 14) | Ev 143 |
| 32 | Surrey and Sussex Healthcare NHS Trust (ISTC 34) | Ev 144 |
| 33 | UNISON (ISTC 42) | Ev 146 |
| 34 | Dr Andrew Bamji (ISTC 10) | Ev 156 |
| 35 | Robert Johnston (ISTC 11) | Ev 161 |
| 36 | Dennis McDonald (ISTC 2) | Ev 162 |
| 37 | Dr Sally Ruane (ISTC 46) | Ev 166 |
| 38 | Ruth Salisbury (ISTC 18) | Ev 168 |
| 39 | Dr David Sowden (ISTC 19) | Ev 168 |
| 40 | Mr Z (ISTC 44) | Ev 171 |

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons Library where they may be inspected by Members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1. (Tel 020 7219 3074). Hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

The Department of Health

Mercury Health Will Adams NHS Treatment Centre

Woodland NHS Treatment Centre

Capio Healthcare UK

Supplementary Information from Mercury Health

Christian Healing Workshops

Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2005–06

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| First Report | Smoking in Public Places | HC 436 (Cm 6769) |
| Second Report | Changes to Primary Care Trusts | HC 646 (Cm 6760) |
| Third Report | NHS Charges | HC 815 |
| Fourth Report | Independent Sector Treatment Centres | HC 934 |

The following reports have been produced by the Committee in the previous Parliament.

Session 2004–05

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| First Report | The Work of the Health Committee | HC 284 |
| Second Report | The Prevention of Thromboembolism in Hospitalised Patients | HC 99 (Cm 6635) |
| Third Report | HIV/AIDS and Sexual Health | HC 252 (Cm 6649) |
| Fourth Report | The Influence of the Pharmaceutical Industry | HC 42 (Cm 6655) |
| Fifth Report | The Use of New Medical Technologies within the NHS | HC 398 (Cm 6656) |
| Sixth Report | NHS Continuing Care | HC 399 (Cm 6650) |

Session 2003–04

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| First Report | The Work of the Health Committee | HC 95 |
| Second Report | Elder Abuse | HC 111 (Cm 6270) |
| Third Report | Obesity | HC 23 (Cm 6438) |
| Fourth Report | Palliative Care | HC 454 (Cm 6327) |
| Fifth Report | GP Out-of-Hours Services | HC 697 (Cm 6352) |
| Sixth Report | The Provision of Allergy Services | HC 696 (Cm 6433) |

Session 2002–03

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| First Report | The Work of the Health Committee | HC 261 |
| Second Report | Foundation Trusts | HC 395 (Cm 5876) |
| Third Report | Sexual Health | HC 69 (Cm 5959) |
| Fourth Report | Provision of Maternity Services | HC 464 (Cm 6140) |
| Fifth Report | The Control of Entry Regulations and Retail Pharmacy Services in the UK | HC 571 (Cm 5896) |
| Sixth Report | The Victoria Climbié Inquiry Report | HC 570 (Cm 5992) |
| Seventh Report | Patient and Public Involvement in the NHS | HC 697 (Cm 6005) |
| Eight Report | Inequalities in Access to Maternity Services | HC 696 (Cm 6140) |
| Ninth Report | Choice in Maternity Services | HC 796 (Cm 6140) |