Briefing
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Independent sector treatment centres

Introduction

Independent sector treatment centres (ISTCs) provide services to NHS patients but are owned and run by organisations outside the NHS. They were introduced in England in 2003, primarily to help the NHS reduce waiting times for planned operations and diagnostic tests.

Although the NHS has used services provided by the independent sector throughout its history, ISTCs are distinctive in two ways:

- ISTCs were created as a deliberate policy of central government
- athough privately owned, ISTCs provide services only to NHS patients.

ISTCs therefore represent a new form of independent sector involvement in public health care, and have been the subject of considerable controversy since their introduction.

This briefing paper explains why ISTCs were introduced, and how they are funded, staffed and regulated. It assesses their impact so far, including the quality of their services and whether they provide good value for money. Finally, it examines what their future may be now that the contracts ISTC providers hold with the Department of Health are beginning to expire.

Why were they introduced?

The rationale for introducing ISTCs can be explained by addressing two questions: first, why were treatment centres set up separate from hospitals; and second, why was the independent sector involved in providing these services?

The NHS Plan (Department of Health 2000) announced the intention to establish 'Diagnostic and Treatment Centres'. These would begin to address a long-standing concern

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– that hospitals were not providing planned tests and operations efficiently because the competing demands of providing emergency care frequently led to appointments being delayed or cancelled. It was hoped that by separating planned operations from emergency care, treatment centres would help to reduce waiting times. They would also increase capacity in specialties with long waits, such as ophthalmology and orthopaedics, again helping to reduce waiting times in these areas.

The rationale for involving the independent sector in the delivery of treatment centres was originally based on creating additional capacity to reduce waiting times. In 2002, the Department of Health engaged strategic health authorities (SHAs) in a national capacity planning exercise, and concluded that in order to achieve rapid reductions in waiting times, an expansion of independent sector capacity would be required. This expansion was achieved through the ISTC programme, which procured treatment centres from the independent sector (Department of Health 2002a). The Department later stressed that the ISTC programme could also play a role in achieving other government ambitions (Department of Health 2006a; House of Commons Health Committee 2006a):

- introducing competition with the intention of stimulating NHS providers to improve their own services, particularly in terms of increasing productivity and reducing waiting times
- providing patients with a greater choice of providers
- creating a space for innovation, in which new forms of service delivery could be developed
- providing a more cost-effective way for the NHS to utilise capacity in the private sector. By purchasing services in bulk rather than through ad hoc 'spot purchasing' arrangements, it was hoped that the ISTC programme would provide better value for money.

How many ISTCs have been set up?

There have been two 'waves' of ISTCs procured centrally by the Department of Health, each constituting a five-year investment programme. The first ISTC opened in 2003. The second wave of procurement was announced in 2005, with the first centre opening in 2007.

Under Wave 1, 25 fixed-site centres and two chains of mobile units were opened (Hansard 2009a). The Department of Health states that these were targeted on areas with a lack of capacity or long waiting times, as identified by SHAs in conjunction with local primary care trusts (PCTs) (House of Commons Health Committee 2006a).

Wave 2 initially involved 24 schemes (House of Commons Health Committee 2006a), but was scaled back to 10, of which nine were operational by June 2009. The Department of Health explained this reduction by stating that 'the changing situation in health economies' meant that extra capacity was no longer needed in some areas (House of Commons Health Committee 2006a). It should be noted that Wave 2 contracts were considerably wider in scope, covering services provided over multiple sites rather than a single centre.

A number of NHS-owned treatment centres have also been developed since 2000. By 2006, 48 NHS treatment centres were open or under development (Department of Health 2006b, 2006c).

What services do ISTCs provide?

ISTCs vary widely in terms of the scope of their services and the way they are organised. Some offer only a narrow range of services while others cover multiple specialties and offer

outpatient care, diagnostics and day surgery. Specialties commonly provided include orthopaedics, ophthalmology, and various forms of surgery. ISTCs do not provide high-level intensive care.

A small but growing proportion of NHS elective care is now provided by ISTCs. Table 1, below, shows the proportion accounted for by ISTCs each year since the programme began. The figures are based on inpatient procedures, and do not include diagnostics.

Table 1 ISTC activity as a proportion of total NHS activity

Year	ISTC activity (FCEs)* (from HES** data)	Total NHS elective activity (from HES** data)	ISTC activity as proportion of elective activity (%)
2003/4	3,633	5,544,864	0.07
2004/5	36,599	5,530,359	0.66
2005/6	53,388	5,821,062	0.92
2006/7	67,210	5,590,579	1.20
2007/8	105,604	5,900,000***	1.79

* Finished Consultant Episodes - represents a patient's completed period of care under a consultant.
** Hospital Episode Statistics
*** Audit Commission estimate
Source: Audit Commission (2008)

Within particular specialties, the proportion of work conducted in ISTCs is higher. By the end of 2006/7, ISTCs were performing 4 per cent of cataract procedures, 7 per cent of hip procedures, and 9 per cent of arthroscopies nationally (Audit Commission 2008). But these national-level statistics fail to shed light on the proportion of activity accounted for by ISTCs at local level. The Healthcare Commission reported that in some areas, all elective care within particular specialties is conducted in an ISTC (Healthcare Commission 2007).

The proportion of NHS elective activity performed by ISTCs will continue to rise as Wave 2 schemes become fully operational. But for the foreseeable future, it is unlikely to reach the 15 per cent envisaged at one stage by the Department of Heath (Department of Health 2006a).

How are they funded and how much do they cost?

The funding arrangements for ISTCs were specified in five-year contracts negotiated by the Department of Health. These contracts have not been published in full on the grounds of commercial sensitivity, but certain details are known.

The price for work conducted in ISTCs is based on the national NHS tariff – the standard payment system for providers of NHS services – supplemented with an additional provider-specific premium to encourage entry into the market and cover the costs associated with setting up a new treatment centre. The size of these premiums have not been published, but the Department informed the House of Commons that Wave 1 ISTC providers received, on average, payments that were 11.2 per cent greater than the NHS equivalent cost. The NHS equivalent cost is derived from tariff values but also includes fixed costs borne by the NHS outside of the tariff – for example, pension payments (House of Commons Health Committee 2006a).

In addition to the premium paid per procedure, ISTC contracts also include minimum volume guarantees to act as a further incentive for providers to enter the market. Wave 1 ISTCs were given a 'take or pay' guarantee, stipulating that PCTs would pay for 100 per cent of the contract value, regardless of whether activity reached the contracted level. Wave 2 ISTCs are not guaranteed to receive 100 per cent of the contract value, but do receive a guaranteed fixed value (GFV). GFV payments are calculated with reference to providers' fixed costs, and reduce incrementally over the course of the contract. The Department of Health rather than PCTs is liable for GFV payments.

The total cost of payments to ISTCs from the programme's inception up to 31 March 2009 was £1.2 billion (Hansard 2009b). The estimated cost for the next five years, from April 2009, is £1.4 billion (Hansard 2009c). Averaging this out over five years, and taking the total budget for the NHS in England of £98.4 billion in 2009/10 (HM Treasury 2008), this represents less than 1 per cent of overall annual expenditure.

How are ISTCs staffed?

To avoid staff being 'poached' from the NHS, Wave 1 ISTC providers were not allowed to recruit staff who had worked within the NHS in the previous six months. As a result, many staff were recruited from other countries. The House of Commons Health Committee strongly criticised this 'additionality' policy as having led to a lack of integration with local NHS providers and problems associated with staff not being familiar with surgical techniques and administrative processes used in the United Kingdom, as well as language problems (House of Commons Health Committee 2006a).

Mindful of these concerns, the Department of Health relaxed the recruitment restrictions for Wave 2. Providers are now permitted to recruit NHS staff, but staff within defined 'shortage professions' are allowed to work for ISTCs only outside their contracted NHS hours (NHS Employers 2007).

The profile of the workforce in ISTCs is evolving over time, and also varies between centres. For example, in 2007, 25 per cent of clinical staff (on average) in Wave 1 ISTCs were on secondment from the NHS, but this was as high as 83 per cent in one centre (Player and Leys 2007).

Wave 2 ISTCs are contractually obliged to make at least one-third of all activity available for the training of junior clinical staff, should the deans of local educational bodies require it. This was a response to the concern that if a large proportion of simpler, routine work was to be conducted within ISTCs, local NHS hospitals would be left with a disproportionate number of more complex cases that may not be suitable for training purposes (House of Commons Health Committee 2006a). Evidence suggests this concern is legitimate – for example, in one NHS hospital, the percentage of patients referred for cataract surgery whose condition required them to be operated on by a consultant increased from 5.5 per cent to 19.6 per cent after an ISTC opened in the area (Barsam *et al* 2008).

As is the case in all NHS and private hospitals in the United Kingdom, doctors and surgeons working in ISTCs (including those from outside the United Kingdom) must be registered with the General Medical Council for the specialism they wish to practise, and other professionals must be registered with the relevant regulatory body. This is designed to provide some guarantee of competence. However, ISTCs do not have an equivalent of the Advisory Appointments Committees used in the NHS, which include representation from the royal colleges and serve as an additional quality control mechanism. Without this, the onus lies on ISTC providers to ensure that recruitment processes are robust. An investigation by the Healthcare Commission found that ISTCs generally met national minimum requirements in this respect, but found 'some shortfalls in areas such as continuing professional development and appraisal' (Healthcare Commission 2007).

How is the quality of their services regulated?

The quality of work performed by ISTCs was regulated by the Healthcare Commission until 2009, and is now regulated by the Care Quality Commission (CQC). The standards for independent sector providers differ from those used for public sector providers, as different legislation applies. Under the Healthcare Commission, independent sector providers were required to meet the 'national minimum standards' (Department of Health 2002b), whereas NHS providers were regulated against the NHS 'core standards', along with more demanding 'developmental standards' (Department of Health 2006d) and additional requirements described in other policy documents such as the National Service Frameworks (NSFs). These arrangements have been continued on an interim basis by the CQC.

From April 2010, the current regulatory framework will be replaced with a single registration system. All organisations providing services to patients, whether publicly or privately funded, must be registered with the CQC by law. The registration requirements will replace the national minimum standards and NHS core standards, representing a degree of harmonisation in the regulation of publicly and privately owned providers (Health and Social Care Act 2008). However, the new 'improvement standards', which will replace the current developmental standards, will apply only to public providers.

ISTCs must also report to the Department of Health on 26 key performance indicators (KPIs), covering areas such as clinical measures, complaints, and patient satisfaction. These indicators are reported at least once a month, with some being reported on a daily basis (House of Commons Health Committee 2006b). The data submitted to the Department of Health are not made public, as it is argued that this information is commercially sensitive. If an ISTC persistently breaches defined thresholds for any of the indicators, sponsoring PCTs are able to impose financial penalties or, ultimately, terminate the contract (Department of Health 2006a).

What impact have ISTCs had?

The information available is not adequate to support a conclusive assessment of the impact of the ISTC programme. However, there is some limited evidence relating to waiting times, quality of care, value for money, and innovation.

Waiting times

The ISTC programme was intended to reduce waiting times for diagnostics and planned operations in two ways – first, by adding extra capacity to the system, and second, by introducing competition that would stimulate productivity improvements in NHS facilities.

The ISTC programme has made only a small contribution in terms of adding extra capacity. As noted earlier, in some areas, and within certain specialties, ISTCs may account for a substantial proportion of activity (Audit Commission 2008). However, at the national level, only around 2 per cent of all NHS elective activity occurs in ISTCs, which suggests that their contribution has not been a significant factor in the dramatic reductions in waiting times for elective procedures.

It is more difficult to assess the contribution ISTCs may have made to reducing waiting times by stimulating productivity improvements in NHS facilities. Anecdotal evidence suggests that some NHS providers have made changes to the way they deliver services in response to an ISTC opening in their area. A joint report from the Audit Commission and Healthcare Commission found that for some NHS providers, the competitive threat posed by ISTCs provided 'a useful tool to engage clinicians and work with them to deliver change' (Audit Commission 2008).

Based on evidence submitted by NHS providers, the House of Commons Health Committee enquiry into ISTCs concluded that the galvanising effect of competition on the NHS *may* have been the greatest benefit delivered by the ISTC programme, but criticised the government for not systematically evaluating this effect. The committee recommended that the National Audit Office should conduct such an evaluation, but to date this recommendation has not been acted on (House of Commons Health Committee 2006a).

There is no quantitative evidence to substantiate suggestions that competition with ISTCs has been a factor in reducing waiting times in NHS facilities. A recent analysis by The King's Fund, comparing areas with ISTCs to those without, found no difference in the rate at which waiting times were reduced.

Quality of care

Comparing the quality of care provided in ISTCs with that in NHS facilities is not simple, as they differ in terms of the profile of patients treated (case-mix), the regulatory framework they operate within, and the data they collect on their activities. However, the evidence that does exist suggests that most care provided is of a comparable standard to that found in the NHS.

One research study found that improvements in functional status and quality of life were slightly higher in ISTCs for patients undergoing cataract and hip replacement operations, but slightly lower for patients undergoing hernia repair (after adjusting for case-mix). The authors cautioned against placing too much weight on these findings, though, as the number of ISTCs participating in the study was low and it is possible that case-mix adjustment was inadequate (Browne *et al* 2008).

A review carried out by the Healthcare Commission in response to concerns submitted to the House of Commons Health Committee reported that it could provide 'some positive assurance about the quality of care provided by ISTCs'. Their inspections found that processes of care in most ISTCs 'appear to function well'. They did, however, find 'isolated examples of poor care and of centres where staff did not properly understand the need to set up systems for clinical governance'. In particular, there were some difficulties around the transfer of care from ISTCs to NHS facilities – for example, when patients experience complications beyond the scope of services ISTCs are able to provide (Healthcare Commission 2007).

The same report criticised the Department of Health and other statutory bodies for not ensuring that ISTCs provided high-quality data on patient care. Despite improvement over the last two years, the quality of data is still not comparable to that collected by NHS providers (NHS Information Centre 2008). For example, in the second quarter of 2007/8, information on patient diagnosis was missing for 42.6 per cent of records submitted by ISTCs to the Hospital Episode Statistics (HES) database, as opposed to 0.1 per cent from NHS-owned treatment centres, and 1.5 per cent from NHS hospital trusts (Healthcare Commission 2008). This limits our ability to compare the quality of services provided by ISTCs and NHS providers.

Value for money

Several issues need to be considered in assessing whether ISTCs have delivered value for money: the higher price paid to ISTCs per procedure; the effect on spot purchasing arrangements with the independent sector; concerns related to case-mix; and the volume guarantees included in ISTC contracts.

The Department of Health argues that the higher prices paid to ISTCs are justified on the grounds that independent sector providers face costs over and above those borne by the

NHS, such as corporate taxation (House of Commons Health Committee 2006a). It has also stated that although prices exceed NHS equivalent costs, they are significantly below typical spot purchasing prices used when the NHS purchases care from the independent sector on an ad hoc basis (House of Commons Health Committee 2006a). However, full details on the data and methodologies used to reach these conclusions have not been made available on the grounds of commercial sensitivity.

There is some evidence to suggest that the ISTC programme may have succeeded in its aim of reducing spot purchasing throughout the independent sector (House of Commons Health Committee 2006a; Audit Commission 2008). It could therefore be argued that the ISTC programme has created an environment in which independent sector capacity can be utilised at lower cost.

ISTCs are constrained in terms of the complexity of the cases they can accept, and there has been some concern that the pricing system used in the NHS may not be sufficiently differentiated to be able to recognise this and reduce payment accordingly (Audit Commission 2008). In theory, this could lead to ISTCs (along with NHS treatment centres accepting a limited range of cases) being overpaid relative to NHS hospitals. Data limitations mean that it is difficult to assess whether or not this is happening (Mason *et al* 2009).

Perhaps the most significant issue relating to value for money is the volume guarantees included in ISTC contracts. Information published by the Department of Health shows that many ISTCs have been under-utilised. By the end of September 2008, Wave 1 ISTCs had performed 85 per cent of the activities they had been paid for up to that time (Department of Health 2008a). For Wave 2 ISTCs, contract utilisation for elective schemes by September 2008 also stood at 85 per cent, and for diagnostic schemes was only 25 per cent (Department of Health 2008b). This under-utilisation may reflect resistance within the NHS to using ISTCs and poor relations with local GPs and other providers (Audit Commission 2008), and has been tackled in some PCTs by giving GPs financial incentives to refer patients to ISTCs (Carvel 2006). It may also indicate that some of the extra capacity created by ISTCs is now surplus to requirements.

Innovation

ISTCs were intended to provide a space in which innovative approaches could be developed, which could then spread throughout the NHS. The Health Committee enquiry concluded that ISTCs have indeed 'embodied good practice and introduced innovative techniques', such as the use of mobile units, streamlining the supply of prostheses, and 'the construction of facilities based around patient flow'. However, some witnesses claimed that these practices were also happening within the NHS (House of Commons Health Committee 2006a). No evidence is available on whether good practice and innovation developed by ISTCs has subsequently been adopted by NHS providers.

What is the future of ISTCs?

Thirteen of the Wave 1 contracts are due to expire by the end of 2009/10 (Hansard 2009d), with most of the remainder expiring in the following two years. Wave 2 contracts will expire between 2011 and 2017 (Hansard 2009c). The Department of Health has stated that there will be no further central procurement of ISTCs (Department of Health 2007).

Once centrally negotiated contracts expire, ISTCs will operate under the same rules as other independent sector providers. They will be able to treat private patients and will no longer be subject to restrictions on employing NHS staff. New contracts will be agreed with PCTs, and competition rules state that these contracts should not contain guaranteed payments or volumes except in 'exceptional circumstances' (Department of Health 2008c). PCT commissioners are expected to base arrangements with ISTCs

on the 'standard NHS contract', which specifies a range of responsibilities providers must accept – for example, compliance with the 18-week referral to treatment target (Department of Health 2008d).

In at least 14 cases, the NHS will be obliged to pay providers for the 'residual value' of ISTC buildings and facilities when contracts expire (Hansard 2008). The NHS will then own these assets and may choose to rent them out to ISTC providers, should the contract be renewed or put out to tender. The estimated total value of these payments is £176 million for Wave 1 and £40 million for Wave 2 (Hansard 2009e). It is unclear whether PCTs, SHAs or the Department of Health will be liable for these payments.

As of April 2008, patients being referred for routine care have the right to be seen by any provider (NHS or independent sector) that is registered to provide the service they need, willing to accept NHS prices, and either holds a contract with their local PCT or is listed on a national 'choice network'. Initially, ISTCs will be registered to provide only those services covered by their original national contracts. However, they will be able to expand their scope by applying to become registered for other services, presenting providers with wide-ranging new business opportunities.

In theory, therefore, the future of ISTCs rests with patients and the choices they make about who provides their care. However, the extent to which patients are currently given a choice of provider at the point of referral is questionable – in 2007, only 45 per cent of patients recalled having been given a choice (Department of Health 2008e). This suggests that, in practice, some power regarding the future commercial success of ISTCs rests in the hands of GPs and others involved in the referral process.

Conclusion

There is a limited amount of information relating to ISTCs due to a combination of problems with routine data collection, commercial sensitivity, different regulatory frameworks applying to NHS and independent sector providers, and a lack of systematic evaluation of the effects of ISTCs on the NHS. These limitations make it difficult to compare different types of provider. Shifting responsibility for ISTCs to the local level may further complicate comparisons, given that the Department of Health is under no obligation to collect details of arrangements agreed between PCTs and independent sector providers.

As the NHS moves towards greater diversity of provision, with increasing involvement of the independent sector, it is important to ensure that data on quality and cost are publicly reported so that regulators, commissioners and patients can judge the relative performance of providers on a level playing field.

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