Staffordshire County Council

Scrutiny Review of the Commissioning/Contractual Arrangements for the Midlands NHS Treatment Centre in Burton upon Trent

Final Report

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Scrutiny Review of the Commissioning/Contractual Arrangements for the Midlands NHS Treatment Centre in Burton upon Trent

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Chairman's Foreword

This is the first time that we have undertaken scrutiny involving an independent health care provider and I would like to thank the Midlands NHS Treatment Centre for co-operating in this review. I am also grateful to the other health representatives involved for their contributions.

I have, however, been disappointed that there has been some information about the contract for the Centre that has not been available to us. Transparency, accountability, public involvement, and public scrutiny are essential when large sums of public money involved - if the public are to have confidence in the organisations serving them.

I would like to thank Jim Muir, the former Chairman of the Staffordshire Health Scrutiny Committee, for instigating this review in response to considerable public interest in the Centre. Thanks are also due to my fellow Panel Members and Graham Jones from the Centre for Public Scrutiny for bringing a breadth of perspective to our work.

We would like to think that the attention our scrutiny review has drawn to the issue of Independent Sector Treatment Centres has in no small way contributed to the announcement by Health Minister Mike O'Brien in July 2009 (as we were concluding our work) that:

"The future use of Independent Sector Treatment Centres in the NHS will be fairer and on the same terms as other providers of NHS services"*;*
and that

"each contract will be reviewed on a case-by-case basis and new services will be commissioned by the local Primary Care Trust where they are designed to meet local needs, provide value for money and benefit the patients in that community"*.*

This is what we want and we look forward to playing our part in making sure it happens.

County Councillor Janet Eagland
Chairman of the Health Scrutiny Committee
October 2009

1. Conclusions of the Scrutiny Review Panel

1.1 The Review Panel commends the recent improvements at the Midlands NHS Treatment Centre (MTC), recognising the work of the staff for the quality of care provided.

1.2 We have found that some considerable effort has been put into relationship management by the various organisations involved in trying to make the MTC perform effectively as part of the local health economy.

1.3 We have found evidence of work to improve the utilisation of the contract and facilities. We have also found some innovative service and patient pathway redesign.

1.4 The Review Panel have not found sufficient evidence of the wider benefits of the Treatment Centre model to say whether it is one that should be extended. However, we agree that it is important to continue to develop models of care to provide quality, value for money and improve waiting times.

1.5 We do not agree that innovation is more likely in independent provision than in NHS provision but accept that having a variety of providers can stimulate development.

1.6 Inviting in new players and complex contractual arrangements have led to a loss of transparency and significant transactional costs, which have meant a lack of value for money. Where large sums of public money are involved, transparency is particularly important. Therefore, we welcome the news that future contracts with the independent sector will be based on standard NHS contracts and tariffs and hope that this will support greater transparency and value for money.

1.7 We cannot say that there has been a major contribution to the long-term development of relationships between the independent sector and the NHS in the attainment of local NHS targets. Evidence of direct impact on targets is scant. However, we think that there has been learning and that relationships are likely to develop with the drawing up of new simplified contracts.

1.8 In terms of the general development of commissioning from the private sector, it will be important to achieve a balance between competition (on the basis of added value) and collaboration so that the system is responsive to the interests of patients and taxpayers, with supply shaped by the needs and choices of patients.

1.9 The Review Panel has some reservations about the concept of choice given the overriding importance of quality but agree that choice should be promoted within the healthcare system with integrity.

1.10 Moving forward, the Review Panel thinks that it is essential that there is local determination of where capacity is needed to ensure that future arrangements are well based in understanding of local health economy and needs and that services are developed where they are clinically and cost effective.

1.11 Commissioning expertise needs to be developed to make sure that the process of capacity planning is robust, and takes account of cultural factors - to make sure that the right amount of affordable capacity is developed in the right localities.

1.12 There needs to be public involvement in and public scrutiny of commissioning processes, particularly in regard to local determination of quality. Decision making and performance management arrangements need to be robust and enable the impact of independent sector provision to be judged and managed to best effect.

1.13 The Review Panel welcomes the intention to consider all options for the future and to proceed to open tender. We are pleased that this work is starting now. It will be important for the various organisations involved to work together to ensure that the MTC facilities (which have a wide range of potential uses) are used to meet local health needs best and that organisational interests are not placed above these.

2. Setting the Scene

2.1 The Midlands NHS Treatment Centre is part of a national Government programme for Independent Sector Treatment Centres. It is a purpose built health care facility where a range of planned surgical and diagnostic services are delivered. It is located in the grounds of Queen's Hospital in Burton upon Trent.

2.2 The MTC opened in 2006 and initially received extensive negative publicity and patient complaint. Examples of patient experience included multiple cancellations and it became evident that on several occasions consultants had no lists (of patients to see) on the days that they were allocated to work at the MTC.

2.3 During 2007/08, the Staffordshire Health Scrutiny Committee Chairman and representatives from Stoke-on-Trent City Council, Derbyshire and Leicestershire County Councils and East Staffordshire Borough Council met to discuss the management and operation of the MTC. A new company subsequently took ownership of the MTC. Members received information from the new owner and from South Staffordshire Primary Care Trust (the lead PCT for commissioning services at the MTC). Some Members had also visited the MTC.

2.4 It was found that there had been significant improvement in the management and operation of services provided at the MTC. The Chairmen of the Staffordshire and Derbyshire Health Scrutiny Committees made this joint statement: "We find improvement in patient care encouraging and we offer our assurance that we will continue to monitor provision at the Treatment Centre to ensure that progress is maintained and earlier fears alleviated."

2.5 Further discussion of this matter took place in the regular, informal meetings held between the Chairman and Vice-Chairman of the Staffordshire Health Scrutiny Committee and the Chief Executives of North and South Staffordshire PCTs and Burton Hospitals NHS Trust (now a Foundation Trust). The Chairman considered that there was scope for further scrutiny around the commissioning/contractual arrangements, to identify learning points for future arrangements, in the context of the delivery of the intended benefits for patients and value for money for the taxpayer. Therefore, Terms of Reference for this work were developed.

3. Terms of Reference

3.1 The objectives for the Scrutiny Review Panel were:

- To review the commissioning/contractual arrangements for the MTC.
- To highlight any learning points that may inform the provisions of future commissioning/contractual arrangements.
- To make any recommendations that, if implemented, will contribute to the delivery of the intended benefits for patients.

3.2 The scope of the Review Panel's work was:

- To understand the aims of the creation of Independent Sector Treatment Centres (ISTCs) and what this provision is intended to deliver.

- To understand the commissioning arrangements in respect of the MTC in Burton upon Trent and the nature of the contract for the MTC, including any adaptation to match provision to local need.

- To be aware of the performance management context for the MTC in respect of regulation and any role of the Strategic Health Authority.

- To consider the relationships required to support the effective operation of the contract (including the role of the sponsoring Primary Care Trusts (PCTs) and other parties in developing these relationships), with specific reference to the relationship between the MTC and acute hospital trusts.

- To gain a picture of current performance in respect of the contract/expectation of delivery and to explore the contract/performance management arrangements - this to include:

    - the benefits anticipated and delivered;
    - any action planned/being taken to improve performance/utilisation of the contract;
    - the contribution of the parties involved to the integration of pathways of care; and
    - the flow of information to support contract/performance management, including learning from the patient experience.

- To find out what happens when the contract ends.

3.3 In addition, the Review Panel were to consider the role of scrutiny in helping to ensure that the intended benefits for patients are delivered in the context of their engagement in the planning, provision and operation of care.

4. Membership

4.1 The membership of the Scrutiny Review Panel was as follows:

Members	Representing
Councillor Jim Muir Councillor Janet Eagland	Staffordshire County Council: Staffordshire Health Scrutiny Committee
Councillor Alan Jones	Derbyshire County Council: Healthier Communities Improvement and Scrutiny Committee
Dr Guy Daly	Independent Panel Member

Note Stoke-on-Trent City Council and Leicestershire County Council were invited to participate. Stoke were represented by Mandy Pattinson, Scrutiny Officer. Leicester requested to maintain a watching brief.

4.3 The Chairman was aware of the potential for the review to be seen as contentious and, therefore, sought to involve an independent member. Dr Guy Daly is from the University of Coventry and has undertaken research in governance within local government and the health service.

4.4 The Review Panel has also benefited from the involvement of Graham Jones through the Centre for Public Scrutiny Expert Adviser support that is available to health overview and scrutiny committees. Graham is a lecturer in social science and health at the University of Sheffield, a peer inspector for Health Inspectorate Wales and a former senior NHS manager. He assisted the Panel with developing lines of enquiry, questioning and drawing conclusions from the evidence gathered.

5. Methods of investigation

5.1 The scrutiny process involved:

- background research;
- writing to local MPs asking if they wished to make any comments or wished the Panel to follow any particular lines of enquiry;
- interviews with representatives of the PCTs in Staffordshire and Stoke-on-Trent and Burton Hospitals NHS Foundation Trust;
- a meeting at the Midlands NHS Treatment Centre with the Manager, consultants and senior management team;
- a conference call with representatives of the Strategic Health Authority (NHS West Midlands);

- questions to the other acute hospital trusts in Staffordshire; and
- a conference call with a GP representative of the South Staffordshire Local Medical Committee.

6. Findings

The Review Panel's lines of enquiry and findings are set out below. Comments and recommendations are at the end of each section (and summarised in the conclusions set out at the beginning of this report).

6.1 The aims of the creation of Independent Sector Treatment Centres (ISTCs) and what this provision is intended to deliver

6.1.1 The Government's intention to use the independent sector to benefit patients was set out first in The NHS Plan (Department of Health, July 2000). The Treatment Centre programme, with some facilities run by the NHS and some by independent sector providers, was part of a wider programme of health investment and reform. The programme was intended to create a more diverse provider base, giving patients greater choice and reducing waiting times for treatment (through increasing clinical capacity). The first Independent Sector Treatment Centre (ISTC) opened in October 2003.

6.1.2 The Government stressed that the involvement of the independent sector was not to be viewed as a departure from the NHS's values, which are: a health service funded by all, available to each person equally, free at the point of use, with care based on need and not ability to pay. The Government made a commitment to using independent or not-for-profit providers if they could help the NHS provide better services for patients and better value for taxpayers.

6.1.3 Treatment Centres are dedicated units that provide pre-booked day and, in some cases, short-stay surgery as well as diagnostic procedures in a range of specialties, for example ophthalmology and orthopaedics. These may include hip and knee replacements, hernia repair and gallbladder and cataract removal.

6.1.4 The Centres are located across the country in a variety of settings: some are refurbished sections of existing hospitals, or new buildings and some are mobile units. Centres are staffed in a number of ways: entirely by NHS staff; a mix of NHS and independent sector staff; by NHS and overseas staff working together; or entirely by independent sector staff.

6.1.5 The core objectives of the ISTC programme were to:

- support the NHS in reducing waiting times (meeting the 18 week waiting time target);
- support choice and contestability;
- create an independent sector market that delivered Value for Money;
- support the shift from secondary to primary care;
- promote innovative service models;
- reduce costs of 'spot purchasing'; and
- contribute to the long-term development of relationships between the independent sector and the NHS in the attainment of local NHS targets.

6.1.6 The stated goal of a Treatment Centre is to deliver high quality, cost effective scheduled diagnostic and/or treatment services that optimise service efficiency and clinical outcomes and maximise patient satisfaction. The defining characteristics of a Treatment Centre should be that:

- it embodies throughout its life the very best and most forward thinking practice in the design and delivery of the services it provides;
- it delivers a high volume of activity in a pre-defined range of routine treatments and/or diagnostics;
- it delivers scheduled care that is not affected by demand for, or provision of, unscheduled care either on the same site or elsewhere;
- its services are streamlined and modern, using defined patient pathways;
- its services are planned and booked, with an emphasis on patient choice and convenience together with organisational ability to deliver;
- it has a clear and trusted identity that is valued by its patients and by its other stakeholders;
- it provides a high quality, positive patient experience;
- it creates a positive environment that enhances the working lives of the people who work in it; and
- it adds significantly to the capacity of the NHS to treat its patients successfully.

6.1.7 In terms of benefits to patients, those referred to a Treatment Centre should be able to choose the date and time of their initial appointment, usually within six weeks of referral, and arrange any necessary treatment at a time which suits them. Patients should:

- wait less time for many routine operations;
- have a choice about where and when they are treated;
- be looked after by teams of health professionals specialising in that area of care;
- not have their operations cancelled for non-clinical reasons; and
- be treated in comfortable, modern surroundings.

Learning points

- Any evaluation of the Midlands NHS Treatment Centre (MTC) should consider issues such as the benefits to patients and value for money but also the wider benefit of the introduction of such Treatment Centres, which extends to issues such as changing cultures, behaviours and expectations, as well as the impact on the health care workforce.
- There are now "Principles and Rules for Co-operation and Competition" (Department of Health, 2007). Competitive procurement is integral to the NHS World Class Commissioning programme intended to bring a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes. The Strategic Health Authority (SHA) and PCT representatives interviewed during the course of the review all appear to believe that introducing new and independent providers into the health economy will drive innovation and improve the quality of services.
- The overall quality of services provided relies on good quality care before, during and after the care provided by ISTCs. Thus admission and discharge procedures and communications need to be integrated with the local NHS, so the whole "pathway of care" is effective.

Comments/Recommendations:

The Review Panel have not found sufficient evidence of the wider benefits of the Treatment Centre model to say whether it is one that should be extended. Many systems can be made to work given the will and the resources. Members are not clear that there are advantages that cannot be found within the 'traditional' NHS model. However, the Panel agree that it is important to continue to develop models of care to provide quality, value for money and improve waiting times.

There may be future areas of demand that can be met best by services delivered in such an environment. In terms of the general development of commissioning from the private sector, it will be important to achieve a balance between competition (on the basis of added value) and collaboration so that the system is responsive to the interests of patients and taxpayers, with supply shaped by the needs of patients.

6.2 The commissioning arrangements in respect of the MTC in Burton upon Trent and the nature of the contract for the MTC, including any adaptation to match provision to local need

Note The Review Panel were mindful that, since the contract for the MTC was put in place, the SHA and PCT structure has been reconfigured and the ownership of the MTC has changed hands. Most of the people who gave evidence for this review were not involved at the beginning of the contract.

- **Background**

6.2.1 The MTC was established as part of Wave 1 of the Treatment Centre programme. There are a number of other ISTCs using Wave 1 contracts. Many are now coming to an end. There was a second Wave of ISTCs; smaller in number.

6.2.2 The Review Panel found that, at the time of establishing the contracts, the Department of Health (DH) conducted an extensive forward planning exercise, during which all SHAs were asked to identify, with their PCTs, any anticipated gaps in their capacity to meet waiting time targets. This capacity planning was based on historic and waiting list data. Members asked if there had been any particular concerns within the Midlands area. They were informed that there had been a clear lack of capacity at University Hospital of North Staffordshire and some patients were being transferred to the independent sector. However, there had not been a suitable site for a Treatment Centre in north Staffordshire as University Hospital of North Staffordshire NHS Trust had been in the middle of working on their Private Finance Initiative business case. Burton Hospitals NHS Trust had proposed hosting the Treatment Centre. The location of an ISTC next to a hospital was a popular type of setting and Treatment Centres were intended to cover a large geographical area. Members understand that there was a process of persuading the SHA that this proposal could work but that concerns about whether the location was right were raised at the time.

6.2.3 Members were informed that the sponsoring PCTs then led on working with the DH to establish the Treatment Centre (as the DH were running the procurement and the PCTs were to take over once the contracts started and pay for them). The Panel have not been able to clarify the level of involvement of the SHA at this time.

- **Contracts and Contractual parties** (What are the current contractual arrangements? Who currently contracts with whom? What periods are covered by these contracts? How does the NHS organise itself?)

6.2.4 The DH Commercial Directorate developed the contract for the MTC. The Review Panel was told that the PCTs had no direct input to shaping the contract and that it is very different to other NHS contracts.

6.2.5 The MTC provides services to the NHS under one contract that commenced delivering services to patients in July 2006 and expires in July 2011.

6.2.6 The contract is not a public document but the current contractual parties are understood to be:

- Secretary of State for Health;
- South Staffordshire PCT;
- Stoke on Trent PCT (NHS Stoke on Trent);
- Derbyshire County PCT;
- Leicestershire County and Rutland PCT;
- North Staffordshire PCT (NHS North Staffordshire);
- Nations Healthcare (Burton) Ltd; and
- Burton Hospitals NHS Foundation Trust.

Nations Healthcare (Burton) Ltd has been the provider under the contract since contract award; however, this company is now owned by a new parent company, Circle.

6.2.7 The MTC is contracted to provide outpatient consultation and day surgery to NHS patients. The Review Panel found that about 70% of the MTC's contracted activity is transferred activity from Burton Hospitals NHS Foundation Trust (Queen's hospital). The MTC is required to use the hospital's staff to deliver this. Burton Hospitals NHS Foundation Trust has a corresponding five-year deal to supply consultants and nursing staff on a structured secondment basis (which avoided The Transfer of Undertakings (Protection of Employment) Regulations 2006 [TUPE]). Consultants are paid the same to work at the MTC as they are to work at the hospital - the MTC work is part of their general contract.

6.2.8 The remaining 30% provides the additional capacity. The MTC is required to employ its own staff for this activity (the hospital staff cannot do this according to the contract) and for administration. The MTC contracts back-up services (such as estates, cleaning, technical, sterile and pathology services) from Burton Hospitals NHS Foundation Trust. There are 16 service level agreements for such services. There are no overnight facilities at the MTC; patients requiring overnight admission for medical reasons are treated at the hospital, whereas those patients who have no-one at home to supervise them for 24 hours after surgery are, in some circumstances, provided with a sitter. The sitting service is funded by the relevant PCT.

- **Contract values** (What have been the costs of the contract to the NHS (by specialty, by year, by PCT)? What are the commissioning and contracting costs and overheads associated with this contract?)

6.2.9. The Review Panel were made aware that the way in which the Wave 1 ISTC contracts were set up was designed to encourage independent sector providers to enter the market, with the DH providing additional finance to give some protection from the risks and costs not borne by NHS providers. This protection tapers to zero by the end of the contract period but means that the total cost of the contract is more than the NHS Equivalent Cost. The average premium paid was 11.2% above the NHS Equivalent Cost for Wave 1 contracts. For the MTC the actual amount is thought to be about £6 million over the contract period.

6.2.10 The Review Panel found that the DH had instructed the PCTs not to give split figures for the contract value on the grounds of commercial confidentiality. The total value of the contract is thought to be £77.9 million over five years.

- **Contract Volumes** (What are the contracted volumes? Can these be broken down by eg Healthcare Resource Group, specialty, by year, by PCT? How were they established?)

6.2.11 The DH's aim was to offer sufficient levels of activity to the independent sector providers to enable them to continue beyond the end of their contracts, if they can compete in the market. The Review Panel were not given detailed information on the MTC contract volumes. The numbers were established on the basis of the capacity planning (paragraph 6.2.2 refers). Members were informed that the contract is a block contract. It varies with volume of activity but there is a monthly minimum cost regardless of the level of activity ('take or pay').

There are 'buckets' in the contract; these refer to specialties. There are ten clinical specialties (including oral surgery, urology, ophthalmology and orthopaedics) as well as a pain clinic. The numbers of procedures paid for under the contract vary every year of the contract. There are various ways to allocate against buckets but, mostly, a monthly minimum take based on the number of referrals is used. This method of contracting differs substantially from the standard mechanisms in place for contracts between NHS bodies.

- **Asset ownership** (Who owns the land, building and equipment?)

6.2.12 Burton Hospitals NHS Foundation Trust owns the land on which the MTC is built, for which a ground rent of £20,000 a year is paid. In addition, the Trust has granted the MTC an additional 20 parking spaces over the initial allocation.

6.2.13 Private finance was used to build the MTC, which is leased to the Secretary of State. The Panel do not know the annual value of the lease. The leasing/sub leasing arrangements are reflective of a particularly complex property contract. The contract governing the construction and commissioning of the facility is also the current contract that provides the services. The Panel understands that this is a typical feature of Private Finance Initiative deals.

6.2.14 A private company owns the equipment which is leased to the MTC.

- **Public Involvement** (How have the public been involved in the commissioning and contracting processes undertaken?)

6.2.15 The Review Panel have not received any evidence of patient or public involvement in the commissioning and contracting processes for the MTC.

Learning points

- It is clear that the PCTs were under considerable pressure to agree to the contract. The Review Panel found general agreement that the contract is of great legal sophistication and is complex and difficult to work with, requiring unusually high levels of commissioning expertise. The contract is not well based in an understanding of the local health economy and health needs and is expensive, in terms of total cost to the tax payer, compared to other NHS contracts.

- To enable the MTC to operate, there is a complex set of other contracts and sub-contracting arrangements and an equally complex mix of competition and collaboration between the MTC and different local NHS bodies, with many inter-dependencies.
- There has been a step change in contracts between the NHS and independent sector providers. One of the benefits of contract standardisation is that a particular section of a contract can be invoked and all parties know what is being referred to, reducing the need for advice on the conditions of the contract. Some of the good features of the original ISTC contracts, such as the inclusion of performance indicators and descriptions of quality, are reflected in new NHS contracts. The Guidance on the Standard NHS Contract for Acute Hospital Services that accompanies "The NHS in England: The operating framework for 2009/10" (DH December 2008) states the intention that the independent sector wishing to contract for NHS funded services will transfer to the Contract. The co-ordinating commissioners and independent sector providers are expected to work together supported by the DH to make this change. Any contracts replacing those that expired on 31 March 2009 will be Standard Contracts. Those independent sector providers whose contracts extend beyond March 2009 may, subject to agreement, choose to adopt the Standard Contract or retain their existing contracts until the required period of notice to change has expired. The Review Panel has been told that it is not an option for the NHS to change the current MTC contract, which is likely to remain in its current form until 2011. Circle have said that they could work with the Standard Contract.
- Within the "Principles and Rules for Co-operation and Competition" in certain circumstances where existing tariffs preclude competition, paying above tariff remains permissible.
- The Review Panel's scrutiny has led to questions being asked in the House of Commons about the Government's intentions for Wave 1 ISTCs and the MTC in particular. In the House of Commons debates for 10 February 2009, when Joan Walley, MP for Stoke-on-Trent, North (Labour) asked for confirmation that the letting of the new contracts will be determined locally by the PCTs, Ben Bradshaw, Minister of State, DH replied: "Not if that means withdrawing from the public the choice that I hope my hon. Friend agrees with us they are entitled to".

Comments/Recommendations:

The Review Panel regrets that the NHS is not able to make public the value and activity associated with the MTC contract - especially when many figures are already in the public domain. Where large sums of public money are involved, transparency is particularly important. Similarly, it is important to know who actually owns assets where the public has a substantive long-term investment.

The Review Panel is glad to hear that any future contracts with the independent sector will be based on standard NHS contracts, and standard NHS tariffs, so there should be no question of the NHS paying 'over the odds' for MTC services. In general, the Review Panel is not in favour of preferential arrangements for particular suppliers. Any case for paying above tariff should be tested.

The Review Panel do not want PCTs to be pressured into agreeing future provision that is not appropriate. There needs to be local determination of where capacity is needed to ensure that future arrangements are well based in an understanding of the local health economy and needs and that services are developed where they are clinically and cost effective. This will require collaboration and understanding between the PCTs.

6.3 The performance management context for the MTC in respect of regulation and any role of the Strategic Health Authority (How is performance regulated? What performance management arrangements are built into the contract? How would the PCTs know of performance issues?)

6.3.1 The responsibility for performance management of the ISTC programme contracts lies ultimately with the DH. In October 2006, the Government responded to the Health Select Committee's Fourth Report of session 2005-06 on ISTCs, stating a commitment to evaluating the impact of the NHS system reform programme following from The NHS Plan. Learning from the Wave 1 ISTC contracts informed Wave 2 of the programme. In 2007, the Healthcare Commission published a review of the quality of care in ISTCs and in 2008, the Audit Commission and Healthcare Commission published a review of progress with the reform programme called "Is the Treatment Working".

6.3.2 Certain independent healthcare providers in England must be registered with the Care Quality Commission (previously the Healthcare Commission). To register, they need to demonstrate compliance with the Care Standards Act 2000 and associated regulations. The MTC was registered with the Healthcare Commission in July 2006. The new registered manager was appointed in October 2008. The Commission tests providers' compliance by assessing each registered establishment against a set of National Minimum Standards, which were published by the Government and cover different types of independent health services. The Review Panel asked if how the MTC was assessed differed from the assessment of NHS provision. They were informed that although the contract provisions are different the considerations are broadly the same: safety, clinical and cost effectiveness; governance; patient focus; accessible and responsive care; and care environment and amenities.

6.3.3 The responsibility for managing the performance of the MTC contract lies with the PCTs. The contract prescribes governance and performance monitoring and measurement requirements. Benchmarks include: waiting times, clinical outcomes, cancelled operations, readmission rates, Healthcare Acquired Infections etc. Each part of the contract is monitored separately in terms of activity. There are monthly contract management meetings and quarterly reviews of performance against Key Performance Indicators. There are rules around quoracy etc for the contract management meetings. As lead PCT, South Staffordshire has a described role in the contract and in some circumstances can represent all the PCTs, for example if there is a decision required between meetings. The lead PCT contract manager is in weekly contact with the MTC.

6.3.4 A representative of the SHA attends the contract management meetings as an invitee (not with a formal seat).

6.3.5 The Review Panel asked about the MTC's own governance arrangements. The MTC is putting in place a new model of clinical governance arrangements / management processes to include GP/patient representatives. In response to a question, it was explained that those who work for the company have the opportunity of shares, giving a piece of ownership of company, based on the level of their contribution (linked to seniority and appraisal). They have a face value of 0.01p but the potential to increase in share value as the company grows. Circle own the company (which is not publically quoted): 51% is owned by the people who put up the money; and 49% for staff (allocated in chunks).

The number of GPs who hold shares is few and they are those partners contributing to running the company. Members were assured that there is no link between share allocation and referrals or the generation of business; Circle would not countenance such a link as the reputational damage would outweigh any short term gain. The Panel asked about the relationship of the MTC with the Board of Circle and found that an annual performance plan is in place. The managing partner meets the Board monthly to review operations and has recently put forward a business case for some IT development.

Learning points

- The Review Panel found that the Healthcare Commission had inspected the MTC on 28 January 2009. Eight National Minimum Standards were inspected, following a review of the establishment's self-assessment submission. At inspection, compliance with these eight Standards was found to be high. The building was found to be clean and well maintained. The staff were able to demonstrate that systems are in place to assess, minimise and manage risks appropriately. Processes were found to be in place to monitor the quality of care provided to patients and feedback was found to be generally positive.
- There are various levels of performance management. The Review Panel was concerned that the complexity of the contractual arrangements would adversely affect the ability to monitor them but this does not appear to be the case (although it has required expensive external legal expertise to interpret the contract).

Comments/Recommendations:

A defining characteristic of an ISTC is supposed to be that it has a clear and trusted identity that is valued by its patients and by its other stakeholders. Frequent changes of ownership can damage reputations, and there is some confusion in the name of the owners. The Review Panel recommends the MTC to combat this by advising stakeholders and the media of success stories such the positive result of their Healthcare Commission inspection.

The Review Panel seeks an assurance that the SHA and PCTs will continue to ensure that future local performance management arrangements for contracts with the independent sector are robust and complementary, including with the systems of the DH and the independent providers themselves. In the move to more streamlined contracts, where there is local discretion they should propagate what is good in the performance management arrangements but seek to ensure there is value for money in the resources invested in quality assurance.

The Review Panel supports the involvement of clinicians in decision making processes. The Review Panel accepts the assurance that there is no link between share allocation and referrals to the MTC. The Panel supports the principle that people with the ability to generate or influence the generation of business should not be able to receive benefits from the provider. This is important for transparency and public confidence.

6.4 The relationships required to support the effective operation of the contract (including the role of the sponsoring PCT/s and other parties in developing these relationships), with specific reference to the relationship between the MTC and acute hospital trusts
(How does each party contribute to relationship management?)

6.4.1 Clearly, the key relationships are those between contractual parties. It is in the interests of patients and tax payers to make sure that the contract is mobilised as effectively as possible. The Review Panel found a shared understanding that good communications and relationships underpin this. The preferred approach is agreed to be for parties to collaborate to make the best use of the MTC facilities. There was general agreement that there are few problems now with the relationships between the PCTs, the MTC and Burton Hospitals NHS Foundation Trust. The new MTC manager has been well received. The relationship between the PCTs and the MTC hinges on the contract manager. The Review Panel understands that most of the Service Level Agreements between the MTC and Burton Hospitals NHS Foundation Trust are working well and there is a partnership approach to addressing any issues. The Review Panel has not received any details of the property aspects of the contract for the MTC building but understands that negotiation takes place where necessary in regard to the use of the building, for example putting up signage.

6.4.2 Members learned that a "patient pathway" is the route (and timeline) that a patient follows from their first contact with an NHS member of staff (usually their GP), through referral if appropriate, to the completion of any treatment. This includes, where necessary, attendance at a hospital or a Treatment Centre. Template pathways can be created for common services and operations, to outline what is likely to happen. They can be used both for patient information and for planning services. In terms of wider relationships, the Review Panel found that demand for services at the MTC depends partly on the development of patient pathways and referral mechanisms. Other providers and GPs appear to be willing to consider patient pathways that include the MTC and referrals to the MTC.

6.4.3 In "Is the Treatment Working", it was concluded that the impact of ISTCs on other local providers is hard to judge. The Review Panel was interested in the impact of the MTC on the acute hospital trusts in the area. In terms of the transferred activity from Queen's hospital, this represented about 9% of the hospital's activity. Owing to the transfer, the Trust lost £6/7m of revenue. It received some transitional relief of £2.4m the year the MTC opened which helped it to fill the gap in activity and absorb the fixed costs. There is about a £3.5m net effect annually. The hospital has filled the gap with elective and non-elective activity and it still provides day case care that falls outside the scope of what the MTC can offer. There have been operational implications such as the hospital has had to change the way its theatres are used as the day case procedures transferred to the MTC can no longer be used as 'fillers'. The hospital has taken on an Ear Nose and Throat consultant, general surgeon and nurses to back up elective growth. The Trust continues to make a surplus.

6.4.4 The Panel has not been made aware of any significant impact on the business of other acute hospitals in Staffordshire.

Learning points:

- In "High quality care for all: NHS Next Stage Review final report" (Professor the Lord Darzi of Denham KBE, 2008) it states that "As the NHS evolves, a wider range of providers, including those from the third and independent sectors are offering NHS-commissioned services. Patients expect that wherever they receive their NHS-funded treatment, the same values and principles should apply. All organisations are part of an integrated system for the benefit of patients."
- There are both advantages and disadvantages to separating elective and emergency care.

Comments/Recommendations:

The Review Panel commends the recent improvements to working relationships between the contractual parties.

The Review Panel wishes to see the SHA exert its influence to ensure that the necessary parties continue to collaborate to make the best use of the MTC contract and facilities and to ensure that the provision is promoted in other parts of the system with integrity.

The Review Panel wishes to see the SHA and PCTs exert their influence to ensure that the values and principles set out in the NHS Constitution and established locally are applied, including when working with the independent sector. They should also play their part in ensuring that the impact of independent sector provision can be judged and managed to best effect.

6.5 Current performance in respect of the contract/expectation of delivery and to explore the contract/performance management arrangements (What has worked well? What have been the main problems and issues? How have these been tackled? Which are currently outstanding?)

The benefits anticipated and delivered

- **Contract Volumes** (What have been the delivered volumes ie how much activity has actually occurred?)

6.5.1 The Review Panel has not been given detailed information on the use of the contract volumes. However, it found general agreement that the demand has been less than predicted and contract volumes are under used. Utilisation of the contract is understood to be at around 68-70% and continuing to improve. Some 'buckets' are better used than others. Ophthalmology is the best used; pain management the second best; surgical procedures are less well used. The MTC are seeing more outpatients than they were contracted to see.

6.5.2 Members asked about the use of the MTC's theatres. There are six theatres all in use but with the equivalent of about two theatres worth of under use. The MTC is constrained by being stand-alone, in that the case mix is more difficult to manage. The absence of 'filler' procedures has an impact. Partly, the difficulty in the use of theatres is to do with them being constructed on an American design which omits pre-surgery preparation space.

6.5.3 As demand is not what was anticipated, and also as changes in clinical practice increase efficiency, all the additional capacity has not really materialised. Although the MTC has some staff, they are not really augmenting the NHS workforce. It only directly employs one consultant. However, where capacity is needed and used, for example trained theatre staff, the MTC is constrained by not being able to advertise in the same way as the NHS. (These rules were relaxed for the Wave 2 ISTCs as they made professional integration more difficult.) The MTC is focusing on working with students (it has begun to build links with Derby University) although it will take time to see the results of this. The MTC also works to develop its own staff.

The MTC is aware of the need to offer competitive terms and conditions. The staff the Panel met reported the MTC to be a much improved place to work since Circle took ownership.

- **Quality of services** (What is known about the quality of services provided? What is the evidence base for this? Does it include evidence from patient experience? For example, what information does the PCT receive on complaints and untoward incidents?)

6.5.4 Following on from the Healthcare Commission's review of the quality of care in ISTCs, the DH's Commercial Directorate has worked with the Healthcare Commission, DH Commissioning Directorate and providers to develop a methodology that enables independent sector providers to collect and publish patient experience information that is comparative to other providers.

6.5.5 No concerns were raised in the recent Healthcare Commission inspection. South Staffordshire PCT, NHS North Staffordshire and Stoke-on-Trent PCT all stated to the Review Panel that the MTC is good now from a clinical, quality perspective. As commissioners they seek to commission on quality and outcomes, so do scrutinise this closely. Obtaining information from patient experience feedback is built into the contract; the MTC is required to do patient satisfaction surveys for all patients. When visiting the MTC, the Review Panel saw evidence of the use of patient feedback cards. In comparison to the NHS, there is generally very positive feedback and there are few problems with the quality of patient care. Members were told that in the past there had been the odd joint service review as a result of looking at the performance indicators but the situation is much improved since Circle took over. Burton Hospitals NHS Foundation Trust referred to a greater number of 'bounce backs' (of more complex cases) than anticipated. A GP concern was that longer term following up is sometimes missed due for example to the turnover of ophthalmologists.

6.5.6 In respect of the physical environment, the building is probably too big and there have been some difficulties in making it work well for UK patients and health care practices. This is also partly due to the contractual arrangements for the MTC placing some constraints on the use of the building. Privacy/space might be an issue if the theatres were at full capacity. However, on their visit the Review Panel saw that the MTC is making every effort to make best use of the building for the benefit of patients. The use of clinic rooms has been adjusted to improve throughput/patient experience. Patient feedback is generally positive in terms of the standard of the building and the quality of the facilities.

- **Value for money** (Does the contract represent good value for money? What would it have cost to purchase the equivalent volume of services at standard NHS tariffs? Have the contract arrangements been assessed by any internal or external auditors? Have the auditors commented?)

6.5.7 In its response to the Health Select Committee report on ISTCs, the DH states that, through the ISTC programme bulk procurement, it has significantly cut the cost of doing business with the private sector. However, even leaving aside the premium paid above the NHS Equivalent cost, the under use of the contract volumes lowers value for money further. The cost of covering activity not performed is classified as commercially sensitive. Where a 'bucket' is over subscribed, there is the possibility of an additional cost. The Review Panel have not been able to make unit cost comparisons. The cost of any complications resulting in admission or corrective treatment is borne by the MTC, in certain circumstances. The Panel asked whether there was any evidence of a reduction in spot purchasing that can be attributed to the use of the MTC. Whilst the MTC is likely to have removed some of the need to spot purchase services, given the historic nature of this issue, it is not possible to evidence this.

6.5.8 The Review Panel has not explored the context of Payment by Results. The nature of the contract means that there is not the link between activity and payment promoted by PbR and this may affect money for treatment following the patient.

6.5.9 It is understood that the commissioners' auditors do look at all contracts but no opinion on this contract was drawn to the Review Panel's attention.

- **Waiting times**

6.5.10 These have come down and the Review Panel has been told that the 18 week target is being met and this can be evidenced by the relevant PCTs' public reports. However, it is agreed that this is due to the additional spending and a focus on timely access to treatment across the NHS of which the MTC plays only a part, which Members are not aware has been quantified. Members were informed that once the waiting times come down demand tends to level out. Referrals can increase (more people are being seen for opinions because waiting times are short) but this does not necessarily mean that more treatment takes place. However, Members were also told that the amount of patients requiring treatment shows an upward trend.

- **Choice**

6.5.11 The Review Panel found that choice has not really been delivered. Though not necessarily a problem, patients do not always differentiate the provider. In terms of access, there has not been a great deal of movement (much less than was predicted) with conventional patterns of behaviour persisting. Key factors are thought to be patient loyalty to other providers and an unwillingness to travel, even if it means a longer wait. The distribution of patients accessing the MTC is about 80% from South Staffordshire, 12% from Derbyshire and the remaining 8% from North Staffordshire, Stoke-on-Trent and Leicestershire. Only 5% of the resident population in Newcastle-under-Lyme and Staffordshire Moorlands is within 45 minutes travelling time of the MTC.

6.5.12 Unless the MTC appears as a 'Choose and Book' (C&B) option, patients may not be aware that they can go there. The Review Panel sought a view from a GP representative and found that in south Staffordshire whilst the MTC is available as a C&B option direct GP referral is fairly limited. For eye treatment, the C&B system has been largely taken over by direct referrals from optometrists. GPs have agreed they may do this and now rarely get involved. For orthopaedic treatment, referrals go through a clinical triage system, the Primary Care Outpatient Service at Cross Street, acting as filter between the MTC and Queen's hospital.

- **Support the shift from secondary to primary care**

6.5.13 The Review Panel is not quite sure how Independent Sector Treatment Centres are supposed to do this, aside from the issue of capacity, but the Panel did receive evidence of the re-engineering of patient pathways to cut down on number of required hospital visits.

- **Promote innovative service models**

6.5.14 The Review Panel found that service and patient pathway redesign had taken place and had improved utilisation of the contract. The uptake in ophthalmology at the MTC has resulted from the work done to redesign the pathway. For the one-stop cataract surgery, telephone triage takes place first, assessment and (if the assessment is satisfactory) surgery takes place on the same day, with follow up taking place in the community with an ophthalmologist trained for this task by the MTC. The reduction of three journeys to one is a factor in increasing take up. The pain clinic was developed in response to identified need.

The Panel understand that Burton Hospitals NHS Foundation Trust did not want to offer this service and the PCT decided that the MTC would do this. It did not go well initially but is being reviewed by Circle with the involvement of a GP.

- **Contribute to the long-term development of relationships between the independent sector and the NHS in the attainment of local NHS targets**

6.5.15 The Review Panel has noted that the PCTs have indicated that they would be happy to work with Circle in the future. Over the life of the MTC relationships between the Centre Management and other NHS agencies have increasingly improved. For example, Circle has gone out to gather, listen to and accommodate GP views.

Any action planned/being taken to improve performance/utilisation of the contract

6.5.16 Where estimates of demand have not been met, possible ways to improve utilisation include: referral management; a flexible approach to activity levels across the life of the contract; case mix changes; substitution between specialties; and extensions to contracts. The Review Panel noted that the PCTs can liaise but that, without negotiation, it is not possible to 'trade' between buckets. If there is growth in a particular area then the PCTs have to use additional purchasing power. It is understood that case mix review has taken place. It is clear that there has been some effort to manage referrals (paragraph 6.5.12 refers).

6.5.17 The provision of transport and outreach clinics have been used to help utilisation of the contract.

The contribution of the parties involved to the integration of pathways of care

6.5.18 Despite contractual and financial constraints, the Review Panel found that all parties to the contract were willing to work collaboratively on this but that it takes time to: find out what patients want; trial, assess and implement new pathways; review if they work for patients; and build up clinical competence in other parts of the pathway. As the general thrust of service redesign is to have services nearer to people's homes, there can be a tension for commissioners in terms of patient pathways involving the MTC.

6.5.19 Members are aware that GP practices, through Practice Based Commissioning, will be central to this integration. There is an agreement for Circle to involve GPs in the development of new services. In terms of GP influence, there is also a sub-committee of the Local Medical Committee - the South East GP committee for the Burton, Lichfield, Tamworth area, chaired by a GP. Meetings of this sub-committee are attended by representatives from South Staffordshire PCT, Burton Hospitals NHS Foundation Trust, South Staffordshire and Shropshire Healthcare NHS Foundation Trust and Circle.

The flow of information to support contract/performance management, including learning from the patient experience

6.5.20 The Review Panel has not been advised of any major issues in this area. In general communications are reported to be much improved. A recent focus of the South East GP committee has been improving the standard of letters. The GP representative stated that there were still "niggles" such as the availability of medical history information for the MTC doctors from the Queen's Hospital Records Department.

What happens when the contract ends

- **Contract termination** (What are contract termination arrangements? What provisions are there about the key assets? What happens to the key assets if the contract is not renewed?)

6.5.21 The contract ends in 2011. NHS North Staffordshire and NHS Stoke-on-Trent can exercise the right to exit in July 2010 and are understood to be likely to do so (NHS North Staffordshire has confirmed this).

6.5.22 Members found that issues to be clarified are:

- Burton Hospitals NHS Foundation Trust rights as landlord, in the context of their Foundation Trust status.
- The liability for the residual value of the MTC building. This shows 'on the books' of the lead PCT and there is a penalty for early exit from the contract but the liability at the end of the contract (in the region of £16 m) is understood to rest with the Department of Health as part of the Operating Framework and to taper over 25 years. Confirmation of this is being sought from the DH. Although the contract was not set up in anticipation of the building being taken over by Burton Hospitals NHS Foundation Trust at the end, in principle the Trust is willing to do so, so the building is a low risk to the NHS.

- The leased equipment.
- The contract between Burton Hospitals NHS Foundation Trust and the provider, which has been described as 'muddy' at the end - if someone else takes over other than the Trust then TUPE will apply. (The NHS is no longer keen on structured secondment.)

6.5.23 The Review Panel asked about the possibility of NHS North Staffordshire and Stoke-on-Trent PCT leaving the contract an extra year early (2009) which they understood had been mooted in an exchange of correspondence between MPs and Ben Bradshaw. However, in discussion it emerged that it would be difficult for the two PCTs to do this. It would have taken some time to arrange a brokering deal between all the PCTs involved about where the ongoing costs would be picked up and there had been no indication that Boards would look at this.

- **Contract renewal** (What provisions for contract renewal does the current contract make? What are current plans and intentions for contract renewal? When is it due for renewal? What will be the decision-making processes? How will PCTs be involved? What role will the SHA play? Will the SHA be the official contract holder? For the future, do the current contractual arrangements inhibit what can be done?)

6.5.24 There is an option to run on for five years. For this to happen everyone would have to agree, under the same Terms and Conditions and minimum take arrangements (the dual tariff is not mentioned). The Panel understands that this option will not be taken up.

6.5.25 In terms of the Government's intentions, Ben Bradshaw had said that there would be work with NHS West Midlands, the PCTs and Burton Hospitals NHS Foundation Trust on what happened at the end of the contract and that all options would be considered. The Panel found that a robust option appraisal was being instigated.

6.5.26 If the contract were for the relevant PCTs to negotiate, they would have to comply with the "Principles and Rules for Co-operation and Competition". They would not be able to behave in a collusive way but would have to consider the implications of the potential exit of the provider in the context of whether there was sufficient provision available in the health economy. The Review Panel was informed that a PCT progression board had been established (with GP and patient representation) to begin discussion about commissioning gaps and preparation for the demobilisation of the current contract.

6.5.27 There is Healthcare Commission approval to do certain activities in the MTC; it will need to be made clear if these can be changed. The potential for growth depends upon identified need and also the advancement of surgical techniques and technology. There could be more treatment out in community settings. In the longer term, day case obesity surgery or dermatology could be possible growth areas. Other possibilities mentioned were epilepsy, Parkinson's and dementia care (for example 'memory clinics') given that ageing issues will generate significant demand.

6.5.28 The Review Panel asked about any implications of Burton Hospitals NHS Foundation Trust status for their position in regard to their involvement in discussions about the future of the MTC. The DH still expects Foundation Trust to co-operate with all relevant parties in the best interests of patients. Foundation Trusts have access to different financial systems and support. The Trust is understood to be planning on the basis of either itself or another provider using the MTC. Circle will also have a position on whether it wishes to retain the MTC. In all probability a tendering process will have to be undertaken.

Learning points:

- It is clear that the assessment of the capacity needed was not robust and quickly became out of date, predating other initiatives to reduce waiting times and not taking account of the prospect of increased NHS efficiency and productivity. It is agreed that the new process of capacity planning needs to be much more robust than previously.
- However, there is also a complex interrelationship of other factors, difficult to unpick, that have contributed to lower take up of contact volumes than expected. Not least of these, local people have demonstrated their preference for ensuring that the quality of their local facilities is good, not necessarily wishing (or being able) to travel 'great' distances.

Comments/Recommendations:

The Review Panel wishes to see the SHA and PCTs ensure that the new process of capacity planning is robust, and takes account of cultural factors including local travel preferences and patterns. Significant commissioning expertise is needed to make sure that the right amount of affordable capacity is developed in the right localities. The Review Panel wishes to see the SHA and PCTs work together to develop commissioning competency.

There should be proper public involvement in and public scrutiny of commissioning processes, particularly in local determination of patient expectations/quality.

The Review Panel supports the relaxation of rules about the recruitment of staff for ISTCs to the extent that this supports training and professional development.

The Review Panel commend the MTC, recognising the work of the staff, for the quality of care provided.

The Panel does not agree that innovation is more likely in independent provision than in NHS provision but accepts that having a variety of providers can stimulate development. The Review Panel has found some innovative service and patient pathway redesign demonstrated by both MTC and other parts of the NHS and look to this being continued. It supports the MTC's efforts to find ways to use their facilities focusing on patients' needs.

Substantive changes to practices can be expected over the lifetime of the building, and the Panel is concerned about whether contractual arrangements allow sufficient flexibility to allow the asset to be properly adapted to changing practices (without the NHS 'paying through the nose').

The Review Panel has found evidence of work to improve the utilisation of the contract. It seeks an assurance from all parties that they will continue to pursue this to the end of the contract. The Review Panel has some reservations about the concept of choice (many people wish to ensure that their local NHS provider offers a consistently high quality service) but agree that the person seeing the patient has a responsibility to help patients exercise choice. The Panel asks the PCTs to ensure that the MTC is included on the Choose and Book system where appropriate. The Review Panel recommend that the Staffordshire Health Scrutiny Committee asks the Staffordshire PCTs for information on progress with Choose and Book utilisation across the board.

There will be learning by all parties involved in trying to make the MTC work that can be applied going forward but the Panel cannot really extrapolate from this to say that there has been a major contribution to the long-term development of relationships between the independent sector and the NHS in the attainment of local NHS targets. Evidence of direct impact on targets is scant. However, the Panel think that relationships would be likely to develop with the drawing up of new simplified contracts.

The Review Panel wishes to see all parties (the SHA, PCTs, GP practice based commissioners and local authorities) continue to work together on the integration of pathways of care.

Given the complexities of the contract, the Review Panel is concerned that all the implications and liabilities associated with contract termination are not clear and look to these being addressed.

The Review Panel welcomes the intention to consider all options for the future and to proceed to open tender. It is pleased that this work is starting now. The Review Panel wishes to be assured that all NHS bodies including Burton Hospitals NHS Foundation Trust will work together to ensure that the facilities (which have a wide range of potential uses) are used to best meet local health needs and that organisational interests are not placed above these. Rather than a focus on which services are more or less attractive from the perspective of tariff, future arrangements should be based on clear view of what services are needed and the work force and back up services required to deliver them. The next contract should be about who has the right to be in the local healthcare market; PCTs are not in a position to guarantee volumes, which will be determined by patient choice.

The Review Panel wishes to see good staff involvement processes in transition.

The Review Panel requests follow up of the issues raised about: 'bounce backs'; longer term follow up; and the availability of patient history information.

6.6 The role of scrutiny in helping to ensure that the intended benefits for patients are delivered in the context of engagement in planning, provision and operation of care

6.6.1 It was agreed that any substantial variation or development should, of course, be subject to consultation with overview and scrutiny who would want to promote patient/public involvement, including if appropriate local determination of quality/value.

6.6.2 Members sought views on how patients/the public could be involved. They were told that it will be important to determine what to consult on; there will be a number of mechanisms for arriving at questions. In terms of fit with local service planning, it will be important to present a view of how things will look and ask precise questions. The best engagement will be to present options but if there is only one option there might be limited value in consultation.

There is an opportunity to use the membership of Burton Hospitals NHS Foundation Trust as consultees. Commissioners will also need to think about engagement with others who might use services eg Derbyshire/Leicestershire. Consultation should adhere to the Government's Code of Practice on Consultation (2008).

Comments/Recommendations:

The Staffordshire Health Scrutiny Committee will seek a response to this report from the relevant parties and, going forward, request to be engaged in the commissioning process.

7. Implications

7.1 Resources and Value for Money - The Review Panel support local determination of future commissioning/contractual arrangements to ensure that they provide value for money.

7.2 Equalities and Legal - The Review Panel support local determination of future commissioning/contractual arrangements (in compliance with the relevant legislation) to ensure that they meet local needs.

7.3 Risk - The Review Panel believe that transparency, accountability, public involvement, and public scrutiny in regard to future commissioning/contractual arrangements are likely to improve the quality of decisions made as well as public confidence in the organisations involved.

7.4 Climate Change - The PCTs as commissioners should consider climate change implications as part of the commissioning process.

8. Acknowledgements

8.1 The following officers supported the Working Group:

Tina Randall	Scrutiny and Performance Manager
Sarah Garner	Scrutiny Officer

8.2 The Working Group would like to thank:

Michael Brookes	Head of Contracting and Procurement, NHS Stoke-on-Trent
Paula Clark	Former Chief Executive, Burton Hospitals NHS Foundation Trust
David Dickson	GP, South Staffordshire Local Medical Committee
Mark Hamlet	Orthopaedic Consultant, MTC
Phil Harvey	Consultant ophthalmologist, MTC
Kate Hughes	HR Manager, MTC
Graham Jones	Expert Adviser, Centre for Public Scrutiny
Eamonn Kelly	Director of Commissioning, NHS West Midlands
Richard Lee	Finance Manager, MTC
Mandy Pattinson	Scrutiny Officer, Stoke-on-Trent City Council
Sue Price	Locality Director (East Staffordshire), South Staffordshire PCT
Kelvyn Price	MTC Manager
Helen Tate	Business Manager, MTC
Marcus Warnes	Deputy Director of Commissioning and Redesign, NHS North Staffordshire
Dawn Wickham	Assistant Chief Executive, NHS Stoke-on-Trent
Stellios Vakis	Consultant surgeon, MTC
Richard Yeabsley	Contract Manager, South Staffordshire PCT
Jan Yeates	Programme Consultant, Urgent and Planned Pathways, NHS West Midlands

County Councillor Janet Eagland
Chairman of the Health Scrutiny Committee
October 2009

Contact Officers

Tina Randall, Scrutiny and Performance Manager
Staffordshire County Council
Telephone: 01785 276148
E-mail: tina.randall@staffordshire.gov.uk

Sarah Garner, Scrutiny Officer
Staffordshire County Council
Telephone: 01785 276144
E-mail: sarah.garner@staffordshire.gov.uk

List of Appendices/Background Papers

- The NHS Plan (DH, July 2000)
- Principles and Rules for Co-operation and Competition (DH, 2007)
- The NHS in England: The operating framework for 2009/10 (DH, 2008) and accompanying Guidance on the Standard NHS Contract for Acute Hospital Services
- Health Select Committee's Fourth Report of session 2005-06 on ISTCs and The Government's Response (2006)
- Is The Treatment Working (Audit Commission and Healthcare Commission, 2008)
- High quality care for all: NHS Next Stage Review final report (Professor the Lord Darzi of Denham KBE, 2008)

- Letters to local MPs and responses
- Notes of interviews with representatives of the PCTs in Staffordshire and Stoke-on-Trent and Burton Hospitals NHS Foundation Trust
- Notes of the meeting at the MTC with the Manager, consultants and senior management team
- Notes of conference call with representatives of the Strategic Health Authority (NHS West Midlands)
- Notes of conference call with a GP representative of the South Staffordshire Local Medical Committee