



DEPARTMENT OF HEALTH

THE GOVERNMENT'S RESPONSE
TO THE HOUSE OF COMMONS
HEALTH COMMITTEE'S FIRST REPORT
ON THE ROLE OF THE PRIVATE
SECTOR IN THE NHS

*Presented to Parliament by the Secretary of State for Health
By Command of Her Majesty
July 2002*



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INTRODUCTION

This Command Paper sets out the Government's response to the Health Committee's First Report of the Session 2001–2002 on the Role of the Private Sector in the NHS.

The Government welcomes the Committee's consideration of some of the partnerships between the NHS and the independent sector and its recognition of the positive role that the independent sector has played in helping to reduce waiting times for NHS patients. Since the NHS Plan set out the framework for the NHS to engage constructively with the independent sector to treat more NHS patients where this will provide high clinical standards and good value for money, thousands of NHS patients have been treated in independent hospitals.

As the Committee points out, partnerships between the public, private and voluntary sectors have been a feature of the NHS since its inception. They are now more important than ever. To make best use of the significant investment the Government is making in the NHS, and to meet patients' expectations, which are rightly high, fundamental reform of the NHS is required. Not in how the NHS is funded or in the values on which it is founded, but in how it is organised. The NHS cannot remain a monolithic, centrally-run monopoly provider. Ideological or institutional boundaries should not stand in the way of better care for NHS patients.

This Government is making the largest ever sustained increase in funding in the history of the NHS. In the April 2002 Budget, the Chancellor announced investment for the NHS in England: an average of 7.4 per cent in real terms between 2002–03 and 2007–08. These resources will be committed to building NHS capacity to enable more patients to be treated more quickly to higher standards. There will be a refocusing of health services on the needs of patients and to give them more choice about where and when they are treated.

More choice for patients requires more capacity in services. Consistent growth in staff numbers and in capital infrastructure will be needed if local NHS services are to expand patient choices and increase activity to meet the ambitious waiting times targets. Now, with the investment announced in the Budget, health and social care organisations may plan ahead with confidence and stability.

The Government will help the NHS to recruit and retain more key staff. By 2008 the Government expects that the NHS will have net increases over the September 2001 staff census of 35,000 nurses, 15,000 doctors and 35,000 scientists and therapists.

There will also be more growth in capital infrastructure. Private Finance Initiative (PFI) major construction projects are already helping to deliver the largest hospital building programme ever in the NHS. 64 major PFI hospital building projects have been initiated with a value of over £7.5 billion and these along with medium sized and smaller schemes will ensure that the NHS Plan target of 100 new hospitals by 2010 will be easily exceeded. The PFI is being extended to other parts of the health and social care system and there will be substantial investment in new primary care facilities through NHS LIFT.

Much of the increase in activity needed to reduce waiting times for patients will be achieved by increasing investment in existing NHS providers. But to meet the challenge, the NHS also needs to grow additional high quality, cost-effective health care capacity. So, it is an explicit objective of Government health policy to shift towards greater plurality and diversity in the delivery of elective surgery services. This will result in a permanent, structural increase in the nature and volume of health care services delivered to NHS patients in England. Care will remain free at the point of use, based on patients' need, not their ability to pay.

A new generation of diagnostic and treatment centres (DTCs) will be established, separating elective from emergency work. Some of these DTCs will be run purely by the NHS, some by the independent sector, some through partnerships between public and private organisations. In addition, on 25 June 2002 the Government published a prospectus, *Growing Capacity: A New Role for External Healthcare Providers in England*, encouraging prospective providers in the independent sector to invest in new surgical and diagnostic units using medical staff from abroad. There will be a new sector in health care provision in England of units set up and run by independent operators and staffed with overseas clinicians, helping NHS commissioners to make radical and sustained in-roads into waiting times in key elective surgical specialties.

The Government intends primary care trusts (PCTs) to be free to arrange care for patients from the most appropriate provider whether they are public, private or voluntary. To support this, the hospital payment system will switch to payment by results, with incentives underpinned by explicit patient choice. By 2005 patients will be able to choose not just the location of their treatment but when to be treated and by whom. Over the next four years an increasing proportion of each hospital's income will come to it as a result of the choices patients make.

The Government agrees with the Committee that there should be one inspectorate for all providers of health care services. There will be a new tough independent healthcare regulator/inspectorate covering both the NHS and the independent sector, with a new Chief Inspector of Healthcare – not appointed by Ministers and reporting annually to Parliament. An equivalent body will be created for social services.

Working with providers from the independent sector and from overseas is not a temporary measure. They will become a permanent feature of the new NHS landscape and will provide NHS services. Different health care providers will work to a common ethos, common standards and a common system of inspection. Wherever patients are treated they remain NHS patients because they get care according to NHS principles – treatment that is free and available according to need, not ability to pay. This is the modern definition of the NHS.

SUMMARY OF RECOMMENDATIONS AND RESPONSES

THE CONCORDAT

Capacity

- (a) **It remains to be demonstrated that greater use of the capacity of the independent sector poses no direct threat to resources in the public sector. Careful definitions need to be adopted when defining “shortages of capacity” in the NHS and “surplus capacity” in the independent sector. We recommend that the Department should commission an independent assessment of the impact of the purchasing by the NHS of activity from independent providers on staff availability within the NHS.**

The Government agrees with the Committee that it is important that new capacity is genuinely additional, and does not simply mean moving capacity from one place to another. This is true of the development of new capacity within NHS organisations, as it is of the use of capacity in the independent sector.

The terms “shortages of capacity” and “surplus capacity” will have different meanings in different circumstances. In some places, the NHS needs – and the independent sector can offer – additional capacity in terms of the time of skilled staff that might not otherwise be available to the NHS. In other places, it may be that the need is for access to additional facilities, including beds and operating theatres.

These issues are best addressed locally. That is why the Government has asked each strategic health authority to prepare a capacity plan. Through these plans, local health communities will take stock of the capacity already available, assess the capacity they need to deliver objectives for waiting and access, and systematically identify the most appropriate ways of accessing the additional capacity they require. The Department of Health does not, therefore, propose to commission a separate assessment, focussing only on one aspect of the development of new capacity, of the kind the Committee recommends.

- (b) **We have no objection to the NHS combatting shortages of capacity (in terms, for example, of lack of theatre space or shortages of beds staffed by nurses) by making use in the short-term of the independent sector. Moreover, we acknowledge that waiting lists of themselves entail costs in terms of additional burdens on social care, the welfare system and the health service itself as a consequence of the additional expense of treating more advanced conditions. Above all longer waiting times have a real impact on patients’ quality of life. However, we think it imperative that the NHS develops sufficient acute capacity to keep down waiting times. The extensive capital development programme under way needs to be complemented by contractual arrangements which ensure that the NHS has the consultant time and**

other resources it needs to carry out this higher level of activity. We recommend that the Department, together with trusts, should look at ways of providing further incentives to staff to work for the NHS.

While welcoming the Committee's acknowledgement of the role of the independent sector in helping to bring down waiting times for patients, the Government believes it will be needed for the medium to long term.

The 2002 Budget resources will allow the NHS and social services to plan increases in capacity, including additional beds, major hospital schemes and the recruitment and retention of increasing numbers of key staff.

Capacity provided by independent sector providers will augment this in several ways. For example, as well as the use of existing spare capacity, the Government is encouraging both UK and overseas providers to establish new services here using clinical staff from abroad, specifically to provide NHS services. What matters ultimately is not who manages particular services – public, private or voluntary organisations – but that those services deliver high clinical standards and good value for money, and that there is a co-ordinated overall increase in resources available to treat NHS patients.

The Government agrees with the Committee that it is very important that skilled individuals are incentivised to work for the NHS.

The Department of Health has recently reached agreement with the British Medical Association on a framework for a new consultant contract. Implementation of the contract is planned to start from April 2003. The Government believes that this new framework, which has been developed in partnership with NHS employer representatives, will help drive forward major improvements in NHS patient care. It will create a career structure and remuneration system to reward consultants who make the biggest contribution to NHS service delivery and who make a long-term commitment to the NHS.

The new contract introduces a stronger, unambiguous framework of contractual obligations, with greater management control over when consultants work for the NHS and over their performance. It will tackle any perceived or actual conflict of interest between consultants' work for the NHS and their own private work, for the first time writing into the contract the overriding principle that an NHS consultant's first and foremost commitment is to the NHS and to their NHS patients and that work for the NHS must take priority over any work undertaken for other organisations. There will also be a new set of contractual provisions governing the relationship between consultants' NHS commitments and any private practice they undertake. Pay progression will depend, amongst other criteria, on consultants having met the required standards of conduct embodied in these provisions.

The contract framework also includes a number of incentives for consultants committed to the NHS. For example, there will be additional supplements for on-call availability and recognition for consultants with flexible working patterns including out-of-hours work.

For other health professionals, the Government is committed to concluding talks on *Agenda for Change* – its proposals for modernising pay for the majority of NHS staff. *Agenda for Change* has been developed in partnership with NHS employers and staff side organisations. The aim is to ensure that the pay system reflects the contribution staff make to NHS services. A single job evaluation scheme will be an important part of the new pay system helping it to deliver fair pay, consistent with the principle of equal pay for work of equal value. The new system will give greater opportunities for career progression for staff who are willing to take on new responsibilities, skills and knowledge. These, together with consistent conditions of service, will provide a coherent system of pay and conditions recognising what people contribute to the NHS.

Of course, incentives to work in the NHS go beyond pay. The Government has made significant investment aimed at making the NHS an employer of choice, including developments in childcare, flexible retirement and work undertaken through the *Positively Diverse* organisational development programme. For example, the childcare strategy is focusing on the development of around 150 on-site nurseries by 2004.

By April 2003 NHS organisations will be required to achieve accreditation against the *Improving Working Lives* standard announced in the NHS Plan: that every member of staff in the NHS is entitled to work for an organisation which is committed to providing a range of flexible working conditions, including flexible working patterns, team-based self-rostering, annual hours and flexitime.

- (d) **We recommend that the Department publishes data on the impact of this measure [consultants working exclusively for the NHS for a period of seven years following their qualification] on NHS capacity to enable planning of the other resources needed to match any additional consultant availability.**

The new contract framework includes the expectation that consultants in the first seven years of their career will be expected to make available to the NHS (in preference to other organisations) the first portion of any spare professional capacity that they have, up to the working time regulations limit of 48 hours per week. This will achieve the Government's objective of securing consultants' full commitment to the NHS during the first phase of their career. Planning of resources to increase activity, for which consultant resources are an important part, is discussed above.

- (c) **The current balance of provision between public and independent sectors is clearly under review. So we believe that now would be an appropriate time for the Department of Health to ensure trusts have undertaken a recent cost-benefit analysis of the reclaiming for the NHS of capacity utilized to provide private pay beds in NHS hospitals. This could establish whether there are any trusts which might find it more cost-effective to use this capacity within the NHS instead of buying in operations from independent hospitals.**

The Government agrees that NHS trusts should examine whether capacity used to treat private patients could be more cost-effectively used to treat NHS patients.

Income generated by treating private patients is ploughed back into NHS services. However, the first priority of the NHS is to treat NHS patients. NHS hospitals may only treat private patients in pay beds or private patient units where that does not interfere with care for NHS patients.

Strategic health authorities are engaged in capacity planning with the PCTs and acute trusts in each area to secure the capacity to deliver the NHS Plan waiting time and emergency care targets. They will be considering which interventions are likely to be most appropriate to secure the necessary capacity locally. One of the possibilities they have been asked to consider is turning one or more NHS private patient units over to exclusive use for NHS patients, considering the costs and benefits to the NHS of maintaining the units against using them to treat NHS patients exclusively.

- (e) **We would like to point out that it is now almost two years since our predecessor Committee published its report into *Consultants' Contracts* which expressed “astonishment” that job plans, reviewed annually, were not in place for every consultant. Our predecessor Committee’s report prompted the then Government to say that it regarded job planning as “a clear and compulsory activity”.**

The Government shares the Committee’s view of the importance of job plans.

The agreed framework for the new consultant contract includes a new system of mandatory job planning. This will provide a much more effective system of planning and timetabling consultants’ duties and activities for the NHS, giving NHS employers the ability to manage consultants’ time in ways that best meet local service needs and priorities. The key elements of these new arrangements include: replacement of the current system of fixed and flexible sessions with a system in which all NHS work (except unpredictable emergency work) is timetabled and typically carried out on-site with no non-NHS work during this time; a new framework for setting and reviewing job plans; and a new, longer pay scale with progression through new pay thresholds based on meeting commitments and job plans.

Unlike the previous system, consultants will be expected to take part in the job planning and appraisal process, holding current job plans agreed annually and meeting commitments set out in those job plans. This will be a contractual requirement and will determine access to further pay progression. Consultants will also be expected to meet (or take reasonable steps to meet) objectives set in job planning.

- (f) **We believe that the Department should ensure that all consultants have job plans and that this is an essential prerequisite for the appraisal of NHS consultants. Since appraisal and revalidation are being progressively introduced for all registered medical practitioners, there is scope for consideration to be given to the impact of any work done in the independent sector on a consultant’s NHS responsibilities. We recommend that this opportunity is taken and that the resulting mechanisms should include provisions (for**

example, sanctions in relation to pay and conditions) which guard against the potential conflict of interests for consultants working in both the NHS and independent sectors.

Under recently introduced arrangements, consultants are required to attach a job plan to their appraisal forms before the appraisal interview takes place. The appraisal documentation (launched for consultants in April 2001) also requires the consultant to complete a section describing their whole practice, including work in the independent sector. This provides the NHS with an overview of the doctor's practice and development needs and will also be helpful to the General Medical Council in looking at the individual's evidence for revalidation.

Under the new consultant contract, there will be a new system of job planning, with annual job plan reviews. Job plans will set out a consultant's duties, commitments and responsibilities and programme all of a consultant's NHS work into a timetable. The annual job plan review will assess performance against the job plan and agree the work programme, responsibilities and service and personal objectives for the following year. Consultants will be required to inform NHS employers of all their work in the independent sector as part of this.

The Government and the British Medical Association have also agreed that for the first time there will be a new set of contractual provisions governing the relationship between consultants' NHS commitments and any private practice they undertake. These rules will be designed to minimise the potential for conflicts of interest to arise between private and NHS commitments. Employers will be required to satisfy themselves annually that a consultant is meeting the requirements set out in these rules in determining eligibility for pay progression.

- (g) In order to ensure greater accountability, we recommend that details of payments for NHS activity made to consultants working in private settings should be published by trust boards.**

The Government does not agree that details of payments made to individual consultants for their work treating NHS patients in private settings should be published. Arrangements made between NHS trusts and independent providers are typically for the provision of a package of care for patients, which includes treatment by consultants alongside nursing care, accommodation, medication and other services as necessary. In such cases, consultants typically negotiate their fees with the independent provider and not directly with the NHS trust. Some NHS consultants do also undertake sessions in independent hospitals working directly for their NHS employer (with the independent provider being responsible for the provision of the facilities and associated nursing and other services). However, the Government does not believe it would be appropriate to require NHS employers in such cases to publish details of individual consultants' remuneration.

Equity in Access

- (h) **It would be invidious if the uneven geographical distribution of independent sector provision exacerbated inequalities in waiting lists and times. Therefore we recommend that further money aimed at reducing waiting lists and times should not be earmarked specifically for Concordat activity or restricted to the use of private and voluntary sector provision but should be available for use in whatever way is best suited to local circumstances. This may include the development of local NHS capacity.**

Strategic health authorities are in the process of carrying out a comprehensive capacity planning exercise to identify local capacity requirements and ways of meeting them. These plans will inform strategic decisions about the development of new NHS capacity, as well as the use of existing spare capacity within the independent sector. By taking a strategic approach to capacity planning, we will avoid the inconsistencies and inequities that can result from looking in isolation at particular elements of capacity.

It is the Government's intention to reduce to a minimum the earmarking by the Department of Health of local NHS resources, so that primary care trusts will have discretion over how growing NHS resources are used. However, by its very nature, earmarking is used to address specific issues at specific times, and therefore we do not think it would be sensible to rule out categorically any particular use of earmarked funding in the future.

- (i) **A basic tenet of the National Health Service is that there should be equal access for those with equal need. This principle underpins the Government's policy of national targets for waiting times, for access to cancer treatment and the progressive development of national service frameworks. Strategies for the development of services take account of the drive for equity of provision, though clinicians themselves will rank the priority of individual patients. We judge it to be essential that the use, by the NHS, of clinical capacity within the independent health care sector does not depart from these positions. NHS waiting times should therefore be maintained on a basis that ensures equity of access to health care services contracted from the independent sector irrespective of the locality of the commissioning authority.**

The Government agrees that the use of the independent sector to treat NHS patients must be governed by the fundamental principles of the NHS, including the principle that care should be free at the point of use and provided in accordance with clinical need, not ability to pay. It believes that the use by the NHS of spare capacity in the independent sector promotes equity of access by enabling NHS patients to be treated sooner than might otherwise have been the case.

In future, it is likely that primary care trusts, either singly or jointly, will increasingly contract with independent sector providers for blocks of service over a period. Those independent providers will, like NHS trusts, be expected to prioritise the referrals they receive from different sources.

We will expect the primary care trusts commissioning such services to ensure that the independent providers prioritise in accordance with best NHS practice.

However, contracts with independent providers are often for the treatment of a relatively small number of patients of broadly equal clinical priority who have already spent some time on a NHS trust's waiting list. In these cases, the patients effectively remain on the relevant NHS trust's waiting list and the independent provider is required by its contract to treat each patient within a fixed and, typically, quite short time. In such cases, the independent provider has no control over the time that patients have been waiting before their care is "sub-contracted" in this way. It could therefore be that an independent provider has such contracts with more than one trust, whose patients have been waiting for different periods.

In these circumstances, the Government believes that it would neither be practical nor sensible for an independent provider to delay treatment of one group of NHS patients until it had completed treatment of patients from another trust who had perhaps waited longer, any more than it would be sensible for one trust to delay treating its patients until its waiting times matched those of another trust. That would mean levelling down standards of access rather than levelling them up. It will be sufficient for the provider to ensure that all the patients are treated within the periods fixed in the relevant contract.

Independent providers should not, of course, accept contracts to treat NHS patients unless they are capable of executing them fully within the specified times. In the unlikely event that a provider could not fulfil multiple contracts without distorting clinical priorities, we would expect it to raise the problem with the relevant NHS bodies, who would between them agree an appropriate solution. Primary care trusts are expected to ensure that all patients for whom care has been commissioned will receive treatment within the relevant waiting time standards.

Value for Money of Concordat Activity

- (j) The results of the East Surrey survey of the costs of Concordat activity are encouraging, but given the very wide regional variations in the costs of work carried out under the Concordat, we find it hard to see how the public can be confident it is always getting value for money. Moreover NHS reference costs, which are themselves subject to wide variation, are not yet an appropriate means of judging value for money. We believe that the Audit Commission should urgently review a representative sample of this activity to assess value for money. We also believe that the Department should take urgent steps to improve the methodology underlying NHS reference costs so that they can eventually act as a meaningful benchmark.**

The Government has been open about the fact that some NHS bodies have been more successful than others in negotiating prices with the independent sector. However, experience shows that the best prices available are competitive against the costs of providing services within a NHS trust.

To improve value for money (VFM), we are encouraging NHS bodies to take a more planned and co-ordinated approach to commissioning. Best prices are unlikely to be obtained by spot purchasing. Better prices can be negotiated by commissioning larger volumes of activity more evenly spaced across the year, rather than only during winter months, when the independent sector, like the NHS, tends to have less spare capacity available.

The Government does not accept that NHS reference costs currently fail to provide meaningful benchmarks for the true cost of providing NHS services. Reference costs provide useful management information to health bodies on how their costs compare. They are interpreted locally in the light of local knowledge of the circumstances of each health body. Reference costs are not in themselves a sufficient measure of value for money, nor will they be in the near future. But they assist in the assessment of VFM alongside indicators relating to the quality of service delivery. When contracting with independent providers, the NHS will be expected to be alert to the prices that they are being asked to pay, as they would for any procurement, and reference costs offer a benchmark for individual aspects of healthcare.

The reference costs quoted in the Committee's report were for 1999/2000. Since then a number of actions have been taken to further improve the robustness of reference costs:

- the NHS Costing Manual has been revised and the costing guidance has been tightened in a number of areas. This continues to be an iterative process and responds to issues raised in each year's collection;
- District Audit have led work in some local areas to audit the reference costs process as part of the final accounts audit processes;
- a verification process has been introduced which allows all NHS organisations submitting reference costs the opportunity to verify their individual organisational data prior to the production of consolidated figures. The previous year's averages are used as a baseline for comparison in the verification report and levels of variation from this mean are shown to assist each organisation in assessing the reliability and reasonableness of the figures produced by costing systems;
- the statement of compliance to be signed by the Finance Director of each organisation has been amended to state that the individual confirms that the costing has been carried out in line with all the current costing guidance and the NHS Costing manual.

(k) We are also concerned that independent providers may sell activity to the NHS with a view to establishing a dependence on their services which would then put them in a position to increase prices to the NHS in the future. We have received no assurance that if there is to be a longer term relationship with the private sector then contract prices with the NHS will be protected in the longer term. Where spot purchasing is taking place, for example to reduce waiting lists, in general we would expect the prices to be below relevant NHS

reference costs as the NHS should be able to use its bargaining power to pay not much more than marginal cost for this activity. We recommend that the Audit Commission is given a right of access to independent sector providers of NHS healthcare, and that “open book accounting” principles should operate in respect of these providers.

In the medium term, the Government’s intention is that NHS services will be commissioned from all providers, whether public, private or voluntary, within the same overall financial framework. This will provide standard tariffs based on Healthcare Resource Groups (HRGs), or other appropriate measures, for activity regardless of provider (although reflecting unavoidable differences in costs in different parts of the country). By 2005-06 most funding flows for NHS hospital treatment will be based on a price per case in this way.

Including independent providers within the overall system of standard tariffs will provide a new framework of prices within which the NHS locally may negotiate contracts focusing on volume, appropriateness and quality. This will in turn protect the NHS against the kind of increased prices to which the Committee refers and will facilitate the implementation of genuine choice for patients. We will be working with the NHS and with independent providers to develop and pilot these new arrangements, and to ensure an orderly transition.

All arrangements for NHS patients to be treated by independent sector providers must be based on an appropriate legal contract, covering amongst other things robust arrangements for financial audit. “Open-book accounting” principles are likely to be appropriate where the NHS is the main or exclusive purchaser of services from a given facility, for example an independently run diagnostic and treatment centre. However, they will be less appropriate where the NHS is only one of a number of commissioners, for example, where it is commissioning only spare capacity within an existing independent hospital.

In April 2002, the Government announced the creation of a new independent healthcare inspectorate, which will bring together the work of the Commission for Health Improvement, the private health care role of the National Care Standards Commission and the health value for money work of the Audit Commission. Rights of access will be considered as part of the development of that new body.

- (1) **We further recommend that the Government introduces guidelines on the basis of which all NHS trusts will be required to develop explicit, publicly available protocols setting out the principles governing their use of the independent sector.**

In April 2002, the Department of Health issued Health Service Circular 2002/007 *Securing Service Delivery: Commissioning Freedoms of Primary Care Trusts* reinforcing the discretion PCTs have in commissioning care for NHS patients. It stated that PCTs should feel free to commission care from wherever they can obtain the best services for patients, and that commissioning decisions should be judged against the twin tests of high clinical standards and good value for money. These are

the key principles by which all NHS organisations should enter into partnerships with the independent sector. It is, of course, important that decisions about the use of the independent sector are fully consistent and integrated with local NHS strategies and that patients and the public are properly involved and informed, but the Government does not think that it would make sense to mandate the way in which this should be done.

The Interoperation of Public and Private Healthcare: Regulatory and Training Issues

- (m) We note that the Government plans to make regulations so that the Commission for Health Improvement may exercise the National Care Standards Commission's function of inspection in relation to independent hospitals. We would be very concerned if such arrangements resulted in a diminution of health care skills in the regulation and inspection of nursing and health care services provided to people accommodated in social care settings – including those of care homes in which nursing care is provided**
- (n) Our predecessor Committee's report into the Regulation of Private and other Independent Healthcare drew attention to some of the difficulties caused by separate arrangements for the regulation and accountability of the public and independent sectors. Ever greater degrees of transfer between the two sectors place even greater question marks over the sustainability of separate regimes. In the light of the Government's reply to the Kennedy report and the Secretary of State's argument that CHI and the Care Standards Commission have been developing powers to share their work, we recommend that the Government produces a common regulatory framework as a matter of urgency.**

In *Delivering the NHS Plan* (April 2002), the Government announced the establishment of new health and social care inspectorates. A new health care inspectorate will bring together the work of the Commission for Health Improvement (CHI), the private health care role of the National Care Standards Commission (NCSC) and the health value for money work of the Audit Commission. A new social care inspectorate will bring together the Social Services Inspectorate (currently part of the Department of Health) and the social care functions of the National Care Standards Commission. Legislation will be introduced to establish these new bodies as soon as Parliamentary time allows.

The Government is reviewing how CHI and the NCSC can best work together prior to the introduction of the new health inspectorate, which will have responsibility for both public and independent health care in a common regulatory framework.

The intention is that these joint working arrangements – and the future introduction of a new social care inspectorate – will not lead to any diminution in the health skills in the regulation and inspection of nursing and health care services provided to people accommodated in social care settings.

- (o) **We believe there is a case for the independent sector taking on more of the burden of training staff and call on the Department to consider imposing a levy on the independent sector towards the training, including first qualification, of some health professionals.**

The Government is not currently persuaded that there would be significant benefits in imposing a levy on independent sector employers to support the education of healthcare professionals. The vast majority of people who receive their professional education and training within or associated with the NHS go on to work within the NHS. We will however keep the issue under review.

It should be noted that the independent sector does provide extensive facilities for the support of placements for trainees for the healthcare professions and the Government welcomes their plans for more provision of this kind.

Furthermore, independent acute hospitals treating mainly privately-funded patients employ only a minority of nursing staff in the independent sector. The majority work in independent sector nursing homes where most patients are funded at public expense. It is estimated that around two thirds of an average nursing home's income is derived from local authority or social security payments. The levy of a charge on such homes could shift costs between different areas of public expenditure, and would also be likely to impose a significant burden on private clients in such homes.

In addition, although NHS funding for the tuition of healthcare professionals is drawn from resources for health, it is not directly levied on NHS or independent sector employers. The NHS benefits from the investment from the years in which the staff work in the NHS. The Secretary of State for Health has no existing legal power to charge the independent sector for the training of professionals, so a change would require primary legislation. The maintenance of a level playing field in cost terms would require any levy to be imposed on both the independent and public sectors which would mean significant cost shifting and, potentially, additional bureaucracy within the NHS.

TREATING NHS PATIENTS ABROAD

- (p) **In the short-term at least, we believe that the treatment of NHS patients abroad is likely to prove a fairly marginal activity. Initial patient reactions seem to be encouraging and the excess capacity in continental Europe offers the possibility of the NHS securing good value for money and reducing waiting lists. Clearly it is essential that patients are assured of the quality of the care they receive. So we believe that the Commission for Health Improvement is the appropriate body to inspect standards in hospitals abroad treating NHS patients. It is also essential that robust mechanisms are put in place to ensure that patient follow-up can successfully take place and that the Department sets out clearly the legal implications of adverse clinical incidents.**

The opportunity to travel abroad for NHS treatment is important for individual patients, although the Government agrees that the number of NHS patients travelling abroad for treatment in the future will be a fraction of overall NHS activity.

As a general rule, the Government's preference is to bring spare capacity from other health systems to the patients rather than large numbers of patients travelling to other European countries. This summer there will be some "first mover" schemes to bring clinical teams over to operate in this country. By the autumn the Department of Health expects to have firm plans for how to use clinical teams more widely in the NHS and, with the publication of *Growing Capacity: A New Role for External Healthcare Providers in England*, discussions are also now under way about the potential for new units to be established by independent operators and staffed by overseas clinicians.

To ensure that the referral of NHS patients to other European countries is managed effectively, the Department of Health has set up lead commissioning arrangements. The lead commissioners are based in London and the South of England, as these are the areas of greatest pressure on waiting times. NHS trusts in other parts of England are encouraged to use these arrangements.

The Commission for Health Improvement will look at the commissioning arrangements made by the lead commissioners or other NHS bodies whose patients are treated overseas as part of its review, investigation, or inspection processes in those NHS bodies. In addition, the Government's intention is that contracts with overseas providers will require them to afford reasonable access to CHI and other appropriate bodies.

The Government agrees that it is important that patients receive appropriate follow-up treatment. It is important that patients' care is not made any more difficult at any stage as a result of receiving part of their treatment in a hospital overseas, just as is the case when patients receive part of their treatment in a UK independent hospital. Responsibilities should be made clear in contracts and planning done to ensure that effective arrangements are in place for the whole of patients' care pathways. For example, clinicians working for the French provider involved in one of the pilot schemes in the first part of 2002 travelled to England to undertake pre- and post-operative appointments.

Patients treated overseas remain NHS patients, and the Government's policy is that patients going overseas should have the same rights of redress as other NHS patients. Although patients might also have legal avenues open to them in the foreign courts, the Government's presumption is that patients who wish to pursue litigation will prefer to do so through the English system.

THE PRIVATE FINANCE INITIATIVE

- (q) **PFI is still being blamed for numerous ills not directly related to it whereas the many benefits ascribed to PFI have yet to be proved. The time has come for a more rational and objective debate, and it is the responsibility of the Government to take the lead in achieving this. In order to achieve this there has to be more transparency, openness and accountability.**

The Government welcomes the call for a more rational and objective debate about the Private Finance Initiative (PFI), and accepts the Government's role in this. The Government will continue to provide as much information as possible in response to inquiries and reports, for example to this Committee and to the National Audit Office.

Bed Numbers

- (r) **Those on either side of the argument are adamant in their assertions or denials that PFI has an impact on bed numbers. The planning process is designed to ensure that there is no impact: bed levels are set before the funding route for a hospital is determined. Central Manchester NHS Trust thought that PFI might exert an indirect pressure on bed numbers, though the other three trusts we questioned said that there was no connection between PFI and bed numbers. What is not in doubt is the fact that the lack of transparency in the PFI process has been partly responsible for the impression that PFI can be equated with a reduction in the number of beds. What may also be the case is that the PFI has provided a convenient scapegoat to be blamed for poor bed planning, something which we hope the National Beds Inquiry has addressed. From the evidence we have taken we do not believe that PFI necessarily leads to reductions in bed numbers. We recommend that the government reinforces the planning rules for new hospitals by making it clear to trusts that there should not be any pressure to reduce the capacity of hospitals regardless of which funding mechanism is used.**

The Government welcomes the Committee's finding that the PFI does not necessarily lead to reductions in bed numbers. The Department of Health will continue to provide information on the next waves of major schemes as they reach financial close to demonstrate that this remains the case. As the Committee's report says, the National Beds Inquiry has now brought a national approach to service and bed planning which was set out in Health Service Circular 2001/003 issued to the NHS in February 2001. The circular states categorically that no health authority should plan for a reduction in beds, including general and acute beds, unless there is very clear justification based on exceptional local circumstances.

This requirement has also applied to all the PFI schemes that had not yet reached financial close by that date. All of the 29 schemes approved to go ahead under PFI in February 2001 are planning bed increases or are bed

neutral. The first 17 of these schemes (5 that have already gone to the market and 12 that are expected to be advertised in the next six months) plan an increase in NHS beds of some 1600.

For these and future schemes, the Department of Health requires the bed numbers to be provided in each scheme to be clearly set out right from the beginning to achieve transparency within the national framework. The bed numbers are published in the outline business cases in accordance with the Department's guidance on openness, which means they are available for viewing in the Libraries of the Houses of Commons and Lords as well as in the main public library in the area. The other outline business cases will be similarly published as they come to market.

Value for Money

- (s) Valuation of 'risk' is the key determinant of value for money as between the PFI and Public Sector Comparator. Yet risk valuation is as much of an art as a science. It must, however, be clearly understood that saying that risk is difficult to value is not the same as implying that risk is somehow cost-free. It is not in the interest of the taxpayer to transfer as much risk as possible to the private sector since risk attracts cost. What is essential is that an optimal transfer of risk takes place, with the private sector partner taking only the risks it is best equipped to manage. Again, more transparency would be beneficial, so that the partner best able to manage the risk is identified**
- (t) Given the current discount rate was set when rates were higher, a lower rate may now be more appropriate. We recognise that other factors need to be considered in the current review but we would want to be assured that the fact that the calculations to establish the PSC are so complex is not being used as an excuse to manipulate the PSC to produce whatever result is needed. To stop such a view gaining credence we recommend that the National Audit Office should assess the PSC process as a matter of urgency in the light of any revision of Treasury accounting rules. It is essential that the calculations underlying the determination of the PSC are clear, and that the means by which VFM is established are transparent and in the public domain**

Government policy on risk has always been that it should be allocated to whichever party is best able to manage it. The Department of Health has had a risk allocation matrix in its guidance for trusts for several years with recommended optimal positions for health schemes, although each scheme has to consider risk on a case by case basis to reflect its own circumstances. Risk evaluation and costing is a complex area and to standardise approaches and improve consistency, standard risk register pro-formas were introduced at the same time as the risk matrix. The completed forms must be included in annexes to business cases, which are made public.

Detailed guidance has also been produced on developing Public Sector Comparators (PSCs) by the Treasury and the Department of Health. Calculation of PFI and PSC options must be clearly set out in the business case. The value for money (VFM) calculation is assessed by the

Department of Health's Economics and Operational Research Branch when the cases are submitted for approval. Discounting cash flows has been the method advocated by the Treasury to establish VFM between different investment options since the 1970s and the current rate of 6% predates PFI. It is therefore not a rate set to favour PFI. There are a range of views over what rate should be used and what it represents and these are currently being considered in a review by the Treasury.

The Public Sector Comparator

- (u) The question of a realistic Public Sector Comparator (PSC) has to be addressed. Comparing the PFI with the PSC may well prove that the PFI is value for money against an artificial comparison, without proving that it is value for money in absolute terms. We recommend that the Department refines the way in which the PSC is constructed. What needs to be carefully assessed is how great the non-VFM benefits are and to what extent they are directly a result of the financing mechanism. We further recommend that the National Audit Office undertakes immediate urgent studies of several major health schemes to establish the economic aspects of VFM: it is the appropriate expert body and is statutorily independent of Government. Given the enormous expenditure consequence of PFI schemes, and their long-term nature, we would ask the NAO and the Department to work to a tighter time table than they would normally follow in drawing up such assessments and to report their preliminary findings to this Committee as well as the Committee of Public Accounts.**
- (v) And, as it is the case that some of these [new hospital build] schemes would not attract conventional funding then the NHS should be transparent about this and in these schemes the real comparison to be put to the public should be the comparison between the PFI and the costs and benefits of not proceeding with the PFI project**

Trusts are required to assess non-financial factors between options in both their outline business case and full business case. Weighting and scoring techniques are the suggested way for factors like access, flexibility and functionality to be compared between the PSC and PFI options. PFI Technical Note 5 issued by the Treasury sets out the principles for constructing public sector comparators which are followed in the NHS. That may be subject to change as a result of the current review by the Treasury and the Department of Health will adopt any amended guidelines.

The National Audit Office (NAO) looks closely at the value for money analysis as part of its examination of individual PFI projects. Many such reports have now been completed on PFI projects across all areas of Government activity, including health. The NAO is currently examining the major West Middlesex NHS Trust PFI scheme. Their report is expected in the autumn. The Government welcomes NAO investigations and reports into any NHS PFI scheme. However it is up to the NAO to decide on which projects or issues they wish to examine in their future work programme.

If schemes could not attract conventional funding the Department of Health would ensure that this was clearly stated in the business case. The department's guidance will reflect this when it is next revised. If public funds are not available, then this is equivalent to a "do nothing" option which is one of the options considered at outline business case stage. Another option will have been preferred on cost benefit grounds and this is the option which is worked up into the public sector comparator. As PFI has been shown to be better value for money than the PSC then it follows that PFI will be better VFM than the "do nothing" option.

The NHS as Purchasers

- (w) **For the NHS to purchase capacity by means of the PFI in a consistent and informed fashion it must provide trusts with a relevant pool of experience upon which they can draw. Trusts are often negotiating PFI contracts for the first time with companies who bring far greater experience to bear. There have been some advances. The Department's central PFI unit has made great strides since the earliest PFI projects and the standardisation of contracts and other documentation has clearly been most beneficial. But we would prefer to see greater sharing of central expertise. We recommend that the Department takes responsibility for ensuring that there is a cadre of people with wide-ranging experience and expertise in dealing with PFI available to each trust negotiating a new PFI project.**

The Government fully agrees with this recommendation. The guidance *Improving PFI Procurement* issued to the NHS in March 2002 included an outline of future developments within the Department of Health Private Finance Unit (PFU) to enable appropriate advice and support to be channelled towards those trusts which need it.

Measures being taken include the following:

- the PFU will be increasing its staffing complement to ensure projects receive a higher level of support and guidance. The aim is for all schemes to benefit from mentoring by a PFU consultant on a one-to-one basis right from the start;
- the department is to apply the Office of Government Commerce "Gateway" process to provide independent peer review of NHS schemes at stages in the procurement to advise project teams and ensure that best practice is applied to their project management. It has appointed a Gateway director and in due course a Gateway team will be recruited by the PFU;
- a project directors' course has been established by NHS Estates at Lancaster University which is now on its third intake. Similar programmes have been established with South Bank University and Portsmouth University, which will commence in September 2002;
- several project directors and managers on the schemes approved to proceed with PFI in February 2001 are now on their second projects. For example, the project directors at Bradford, Walsgrave and Oxford Radcliffe have all been through the PFI process before with other schemes.

The PFU has also recently produced further standardised documentation, for example, output specifications and preliminary invitation to negotiate documents which are now available on a website. These enable NHS trust personnel to concentrate on project-specific matters.

PFI Contracts

- (x) **For the debate on PFI to move forward far greater transparency is needed. Lengthy and impenetrable documents do little to inspire confidence in the process. This is an obstacle to objective scrutiny. We recommend that it should be a requirement of the PFI proposal that simplified summary documentation, including a financial summary, should be produced in a standard format and in a form intelligible to lay readers for all stages of the PFI procedure and the PSC**
- (y) **PFI documentation should be made more accessible. While there clearly exists a tension between the imperatives of commercial confidentiality on the one hand and openness in the decision making process on the other, we believe that the Government has to give the lead here and insist that, in privately financed but publicly funded projects with such long-term revenue consequences, the balance should be tilted firmly in favour of greater openness (paragraph 109).**

The Government has taken a number of initiatives to try to ensure transparency in the PFI process. These include making business cases available in public libraries, involving Community Health Councils in consultation on substantial developments and encouraging trusts to involve trade union representatives in discussions with short-listed bidders.

However, we accept the Committee's recommendation that more could be done and we will in future require both outline business cases and full business cases to include a short, succinct executive summary to provide a clear overview of the key aspects of the scheme. These will be published on NHS websites. Also, the Department of Health PFU is to commission a plain English summary of the standard form contract which will be made available to all trusts and to the general public.

A number of PFI schemes already have dedicated websites to provide information to the public. The department will extend this practice and request that each trust undertaking a major PFI scheme establishes such a website so that up-to-date information and business cases are made more readily available to the public.

The Impact of PFI on the Local Health Economy

- (z) **It could be argued that PFI has the potential to inhibit long-term flexibility in the light of new technologies and changing patterns of care. The Government must ensure that PFI contracts are sufficiently flexible to be able to respond to changes in demand without major penalties to the NHS. Therefore we recommend that the Department should assess the future structure and requirement for health assets and that all future contracts- whether PFI or conventionally funded – should be examined in this light.**

From the beginning of the PFI hospital building programme in 1997-98 the Department of Health has recognised the inherent risks and uncertainties involved in service planning. The PFI guidance has placed emphasis on patient environment factors and output specifications sent to bidders must state that flexibility and adaptability should be key features of the design to allow for changes throughout the 30 year contract period. This is formally recognised in the PFI contract between the parties with a 'variation of services' clause allowing for this. Contract clauses on equipment allow for replacements to keep up with technological advances. Costs will be incurred by trusts if PFI contract service variations arise and assets have to be adapted for alternative uses, but it should be noted that similar costs would also be incurred on publicly funded schemes.

All the new PFI hospitals incorporate modern features, for example the "patient-line" initiative (access to TV and telephone via consoles) and telemedicine facilities. Most schemes have also been taking the opportunity to re-engineer their internal work processes in line with the latest initiatives in service delivery, in particular the separation of emergency from elective procedures, in line with development of diagnostic and treatment centres (DTCs).

However, we recognise the Committee's concerns on long term flexibilities and the department will keep the contract terms and other aspects of the PFI process that bear on flexibility under review to look for opportunities to make improvements.

Staff Transfers

- (aa) **There is no dispute that staff transfer [in PFI projects] has proved a highly contentious issue, and there are genuine concerns about the creation of multi-tier workforces working with different pay and conditions. If staff transfers are an inevitable part of the PFI process then greater thought needs to be given to ensuring that NHS and private sector staff have a clear understanding of their roles and duties. We were impressed with the Patient Focus Care model in Durham and believe that the Retention of Employment Model offers the greatest potential for a well integrated workforce. We recommend that the Department redoubles its efforts on the Retention of Employment Model and look forward to seeing the results of the pilot schemes.**

The Government welcomes the Committee's endorsement of the Retention of Employment model (RoE). All sides – trust staff and management, private sector bidders and unions – involved in the pilot schemes have devoted a good deal of time and effort into developing the operational and personnel aspects needed to put the model into operation. Two of the pilot schemes are approaching financial close, which will be subject to business case approval, and following this the Department of Health will look to roll the model out across the NHS.

Design Issues

- (bb) Closer input into the design process [of PFI projects] by trust staff would be beneficial. We recommend that staff should have a greater input in the design phase, even to the extent of requiring that there should be a full mock up of a ward in advance of building work taking place. We also recommend clinical expertise is actively involved in the PFI team in order that functional and clinically operational relationships are understood and incorporated in the design of the project.**

The Department of Health's PFI guidance for trusts states that clinical staff and other departments are to be represented on the project board and project teams from the start, and in practice this happens on all projects. Trusts set up their bidder evaluation teams to include both clinical and non-clinical staff to assess and comment on designs. Nominated clinicians have to sign off the designs before projects can be approved. We recognise that the most successful projects tend to be those that have high levels of involvement of the trust staff who will use the facilities. We therefore encourage trusts to involve fully clinicians and other health staff throughout the design process.

A number of recent steps have been taken to put greater emphasis on the wider issue of hospital design. NHS Estates has entered a partnership initiative with the Prince's Foundation which aims to raise the awareness of the importance of good design of new healthcare facilities, to provide expert guidance on initially five schemes and to provide an accessible source of information and expertise in the area. As part of this initiative the department is also encouraging trusts to appoint a design champion to their project boards, who could be a non-executive director with an interest in design, to oversee design issues.

NHS Estates have also developed a design evaluation toolkit (AEDET) which is available on their website. This provides a methodology for evaluating and tracking the design development of health building projects and assists healthcare planners to develop design output specifications. The department is also revising the design development protocol for PFI schemes to update it and also include emerging best practice.

- (cc) Given that PFI is relatively new, that the money tests are often marginal and that those tests have created much uncertainty, we recommend that more capital monies are made available for major conventionally procured schemes so that PFI schemes could then be properly monitored against a significant number of conventionally procured schemes and the lessons from both learnt for the future.**

The Department of Health is continuing to progress both PFI and public capital schemes. Four major public capital schemes have been completed since 1997 and two major public capital schemes and a number of medium sized schemes are in construction at present. Data on these schemes is provided to an NHS Estates database to establish the rolling average benchmarks for cost and time over-runs, which are recalculated each year.

These benchmarks are then used in the PSC comparison with the PFI solution. NHS Estates also are closely involved with publicly funded schemes and good practice is fed back in their guidance.

PFI has now matured as a procurement method with 11 major schemes now open and treating patients. Public capital is not unlimited so using PFI mainly for the large schemes enables more public capital to be used for other much-needed investment such as equipment and refurbishment. The Department of Health considers that value for money needs to be the deciding criterion of the procurement route so that the best use is made of taxpayers' funds.

- (dd) LIFT is in its infancy, but we believe it does offer the potential to rejuvenate the current stock of primary care facilities in those areas of greatest need. We welcome, in principle, this initiative. However, we recommend that the Government carefully monitors LIFT to ensure that it is directed so as to ensure provision in areas of highest need and promote greater integration of primary healthcare provision.**

The first wave of LIFT schemes was announced in February 2001. They are: Barnsley; Camden and Islington; East London and the City; Manchester, Salford and Trafford; Newcastle and North Tyneside; and Sandwell. Five of these schemes have already been advertised in the Official Journal of the European Communities (OJEC).

The Department of Health deliberately targeted areas with the highest levels of need. Each first wave LIFT is in a health action zone. Health action zones are located in some of the most deprived areas in England. Each locality has a disproportionately high number of sub-standard premises and each of the LIFT areas have relatively poor access to integrated services.

Before each LIFT will be allowed to proceed, a robust business case will be submitted to the Department of Health demonstrating that the project is viable and showing evidence that the scheme is signed up to promote greater integration of primary healthcare provision.

The Government is committed to greater integration of primary healthcare provision. The NHS Plan identifies a target of 500 one stop shops by 2004. New one stop centres will include GPs, dentists, opticians, health visitors, pharmacists and social workers. NHS LIFT will develop a number of these centres.

- (ee) We accept that the pre-LIFT mechanism would often have involved private sector schemes however, we believe that it would have been prudent to conclude the assessments of the first six schemes before rolling out LIFT nationally. We recommend that the Government undertakes a rapid assessment of the first schemes, both in terms of value for money and service provision, though we recognise the urgent need to refurbish the primary care estate.**

All LIFT schemes, irrespective of which wave they fall under, will be fully assessed to demonstrate that they are value for money.

Because there is a pressing need to improve the primary care estate in England (over 60% of the current primary care estate is over 30 years old and very often in a poor state of repair), the Department of Health is actively seeking to co-locate additional services and facilities. For example, space could be used by a range of related health care professionals as well as social services, pharmacists and dentists.

The Department of Health is also providing technical assistance to help primary care trusts develop their investment proposals, and is confident that all localities will attract private partners offering affordable solutions.

- (ff) **We recommend that health authorities should be asked to prove that work has been carried out to show that LIFT schemes have been considered in the context of integrated strategic planning of healthcare assets. We recommend that the business planning process for LIFT and acute hospital PFI schemes should be required, at every stage, to take a whole systems approach, that is, to look at the potential for an integrated local approach.**

The Government agrees with this recommendation.

The Department of Health has adopted a whole health economy approach to the business planning process for the last two years. The major PFI schemes approved to proceed in February 2001 were required to consider their redevelopment impact on acute, intermediate and primary care services. Each proposal had to be linked to the local Health Improvement Programme and receive the support from their health authorities and local primary care organisations to ensure the developments were consistent with the strategic plans of all related health services. The schemes were also encouraged to develop fully vertically integrated proposals across the acute, intermediate and primary care sectors with private sector consortia. The PFI schemes at Torbay and Wolverhampton are examples of this approach with both schemes including acute and community services. Schemes are also required to consider capacity issues, such as admission and discharge arrangements, with all local health and social services organisations as part of their business case.

The first stage in the development of a LIFT scheme is the production of a Strategic Service Development Plan (SSDP) which must be produced by the PCT. These SSDPs require localities to demonstrate an integrated approach to service planning for the needs of the local community. All first and second wave schemes are actively engaged with local authorities and other stakeholders in producing their SSDPs.

PATHOLOGY AND PUBLIC PRIVATE PARTNERSHIPS

- (gg) All sides to the debate [on pathology services] accept the need for rationalisation and structural reorganization and we are attracted to Professor Lilleyman's suggestion that the new strategic health authorities are the appropriate level at which, or areas within which, new pathology networks can be organized. The evidence we have seen suggests that private sector providers have introduced greater efficiency without compromising clinical standards. This, we believe, is partly due to the fact that clinicians have been closely involved at every stage of the reorganization. We especially commend the model of having NHS consultant pathologists in charge of on-site laboratories where "hot" testing takes place, whilst off site laboratories are left to handle large volumes of cold testing.**

Based on growing experience in the NHS, the Government believes that integrated networks offer the best way to plan and manage a comprehensive pathology service to meet the needs of local health systems. Their larger size allows new technologies and modern information systems to be brought in, leading to increased quality and efficiency. They allow more efficient deployment of staff and equipment and more effective sub-specialisation. They also offer better opportunities for training, education and career development and provide increased professional support.

In June 2002 the Department of Health published draft guidance for the NHS on modernising pathology services, *Pathology: the Essential Service*, seeking views on managed networks as a new model of service delivery for pathology. The consultation paper also suggests that such networks should serve populations equivalent to those served by strategic health authorities and seeks views on this point.

The department has not proposed specific models of service organisation within these networks. It would be a matter for local judgement, depending on local health needs and local circumstances, whether to centralise non-urgent services off-site. There are already a variety of service configurations in place in the NHS, providing high quality and effective services. However, we agree that it is vital that clinicians should be involved in every stage of reorganising pathology services to ensure that high quality, cost effective and efficient services are available for patients and their doctors.

- (hh) We would agree with Mr Spiller of MSF and Ms Wannell of West Middlesex University Hospital Trust that a variety of models need to be tested, and it seems to us that many of the benefits being achieved by the private sector companies could be achieved within mainstream NHS provision if sufficient investment were made.**

The NHS Plan pledged to explore with the independent sector its potential contribution to modernising pathology services. Improved working conditions and service provision requires significant investment.

Collaboration with the independent sector can make a positive contribution.

However, the independent sector has more to offer than investment in facilities, for example, expertise and resources to work with the NHS to develop cutting-edge new technologies and tests which will improve services for patients. The independent sector also has expertise in process re-design, procurement procedures and project management, all of which are key to modernising pathology services.

To support this and to test a variety of models, the Government is investing £8 million capital funding in four large-scale pathology modernisation projects in Leeds/Bradford, Pathlinks (Lincolnshire), Teespath (Teesside) and North West London. The Teespath and Pathlinks projects are exploring joint ventures with the independent sector. The Department of Health will be evaluating all the projects and their outcomes.

The Government believes that the independent sector has much to offer in this area and will encourage the NHS to work in partnership with independent sector organisations to use their expertise and resources to improve pathology services and deliver high quality diagnostics for patients.



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