

## ISTCs and the NHS

Sticking plaster or real reform?



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# Foreword

BY RICHARD LAMBERT | DIRECTOR-GENERAL | CBI



With 2008 marking the sixtieth year of the NHS, and with support from senior politicians across all political parties, it would surely seem reasonable to assume it is a fixed part of the British social scene. But the rising expectations of the public, advances in medical science, and changes in life expectancy all mean there can be no prospect of a halt to change in the NHS.

One of the most recent – and controversial – changes has been the introduction of independent sector treatment centres (ISTCs). They have been vital in helping meet the government’s 18-week waiting time target. Perhaps more significantly, the introduction of new providers into the NHS family has brought new ideas and approaches which the NHS does not always find easy to generate from within. Fundamental changes to clinical pathways have transformed the fight against infection, the use of mobile units has improved access for patients in remote areas, and new pain management techniques have allowed hip-replacement patients to start physiotherapy earlier, boosting recovery. It is clear from the patient satisfaction levels report in ISTCs that such innovations have made a positive difference to patients’ experience of the NHS. If we learn from their introduction into the system, we can be more confident that the NHS has the capacity to change.

Despite the government’s original aim for ISTCs – to change behaviour in the NHS by providing a challenge to traditional service delivery methods and in doing so to create a self-improving NHS – the recent cancellation of six ISTC schemes has provoked a debate about the government’s willingness to drive change.

We have reached a critical point in the evolution of the NHS and its use of alternative providers. Does the government learn the lessons from ISTCs about the positive role independent providers can play in providing challenge and innovation into the system? Future decisions on commissioning ISTCs will help answer the question.

In our view, ISTCs have been a success – helping drive up patient choice, introducing innovative working practices to the NHS and cutting costs. As we set out in our report, there is more we think the Department of Health, the NHS and ISTC providers must do to address some of the fundamental blocks that are preventing the full potential of this programme, such as improving procurement and needs analysis. The independent sector – including private and third sector providers – is part of the future of an effective NHS.

*Richard Lambert*

# Executive summary

The CBI's vision of the NHS is as a self-improving organisation – driven by patient choices rather than provider interest. Independent sector treatment centres (ISTCs) were introduced in 2003 as part of a package of reforms to fundamentally shift the power to patients when receiving healthcare. This report looks at the success of the ISTC programme so far and the lessons that should be drawn from this.

ISTCs offer elective (planned) and diagnostic care in dedicated units for a range of conditions such as hip and knee replacements, hernia repair and gall bladder and cataract removal. The government's intention was to encourage private capital to invest in the future of UK healthcare through a series of treatment centres, sitting alongside and offering an alternative to existing NHS hospitals.

Two waves of ISTCs were centrally procured by the Department of Health and any further centres will be procured locally by Primary Care Trusts (PCTs). Twenty-three centres plus three mobile units are now in operation under wave I of the ISTC programme, delivering in excess of 170,000 operations annually over five years and representing an investment of around 1% of the total NHS budget.<sup>1</sup>

Although small in scale, the aim of the programme was to change behaviour in the NHS by providing a challenge to traditional service delivery methods and to develop a 'self-improving' NHS. This was in recognition that the system had in the past failed to reward hospitals and other healthcare providers for responding to patients' needs, improving services and increasing productivity. Payments to healthcare providers have traditionally been based on historical budgets, and because patients did not have a choice, funding was not linked to patients' experience or to the health outcomes achieved. Because financial risk in the system has been low there was little challenge to hospitals that were performing poorly, and high-quality providers had little incentive to develop further. Indeed, an unintended consequence of this system has been that

those who managed their budgets and services poorly were in the end helped out by funds created by greater efficiencies elsewhere.

The government recognised more money would help but only systemic change could address these fundamental weaknesses and so it introduced wide-ranging reforms to link funding of NHS providers to patient choices and outcomes. The intention was to incentivise healthcare providers at grassroots level to drive performance improvements themselves because of financial imperative rather than being pushed into improvements on the instruction of central policy directives. Patient choice means improvements are pulled through the system rather than pushed through, which is a far more effective mechanism to deliver positive change.

In terms of patient care, ISTCs are an NHS success story. Independent assessment shows that as well as providing high-quality clinical care, they are scoring very highly in patient satisfaction surveys.<sup>2</sup> ISTCs have increased efficiency and productivity – thereby reducing waiting lists – through innovations in technique, work organisation and building design. ISTCs deserve to be championed as an example of how excellence in the NHS can be achieved.

The programme also demonstrates that when the independent sector is commissioned and contract-managed effectively, it can deliver the desired results. But when procurements for these centres are delayed and poorly specified, and when centres are set up without buy-in from local NHS providers, projects are unlikely to be a success. This is reflected in the utilisation rates for the centres. Wave I centres are providing an average of 84% of contracted patient procedures. This ranges from 102% in one centre to 48% in another – largely because of poor initial needs analysis and demand projection, resulting in flawed commissioning and procurement and local NHS resistance to ISTCs being introduced. If a centre can achieve over 100% utilisation, we need to look at how it

has done this and to reproduce the conditions in other areas. This also means the provider has to be flexible, and willing to adapt to changing environments by changing the case-mix when it is reasonable and possible to do so.

The procurement of wave II ISTCs by the Department of Health has been beset with delays and uncertainties. Of the 27 schemes originally intended, only nine are going ahead. Five schemes were cancelled in 2006 and a further six in November 2007. The remaining seven contracts are under review until March 2008. Independent sector providers selected as preferred bidders have had to wait up to three years before knowing whether their service offer is going to be contracted or not. This is after investing significant time and money entering into contractual agreements, buying equipment and ensuring people are trained – time and resources that could have been better spent.

We fully agree the Department of Health should only go ahead with schemes that achieve value for money, but this must be joined up with the government's original intentions for the ISTC programme: to change NHS behaviour on putting patients' needs first, to reduce waiting lists to meet government targets, and to reduce reliance on spot purchasing – thereby improving value for money. It must recognise and accept accountability for the fact that this assessment of value for money should have happened prior to starting the procurement process and committing significant resource to it, not in the later stages.

The contestability, quality of care, and innovation ISTCs introduce into the system are beginning to lead to reduced waiting lists, improved NHS productivity, and increased patient right to choose a healthcare provider. But they have the potential to achieve much more for the NHS. This is more than just increasing capacity – ISTCs are a long-term change-agent, not a short-term fix.

The CBI believes ISTCs should continue to play a key role in NHS reform.

The real blockages to the ISTC programme are more fundamental than the procurement process itself, and it is these that must be tackled if the independent sector is to be able to contribute challenge and innovation to the system. Resistance to reform and the continued protection of traditional NHS provider interests means patient choice remains limited. This mindset risks undermining the government's declared intention of fully implementing 'free choice' from April 2008.

A system built around informed patient choice could achieve the goals of the original ISTC programme. Assuming ISTCs are commissioned correctly, in the right places, and with value for money, under-utilisation can then stem from a lack of patient knowledge. If patients know about ISTCs they are likely to want to go to them, because patient surveys show very high satisfaction rates.

The programme has created an opportunity for providers to develop innovative working practices thereby offering patients a real alternative within the NHS. This differentiation is critical to giving patients a choice of provider, which in turn encourages providers to offer more patient-responsive services. But the Department of Health and NHS commissioners should be required to commit to ISTCs as long as the centres are achieving the outputs they were procured to achieve. There should be no shifting of goalposts. In other words, ISTCs are part of the NHS and should be considered as such by the rest of the NHS.

This report sets out the following:

- ISTCs are an NHS success story for patients
- Changing behaviour in the wider NHS remains key
- Real patient choice could create a self-improving NHS.

The recommendations we make are targeted at the Department of Health and ISTC providers:

- 1 Mechanisms of patient choice should be improved with information provided to patients directly
- 2 GPs and PCT commissioners should be incentivised to refer patients to ISTCs
- 3 Opportunities to co-operate should be explored by both NHS and ISTC providers and piloted
- 4 Independent decisions on the NHS tariff and the NHS funding formula should be made
- 5 Patients must be allowed to choose any accredited provider that meets NHS tariff costs
- 6 The market should be regulated in an independent and transparent way.

We also recommend the government acts immediately to lead all stakeholders in the same direction in the interests of patients by strongly articulating its vision of NHS reform. The report to be published by health minister Lord Darzi in spring 2008 provides an ideal opportunity for this.

# 1 ISTCs are an NHS success story for patients

The government's NHS Plan, published in 2000, recognised the UK was lagging behind many European countries on indicators such as equity of patient access to health services, life expectancy and waiting times for treatment. It also recognised that the NHS was facing unprecedented demands from an ageing population, technological advancements and rising costs. These pressures remain and it is essential that productivity increases if the NHS is to meet reform challenges without the growth in the level of public spending to which it has become accustomed.

The ISTC programme was introduced in 2003 and aimed to:

- Facilitate patients' right to choose a healthcare provider and therefore encourage more patient-responsive services
- Stimulate improved efficiencies and patient responsiveness in NHS providers through contestability
- Reduce the costs of spot purchasing from the independent sector
- Introduce additional capacity by providing facilities and staff at a much quicker rate than the NHS could manage.

As dedicated and streamlined facilities, ISTCs can offer patients scheduled procedures allowing them to book appointments and return home quickly. Because they are specialised separate units, they are not affected by emergency or seasonal demands and have ring-fenced staff, facilities and operating theatres. The separation of elective from emergency procedures has been advocated by clinicians since the 1990s, and helps provide additional capacity, allows better planning and scheduling and reduces waiting lists by increasing productivity.<sup>3</sup>

ISTCs are an NHS success story for the following reasons:

- Patient satisfaction and care outcomes are very high for ISTCs
- Innovations in techniques and organisation show excellence can be achieved
- Rationalisation of purchasing has reduced spot purchasing prices.

## Patient satisfaction and care outcomes are very high for ISTCs

Although it is not easy to make comparisons, ISTCs are independently outperforming NHS institutions on a number of indicators:

- **ISTCs offer patient-centred care** and this is reflected in independent surveys. Patient satisfaction is generally high for NHS provided care, averaging 89% across all NHS acute trusts,<sup>4</sup> but is even higher in ISTCs, averaging 97.3%.<sup>5</sup> Again, most patients (81%) in NHS hospitals 'always' have confidence in their doctor, but 96% of ISTC patients felt this<sup>6</sup>
- **ISTCs have implemented several new working methods** to measure and increase patient satisfaction. In many centres, patients are offered a survey covering up to six aspects of care, and are repeatedly surveyed throughout their stay by an easy-to-use electronic tool. Patients can register satisfaction and dissatisfaction easily at various points in their visit. It is also common for patients to be called 24 hours after discharge for a mini check-up and to answer any questions they may have<sup>7</sup>

- **ISTCs are successful at offering short referral-to-treatment times.** This is due to well-designed clinical processes – for example, many centres are one-stop-shops offering consultant appointment, MRI scan, consultant follow-up, a pre-operation assessment and the opportunity to book surgery in one out-patient visit. To increase their attractiveness to patients living further afield, some ISTCs have amended the arrangements for pre-operative care by reducing the number of trips that have to be made to the centre before treatment.<sup>8</sup> Twice as many patients in ISTCs are given a choice of admission dates than in NHS centres and around 10% more patients do not receive any changes to their admission date in independent centres<sup>9</sup>
- **Complication rates are either lower in ISTCs than in NHS run institutions, or there is no significant difference.**<sup>10</sup> ‘Complication rates’ refers to the likelihood that patients will suffer from further health problems after they receive treatment. Emergency readmission rates are a useful indicator of treatment quality and of discharge processes and these are significantly lower in ISTCs than

the NHS. ISTCs use several strategies to reduce complications. For example, one centre holds a weekly forum for discussing complications, with consultants reviewing major procedures performed that week and any minor procedures in which there was a complication. This led to differences in clinical practice between doctors being quickly identified and best practice shared

- **Patients agree that ISTCs are generally cleaner than NHS facilities,** with cleanliness of toilets, bathrooms, rooms and wards rated at 99% satisfactory.<sup>11</sup> And this is backed up by statistics, which show that hospital-acquired MRSA infection rates are extremely low in ISTCs. A case study of three centres found there had been no cases of hospital-acquired MRSA detected over a 12-month period. Whereas MRSA prevalence among admitted patients is 0.06% in the NHS, it is only 0-0.04% in the three ISTCs studied.<sup>12</sup> This is largely because most ISTCs screen patients for MRSA at the outpatient visit.

#### CASE STUDY 1

#### Delivering excellent patient care: Runcorn ISTC

- **Innovative working practices have improved patients’ experience**
- **No cases of patients contracting hospital acquired MRSA and Clostridium difficile.**

Runcorn ISTC is a diagnostic and treatment centre which opened in June 2006. The centre is one of two operated by the independent company Interhealth Canada with the other situated at Kidderminster. The centre has seen 4,500 surgery cases and 15,000 outpatients over the last year. It aims to discharge patients within 13 weeks of their referral.

Care is of a high quality before, during and after the procedure. The post-operative complication rate is almost zero. But rather than stand still, the centre has adopted several new improvements. For instance, on being admitted to the centre, patients are immediately screened for MRSA. Even though the centre maintains a 0% MRSA and Clostridium difficile rate, it is planning to introduce a state-of-the-art air filtration system to prevent any risk of infection occurring in the future. Furthermore, the centre

now completes five procedures in the time it takes an equivalent NHS centre to do two or three.

Introducing innovative working practices has been crucial to the success of the centre. The passage of clean and dirty materials is separated at all times by a revolutionary but simple workflow system. Another system makes sure only clean air enters operating theatres, with dirty air expelled to prevent infection. The building is designed in a square ‘doughnut-shape’, which helps control the clean and efficient movement of patients, staff and surgical waste around the facility. By standardising prostheses in conjunction with surgeons, the centre achieves lower procurement costs – an estimated 55-70% of typical NHS trust costs, in spite of their larger volume. This has further advantages as standardising theatre processes can reduce risk of errors.

There is one manager responsible for in-patient, out-patient and day care, providing a more over-arching and efficient governance framework. Day care patients are consulted by a nurse, who assesses whether they require help at home following the procedure.

### Innovations in techniques and organisation show excellence can be achieved

Not only are ISTCs offering high-quality patient care, they have also led by example by improving productivity and introducing new and innovative work practices in the wider NHS. These will help considerably towards meeting the government's 18-week waiting time target. They have achieved this while driving value for money and reducing the cost of purchasing from the private sector.

The ISTC programme has given new providers the opportunity to introduce innovative new working methods to routine procedures – for example, as with the Shepton Mallet treatment centre (see case study 2). Differentiation of service provision comes largely through the independent sector's willingness to innovate and adopt best practice from around the world. The programme has also acted as a springboard for discussion on how to improve processes more generally in the NHS. Innovations range from the physical layout of facilities to elements of administration and clinical practice, including:

- Mobile units delivering healthcare services which can improve access for patients in remote areas
- Construction of new facilities designed around patient pathways, which increases productivity
- Process design, to improve the patient's experience
- Taking extraneous administrative processes off-line so surgery is not delayed
- Multi-tasking the workforce to make optimal use of staff resources – eg Blakelands NHS Treatment Centre (see case study 3)
- Administering local rather than general anaesthetic for primary joint replacements which reduces the risk from the anaesthetic and the length of stay of the patient to an average 5.3 days from eight days experienced in the NHS<sup>13</sup>
- Using effective pain management techniques to allow post-operative physiotherapy to start earlier, thus reducing length of stay – eg Boston and Gainsborough NHS Treatment Centres (see case study 4).

#### CASE STUDY 2

#### Offering a real alternative: Shepton Mallet Treatment Centre

- Tailored patient support reduces patients' length of stay in the centre
- Operating a one-stop clinic offers efficient and convenient patient support.

UK Specialist Hospitals' Shepton Mallet Treatment Centre (SMTC) provides inpatient joint replacements. From first contact the patient is put in control, choosing the date for their appointment, leading to a below-average length of stay. SMTC is run as a one-stop clinic with surgeon, nurse and physiotherapy assessments, imaging as required, and the start of the patient's treatment.

The required equipment aides are then ordered and delivered one week prior to surgery. This one-stop visit allows for prompt and timely decision making, and most patients leave having chosen their date for surgery. Mobilisation starts as soon as possible after surgery and is tailored to meet mobility targets. The average length of stay for both hips or knees at SMTC is four days and only 5% of patients require any community or ongoing physiotherapy care. This is due to the type of anaesthesia and pain relief used, as well as intensive physiotherapy support.

## CASE STUDY 3

## Innovative workforce management: Blakelands NHS Treatment Centre

- **Breaking down professional boundaries has improved patient care**
- **Regular staff consultation has helped deploy resources better.**

Run by the independent sector company Ramsay Health Care UK, this purpose-built centre opened in 2006 in Milton Keynes to treat patients requiring day case orthopaedic procedures to hands and general surgical procedures. The centre has been very successful in innovating working practice, staff organisation and techniques. Good communication is paramount. A staff feedback channel ensures lessons and problems are shared and discussed openly. Processes are constantly reviewed and improved in line with staff and patient feedback.

The centre conducted a workforce analysis review which identified available resources not being used – for example, staff time and skills. This led to an operational four-day week which allows effective use of the theatre, staff times and maximises the use of resources. Fridays

are administrative days, focusing attention on administration, training and meetings. These measures have promoted a time management culture within the centre.

Staff are now multi-skilled throughout the unit to maximise resources, for example:

- The physiotherapist carries out suture removal and completes 24-hour follow-up calls. He is trained and competency assessed for 'nurse' clinic which provides consistency to follow up consultations
- The radiographer supports the administrative team by co-ordinating the scanning of medical files
- Nursing staff follow patients through their pathway from clinic appointment to admission, recovery, and discharge to minimise risk and provide continuity of care
- In the management team, the clinical lead is also the administrative lead, which allows a high level of senior lead involvement throughout the patient's treatment.

Given the slowdown in NHS funding from next year onwards and increasing demand, improvements in productivity and efficiency will be key. By providing a challenge to existing providers, and introducing innovative working practices, ISTCs have the potential to increase the number of patients the NHS can treat with the same resources.

Innovative working practices mean ISTCs perform better than NHS-run centres on productivity measures. Length of stay is consistently lower in ISTCs – for example, the average stay is 4.5 days for joint surgery in the Runcorn ISTC, compared with eight days in an NHS trust. A reduced length of stay is an advantage, reducing the risk of becoming institutionalised and mobilising the patient quicker. Much of this is the result of multi-disciplinary working between anaesthetists, surgeons, nurses and physiotherapists – for example, to use anaesthetic and pain relief techniques that enable physiotherapy to start often on the day of surgery. Reducing length of stay is a worldwide trend which the UK is still behind. This is

an example of ISTCs proving themselves to be adept at picking up international best practice. This increase in productivity is crucial. A sustained 1% improvement in NHS productivity is predicted to generate £750m savings even if confined to elective care.<sup>14</sup>

In 2006, The Health Select Committee stated that competition from ISTCs may have had a significant effect on improving NHS services, and that this may be one of the most important contributions of the ISTC programme.<sup>15</sup> This is supported by a growing quantity of evidence. Somerset PCT (formerly known as Mendip PCT) claims that the establishment of an ISTC has given its commissioners leverage over local NHS trusts to reduce their waiting times: two acute hospitals in the area subsequently improved performance without extra resources, and one is now likely to reach the government's goal of 18 weeks waiting time this year as a result of these efforts.<sup>16</sup>

## CASE STUDY 4

## Introducing innovative clinical work practices: Boston and Gainsborough Treatment Centres

- **Implementing international best practice to reduce patients' length of stay.**

Boston and Gainsborough NHS Treatment Centres in Lincolnshire, run by the independent company Ramsay Healthcare UK, have recently implemented new techniques for general anaesthesia to improve comfort and recovery times for patients. TIVA/TCI (total intra-venous anaesthesia/target controlled infusion) is a technique recently incorporated into the organisation's protocols. TIVA/TCI dramatically reduces patients' symptoms of post-operative nausea and vomiting. By decreasing the

level of anaesthesia, this technique also lowers the risk of anaesthetic reaction.

The process significantly lessens the time before patients regain consciousness – therefore cutting their recovery time – and also reduces the time before discharge, so the overall patient pathway through treatment is substantially lower. Monthly key performance indicator reports have demonstrated this improvement, and the many benefits to the patient and the unit were realised immediately on adoption of the new techniques.

Providers who previously had a secure, constant patient flow are now aware that there are other ways that PCTs can commission services – and that they will have to improve their performance to keep attracting the same number of patients.<sup>17</sup> The increase in capacity from the independent sector has affected the system as a whole by encouraging greater productivity in incumbent providers. Oxford Radcliffe Hospitals NHS Trust, for example, highlighted the competitive threat that ISTCs present in a recent strategic review, concluding that unless the trust focused on patient satisfaction, patients might choose to go elsewhere.<sup>18</sup> Another trust chose to commission an in-depth study into the productivity improvements that the local ISTC had created.

Robin Smith, Chief Executive of Mendip PCT (as it was formerly known), stated that he sees ISTCs as a “...*tool to delivering fast and appropriate patient care when we need to and at the time we need it. Cataracts in our area are no longer a problem. You were waiting 15 months two years ago...there should, in my view, always be an opportunity to test the way we work and challenge the way we work such that we are getting best value all the way through and all the time. The best way to improve performance is to introduce a degree of challenge.*”<sup>19</sup>

### **Rationalisation of purchasing has reduced spot purchasing prices**

Integral to the ISTC programme is the drive for value for money. In 2003-4 the NHS bought 99,000 operations from private providers locally through spot-purchasing. The ISTC programme provides the opportunity, however, for activity to be bought in from the independent sector in bulk, driving down prices and eliminating the premiums that resulted from ad-hoc procurement. The Health Select Committee concluded that ISTCs have had a significant effect in lowering spot purchasing prices.<sup>20</sup> For example, prices fell from £1,815 per finished consultant episode (FCE) in 2002/3 to £1,425 per FCE in 2003/4 – a trend consistent with the move from ad hoc purchasing from the private sector to block purchasing of care under the ISTC programme. In the Somerset PCT area alone, fees for some operations fell by as much as 50% as a result of the existence of ISTCs.<sup>21</sup> This translated into savings for the PCT of £1.2m in 2005/06 because:

- There was no longer a need to undertake as much spot purchasing
- Activity from the local private sector providers was being purchased at the NHS tariff – leading to a reduction in service costs of 20-30%
- Local acute trusts have been incentivised to deliver reduced waiting times without additional investment from the commissioning PCTs.<sup>22</sup>

Another way of achieving value for money is by attracting new providers to the market. The Department of Health believed the UK base of independent sector providers was too narrow to offer the competition needed and ensure innovation and best practice. ISTCs needed an incentive to enter the market and so wave I providers were awarded an average 11.2% premium on costs. This is relatively low considering the costs of competing with a very well established monopoly provider. The longer-term gains in achieving value for money will more than compensate for this additional upfront cost. The contracts closed in wave II

have been set at the NHS tariff price, which is impressive considering the programme is only five years old.

ISTCs also had to compete with NHS consultants' additional work in private medicine. Paying over tariff for wave I has therefore also driven down consultants' private fees. In 2004, the BMA Private Practice Committee said consultants would in future have to accept earning 70 to 80% of their normal private practice fee in return for a guarantee of significant volumes of work.<sup>23</sup>

#### CASE STUDY 5

#### Taking the pressure off the NHS: St Mary's NHS Treatment Centre

##### ■ Integration with the local health economy relieves pressure on neighbouring NHS services.

Working in partnership with Portsmouth City Teaching Primary Care Trust, a consortium comprising the companies Care UK and Mercury Health built and now runs a community based multi-purpose ISTC, which includes a minor injuries unit and walk-in centre. The centre works closely with the A&E department at Queen Alexandra Hospital, Portsmouth, as part of its integration

with the south east Hampshire emergency network. The minor injuries unit is an entirely nurse-led facility and NHS staff are seconded and rotated as part of the unique network partnership.

The minor injuries unit and walk-in centre provide an alternative to GP and A&E services. These can treat up to 130 patients a day and so should take some of the pressure off NHS services in the Portsmouth area.

## 2 Changing behaviour in the wider NHS remains key

The ISTC programme was originally designed to provide 15% of the NHS's elective care capacity. This was considered big enough to achieve a sustainable independent sector market, and to provide a small but significant challenge to existing NHS practice. But the original programme is being scaled back and after wave II procurement is complete, ISTCs are likely to make up only 5% of the NHS's elective care capacity. The programme is valued at approximately £210m a year, as opposed to the originally envisaged figure of £700m a year over five years.<sup>24</sup>

The government's justification for scaling back on wave II of the programme is that some wave I centres are not treating the number of patients as contractually specified and the extra capacity provided under the planned wave II contracts is no longer needed by the NHS. But the aims of the programme were not just to increase capacity, but to encourage positive behavioural changes in the wider NHS. The ISTC programme has already begun to achieve value for money throughout the NHS by increased productivity and innovative work practices, and there is potential for more. Scaling back the programme means wider benefits to the NHS are unlikely to be achieved. With the threat of an ISTC being introduced into an area diminished, NHS providers are likely to revert to former practice. For instance, CBI members are reporting a revival of spot price purchasing from the independent sector. Reducing the number of centres also reduces patient choice and risks the NHS failing to meet the 18-week waiting time target.

There is under-utilisation of some centres, but this is a symptom of poor integration of the centre into the local health economy. There is much scope to improve integration, and success has already been achieved in some areas. This means the ISTC programme can still achieve its original objectives by providing the crucial internal challenge to the NHS, but this depends on whether unimpeded and informed patient choice really does drive NHS improvements.

This section suggests:

- The ISTC programme is not going to reach the capacity originally intended
- Curtailment risks failing to achieve the original aim of changing NHS behaviour
- Under-utilisation of centres reflects poor commissioning and this could be addressed.

### **The ISTC programme is not going to reach the capacity originally intended**

When designing the ISTC programme, the Department of Health had to take a decision on how big the pool of providers needs to be to sustain a healthy, competitive market and therefore to challenge the wider NHS to continually improve. A new market of ISTC providers was intended to deliver up to 15% of the total NHS elective demand and able to react to short-term changes on requirements. This was to achieve a sustainable market, and to provide a small but significant challenge to existing practice.

Waves I and II were estimated at around 7 or 8% of elective care in 2006, but this is before wave II was cut back.<sup>25</sup> We can therefore estimate that the ISTC programme is only likely to reach 5% of the total NHS elective care capacity. A total procurement programme of 27 wave II ISTC schemes officially went to tender in 2005. Four wave II diagnostic schemes reached financial close in December 2006 (north west, south west, London and West Midlands) and two wave II elective schemes reached financial close in 2007— Cheshire and Merseyside in May 2007, and Northumberland, Tyne & Wear in June 2007. Five schemes were cancelled in 2006. The remaining 16 schemes, all at preferred bidder phase, were revalidated by the Department of Health in light of new capacity planning.

The government announced its intentions on the 16 phase II ISTC contracts under review in November 2007, three years since the beginning of the procurement. Of these 16, six have been cancelled, three are going forward and seven are subject to further review. We are unlikely to know of the future of the remaining seven schemes until March 2008.

### **Curtailed risks failing to achieve the original aim of changing NHS behaviour**

The government has justified the scaling back of planned projects on the basis that extra capacity is not needed by the NHS. But the ISTC programme was intended to do more than merely increase capacity: it is a long-term change agent to provide competitive pressure within the NHS with the aim of increasing productivity and innovation. The CBI agrees the Department of Health should only go ahead with schemes that can achieve value for money, but this curtailment does not support the government's original intentions. The contestability, quality of care, and innovation ISTCs introduce into the system are beginning to reduce waiting lists, improve NHS productivity, and increase patients' right to choose a healthcare provider. But they have the potential to do much more and only a sustainable ISTC market will achieve the following goals:

- A tangible choice for every patient
- Innovation and knowledge transfer to the NHS
- Competitive pricing maintained across all regions of the country.

This means ISTCs have to be sustained to be effective. Scaling back wave II projects and an unwillingness to commit to further investment in ISTCs will have a detrimental impact on patient choice and could mean the 18-week waiting time target will not be met.

The government has promised that by the end of 2008, no patient will have to wait more than 18 weeks from referral to treatment. The clock starts ticking at the patient's point of contact with a GP, and covers diagnostics as well as the wait for treatment. Achieving the target will take a quantum leap for the NHS because it measures the time from a patient's perspective rather than hospital waiting lists. A great deal has been done internally to increase clinical capacity but more needs to be done to meet the target and create a fundamental shift in delivering for patients.

At the same time, we support the department's flexible approach to allowing patients to choose when to start, pause or stop their 18-week treatment time under the 18-week national clock rules.<sup>26</sup> But the aims of the target should not be watered down – ISTCs and the independent sector can make the critical difference is achieving it. The system needs to be challenged to perform better by introducing new ways of working. Stimulating 'constructive discomfort' is a stated aim of government policy in order to unlock a system that may not change rapidly enough to satisfy patients and the taxpayers who fund the NHS. Independent sector providers challenge traditional ways of working and are fundamental in shifting power to patients and facilitating choice.

As soon as the threat of an ISTC is diminished, NHS providers are likely to revert to former practice, which without competitive pressure is less efficient. For instance, spot prices are being reintroduced. The initial introduction of the ISTC programme had the effect of almost entirely wiping out over tariff spot purchasing from the independent sector. Most spot purchasing is now at tariff prices so this in itself is a success, but the Department of Health had originally intended to bring spot purchasing to an end. This is because although private hospitals with spare capacity will provide procedures at tariff price, if that capacity is reduced, the cost of procedures is likely to go up – thus taking the NHS back to square one.

### **Under-utilisation of centres reflects poor commissioning and this could be addressed**

The average utilisation rate for wave I ISTCs is 84%, with individual centres ranging from 48% to 102%.<sup>27</sup> Because of five-year block contracts, ISTCs with less than 100% utilisation are accused of being paid for doing nothing. But it is more the case that they are paid whether the NHS refers patients to them or not. Under-utilisation is largely due to poor initial needs analysis and demand projection, resulting in flawed commissioning and procurement and local NHS resistance to ISTCs being introduced. All these factors can be eliminated, or at least reduced to a minimum.

When stakeholders are brought on board, when GPs and consultants are clinically engaged, schemes are much more likely to go well. In some areas, the Department of

Health's national implementation team visited communities where an ISTC was being developed, staying in the local area and talking to local health professionals. This type of good practice is helpful, but it was not the standard in every area. As a result, local clinicians in primary and secondary care in some areas have felt disengaged by the lack of meaningful dialogue regarding local clinical issues and their willingness to work with the ISTCs.

Capacity planning is difficult to predict in healthcare, but the Department of Health has new policies to support the NHS in using ISTCs effectively and to recover previous under-utilised activity where possible, including:

- **Referral management centres.** These are now being used by some PCTs, with the aim of enabling activity to be brokered from neighbouring health communities to ensure monthly 'minimum take' is fully utilised
- **Re-profiling and re-basing.** The Department of Health is working with PCTs and independent providers where there is under-utilisation. In many cases this results in moving activity to a later stage in the life of the contract.

For example, the South West Strategic Health Authority and the Department of Health are working closely to ensure Royal Cornwall Trust transfers waiting list patients to Bodmin ISTC to achieve an 18-week wait. In addition, a contract change has been agreed to allow the ISTC to treat patients needing diagnostic endoscopies to achieve a two-week wait in cancer referrals, and the provider (Ramsay Healthcare UK) is targeting GPs with a marketing campaign to improve direct referrals. Interhealth Canada has agreed with the local PCT that the Runcorn ISTC will treat patients in year two of the contract to make up for under-utilisation in year one.

This demonstrates that more can be done to resolve under-utilisation and to realise the potential benefits of ISTCs in terms of wide-scale NHS reform.

### 3 Real patient choice could create a self-improving NHS

The government has invested approximately £2bn in the ISTC programme but this investment is at risk of being wasted if the programme does not achieve sufficient size. The real blockages to the ISTC programme are more fundamental than the procurement process itself, and it is these that must be tackled if the independent sector is to be able to contribute challenge and innovation to the system. Resistance to reform and the continued protection of NHS provider interests means patient choice is limited and the NHS remains rooted in outdated and inefficient practices.

Patients need more information to make informed choices and their choice should be unimpeded. PCT commissioners and GPs should not be able to block patients from choosing independent providers for fear their established ways of working will be threatened. We therefore target our recommendations at the Department of Health and ISTC providers by suggesting:

- Properly informed patient choice would improve under-utilisation of ISTCs – if patients knew about the high quality of care, they would choose ISTCs
- Unimpeded choice will incentivise all providers to develop patient-responsive services.

#### **Properly informed patient choice would improve under-utilisation of ISTCs**

There is immense choice in our everyday lives – from banking to retail to utilities. In healthcare, choice means patients should have a say in when and where they are treated, and to some extent how they are treated. Their decisions may be based on a wide range of personal factors. The policy of choice gives patients the right to choose their NHS provider, both as an end in itself and also more fundamentally as a means to ensure providers focus on delivering things that really matter to patients – for example, fast responsive treatment times, high-quality

care, focus on patient experience and satisfaction, and cleanliness. Choice is also the mechanism that allows patients to hold healthcare providers to account – if they are not happy with the service they receive, they will go elsewhere next time they need treatment. But for this to work effectively, patients must have a genuine choice between providers.

By providing tangible options in terms of when, where and how the patient receives treatment, the independent sector is fundamental to the choice agenda. Since 2006, patients have been able to choose from at least four providers – from the NHS and independent sector – for their first consultant-led appointment. Some PCT choices will already include an independent sector option, but not all do and if this continues, the NHS risks increased inequality in levels of innovation and productivity across the country.

Although the Patient Choice policy is officially up and running, the programme to deliver it is actually stagnant – more patients are aware of choice but fewer are being offered it by GPs. The 2007 Department of Health patient survey found:

- For the first time in the survey series, there was a reduction in the percentage of patients recalling being offered a choice of hospital for their first outpatient appointment: 44% in May – down from 48% in March although this was up from 30% in the first (May/June 2006) survey
- Thirty-eight percent of patients were aware before they visited their GP that they had a choice of hospitals for their first appointment – up from 37% in March and 29% in the 2006 survey.

Patient satisfaction with ISTCs is very high, so it is fair to assume that the quality of care provided would attract sufficient patients. But many people are still unaware of the right they have to choose and of the option of being treated in an ISTC.

Patients should have the right to choose the service most suited to their preferences and this is largely reliant on patients having access to meaningful comparative information on which they can make an informed decision. This does not exist at present. For instance, the Healthcare Commission states: *'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.'*<sup>28</sup>

## RECOMMENDATION 1

### Mechanisms of patient choice should be improved with information provided to patients directly

The Department of Health should first unify the NHS and independent sector information collection regime. The Department of Health also needs to collect system wide data to determine the impact ISTCs have on health economies. This will assist PCTs, SHAs and GPs in their commissioning roles. ISTC providers themselves need to be proactive and quantify their activity and volumes to show how they can add value. ISTC data should be shown separately as well as part of unified data collection. This will highlight the clinical effectiveness and high patient satisfaction achieved by ISTCs.

### Unimpeded choice will incentivise all providers to develop patient-responsive services

Confident patients with the information to choose their preferred service provider and challenge poor provision will drive improvement from within the NHS itself, rather than having to rely on central government directives to drive improvements through target-setting. But choice, as well as being informed, must be unimpeded. This means there should be no obstacles for providers offering the most patient responsive care, and no obstacles for patients choosing them. Increased information tackles the latter, but to address the former, all accredited providers should be allowed to compete on the basis of patient needs – not the needs of politicians, clinicians, commissioners,

managers or providers. With this common goal, integration of ISTCs into local health economies would not be a problem. In fact, other European Union countries such as, France, Germany, Sweden, achieve very low patient referral to treatment times and high patient satisfaction through unimpeded choice in this way.

The NHS should move towards a level playing field with all providers operating at NHS tariff or NHS equivalent costs, and being compared solely on quality and access by patients. This means an equal set of rules for all providers including transparent procurement processes and equal levels of taxation and regulation.

For this to happen, the following are required:

- Better integration with local health economies
- Any accredited provider must be able to compete to offer services on a level playing field.

### Better integration with local health economies

The government has admitted *'...integration between ISTCs and the NHS has not yet reached the level we should hope for. This has limited the flow of innovation and best practice from the independent sector to the NHS and vice versa.'*<sup>29</sup> But there are examples of best practice in the integration of ISTCs. For instance the Health Select Committee highlighted the example of Shepton Mallet ISTC, where *'...widespread consultation, clear care pathways and co-ordinate[d] referrals [ensured] a high degree of integration between local PCTs, NHS staff and ISTCs.'*<sup>30</sup>

It is difficult for ISTCs to achieve contractual utilisation rates if GPs will not refer patients to the centres. Some GPs and PCT commissioners are blocking patients from choosing independent providers by not offering the appropriate information, fearing that their established ways of working will be threatened.<sup>31</sup> This restricts patient choice, distorts competition and undermines the principle of providers competing to deliver the most patient-responsive care.

There are good examples of co-operative approaches between ISTCs and NHS providers. For instance, the Gainsborough NHS Treatment Centre shares facilities with the John Coupland Hospital. There is a close and co-operative approach between the centre and the hospital to ensure services run side-by-side and complement each other and, wherever possible, equipment is purchased for joint use to maximise resources.

The policy of additionality, which restricted wave I centres from employing staff who had worked for the NHS over the previous six months, ‘... has made integration between the NHS and ISTCs more difficult.’<sup>32</sup> One ISTC provider told the Health Select Committee: “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.”<sup>33</sup> Although recruitment is more flexible under wave II, staff mobility is an important measure of integration and opportunities to improve it should be explored.

While the reduction in spot purchase prices has been clear, the ‘take or pay’<sup>34</sup> element of the contracts for ISTCs in wave I has been controversial. This added incentive was needed to encourage international providers to enter the market and to encourage wider market development. The position in wave II, where the ‘take or pay’ element will be ‘tapered’,<sup>35</sup> is more desirable and schemes will eventually have to operate at the payment by results tariff if they are to survive beyond the five-year contracts. ISTCs should receive the tariff for the patients they treat as the NHS-run institutions do. Most operators would be willing to continue at the end of five years at NHS tariff, and without guarantees of volume, provided patient choice is allowed to operate unimpeded.

Some critics suggest that if ISTCs operate on a tariff basis, their high-volume routine procedure caseload will allow them to capitalise on income and destabilise local NHS trusts which rely on this type of work to fund more complex, costly procedures. But the tariff can be restructured if necessary to prevent this happening. Complex care should be rewarded appropriately. Continuous, independent review would ensure more complex care is not disadvantaged.

## RECOMMENDATION 2

### GPs and PCT commissioners should be incentivised to refer patients to ISTCs

The Department of Health’s *Principles and rules for co-operation and competition* is intended to ensure that no provider is inappropriately excluded from offering patient services and from being listed on the Choose and Book website.<sup>36</sup> Although the CBI sees the recent publication of this document as a positive move, it is yet to be proved that a set of principles will have the desired effect on managing the market.

The Department of Health should continue to explore more proactive policy options, such as including a referral target in GP’s performance measurement system, the quality and outcomes framework (QOF). This could incentivise GPs to see the integration of all NHS service providers within their local health economies as crucial to the service they themselves provide. GPs and ISTC providers must equally take responsibility for communicating effectively with each other.

## RECOMMENDATION 3

### Opportunities to co-operate should be explored by both NHS and ISTC providers and piloted

This includes training opportunities and requires an integrated NHS work environment in which staff are not restricted from working across the NHS and ISTCs.

## RECOMMENDATION 4

### Independent decisions on the NHS tariff and the NHS funding formula should be made

It is important the tariff is set with a view to improving the efficiency of providers across the health service, rather than political motives being dominant. But it should not be set on the basis of the average cost of performing procedures for the most efficient providers – this would cause too much stress in the system. Rather, it should be recognised that there will always be a normal distribution of efficiency, and the tariff should be set with the aim of achieving the optimal efficiency.

### **Any accredited provider must be able to compete to offer services on a level playing field**

The government has committed the NHS to the goal of patients being able to choose their healthcare from a plurality of providers. Therefore, the government must also commit to the operation of a well-functioning provider market that competes in the interests of patient care. The benefits of competition will only be realised in a competitively neutral market.<sup>37</sup> One of the first steps to achieve this must be that any willing and accredited provider should be able to enter the market and offer services and there should be no discrimination between providers. This requires that a level playing field operates, based on transparent procurement, equal levels of taxation, cost of debt, pensions and regulation.

For instance, ISTCs are currently subject to a tougher regulatory scheme than the NHS. They are required to deliver data on 28 key performance indicators (KPIs) to the Department of Health, in addition to inspections by the Healthcare Commission. The 28 KPIs extend well beyond the information NHS-run institutions are required to submit.<sup>38</sup> The regulatory regime should be reformed so that all providers are regulated equally, allowing a level playing field to operate.

PCTs should be responsible for ensuring that an effective market operates in their local health economies, and SHAs have similar responsibilities for their region. For them to do this the government needs to be clear on the rules.

The Department of Health intends to implement a system management framework by April 2008 to help SHAs manage their regional health economies and to ensure the independent sector is used appropriately.<sup>39</sup> The framework is to promote choice and provide recourse when the Department of Health thinks choice is being blocked. The first step of the framework will be to measure the level of contestability in each health economy and then to equip SHAs with the right tools to use competition to drive up productivity and innovation.

Giving SHAs responsibility for governing competition across all of the market while also charging them with ensuring financial health for just part of the market will inevitably present them with moral hazards. We need an independent and transparent process.

Also due to be established this year is a competition panel, made up of experts from the independent sector and the NHS, which providers can consult when they believe unfair

competition is taking place. This is a positive development but the panel members must have independence, authority and experience of wider competition principles if it is to be effective.

Effective commissioning is key to driving improvements in the NHS, and the ISTC programme is no exception. For example, the ISTC programme suffered from poor needs analysis and procurement with contract prices being negotiated at 3-4 times higher than tariff.

Creating plurality of supply needed a centrally driven initiative in the form of waves I and II of the ISTC programme to achieve a critical mass of independent sector supply. The Department of Health now intends to devolve the responsibility of procuring ISTCs to PCTs under the management of SHAs. This is a positive move and should improve integration of ISTCs into the healthcare economy and help ensure procurements are based on clinical and patient needs. Central procurement is often not a particularly good lever for implementing fundamental reforms in a very complex system.

But it is uncertain whether SHAs and PCTs are able to manage devolution of commissioning responsibility. This decentralisation could allow some areas of the NHS opposed to wave II ISTCs in their area to cancel, downscale and delay the contracts. SHAs may not have experience of ISTCs and are therefore unsure as to the benefits. Those in the NHS who have worked with the independent sector are supportive but doubts remain among those who have not seen for themselves the good work carried out in ISTCs. Also, SHAs may lack the commercial expertise and the skills needed to be able to manage the current market, act as de facto economic and competition regulators and thus effectively develop the system in the interests of patients.

As part of this move, the Department of Health Commercial Directorate is shifting its role towards the provision of advice and consultancy. Some of its contract management experts will be transferred to SHAs. But the Department of Health must also retain the capability to continue to work with SHAs and PCTs to ensure ISTCs are operating as a catalyst for change – with sufficient market share to be sustainable, but not to the point where existing capacity needs to be shut down rather than improve. This demands a strong transition management function for the Department of Health. Part of this role must be to support SHAs with their capacity planning. In addition, developing

new market opportunities requires investment, not just financial, but in people. The government and NHS need to recognise the value of longer term commitment and steadfastness and move away from the 'year on year' revenue mentality that risks hampering implementation of true patient choice and future development of our NHS health economy.

### RECOMMENDATION 5

#### Patients must be allowed to choose any accredited provider that meets NHS tariff costs

The role of PCT commissioners should therefore be to:

- Make their decisions on the best possible care available for patients
- Be open to all providers and competitively neutral
- Be imaginative and commission by patient outcome rather than by procedural inputs.

### RECOMMENDATION 6

#### The market should be regulated in an independent and transparent way

To ensure competition operates in the interests of patients, the proposed system framework needs to be rigorously implemented, with sufficient recourse to ensure SHAs implement recommendations accordingly. The Department of Health should place a formal obligation on SHAs to ensure that guidance from the competition panel is followed. As part of this regulation, there should be regular independent analysis of market capacity to ensure it is sufficient to bring about the desired improvements through competitive pressure.

Given the management time and bidding costs associated with such programmes, it is important for the department to learn the lessons from the cancellations and delays at a time when the government wants independent sector providers to play a bigger role in primary care. Investors and providers must be reassured about the scope for market growth. Otherwise providers will find it increasingly difficult to access capital at reasonable costs and meet investor expectations.

The confusion and lack of commitment to the original programme has seen spot purchasing re-emerge as a result of poor planning from PCTs. This is a huge worry as it will represent a very poor deal for the NHS if it returns to the level and rates that existed before ISTCs were introduced, when independent sector providers were typically being paid a premium of 40-100% over reference costs.

Towards the end of 2007, the government made a number of public statements to the effect that its commitment to public service reform remains strong. The government now needs to articulate more clearly the value of a mixed economy in terms of the benefits it brings patients and to demonstrate practical commitment to this through the decisions it takes.

To ensure patient choice really does drive improvements in the wider NHS, the government must give very high priority to the effective, full implementation of genuine patient choice from April 2008. This also means commitment to challenging poor provision and clarity on the failure regime for trusts and other institutions under payment by results. While this is politically sensitive, it must be addressed as the proportion of health services subject to the tariff system is increasing all the time. No ISTC should be propped up if it is not achieving what it is procured to do. Equally, no poorly performing NHS organisation should be supported.

The report to be published by health minister Lord Darzi in spring 2008 provides an ideal opportunity for setting out this vision.

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