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.