The role of the private sector in the NHS : Volume I. Report and proceedings of the Committee / House of Commons, Health Committee.

House of Commons

Health Committee

THE ROLE OF THE PRIVATE SECTOR IN THE NHS

First Report of Session 2001–2002

Volume I

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Volume I:
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Footnotes

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FIRST REPORT

The Health Committee has agreed to the following Report:

THE ROLE OF THE PRIVATE SECTOR IN THE NHS

I INTRODUCTION

1. Considerable interaction between the NHS and the private and voluntary sector was evident even before recent steps by the Government to strengthen their links. NHS private patient units and pay beds comprise 20% of private acute beds. The NHS provides around a third of the funding for voluntary hospices. Almost half of the abortions carried out in the independent sector are funded by the NHS. The NHS also funds around a third of the independent sector acute psychiatric beds and this sector also provides 55% of medium secure psychiatric beds.[1] Over 80 % of brain injury rehabilitation takes place in the private and voluntary sector, as does the bulk of specialist care for eating disorders and substance abuse.[2] Most consultants in the independent sector also work for the NHS.[3] Community pharmacy services are provided exclusively by private sector organizations or individuals.[4] Indeed, the general practice contract is itself a form of public private partnership for the delivery of health care.

2. Our inquiry, however, seeks to examine recent changes and trends in the relationship between the independent sector[5] and the NHS. When deciding on our terms of reference we sensed that events were changing rapidly.[6] Accordingly we chose broad terms, but indicated that the inquiry would specifically focus on:

The NHS Concordat with the Private and Voluntary Sectors
The Private Finance Initiative
Public Private Partnerships[7]

3. Our report deals with each of these areas in turn but also includes evidence relating to the treatment of NHS patients in hospitals overseas, as a consequence of policy developments arising during the course of our inquiry. Our inquiry deals mainly with primary care and the acute hospital sector.

4. Between October 2001 and January 2002 we took oral evidence from the Rt Hon Alan Milburn MP, North Durham Health Care NHS Trust, Consort Healthcare (Durham) Ltd, County Durham and Darlington Health Authority, UNISON, the Business Services Association, Bradford Hospitals NHS Trust, Leeds Teaching Hospitals NHS Trust, Catalyst Healthcare Management Ltd, KMPG, Central Manchester NHS Trust, Royal Berkshire and Battle NHS Trust, South Manchester University Hospitals NHS Trust, Professor Allyson Pollock, Quest Diagnostics Limited, the Royal College of Pathologists, MSF, The Doctors Healthcare Company (TDHC), West Middlesex University Hospital NHS Trust, the NHS Alliance, the British Medical Association, Partnerships for Health, Channel Primary Care Group, the Federation of Independent Practitioners, General Healthcare Group, the Independent Healthcare Association (IHA), Cancer Services Collaborative (South East Region), the Association of Community Health Councils, the

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1 Ev 222. Fifth Report of the Health Committee, Session 1998-99, *The Regulation of Private and other Independent Health Care*, (HC 281), para 32.
2 Ev 220, Ev 222.
3 HC 281, para 32.
4 Ev 1.
5 Independent health care we define as health care which is provided outside the NHS by commercial or charitable interests.
6 Even since concluding our evidence, the Chancellor in his recent Budget has made a number of policy statements relating to healthcare funding and the delivery of *The NHS Plan*, the implications of which we have not been able to address.
7 Health Committee Press Notice No. 1, 18 July 2001.

Royal College of Nursing (RCN), the NHS Confederation, and Department of Health (the Department) officials.

5. We also received around 100 memoranda which informed our inquiry. We are extremely grateful to all those who submitted oral or written evidence.

6. Many of the areas we examined were highly technical in nature so we are indebted to our specialist advisers, Dr Seán Boyle of the London School of Economics, Mr Kingsley Manning of Newchurch Limited and Mr Chris Vellenoweth, an independent adviser and a former manager in the NHS. We greatly benefited from their expertise. In addition the National Audit Office offered us useful technical support for which we are most grateful.

7. The Government has indicated that it wishes to make much greater use of the independent sector, seeing in this relationship the potential to improve public services. In a speech delivered to the NHS Confederation in July 2001 the Secretary of State for Health set the tone:

> "We have taken a hard look at where the private sector can help. First, using spare capacity in the private sector, such as in private hospitals, to perform operations on NHS patients. Second, getting private sector management to run some of the new stand-alone surgery centres our Manifesto commits us to building and which will specialise in precisely those procedures where private hospitals have some expertise. Third, extending PFI beyond the hospital sector where it has already helped deliver the biggest hospital building programme the NHS has ever seen into new Public Private Partnerships in primary care, social services and the provision of equipment. And fourth using private sector management expertise such as in the provision of IT systems. It is around these four activities that we will forge a new relationship between the NHS and the private sector."[8]

8. The key health policy document, *The NHS Plan,* anticipated a greater emphasis on the role of the independent sector when it stated:

> "The time has now come for the NHS to engage more constructively with the private sector, and at the same time make more of its expertise available to employers throughout the country."[9]

The *Plan* gave additional detail on some of the areas where the Government envisaged further co-operation with the independent sector. It proposed the development of a generation of Diagnostic and Treatment Centres "to increase the number of elective operations which can be treated in a single day or with short stay" to be developed in partnership with the private sector and also heralded the formation of new public private partnerships within a new equity stake company, the NHS Local Improvement Finance Trust (NHS Lift), to improve primary care premises in England (see below, section V).

9. The Department referred to four essential tests which would be applied to any proposed partnership with the private sector:

- is it in the interests of patients?
- is it consistent with the local (and national) strategies for the NHS and its development?
- is it value for money?
- is it consistent with public sector values, including that treatment is determined by clinical need and that staff are treated fairly?[10]

These are some of the issues we hope our inquiry will illuminate.

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[8] Ev 1–2 .
[9] *NHS Plan*, July 2001, para 11.1.
[10] Ev 2.

II THE CONCORDAT

Introduction

10. The policy goals set out in *The NHS Plan* were substantiated in October 2000 when the NHS entered into a Concordat with the Independent Healthcare Association (IHA) "to set out the parameters for a partnership between the NHS and private and voluntary health care providers".[11] The opening sentence of the Concordat marked a significant shift in Government policy: "There should be no organisational or ideological barriers to the delivery of high quality healthcare free at the point of delivery to those who need it, when they need it". The Concordat indicated that work would focus initially on three areas:

- "*elective care* - Primary Care Groups or Trusts (PCG/Ts) were to be able to commission or rent accommodation from the independent sector with either the service delivered by NHS staff under their NHS Contract, or the NHS subcontracting the provision of a service to the private or voluntary health care provider; alternatively, PCG/Ts could commission directly from a private and voluntary health care provider

- *critical care* - NHS Trusts were expected to work with local independent providers to coordinate planning in the provision of services in a given geographical area, agree the circumstances in which patients might be transferred between the sectors and the standards of care applicable, and negotiate costs

- *intermediate care* - Partners were to consider "the supporting role private and voluntary nursing homes, residential homes and home care could play in providing these services".[12]

11. The *NHS Plan* also indicated that the Concordat would assist in winter planning and the drive to reduce waiting times.[13] Finally, it suggested that the Concordat was intended to be "the start not the end of a more constructive relationship [with the independent sector]". The NHS would now explore the potential for further collaboration with the private sector in such areas as pathology, imaging and dialysis,[14] and join the NHS in commissioning research and development in "new centres of excellence".[15]

12. We wanted to establish the extent to which the Concordat had been used to date, its impact on waiting lists, its relationship with mainstream public provision and the long-term implications of its use.

13. The Secretary of State told us that he proposed to double the amount of money to be earmarked for Concordat activity, from £20 million in the financial year 2001-02 to £40 million in 2002-03.[16] General Healthcare Group, one of the major private providers, recorded that 70,000 NHS patients had been treated by the independent sector since November 2000.[17] Only part of this activity was financed by Concordat funding. Figures supplied by the Department indicate that the £20 million assigned to the Concordat purchased 10,527 operations from the private sector during winter 2000-01.[18] The Secretary of State suggested that currently somewhere between 50-60,000 operations a year are funded by the NHS in private sector facilities.[19] The IHA maintained that it was

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11 *For the Benefit of Patients: A Concordat with the Private and Voluntary Health Care Provider Sector*, para 1.1.
12 *Concordat*, para 2.10. The principles governing the relationship between the statutory and independent social care, health care and housing sectors were set out in the Department of Health document *Building Capacity and Partnership in Care*, October 2001.
13 *NHS Plan*, para 11.9.
14 *NHS Plan*, para 11.10.
15 *NHS Plan*, para 11.15.
16 Q6.
17 Ev 214; Q829.
18 Ev 275.
19 Q9.

now realistic to expect each independent hospital to treat on average 1000 patients a year, giving a possible annual total of around 200,000, a figure which it described as "large enough to make a real difference to the lives of many people" but in no way sufficient to "threaten the dominance of the NHS".[20]

Capacity

Definitions

14. The Secretary of State suggested that shortages of capacity in the public sector constituted the principal factor prompting him to make greater use of the private sector, and indeed were "the biggest problem" across the health care system.[21] NHS hospitals were currently running very "hot" with bed occupancy averaging 89-90% as against an optimum capacity of no greater than 82%.[22] His approach was both to develop greater capacity in the NHS and to make targeted use of the private sector while this was coming on stream. The private sector was currently working to 55-60% occupancy giving it much spare capacity: BUPA had told him that the number of NHS patients using its hospitals had increased threefold but that it could still accommodate a "doubling" of NHS patients coming through its doors.[23]

15. We asked the Secretary of State whether there was a risk that Concordat activity took place at the expense of the NHS. We wondered whether the same incentives that would persuade clinicians to undertake extra activity within the independent sector, to ease pressures on the NHS, might not have the perverse effect of taking staff away from the NHS. As the Medical Practitioners' Union pointed out: "it would be absurd if the Concordat resulted in fewer NHS operations and more waiting list cancellations because staff were at the local private hospital 'helping the NHS to cope'".[24] The Secretary of State responded that capacity shortages in the NHS were not confined to shortages of consultant time alone, but also included shortages of beds, a lack of operating theatre capacity, and shortages of nurses.

16. What needs to be carefully considered is how capacity is defined and what the impact of additional publicly funded activity in the independent sector will be on capacity within the NHS. There is a danger in equating capacity in the public sector directly with capacity in the independent sector. In fact, the relationship is rather more complex. Most acute hospitals in the independent sector do not employ consultants (though nurses are often directly employed). Instead they grant practising privileges ("admitting rights") to self-employed consultants. The consultants themselves, as the IHA confirmed, are in the vast majority of cases also working for the NHS (usually under maximum part-time contracts).[25] In its report into consultants' contracts, our predecessor Committee noted that 16,000 out of 23,000 NHS consultants maintained private practices.[26] The supply side may be limited in the NHS but the same constraints do not necessarily apply in the independent sector. To some extent the spare capacity in the private sector to which the Secretary of State alluded reflects a lower bed occupancy rate designed to achieve elasticity of supply: in the

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20 Ev 224. According to DH HES data, 6,468,404 operations were performed by the NHS last year. Of these, 15% were classed as 'emergency', giving a total of approximately 5,498,143 'non-emergency' operations. However, there are procedures that go beyond strictly 'elective' as they include maternity procedures as well. The other figure given in these tables is for 'Waiting list' surgery (approximately 4,075,095 operations) but again this is not a true figure for all elective surgery as it does not include what DH classifies as 'planned' surgery (where there is a wait for surgery but this is due to medical or social reasons rather than capacity).

21 Q21; Q15.

22 Q14; Q34. The figures for optimum capacity, according to the Secretary of State, were derived from work the Department had commissioned from York University. The Department referenced this to an article from A Bagust et al, in the *BMJ 1999*, vol. 319, pp. 155–58. However, this article gives a figure of 85% not 82%.

23 Q20; Ev 287.

24 Ev 296.

25 Consultants on maximum part-time contracts receive 10/11 of the full NHS salary and are not subject to a limit on their private earnings. They are expected to work for the NHS for a minimum of 10 notional half days (3.5 hours each).

26 See Third Report of the Health Committee, *Consultants' Contracts*, Session 1999–2000, (HC586), para 1.

event that demand rises, capacity can be increased further. Bed availability is also easier to manage in the private sector since private hospitals take virtually no emergency work.[27]

17. **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.**

Short-term fix or long-term relationship?

18. Using the private sector as a short-term fix to ease the pressure on the NHS and drive down backlogs in NHS waiting lists was generally supported by our witnesses. The Medical Practitioners' Union, for example, accepted there was no objection to using "spare capacity" in the private sector provided that this was a "temporary expedient".[28] The NHS Consultants' Association, though opposed to long-term use of the private sector, agreed that it was reasonable to explore "short-term options to increase capacity".[29] UNISON also felt that there would be "some justification" for the Concordat if it were a short-term expedient but drew attention to what it saw as the undesirability of a "longer-term reliance" on the private sector.[30] The Chartered Society for Physiotherapy called for the Concordat to be "time-limited", believing that too much reliance on the private sector would inevitably cause it to flourish at the expense of mainstream NHS provision. It felt, however, that there was scope to extend the Concordat within the voluntary sector, particularly in areas such as neurology, paediatrics and learning disabilities.[31]

19. The main focus of the Concordat has been on the use of private and voluntary sector elective treatment facilities and nursing home/intermediate care facilities. In both these areas, the NHS has, historically, used private facilities to support waiting list initiatives and targets and to expedite discharge from hospital. But this has been largely on a piecemeal, spot purchasing basis dependent on local initiatives, using whatever capacity the independent sector happened to have available. The key change indicated in the Concordat is a shift towards long-term and continuing relationships between the NHS and its providers in these areas. As the Secretary of State put it to us, there needed to be a move away from "a one night stand" towards "a long-term relationship".[32]

20. BUPA argued that longer-term planning would yield many benefits. It said that although the spot-market approach offered the advantages of being very flexible and responsive it had the disadvantages of being more expensive and limiting the amount of planning that could be conducted.[33] The Secretary of State himself favoured longer-term relationships, believing that these would help level out some of the peaks and troughs of activity in the NHS.[34] The leaders of a project monitoring the success of Concordat activity in East Surrey similarly observed: "The private sector is willing to be a short-term safety valve but is strongly in favour of longer-term arrangements to avoid the annual waiting-list panic, and we fully support this. Fire-fighting at the end of the year is a demoralising and exhausting ritual and does the NHS's reputation as a strategic organisation little good - nor is it the best way to treat patients".[35]

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27 Ev 210.
28 Ev 295.
29 Ev 367.
30 Ev 52.
31 Ev 338.
32 Q971.
33 Ev 284.
34 Q19.
35 Karen Bryson, Elin Williams and Cathy Bell, "Public Pain, Private Gain", *Health Service Journal*, 6 September 2001, p.25.

21. **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.**

Private pay beds

22. We asked the Secretary of State if he would consider creating extra capacity within the NHS by ending the current provision of private patient units and pay beds in the NHS.[36] His response was that the 3000 beds provided in such settings generated income (which is not to be confused with profit) to the NHS of the order of £300 million per annum. The Secretary of State accepted that this figure did not take account of any "hidden subsidies" provided by trusts, but thought that trusts would not want to look elsewhere to find the considerable income such units provided. He felt there could be scope for innovation here, pointing to the example of the Daresbury Orthopaedic Unit at Warrington Hospital. This private unit effectively went bankrupt, and the Secretary of State praised the enterprise of the local trust Chief Executive who bought it for the NHS "at a knock down rate". He equated this initiative with the purchase by the Department of the London Heart Hospital, a transaction he also regarded as being "a really good deal" for the NHS.[37]

23. **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.**

Consultants work in the private and public sectors

24. We asked the Secretary of State whether there might not have been a substantial impact on waiting lists if those consultants who were working part time in the NHS could be persuaded to work full time. According to the Department's own calculations, this would yield capacity amounting to 1,500 whole time equivalent consultants to the NHS, offering an additional 6% consultant hours.[38] The Secretary of State told us that such a course of action would be unfeasible. A legal ban on consultants working for both the NHS and the private sector would, he felt, trigger an exodus of consultants from the NHS. Offering consultants compensation for eschewing private work would be costly and potentially inequitable. If compensation were restricted to those consultants in specialties which offer the scope for lucrative private practices, who might be entitled to compensation running to £100,000 per annum or more, this would have the effect of rewarding those consultants who had undertaken least NHS work relative to those who, perhaps by virtue of their specialty, had done most.[39] On the other hand, the option of compensating *all* consultants might cost as much as £1 billion per year, and would mean

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36 Q1021.
37 Q28.
38 Ev 277.
39 We are aware that there are many consultants who undertake considerable private work while more than fulfilling their full commitments to the NHS.

the NHS was paying some employees much more for the same amount of work.[40] However the Secretary of State agreed that the status quo could only be described as "confusion and mess" and needed reform. He felt that the best way forward was to pursue the proposal set out in *The NHS Plan* to try to ensure NHS consultants worked exclusively for the NHS for a period of seven years following their qualification.[41] It is not, however, clear to us how much extra consultant time this would produce for the NHS. **We recommend that the Department publishes data on the impact of this measure on NHS capacity to enable planning of the other resources needed to match any additional consultant availability.**

25. The Department also acknowledged that there remained great uncertainty as to the quantity of work undertaken by NHS consultants in the independent sector and admitted that too few NHS consultants had job plans, an omission it regretted. **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".[42]**

26. An issue arising from the blurred division between consultants' work for the public and private sectors, to which our predecessor Committee drew attention, was the possibility that consultants might have a perverse incentive to cultivate long waiting lists in the NHS. This they might do in the hope that it would persuade more patients to take up their services in the private sector, where the patient would get an appointment more quickly and the consultant would receive substantially more pay.[43] We would emphasize that most consultants have a strong sense of public duty, and we believe that very few consultants would deliberately exploit this by openly suggesting such a course of action to patients; but we are concerned that patients might be subtly made aware of the existence of a two tier system. In our view, too much onus is placed on individual consultants themselves to keep competing interests apart. We feel some structural reform is needed here to ensure probity.

27. **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.[44] 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.**

28. **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.**

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40 Q973.

41 Q973.

42 See Third Report of the Health Committee, *Consultants' Contracts*, Session 1999–2000, (HC 586), para 23; *The Government Response to the Health Select Committee's Third Report on Consultants' Contracts*, Cm 4930, p.7.

43 Our predecessor Committee wrote: "While causation and proof are hard to establish beyond doubt in this matter, a number of facts are not disputed. The first is the correlation noted in the Department's evidence between those specialties with the longest waiting lists, and those which produce the most lucrative earnings for consultants in the private sector. The second is the finding of the Audit Commission in 1995 that "the 25% of consultants who do the most private work carry out less NHS work than their colleagues" (HC586, para 56).

44 The requirement for consultant appraisal was introduced in December 2000. See www.doh.gov.uk/consultantscontract.htm.

Equity in access

29. Evidence from the Department suggested that spending under the Concordat was resulting in marked geographical inequities. Whereas 3,294 cases have been commissioned by means of Concordat funding in the South East, only 444 have been commissioned in the North West.[45] The Secretary of State responded that pressures, such as workforce shortages, were perhaps more intense in the South East leading to a greater incentive to make use of the private sector. However, he agreed that a key factor underlying the disparity lay in the uneven geographic distribution of private sector capacity, which was heavily weighted towards the southern parts of England.[46]

30. A possible redress for this imbalance, and one alluded to by the Secretary of State in oral evidence, may lie in the location of some of the new Diagnostic and Treatment Centres anticipated in *The NHS Plan* in areas where waiting lists and waiting times are long and private sector capacity short.[47] General Healthcare Group has indeed offered to build at its own expense and risk, and with no up-front NHS contracts, a £30 million Diagnostic and Treatment Centre in just such an area, provided it can be assured that "no political impediments to such a facility building a long-term relationship with NHS purchasers will be introduced".[48]

31. **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.**

32. One of the Secretary of State's prerequisites for additional private sector involvement was that it should be "consistent with public sector values, including that treatment is determined by clinical need and that staff are treated fairly". We put to him the case of a private sector provider, Thornbury Hospital in Sheffield, which had treated NHS patients from at least two different health authorities. In correspondence, the Secretary of State had suggested that "a reasonable degree of consonance had been secured between waiting times" and "clinical priority had not been compromised". We suggested that the protocols relating to these episodes made no mention of clinical priority. The Secretary of State conceded that this was "a very reasonable point" and said that it gave further impetus to his policy of seeking long-term relationships with private sector providers, rather than using them for spot purchasing at one or two peaks in the year.[49] The proliferation of commissioners, with the growth of Primary Care Trusts (PCTs), adds to the danger that inequalities in access to care may grow.

33. **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.**

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45 Ev 275.
46 Q998.
47 Q998.
48 Ev 217–18.
49 Q19.

Value for Money of Concordat activity

34. Another of the Secretary of State's key tests for extending the role of the private sector was whether this activity constituted value for money. We sought to ascertain the extent to which this had been achieved. The Secretary of State told us that one way of establishing the extent to which value for money was being achieved would be to use NHS reference costs as a benchmark.[50] However, the severe limitations of proceeding on this basis, at least at present, were exposed by Mr Auld of General Healthcare Group:

> "There is a suggestion that we should be pricing with reference to what are called the Reference Costs of the National Health Service, and that is a table of costs, a range of costs by procedure. If you take hip replacements, at one end of the range of costs there are some hospitals in the NHS who say they are charging of the order of £10,000 for a hip replacement and, believe it or not, at the other end of the range are hospitals who say that they are charging £800 for a hip replacement ... You cannot buy the prosthesis and the cement for that, far less the theatre time, the cost of employing the doctors, the nurses and all the others."[51]

The Secretary of State accepted that it was "impossible" to believe that an NHS hospital could carry out a hip replacement for £800 and that the disparity in the range of figures caused him to be "slightly concerned". More credence, he felt, could be placed in the inter-quartile range of reference costs, which offered much less startling discrepancies.[52]

35. We asked the Secretary of State why there were such widely differing costs for episodes of treatment under the Concordat, with the average cost in the North West being £2000 and in the North and Yorkshire, £3000.[53] He acknowledged that "differential" prices were being negotiated with private sector providers both in different parts of the country and even within the same areas, with "some hospitals ... negotiating better deals than others". He felt that the best way to ensure value for money was to bring greater "standardisation" to the process.[54]

36. Some evidence does point to the NHS getting good value for money in respect of some of the work it has commissioned from the private and voluntary sector. In the first year of the Concordat, South East region was allocated £5.1 million for use in the private sector. Some 3,326 patients across the region were removed from waiting lists during the first three months of 2001, a third of these from the East Surrey area.[55] The results from East Surrey have been analysed and they suggest that "prices were comparable to, and sometimes cheaper than, the NHS" with the average cost per treatment being £1,120. The following table illustrates some of the procedures undertaken and compares the price paid under the East Surrey project with both the NHS reference cost and typical private sector prices:

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50 Q13.
51 Q882.
52 Q1015.
53 There are even greater disparities between regions: the cost for Trent was just over £500.
54 Q999.
55 *Health Service Journal*, 6 September 2001, pp. 24–26.

Examples of procedural prices compared across NHS and private sector

Speciality	OPCS code	Procedure	East Surrey HA project (£)	NHS Reference Cost (£)	Private Provider (£)	
Trauma & Orthopaedics	W371	Hip replacement	5,466	4,608	6,097-8,500	*
	W819	Sub-acromial decompression	1,770	1,498	2,500-2,700	*
	T521	Fasciectomy	1,400	1,796	2,335	
	W879	Arthroscopy+treatment	1,300	1,208	1,815-2,500	
		Arthroscopy	848	832	1,135-2,200	
	W792	Bunionectomy	900	713	1,430-2,300	
	A651	Carpal tunnel	690	795	1,355-2,300	
Ophthalmology	C712	Phaco-emulsification with lens	900	1,065	2,260-2,604	* *
ENT	F343	Excision of tonsils	975	2,390	1,550-1,700	
	E031	Septum of nose	975	1,275	1,525-1,600	
General surgery	T209	Primary hernia repair	1,200	1,329	1,705-1,800	
	L851	Ligation of varicose vein	1,030	1,174	1,800-2,180	

*Source: Project Bids to SERO, NHS Reference Costs 2000, ** Good Hospital Guide and local private hospitals*[56]

37. Thus, for seven out of 12 procedures the East Surrey project actually achieved prices below NHS reference costs, and in all cases the prices were well below the rates for self-funded private patients. The factors underlying this, according to the project leaders, were a reduction in 'did not attend' rates (0.3% compared with 8% in the NHS);[57] and higher consultant productivity as a consequence of financial incentives, smaller units encouraging greater team work, seamless operational and administrative processes and the use of more dependable equipment.[58] BUPA's suggestion that its own survey of NHS commissioners had reported that "74 per cent thought that BUPA provided good value for money and high quality care" offers further support for the idea that Concordat activity can represent good value for money.[59] In contrast to this encouraging analysis is the assertion of the NHS Consultants' Association: "Information so far suggests that the use of the private sector is almost invariably more expensive than providing services within the NHS".[60] The Socialist Health Association acknowledged the evidence from East Surrey, but believed that a move to longer-term arrangements might ultimately weaken the NHS by reducing the pool of staff available to it so that the NHS might become dependent on the independent provider which could in due course charge more.[61]

38. **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.**

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56 *Health Service Journal*, 6 September 2001, p.26.
57 Direct telephone contact with patients established that 118 patients no longer needed or wanted surgical treatment.
58 *Health Service Journal*, 6 September 2001, p.26.
59 Ev 284.
60 Ev 367.
61 Ev 328.

39. 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.

40. 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.

The interoperation of public and private healthcare: regulatory and training issues

41. The Government's policy of encouraging greater interaction between private and public sectors led us to ask the Secretary of State whether the time had not now come to bring the independent sector into the same regulatory framework as the public sector. The Secretary of State told us that this was an issue that needed to be looked at. He pointed out that the Commission for Health Improvement (CHI) and the National Care Standards Commission (NCSC), which will regulate the independent sector from April, were empowered, under section 9 of the Care Standards Act 2000, to work jointly, and were able to subcontract staff from one organization to another. He also argued that CHI was empowered to follow the NHS patient whether treated in the public or independent sector.[62] The Department drew attention to other differences between CHI and the NCSC: unlike CHI, the NCSC is a regulatory body which registers care providers; the NCSC is mainly concerned with social care services, with the consequence that health care services represent only a small proportion of its activity; and in many of the health care settings covered by the NCSC (for example those dealing with cosmetic surgery) no NHS patients will be treated.[63]

42. Since our inquiry began the Government has issued its reply to the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-95, chaired by Sir Ian Kennedy. The Kennedy Report called for closer inter-operation between CHI and the NCSC and in its reply the Government seemed to accept the force of this argument, asserting:

> "In the short-term, a strengthened inspection role for CHI working within the Social Services Inspectorate and National Care Standards Commission as appropriate [is needed to] give the public an independent assurance that each provider of NHS services has proper quality assurance and quality improvement in place. We will take further steps to rationalise the number of bodies inspecting and regulating health and social care."[64]

43. 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.[65] 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

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62 Q35.
63 Ev 275.
64 *Learning from Bristol: The Department of Health's Response to the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995*, January 2002, Cm 5363, p.3.
65 *Official Report*, House of Lords, 18 March 2002, col. 1203.

accommodated in social care settings - including those of care homes in which nursing care is provided.

44. Our predecessor Committee voiced reservations about levels of cover, facilities and staff qualifications at some independent sector hospitals in its report *The Regulation of Private and other Independent Healthcare*. It argued in favour of greater interaction between private and public sector regulators in order to ensure that patients treated in the private and voluntary sector were not placed at undue risk. A question the Department will need to consider is what the impact on public confidence in the Concordat would be if an NHS patient suffered a serious adverse clinical incident in a private hospital.

45. **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.**

46. It is clear to us that the major providers in the independent sector would welcome a common regulatory framework. But a more mature understanding of the mutual inter-dependence of public and independent sectors perhaps also entails wider shared responsibility. Training clinical staff places a considerable burden on public expenditure. So we asked Mr Hassell of the IHA whether he felt that there was a case for a training levy being placed on the private sector. He asserted that the independent sector already participated in training: for example, the sector took about 2000 clinical placements from the training system and was working to take more.[66] However, **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.**

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[66] Q871.

III TREATING NHS PATIENTS ABROAD

47. On 12 July 2001 the European Court of Justice ruled on two joint cases (*Geraets-Smits and Peerboms, and Vanbraekel*) that some hospital activities might fall within the EC single market rules. The Government then announced that NHS commissioners would be able to commission care for NHS patients from providers in other EU Member States as part of the move to drive down waiting times.[67] The initiative is being led by Mr Peter Huntley, chief executive of the Channel Primary Care Group in Dover. East Surrey and East Kent health authorities have been involved in pilot schemes which seek to establish the value for money of such activity, the extent to which patients would contribute to their travel expenses and other "legal, quality and clinical issues".[68] The Secretary of State told us that use of this route would be confined to patients whose consent had been given and following a full assessment of their clinical needs.[69]

48. Press briefing issued by the Channel Primary Care Group indicated that the pilot schemes would look at the types of procedure which would have the "the greatest impact on waiting times within their local trusts and that fulfil the original criteria of relatively low risk" such as "major joint replacements, cataracts, general surgical procedures such as hernias, varicose veins, haemorrhoidectomies and laparascopic cholecystectomies[70] and possibly tonsillectomies and non-cancerous prostate operations".[71]

49. Mr Huntley told us that he had been given the go-ahead for the pilot projects by ministers in October 2001. At the time of his appearance before us in December 2001, no patients had been treated abroad. Since then, however, the first patients have been treated at La Louviere Hospital Lille for a variety of elective procedures. Hospitals in other countries, including Germany and Greece have also been inspected with a view to extending the scheme.[72] Several European countries, Mr Huntley told us, had excess capacity as a consequence of over-investment.[73]

50. We asked Mr Huntley whether this scheme might be of only marginal relevance to the NHS. He indicated that initial interest in the scheme had been high[74] and that he could envisage as many as 10-20,000 patients being treated abroad annually.[75] Although the initial schemes were based on commissioners in the South East of England, Mr Huntley felt there was no bar to patients elsewhere in the country being treated abroad, pointing out that a flight to Hamburg from the North East of England took less than two hours, which might be quicker than a journey to have an operation out of area in England.[76]

51. Given the paucity of operations carried out to date, and the fact that the Department has cited commercial confidentiality as a reason for not disclosing the cost of individual operations in France, it is hard for us to establish the extent to which operating on NHS patients abroad constitutes good value for money, something which the Secretary of State told us was essential.[77] In written answers, the Government has maintained that the costs of NHS funded operations in Lille are "commercially confidential" but that the prices agreed so far are "in excess of NHS average reference costs but comparable to those in the United Kingdom private sector".[78] General Healthcare Group argued that the private sector would "certainly be competitive" in comparison with Continental suppliers, and that treatment in the private sector in England would be preferable in terms of patient

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67 *Official Report*, 15 October 2001, col. 1042w.
68 *Official Report*, 15 October 2001, col. 1042w.
69 Q57.
70 The surgical removal of the gallbladder.
71 Channel Primary Care Group, Press Briefing No. 2, 19 November 2001.
72 *The Guardian*, 18 January 2002.
73 Q896.
74 Q887.
75 Q898.
76 Q890.
77 Q57.
78 *Official Report, House of Lords*, 25 February 2002, cols. WA 185–86.

convenience and quality assurance.[79] However, Mr Huntley told us that, even without bulk purchasing discounts that would flow assuming there was sufficient uptake, costs compared "favourably" with the private sector in England and were even below NHS reference costs, though here matters were complicated in that the European option included post-operative follow-up and rehabilitation but excluded travel costs.[80] This last complication may underlie the apparent discrepancies in the statements from the Government, General Healthcare Group and Mr Huntley as to the value for money of this activity. The fact that the figures are confidential, together with the unreliability of the NHS reference costs as a benchmark, makes any assessment of value for money difficult.

52. It is acknowledged both by those involved in the pilots and by the Government that a number of legal and logistical obstacles are posed by this activity. The Secretary of State indicated that legislation might be required to fund free transport for individuals to overseas hospitals.[81] Patients have to have access to English speaking staff. Dealing with complaints will be far from straightforward given the lack of a clear chain of accountability, and liability for adverse clinical incidents will undoubtedly yield problems. In terms of medical complications, Mr Huntley told us that rehabilitation would be included in the initial package: it was general practice in Europe for hip and knee replacements for patients to undertake an acute phase of rehabilitation within the hospital of between eight and 12 days then spend between two to four weeks in a rehabilitation centre undergoing intensive physiotherapy, after which time they are fit to go home.

53. **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.**

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79 Ev 215.
80 Q901.
81 QQ63–65.

IV THE PRIVATE FINANCE INITIATIVE

What is the Private Finance Initiative?

54. The Private Finance Initiative (PFI) is a particular type of Public Private Partnership and was launched in 1992 by the then Conservative Government to harness the benefits of private sector finance and services for the public sector. The principle of the PFI is that a public sector body obtains a *service* rather than an *asset*. The public purchaser, in this case the Department of Health, defines the "outputs" that it seeks, in other words the services it requires, and invites private sector bidders to "present their solutions to meet these service needs".[82] As the Department put it:

> "In health this means the public sector delivering high quality clinical services in NHS hospitals, while the private sector provides innovation, management skills and financing to manage the infrastructure."[83]

55. The commissioning authority avoids the need for capital expenditure at the beginning of the project in exchange for making payments for the service as it is delivered. The presence of the words "private finance" in PFI has caused some confusion. In the end the costs of PFI constitute public expenditure, since the service payments are met from public funds. The Institute for Public Policy Research (IPPR) in a recent study of Public Private Partnerships, helpfully drew a distinction between the method and source of payment:

> "To understand why the PFI in no way relaxes the resource constraints faced by government it is necessary first and foremost to grasp the difference between *finance* and *funding* for a project ... In purchasing a car many people will use private finance, that is, they will borrow from a financing company the sum necessary to drive the car away. However, they will have to find the funding for this purchase from their own income, probably paying monthly instalments back to the financing company. That institution does not in the end provide a single penny of actual resource. It is the same with PFI. Although the finance ... comes from the private sector all the funding comes from the public purse."[84]

56. The PFI will only be the preferred option when it is shown, in the view of the Department, to offer better value for money than conventional procurement.[85] When the Department believes this has been demonstrated an NHS trust enters into a contract with a private sector consortium for the supply of a new asset, for example a new district general hospital. The consortium designs, builds, finances and operates the hospital and the trust provides clinical and clinical support services. The trust's existing assets and services are transferred to the consortium. In return for delivery of the contracted services, including for example the availability of hospital facilities, the trust incurs an annually adjusted charge which it pays to the consortium in monthly instalments. This is done on a lease basis the length of which would normally run for 30 years.[86]

57. In its 1997 and 2001 election manifestos, the Labour party committed itself to continuing with PFI to pursue its health objectives.[87] The present Government's approach to using the PFI process has not been half-hearted. Across government, departments have utilised PFI and the Department of Health is no exception. According to the Department's Annual Report for 2001–2, "on current plans PFI will provide nearly £800m worth of capital investment in 2001–2".[88] Some 64 major PFI hospitals have been approved since May 1997. Eight are now complete and operational and 15 others have reached financial

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82 Ev 5.
83 Ev 5.
84 *Building Better Partnerships: The Final Report of the Commission on Public Private Partnerships*, 2001, pp. 79–80.
85 In paras 78 to 97 we consider whether the process assesses accurately value for money.
86 Q47.
87 Ev 5.
88 Cm 5103, para 4.12.

close and are under construction. During the same period only four schemes 'failed' the value for money test, and are to be conventionally procured.[89] In addition, a number of smaller schemes for community and mental health facilities are now in the pipeline - over 50 schemes with values below £25 million have reached financial close.[90]

58. The Department claimed that PFI was providing an unprecedented level of capital investment for the NHS – "the biggest hospital building programme the NHS has ever seen" in the words of the Secretary of State – and the majority of this was coming through PFI projects.[91] While the need for this investment is not in dispute – large-scale investment in the NHS is seen across the board as necessary – there is a fierce debate about whether PFI is the appropriate way to finance capital investment, and whether it will provide the value for money that its supporters claim.

The debate on PFI

Claims and counter claims

59. Although our inquiry looked at public private partnerships of all kinds in the NHS, we received most evidence on the PFI. A wide range of organisations and interested parties gave evidence. Even a cursory examination of this material suggests how polarised the debate has become, with exaggerated claims being made on both sides of the argument in a climate not always conducive to rational analysis. Supporters of PFI have promoted it as the only solution to the problems of the cost and time overruns they regard as synonymous with public sector procurement, and the best means of addressing the large backlogs of essential maintenance of the NHS estate.[92] So, for example, the CBI asserted that the debate on PFI needed to move beyond the technicalities of the cost of the PFI against an artificial public sector comparator to "recognise the benefits of innovation in service delivery, facilities being delivered on time and on budget, assets being properly maintained and the value for money gains over time that come from a diverse and contestable market".[93] KPMG argued that "PFI has led to a higher standard of hospital accommodation that has been delivered more quickly than under conventional procurement".[94] The Business Services Association asserted that private sector involvement in hospitals would also allow for innovation in working practices and purchasing regimes that would, along with service measurements, ensure higher quality services.[95] The Department itself listed three "structural benefits" of PFI: that it transferred the risk of time and cost overruns to the private sector; that the fixed payments over the life time of a contract made for easier planning; and that payments for the service were linked to quality standards, thus providing an incentive to the contractor to offer high standards of maintenance. The Secretary of State described PFI as "a huge success story for the NHS".[96]

60. However, many stakeholders disagreed with this view. UNISON felt that the PFI had not been shown to afford value for money and called for a moratorium on its use and an independent review of all current schemes.[97] The Medical Practitioners' Union told us that PFI projects were "poor value for money, led to less beds and staff and to cramped, poorer premises".[98] Mr T G Fellows, a former Chair of the Oxfordshire Community Health Council, concluded that PFI finance was expensive, its value for money analyses were "untrustworthy", its building quality claims "implausible" and that it had inherent ethical

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89 These are Rochdale, Berks and Battle (from whom we took evidence), Sheffield (Stonegrove) and Guy's and St Thomas's, Ev 6.
90 Ev 6.
91 Ev 1; Q82.
92 *The NHS Plan* estimates that the backlog of maintenance in the NHS now stands at £3.1 billion.
93 Ev 303.
94 Ev 118.
95 Ev 77.
96 Q91.
97 Ev 46.
98 Ev 295.

problems.[99] The Royal College of Nursing (RCN) was another body who thought that the economic case for PFI had not been made, voicing its concern that "the method of costing a traditionally procured NHS hospital is over-inflated" with the consequence that the total costs to the NHS over the term of a PFI contract were "excessive".[100] However, the Business Services Association stated the reverse.[101]

61. These opposing positions were replicated at a local level when we visited two of the first wave of PFI hospitals in Carlisle and Durham.[102] In Durham, in addition to the written evidence we received on the North Durham PFI we also took oral evidence from representatives of the Trust, the private sector partner and the unions. The two sides of the debate were clearly reflected at this session.

62. The trades unions in their submissions had painted a sorry picture of the North Durham PFI project. In written evidence, the GMB and UNISON cited numerous faults in the new hospital, and attributed many of them to the PFI. These included generator failures plunging operating theatres into darkness, overheating, poor planning, and plumbing faults which resulted in sewage flooding through ceilings.[103] UNISON also cited examples of poor planning: the location of sluice areas adjacent to the wards, the absence of a proper waiting area by the mortuary, a lack of natural light and ventilation and inadequate air-conditioning.[104] It was the unions' view that many of these faults were directly attributable to the PFI process. However, these accusations were strongly disputed by the Trust and its private sector partner, Consort Healthcare. In its memorandum Consort Healthcare conceded that there were initial problems, but rejected the accusation that these were inherent to the PFI project.[105] Mr Steven Mason, chief executive of the Trust, dismissed many of the complaints as "urban myths" and submitted a detailed statement on the position.[106] Most of the accusations levelled against the hospital, he felt, could more accurately be described as "minor teething problems ... that are inevitable when moving into such a complex facility".[107] While we accept that there were problems we believe that they were exaggerated.

63. It is difficult to steer a course through this field of claim and counter claim, and perhaps it does not further the debate on the merits of PFI. PFI is a complex subject with long-term implications. As its promoter, the Government has to convince the wider public that it is not just a viable option in terms of value for money for the taxpayer, but also that it presents an opportunity to improve the quality of healthcare provision. The success of such projects will be affected by the perception of them by the wider public and the Department has not been altogether successful in presenting its case. The Secretary of State admitted as much to us:

> "I think we have to be blunt about our own failures, across government we have not successfully defended PFI as well as we should have."[108]

64. The Government needs to address this failure. We were also disappointed at the lack of evidence backing many of the claims made. Despite numerous requests to the private sector for examples of innovation in management we received few. We are not convinced that there is a vast pool of more talented people in the private sector compared with the public, and any implication that there is undermines the public sector. Whilst always inviting new ideas we recommend the Government accepts there are skills in both sectors and amends its stance in this light.

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99 Ev 299.
100 Ev 55. See also Ev 351 and Ev 369.
101 See paragraph 92.
102 We visited North Durham Healthcare NHS Trust and Carlisle NHS Trust on 29–30 October 2001.
103 PS 11 (GMB) Annex (*not printed*).
104 Ev 49.
105 Ev 35–36.
106 Ev 31 Annex (*not printed*).
107 Ev 31.
108 Q82.

65. We were unimpressed with much of the University College London's Health Policy and Health Services Research Unit's (HPHSRU) research and its arguments[109] against the Private Finance Initiative. Its arguments have confused criticism of capital charges introduced in 1991 with criticism of the PFI. Some of the Unit's criticisms, for example its concern over NHS planning, were mainly criticisms of capital charges and were not largely attributable to PFI.

66. The HPHSRU's claims that there had been no checks against any of the value for money tests were untrue, since the National Audit Office had completed at least one such study. In evidence Professor Pollock's assertion that "There is a new pact with big business which is not operating currently in favour of the population"[110] was so extreme as to undermine confidence in the analysis and conclusions of the Unit's report. Similarly, the Unit's claim that PFI involved writing an "open-ended cheque paying four, five or six times more than we should" was not backed up by the evidence we received.[111]

67. Furthermore, the HPHSRU's assertion that it was never a good thing in the NHS to have increased capital charges funded by a revenue budget, for example by staff savings, was dubious. Many projects in the NHS, such as MRI scanners and ward reconfigurations, fall into this category and have led to better patient services. This has raised serious questions about the HPHSRU's ability to analyse rationally the finances of the NHS. An MRI scanner, by scanning patients more quickly, could allow patients to have a better service whilst reducing the need for radiographer time, which could at least in part, pay for the additional capital costs.[112]

68. We found the lack of sound analysis from the HPHSRU additionally worrying because it has been the source of advice for many groups including unions and professional associations, all of whom have used parts of the Unit's work as a justification for their antagonistic attitudes towards the private sector. We recognise that there are potential problems with PFI, but we also can see its potential benefits. At the very least a benefit could be getting more NHS services now, for a cost over the lifetime of a project, should none of the risks come to fruition. Against this possible cost we recognise that the cost of not having NHS services immediately needs to be weighed, which is a cost for patients and the community.

69. The Government has not helped by appearing to assert that private finance and management can always add to the public sector. Similarly some of the antagonistic extreme views that are put forward by the HPHSRU and by other organisations have not helped to promote a sensible and mature debate about what is best for patients and staff in the NHS.

70. 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, points we develop below.

Bed numbers

71. The impact of PFI on bed numbers is a stark example of where the debate on PFI has become polarised. Opponents of PFI contend that the financial constraints imposed by PFI projects drive down the number of beds a trust can afford, whereas supporters of PFI maintain that bed numbers are determined entirely independently of the chosen method of procurement.

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109 Q377.
110 Q483.
111 Q401.
112 Q395, Q396.

72. Most of the evidence we received from bodies representing health workers suggested that bed reductions and PFI were inextricably linked. The RCN argued that bed numbers appeared to be lower in PFI projects. In a recent survey of RCN members involved with PFI projects, staff in all of the larger schemes (greater than £25 million) reported a decrease in bed numbers.[113] UNISON was particularly concerned about the impact of the first wave of PFI Projects on bed numbers.[114] The GMB also reported similar experiences.[115] Professor Allyson Pollock was in no doubt that PFI did have an impact on bed numbers.[116] Her studies led her to conclude:

> "It was notable that all PFI schemes involved major reductions in acute bed numbers and services and that rehab and longer stay beds are being closed to fund PFI hospitals."[117]

73. Again, this argument was played out to us when we visited Durham and Carlisle. At Durham we took oral evidence from those directly involved in the new hospital. Commenting on the development stages, UNISON recalled that the original project in 1991 had envisaged a centralised hospital service in a 900-bed district general hospital. Since then, in its view, every stage in the procurement process had been associated with a reduction in bed numbers with the consequence that the final figure for beds had fallen to 454. In addition to the headline reduction, UNISON maintained that the cost of the PFI payments had also forced a reduction in clinical staffing budgets with the result that only 350 beds would be staffed.[118] Mr Robin Moss, Head of Health for UNISON's Northern Region, acknowledged that many factors affected bed numbers but told us that he remained convinced that the "number of beds in the hospital was tailored to the financial equation, not to health needs".[119] This was strongly disputed by the trust which averred that "bed numbers would have been the same under the public sector option".[120]

74. The presence of a direct link between bed reductions and PFI was denied by both the Department and those trusts involved in PFI projects. When we questioned the Secretary of State on the relationship between PFI projects and bed numbers he argued that the reduction in bed numbers had been occurring for decades before PFI. He told us that the idea that PFI equated to bed cuts was "simply wrong and not borne out by the evidence".[121] Mr Norman Rose of the Business Services Association, a trade body representing most of the major private sector companies involved in PFI, confirmed the evidence of most of the trusts we spoke to:

> "[any] decision on beds is made by the Trust, and solely by the Trust, before the outline business case comes out; we have no hand in it at all. When bids come in from the variety of companies, or consortia, who are asked to bid, if at that stage the Trust then decides that the cost is higher than the budget the Trust has, then the Trust itself may decide to look at reducing the number of beds; we have no role in this and we wish no role in it."[122]

75. However, Ms Jane Herbert, Chief Executive of South Manchester University Hospitals NHS Trust, said that PFI did influence bed numbers, albeit indirectly. The increased pressure on cash flow, which she associated with PFI, had resulted in more pressure in the system generally, though she thought it would be wrong to characterise it as a "driving factor". When pushed for an illustrative figure for the impact of PFI on bed

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113 Ev 55.
114 Ev 50.
115 Ev 352.
116 Q403.
117 Ev 355.
118 *Downsizing for the 21st Century*, 1999, para 1.
119 Q160.
120 Ev 31.
121 Q1073.
122 Q362.

numbers she estimated "maybe 10 per cent more pressure because of the PFI".[123] However, the chief executive of the nearby Central Manchester NHS Trust was confident that the new hospital for his trust would have an extra 190 beds and that this figure would have been the same regardless of whether it had used PFI or conventional funding. He felt the difference in emphasis between his position and that of Ms Herbert was a consequence of the fact that his was a later scheme and benefited from the major expansion in spending signalled by the *NHS Plan*.[124]

76. Several of our witnesses drew this distinction between the first wave of PFI and subsequent waves and in particular drew attention to the impact of the National Beds Inquiry (NBI). The NBI grew out of concerns within the Department that the long-term decline in staffed hospital beds might have gone too far.[125] Commenting on the conclusions, the Secretary of State said that the Inquiry showed "we need to take a whole-system view of services, and under any scenario, this is likely to require an increase in the number of beds in the whole system".[126] This meant that those PFI projects concluded following the NBI were not subject to the pressures evident in the first wave of PFI projects. Even Professor Pollock agreed that the National Beds Inquiry had reversed the policy of bed reductions, but she remained of the opinion that beds were still being closed.[127]

77. **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.**

PFI versus conventional public procurement: assessing Value for Money

78. In its memorandum the Department underlined the fact that value for money (VFM) had to be proved before a project could proceed down the PFI route. The only way to prove this with absolute certainty would be to build two identical hospitals, one using conventional, Treasury funding and the other PFI.[128] In the absence of this, the PFI has to be tested against a hypothetical model, the Public Sector Comparator (PSC). This value for money test compares the full life cost of public provision (the PSC) with that of the PFI alternative, and assesses the value of the risk retained by the public sector in both options.[129] Therefore, the PSC is basically a pass or fail test: if the net present value of the PFI bid is below that of the PSC then the deal is considered to be good value for money.

79. The value of the risk and its transfer from the public sector to the private sector is central to the value for money equation. As the Department explained: "PFI transfers the risk of time–and cost–overruns to the private sector, who are only paid once the facility is

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123 Q503.
124 QQ503–4.
125 *Shaping the Future NHS:Long Term Planning for Hospitals and Related Services*, para 4.
126 *Shaping the Future NHS:Long Term Planning for Hospitals and Related Services*, Introduction.
127 Q505.
128 Q1058.
129 Ev 279.

operating to the required standard. Publicly funded projects were often subject to delays and increased costs, and required extra capital to repair defects." Furthermore, "under the PFI contract the annual payments to the private sector partner are linked to performance and quality standards which is not possible under the conventional public capital funding route".[130] The Secretary of State made this point to us when he suggested that the only things which were privatised through the PFI were the cost overruns and the time overruns.[131]

80. Certainly the performance of conventionally procured projects has not always been impressive. Rectifying faults at St Mary's Isle of Wight is costing the NHS £20 million, and the cost of Guy's Hospital Phase 3 has risen 300 per cent and been delayed by over three years.[132] The Secretary of State believed that there were fundamental problems with publicly procured projects:

> "The point about the way that we procure traditionally through the public sector regime is there is no real incentive on the contractor to come in on time or on cost. By and large what happens in the real world is they know a new National Health Service hospital is a precious thing, precious to the trust and precious to the government and they assume that we will bail them out. The truth is that is what has happened. Chelsea & Westminster is a great example of that, we bailed them out, we are still bailing them out today as a consequence of that."[133]

However, major construction contracts include substantial penalty clauses in relation to time overruns and can limit the passing on of costs, although not to the same extent as is possible in PFI contracts. In the event of a PFI contractor walking away from a project the DoH would ultimately have to meet the additional costs of replacing the contractor or bailing out the project, as it would with a conventionally procured project. In reaching this position it is acknowledged that the PFI contractor will have incurred substantial losses.

81. As the risk is being taken on by the private sector, it has to be reflected in the VFM comparison between the PFI and PSC models. This is a complex calculation and as many people have commented, risk transfer is an art not a science. Risk valuation is not conducted to a standard procedure, but carried out on a trust by trust basis.[134] The Department explained that this was done because the individual trusts were best placed to understand local circumstances. The Department did, however, provide trusts with advice on how to quantify these risks and its PFI guidance outlines 22 typical construction and development risks. It also provided guidance on how individual risks could be allocated between the NHS and the private sector. [135]

82. The Institute for Public Policy Research suggested that some risks could be clearly assigned but others could not. In the view of the IPPR, design and construction risks (including time and cost overruns) and operating costs should be borne by the private sector partner, while the 'political' risks involved in changes to health policy should be borne by the public sector. However, risks associated with the demand levels for the service, and the obsolescence of technology in the project were far harder to assign.[136] Appropriate risk allocation between the public and private sector is a key requirement to the achievement of value for money on PFI projects. In its report on VFM in PFI deals the National Audit Office explained the importance of this:

> "Without risk transfer the private sector receive the benefit of a very secure income stream, similar to a gilt-edged security, but may set their charges at a level which

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130 Ev 5.
131 Q82.
132 Ev 5.
133 Q98.
134 Ev 279.
135 Ev 280.
136 *Building Better Partnerships*, p. 83.

> earns them a return far higher than is available on such a security. However, if a Department seeks to transfer a risk which the private sector cannot manage, then the value for money will reduce as the private sector seeks to charge a premium for accepting such risks. [A department therefore should seek to achieve] not the maximum but rather the optimum transfer of risk, which allocated individual risks to those best placed to manage them."[137]

The IPPR agreed with this assessment: "Departments should strive for optimal risk allocation, not maximum risk transfer; whether this results in the project being off or on the public sector's balance sheet should be irrelevant to whether the project goes ahead".[138]

83. Several of our witnesses questioned the validity of risk transfers. The NHS Confederation believed that while any assessment of the true value of risk transferred could only be calculated once a contract had run its course, there remained a concern that some of the transfer of risk had not been particularly valid.[139] The Confederation also drew attention to recent work by the Office for Health Economics which suggested that the original claim that PFI procurement reduced the risk of cost overruns was open to question.[140] Professor Pollock argued that at the point when the contract is drawn up risk valuation was theoretical rather than real.[141] As an example of how this could unravel, she cited the Passport Agency's PFI deal with Siemens. Siemens Business Services were contracted to develop IT systems for the Passport Agency. Part of the contract included the transfer of risks of late delivery or system failure. When failure occurred it was valued at £12.6 million. Yet according to Professor Pollock, only £2.44 million was being paid in compensation by Siemens.[142] She further asserted that it was not possible to identify and cost risks which might arise over the course of a 25-35 year contract and therefore that it had to be a subjective judgement.[143] Professor David Mayston from York University also suggested it was difficult to assess the risks of PFI contracts in their present form. In order correctly to assess risk, he proposed that PFI projects should be unbundled into their component parts (that is, Design, Build, Finance, Maintenance and Operation), with separate tendering for each. Doing this "would provide the opportunity to purchase the constituent elements from the most efficient sources, with a much closer association between risk and reward than PFI projects at present provide".[144] This, he maintained, would provide a level of transparency that could "overcome the suspicion that PFI is driven mainly by ... political factors that are extraneous to the long-term needs of the NHS".[145]

84. Professor Pollock in a supplementary memorandum cited the research of Jon Sussex, Associate Director of the Office of Health Economics, who argued that, in Professor Pollock's words, " risk transfer is liable to exaggeration in PFI business cases" and that this "arises because of trusts' perception that there is no alternative to PFI when public capital is subject to tight cash limits. Trusts are therefore inclined to treat VFM as a hurdle they have to surmount rather than as an objective test".[146]

85. 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

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137 *Examining the Value for Money of Deals under the Private Finance Initiative*, Session 1998–99, (HC 739), para 2.11.
138 *Building Better Partnerships*., p84.
139 Ev 244.
140 Ev 244.
141 Ev 362.
142 Ev 363.
143 Ev 362.
144 Ev 324.
145 Ev 324.
146 Ev 371.

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.

86. Once the risk transfer has been assessed and apportioned, a public sector discount rate is applied to anticipated future cash flows to allow the 'present cost' of a project to be assessed. The IPPR explains:

> "payments from the public purse for the capital element of a PFI scheme will be made at a later date than is the case under conventional procurement. A payment made later effectively costs less so these future payments have to be discounted."[147]

87. The discount rate chosen for VFM purposes has for many years been set by the Treasury at 6% and is intended to represent the pre-tax long-term cost of capital for low risk purposes in the private sector.[148]

88. The VFM margin between PFI projects and the PSC is relatively slim, and according to the Department averages out at 1.7%.[149] Therefore, if the discount rate is revised downwards by a couple of points it could make the PFI route the more expensive option – all other things being equal, a lower net discount rate favours public procurement over PFI. Professor Pollock gave us an example of how a change in the percentage rate could dramatically affect the value for money of a PFI. She contended that the Carlisle PFI scheme showed a £1.7 million margin in favour of the PFI scheme against the PSC at a discount rate of 6%, but a margin against of £900,000 at a rate of 5.5% and of £13.6 million at a rate of 3%. The IPPR also stated that changes in the net discount rate could have a significant impact on the PSC. It therefore recommended that all PPP/PFI proposals should be subjected to a "sensitivity analysis to see whether different assumptions, for example about different forms of risk allocation or a different discount rate, would significantly alter the value for money assessment".[150]

89. We explored this point with Mr Nicholas Macpherson, Managing Director of the Public Services Directorate at the Treasury. Mr Macpherson explained that the net discount rate was currently under review as part of the review of the Treasury Green Book.[151] On the specific point of the influence of the level of the rate he agreed that if the rate was lowered, in isolation, that would indeed make conventional procurement more attractive than the PFI. However, he argued that the net discount rate was in fact being reviewed in a wider context which would also take into account issues such as the treatment of risk and uncertainty, both in terms of time and cost overruns, tax, and possible flow backs to the Exchequer from private operators. Looking ahead to the outcome, he said that he certainly would not conclude that the review would necessarily change the balance between the public sector comparator and PFI projects.[152]

90. **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**

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147 *Building Better Partnerships*, p.86.
148 Ev 279.
149 Q75.
150 *Building Better Partnerships*, p.100.
151 Q70.
152 Q1065.

clear, and that the means by which VFM is established are transparent and in the public domain.

The Public Sector Comparator

91. The inadequacy of the Public Sector Comparator (PSC) appears to be one of the few areas that united the majority of our contributors on PFI. To a greater or lesser extent, the PSC in its current form was criticised. UNISON argued that the PSC was not a true comparator as it compared a scheme that would be built with one that would not. It believed that the PSC should be replaced by a properly costed, alternative scheme, which would be financed by public sector capital should that prove the most economic option.[153] Professor Pollock asserted that "the function of the economic appraisal is to disguise the true costs of using private finance. It does this by inflating the cost of the PSC by a value broadly equivalent to increased costs of using private finance. Risk transfer assumptions are the main mechanism for disguising the true costs of using PFI compared with a public sector alternative".[154]

92. The business community also voiced doubts about the PSC. Mr Rose of The Business Services Association told us:

> "If there is one thing that you could do, which I think we would all agree needs to be looked at, it is to recommend that public sector comparators become real comparators. There is not one that I am aware of so far which has really understood what the future provision of a hospital would cost, because ... the figures have to be based, in general, on historic costs, to show how the hospital has been treated in the past. And since we know there is a woeful lack of maintenance in the last 20 to 30 years in the public sector, it is difficult then to put in a full maintenance figure, or else the Trust publicly is admitting it has not maintained the estate properly."[155]

93. Catalyst Healthcare, a leading consortium of businesses involved in several PFI schemes, suggested that PSC assumptions varied wildly and "do not seem always to be a realistic basis on which to make planning decisions about the reform of local health economies".[156]

94. The Secretary of State admitted that the PSC was to some extent an artificial exercise. We put to him the suggestion that, in the great majority of cases, the PFI constituted the only likely source of funding for a new hospital. He acknowledged that there would not be sufficient capital to finance all the hospital building programme at one go via conventional procurement:

> "Although we make the assumption in the public sector comparator that capital is available, as we all know, despite the fact that we are putting more capital into the National Health Service through the Treasury than we have ever done that would not be enough to meet our ambitions around this."[157]

The Secretary of State cited the example of University College Hospital London which he said would probably be the first half a billion pounds hospital in the NHS; in his view, it was "not the case" that this money would otherwise automatically be available from the

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153 Ev 47.
154 Ev 359.
155 Q373.
156 Ev 117.
157 Q82.

London Regional Offices Capital Fund.[158] He was, however, adamant that the process offered a genuine test of value for money.[159]

95. **It needs to be emphasized that PFI is not new money, it is a new way of managing the flow of tax-payers' money.** A key difference between PFI and PSC lies in their cash profiles. A publicly funded project is "front-loaded" with significant levels of funding needed in the construction years. After that expenditure levels tail off rapidly. This contrasts with a PFI scheme which has more even levels of year on year funding. The Government argues that this enables the PFI route to bring forward more schemes at one time than the publicly funded route. Assuming equal VFM as between the PFI and the PSC, the same number of hospitals would be built under either route, but not at the same time. However, Professor Pollock questioned whether conventionally funded projects needed to be front-loaded. She suggested that a public sector model could also use discounted cash flow which would even out its year on year expenditure profile[160] and make the PSC more competitive.[161] We are, however, not convinced that this would be feasible.

96. We questioned the Secretary of State on the Public Sector Comparator and its implications for value for money. While he defended the criteria adopted, he did offer an interesting insight into the arguments over the validity of the value for money exercise:

> "I think in the end we can have a huge load of arguments about the Private Finance Initiative and whether it is good, bad or indifferent, whether it is good value for money, bad value for money, and all these different things, but in the end its compelling attraction as far as the National Health Service is concerned is that we can get more hospitals built more quickly."[162]

This may well be true. Certainly there is added value to the NHS in getting delivery of new hospitals sooner rather than later. It could, however, be argued that if the hospital is not going to be built using conventional funding the Department should be comparing the cost of the PFI with the costs of not proceeding with the hospital at all.

97. **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. And, as it is the case that some of these 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.**

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158 The IPPR assert that if PFI had been abolished at the time of the Comprehensive Spending Review and the same capital spending had been undertaken through normal public spending channels, the sustainable investment rule would easily have been satisfied , and by definition so would the golden rule (the golden rule states that over an economic cycle a government must only borrow to invest). [*Building Better Partnerships* p.82.] We recognise that any public spend ultimately will have an impact on economic indicators.

159 QQ82–84.

160 Ev 359.

161 Ev 361.

162 Q1070.

The NHS as purchasers

98. The PFI process is a relatively new departure for the NHS. Those involved in PFI contracts have had to learn quickly the rudiments of negotiation, with little or no experience upon which to draw. In the absence of such experience, much reliance has been placed on outside legal and financial advisers. Several witness commented that the costs for these advisers were unacceptably high. The Department estimated that roughly £52 million had been spent on advisers on the first 18 major PFI schemes.[163] However, the Secretary of State was at pains to point out that the levels of spending on subsequent waves of PFI projects were significantly lower: "As far as average legal fees and average financial fees are concerned between the first wave of PFI and the second wave of PFI on legal fees we have seen a 41 per cent improvement, 41 per cent cheaper to the National Health Service, on financial fees a 48 per cent improvement, 48 per cent cheaper to the National Health Service".[164]

99. The PFI experience has also been refined with the introduction of standard contracts. Mr Peter Coates, Head of the Department's Private Finance Unit, explained that the standard form of contract drawn up by his unit was now obligatory for all PFI schemes and afforded savings of around £200,000 to £300,000 per transaction:

> "We introduced the standard payment mechanism to stop negotiation around paying for the scheme. There is standard central guidance on what level of output we want, what level of service we want from the contractor and we negotiated a design development protocol agreement with major contractors ... about what information is required by both sides to deliver a fixed price PFI contract."[165]

The CBI commented that the standard contract had greatly improved the time and costs of procurement and had also improved risk transfer.[166]

100. Of the trusts we examined there was an improving trend as the lessons of the first wave were learned by the second wave. Our witnesses from Durham told us that, as theirs was one of the first trusts to undertake a PFI project, it was very much a new initiative and there was nobody within the trust with previous experience of a PFI deal.[167] In addition to this lack of experience, the process itself was in its infancy. The Private Finance Unit in the Department did allocate an officer to the Trust, who would attend some of the negotiations, but Councillor Kevin Earley, Chair of the North Durham NHS Trust, without wishing to criticise the unit, felt that the PFI unit "could have been a bit more of a support unit in the true sense of the word".[168] Mr Mason, who managed the first Durham PFI is now managing a second and he declared himself impressed with the new standard contracts believing them to be "the single most important advance" in PFI procurement.[169]

101. The business community also acknowledged the benefits of dealing with experienced NHS partners. KPMG have extensive knowledge of PFI and its representative, Mr Tim Stone, provided us with their view. He felt that while the NHS now had a number of individuals who were experienced in PFI negotiations, "very, very few of them take the experience they have learned ... and reapply it" on other projects. He could think of only two senior personnel who had been involved in more than one project. This he felt was a waste because where individuals did have the opportunity to take part in another PFI there was a step change in the quality of the process: "The re-use of that expertise is spectacular. It is bliss for us because we then have a lot less grief to go through; it is real value for the public sector".[170]

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163 Ev 7.
164 Q99.
165 Q101.
166 Ev 302.
167 Q112.
168 Q117.
169 Q115.
170 Q392.

102. It is at least arguable that the DoH is more vulnerable during negotiations over PFI as a consequence of its practice of allocating contracts to its preferred bidder at an early stage in the process. Once a preferred bidder has been announced competition ceases and any increases in the tender price will not be subject to further competition.[171]

103. **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.**

PFI contracts

104. Drawing up and agreeing a contract involving large amounts of finance and covering a 30 year period is a complex process for those involved. It is an even more complex process for those not directly involved, but with an interest in the outcome. Many of the memoranda we received from Community Health Councils and action groups complained about the style, production and availability of these business cases. Certainly, from the examples that we have seen, the PFI contracts and their supporting documentation are voluminous and unwieldy. To cite just two examples, the Full Business Case for the North Durham PFI occupies 145 pages, and boasts three and a half inches of accompanying documentation while the Full Business Case for Coventry Walsgrave Hospital runs to some 17,000 pages.[172] CHCs and similar organisations play an important role in the public scrutiny of NHS expenditure, and are at a distinct disadvantage when it comes to assessing a project and its component parts.

105. Mr Coates for the Department acknowledged the problem of getting to grips with the business cases and explained that the Department had experimented with providing summaries: "We did try this process once at Norfolk and Norwich where we produced a summary of the contract rather than the contract itself with in layman's terms what each clause meant and we were unfortunately accused of being secretive because we did not release the contract, we released just a summary. Whatever you do you seem to upset somebody".[173] When pressed, he conceded that publishing both the summary and the full contract together could be the way forward.

106. Many organisations have also been critical of the lack of accessibility of documentation supporting PFI projects. The Democratic Health Network highlighted the tensions between the public sector and the private partner. It felt that considerations of "commercial confidentiality" were likely to interfere in the "openness and transparency" that should characterise decision making in the public sector.[174] This has been the experience of several organisations involved with PFI projects at a local level. Oxfordshire PFI Alert group, a collection of health and community organisations, was formed to monitor its local PFI project. It felt that its task had been impeded by a lack of access to information. In particular, the group was scathing about the public consultation stage of the PFI which it felt demonstrated "almost a complete lack of financial analysis and

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171 However, proposed changes to the European Commission's rules for public procurement (COM (2000)275 final) may mean that public sector managers will no longer be able to select a preferred bidder to negotiate contract details on an exclusive basis. Industry is concerned that this will significantly raise the cost of tenders and deter contractors from working on public sector deals.

172 *PFI in the NHS: A Dossier*, GMB, 2001.

173 Q1081.

174 Ev 335.

reporting".[175] The Group said that it had encountered great difficulty in tracking down the Outline Business Case for the transfer of services from the Radcliffe Infirmary to the John Radcliffe Hospital site: "public consultation seems to have been lost in a fog of referring back for revision of plans, financial consultations and patient statistics".[176] South Manchester Community Health Council was also critical of the lack of openness of the PFI project in its area and the approach taken by South Manchester NHS Trust. The CHC argued that a lack of information seriously hindered its task and that significant changes to the PFI schemes had been made without any consultation. Too often it had come up against the barrier of commercial confidentiality. The CHC believed there was no justification on the grounds of commercial confidentiality for concealing the costs of PFI schemes. It also wanted to see public discussion on the strategic impact of a scheme on the wider health economy.[177]

107. Tensions between transparency and commercial confidentiality are an operational hazard, but this should not be seen as unresolvable. The Highways Agency is an experienced purchaser of PFI projects and its standard rules now operate with a presumption in favour of openness which now applies in respect of PFI contracts.

108. **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.**

109. **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.**

The impact of PFI on the local health economy

110. When a PFI project is complete an annual charge is paid by the trust. This charge is ring-fenced expenditure and has prompted concerns in a number of our witnesses over its impact on revenue budgets. UNISON noted that "the payment stream is effectively ring-fenced as it cannot contractually be changed by the NHS without incurring penalties". A commissioner under financial pressure would be obliged to look to their non-PFI expenditure for any savings which needed to be made.[178] Some of those trusts we have spoken to were confident that PFI projects were not a constricting burden on their finances. Mr Moss from UNISON drew our attention to a letter written by the Chief Executive of the County Durham and Darlington Health Authority which, in his view, constituted a plea for additional funding for the local health economy as a consequence of the impact of two local PFI schemes.[179] Mr Flook, Finance Director for the County Durham and Darlington Health Authority, said the letter was in fact only "a bid to the Regional Office for recognition of past under-funding and for the allocation of additional resources".[180] Nevertheless, monies paid out to support PFI will be a first call on commissioners and this will limit their future flexibility in times of budgetary constraint.

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175 Ev 333; Oxfordshire PFI Alert Group comprises local branches of the BMA, the RCN, the NHS Consultants' Association, the CHC, health trades unions and the Oxfordshire Pensioners' Action Group.
176 Ev 333.
177 Ev 294.
178 Ev 48.
179 Q153.
180 Q204; Ev 75.

111. Professor Mayston questioned the potential long-term ramifications of this inflexibility. He felt the need for future flexibility was underlined by both the multi-dimensional nature of demand across different forms of treatment and the technological uncertainty that currently exists over the nature and extent of future cost-effective forms of health care treatment. For this reason he questioned the desirability of the NHS tying itself into 30-year contracts which might constrain its flexibility to respond to future changes and might "risk expensive disputes and litigation if the PFI contract does not easily accommodate such future changes".[181] One such risk was that a PFI hospital could be rendered obsolete before the end of its expected life-span. Though the risk of obsolescence is common to both conventionally financed projects and PFI projects, the level of risk differs between the two. Under a conventionally financed project the risk is limited to the monies invested in the physical asset. A PFI project carries a different risk of the service charge: it should be re-emphasised that PFI provides a service not just an asset.[182] Even if a PFI hospital were to be mothballed, there would remain the liability of the service charge for the duration of the contract.

112. **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.**

Staff transfers

113. Intrinsic to PFI schemes is the maintenance of the fabric of the hospital by the private sector partner and also the operation of hotel services. This involves private contractors taking over the non-clinical responsibilities, and the transfer of non-clinical staff to the contractor. Where staff are transferred, following a PFI project, the consortia must ensure that Transfer of Undertakings (Protection of Employment) (TUPE) applies and pension schemes have to be broadly comparable to the existing scheme.[183]

114. While trades unions welcomed TUPE protection for transferred staff, most of those submitting evidence remained opposed to staff transfers. UNISON's view of private sector involvement was unequivocal: "The experience of private sector provision of support services in the NHS has been one of failure. Private sector provision has not improved the quality of services, it has broken up the NHS team and created a two-tier workforce and it creates obstacles to the provision of integrated services".[184] To support its argument, it pointed to the Government's own audit of cleaning standards of April 2001 in which 20 of the 23 hospitals that failed the audit were from the private sector.[185] Mr Stephen Weeks, National Officer for UNISON, was also concerned that new staff taken on by the private sector would not be offered similar conditions of service, resulting in the creation of a 'two tier workforce'. He further argued that pay and conditions would deteriorate with private sector contractors unable to offer enhanced terms and conditions for fear of being undercut by competitors.[186] A rather different position was taken by Amicus-AEEU, whose member survey of those transferred to private contractors suggested high levels of satisfaction and a strong sense of protection in their employment.[187]

115. Although Registered Nurses are not transferred under PFI schemes, the RCN raised concerns about the increase in the proportion of non-registered nurses at PFI hospitals. In

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181 Ev 319.
182 See para 54.
183 Ev 4.
184 Ev 84.
185 Ev 86–87.
186 Ev 52.
187 Ev 369.

its recent survey, only one of the six largest schemes had reported growth in the number of registered nursing staff employed by the trust, and in one trust the number of non-registered exceeded that of registered nurses.[188] However, we have not received any evidence to compare this with other new schemes or existing trusts.

116. The trusts also voiced some doubts over the practicalities of staff transfer. When we took evidence in Durham, Councillor Earley argued that staff transfer created "a lot of uncertainty on a very individual, person by person basis" and that his preference would be for all staff to remain in the public sector.[189] Mr Phillip Turner, Director of Operations for Non-Clinical Support Services, Bradford Hospitals NHS Trust, explained the potential conflicts:

> "I think you do lose control of the services, in a number of ways ... The debates that I am having with nursing at the moment, is that they want the soft FM [Facilities Management] people to be part of the ward team, they are not bothered about having the budgets, but they actually want them to be part of the team ... they said that in their experiences they have not felt that when they have had contractors on the ward they have actually felt they belong to the Trust, they work for somebody else, and they have found that difficult."[190]

117. When we visited Durham, the ward sisters explained that they now worked within a structure called 'Patient Focus Care'. This brought together both NHS staff and contract staff on the wards under the management and leadership of the ward matron. The matron had the authority to organise all the contract staff as if they were NHS staff.[191] This had had positive effects and re-established a team approach. This was not the experience in Carlisle where the private sector partner retained the day-to-day management of its staff.

118. The Government is clear that it considers staffing matters to be important. The 2001 Labour manifesto contained the commitment that: "PFI should not be delivered at the expense of the pay and conditions of the staff employed in these schemes. We will seek ways in which, within the framework of PFI management, support staff could remain part of the NHS team".[192] As part of this commitment, the Department is now operating three pilot schemes at Stoke Mandeville, Roehampton and Havering in which 'soft' facility staff retain all their NHS employment terms, but are managed by the private sector (the "Retention of Employment Model").[193]

119. Notwithstanding their opposition to staff transfer, the unions were willing to work with the Retention of Employment Model (REM). However, both the GMB and the NHS Confederation were concerned that progress on the pilots schemes had stalled.[194] They argued that this was because of a reluctance by the private sector to give up direct control of staff terms and conditions.[195] Certainly our witnesses from the private sector gave the REM a cool reception. The Business Services Association (BSA) believed that the model presented numerous potential difficulties. Amongst many employment issues, the BSA argued that the Retention of Employment model would itself create a "them and us" culture between the trust's employees and those employed by the private contractor, which would become more pronounced as secondees were offered posts on promotion for which they had to become employees of the private contractor.[196] In terms of risk, the BSA was concerned that the private contractor would not be comfortable managing the risk of penalties for non-availability of services when the contractor did not employ staff directly. The BSA suggested this might entail additional risk costs in the contract. Similarly, any

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188 Ev 58.
189 Q117.
190 Q230.
191 Q124.
192 Ev 4.
193 Ev 4.
194 Ev 244; Ev 352.
195 Ev 352.
196 Ev 81.

penalty regimes would be hampered by the need to establish whose staff were responsible for any problems caused.[197] The CBI believed that the REM was "deeply problematic" and that "workers would lose out on promotion and blame each other where problems did arise".[198] KPMG was of a similar view stating that there has been "considerable private sector concern about the pilot projects where the workforce remain in the public sector".[199]

120. **There is no dispute that staff transfer 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.**

Design issues

121. One of the benefits sometimes attributed to PFI is that of innovation in design. Mr Stone of KPMG told us that the PFI released "an army of skills" in the private sector, when contractors were given a brief which demanded a particular end-product, rather than one which demanded control over every last detail.[200] However, the evidence here is mixed. UNISON was unimpressed with the standard of design in the PFI projects it had studied, complaining of faults which it attributed to cost cutting and sheer bad design.[201] The Commission for Architecture and the Built Environment (CABE) also questioned the delivery of better design. Its design review committee and enabling panel has advised its clients working on PFI projects and therefore has close experience of them. It concluded that to date "many PFI hospitals have failed to deliver the step-change in the quality of the built environment–in terms of functionality, overall appearance and comfort–that is clearly desired by the Government".[202] CABE also referred to evidence from the King's Fund, the IPPR and the Office of Health Economics which supported their view.[203]

122. This may be due, in part, to the speed with which PFI projects are concluded. Several witnesses argued that there was not sufficient time allowed for design. Furthermore, we have seen examples of where the design team and the trust have not been sufficiently close. This also can create problems. In Carlisle we were told that, during the design process, clinical staff were shown small scale models which looked impressive, but disguised the fact that spaces between beds were smaller than anticipated. They suggested that the use of full scale mock-ups of wards would have prevented these problems.

123. **Closer input into the design process 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.**

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197 Ev 84.
198 Ev 304.
199 Ev 119.
200 Q390.
201 Q171.
202 Ev 312.
203 Ev 312.

124. **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.**

V NHS LIFT

Introduction

125. The Government is also applying the principles of Public Private Partnerships to primary care facilities though the introduction of Local Improvement Finance Trust (LIFT) schemes. The drive behind this initiative is the need to improve the current stock of primary care facilities. In its memorandum, the Department acknowledged that a large element of the current primary care estate was no longer suitable for the provision of modern healthcare.[204] This point was reinforced by the Secretary of State:

> "Primary care in too many parts of the country, particularly the poorest parts of the country, is appalling. 40 per cent of GP surgeries are purpose built, virtually the remainder are either adapted houses, residential buildings, or adapted shops, and we expect modern primary care to be carried out in those circumstances. 80 per cent of the accommodation is too cramped to meet modern requirements now."[205]

Furthermore, the Department pointed out that fewer than 5% of premises were co-located with a pharmacy, and that a similar number were co-located with social services.[206]

126. It is widely accepted that the current stock of GP premises is in disrepair. The NHS Alliance told us that traditional investment by GPs themselves had been poor, while the BMA contended that "the investment to replace the old NHS building stock and to catch up on the backlog of maintenance was sorely needed".[207] The CBI believed that LIFT represented a "critical initiative which should help stem the massive loss of inner city GPs 35 per cent of whom have been scheduled to retire between 1998 and 2005".[208]

127. The LIFT initiative was first announced in *The NHS Plan* when the Department committed itself to investing up to £1 billion in primary care facilities. This would be targeted at a substantial refurbishment or replacement of up to 3,000 family doctors' premises by 2004, and the creation of 500 one-stop primary care centres.[209] These new centres would draw together the many strands of primary care to include GPs, dentists, opticians, health visitors, pharmacists and social workers. Though the bulk of this investment would come from the private sector, the Department was also investing £195 million in the initiative.[210] Therefore, unlike PFI projects, the Department would hold a financial interest in the projects.

128. The Government put flesh on the bones of this announcement with the publication of the LIFT prospectus in July 2001.[211] The prospectus noted that while private money was not a new development in primary care – many primary care premises had traditionally been built and provided by the private sector – hitherto such investment had tended to be on a piecemeal basis.[212] This investment was not well targeted and as a result GPs faced significant disincentives to practising in inner city areas. The Department asserted that LIFT would counter these problems by "providing an integrated range of primary and intermediate care services; leasing premises to individual primary care service deliverers, such as GPs, on flexible terms that can respond and adapt to changing requirements over time; and management of the facilities provided, such as maintenance over the whole life of the assets, providing all energy and utility requirements".[213]

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204 Ev 7.
205 Q1087.
206 Ev 7.
207 Ev 186; Ev 188.
208 Ev 300.
209 *NHS Plan*, paras 4.11 and 4.12.
210 Ev 8.
211 *Public Private Partnerships in the NHS: Modernising Primary Care in the NHS/ NHS Local Improvement Finance Trust (NHS LIFT).*
212 Ev 7.
213 *LIFT prospectus*, p.20.

129. The Department explained that LIFT would operate at both national and local level. At the national level it had established a national joint venture company, Partnerships for Health, comprising Partnerships UK and the Department which had as its corporate objective the facilitating of the development of the LIFT initiative.[214] At local level, LIFT schemes would engage a range of private and public sector interests in a joint venture drawing together local health bodies, the national joint venture company and the private sector. The private sector partner would be identified through a competitive procurement exercise and then a joint venture would be established between local health economy bodies, the national joint venture company and the private sector partner.[215]

130. Mr David Goldstone, Chief Executive of Partnerships for Health, told us that the national joint venture had been set up to make LIFT work in practice. As a facilitator, Partnerships for Health's role was to encourage greater common thinking about those services and facilities that were required locally. It would also lend assistance to the contract process and was developing a suite of documentation intended to become a standard package to implement local projects.[216] One of the driving forces behind this was the experience of the first PFI Schemes. Mr Goldstone explained that such documentation would facilitate the recycling of knowledge and experience and that "setting up a focused organisation to deliver this is helping to ensure consistency of approach and recycling of lessons [learned]".[217]

131. Central to the LIFT initiative would be the targeting of Health Action Zones with high levels of unmet need.[218] While surgeries in more affluent areas are generally able to attract private investment, surgeries in more deprived areas tend to suffer. Therefore LIFT will specifically target those areas with the greatest need. The Secretary of State suggested LIFT would be a means of addressing health inequalities:

> "The existing way of providing primary care premises and providing primary care positions, GPs, has been to gravitate more and more resources crudely to the leafy suburbs and less to the inner cities. We know that the biggest health needs are in the latter rather than the former. The leafy suburbs do pretty well out of the existing arrangements, which are partly private sector led. What this is all about is trying to address the balance and making sure, again through innovative PPP arrangements, we get more resources and more capacity into those parts of the community which need the most."[219]

132. The NHS Alliance welcomed this targeting but was concerned that areas where there had been adequate investment by GPs would appear the most attractive areas to private investors in LIFT.[220] The Department's first six LIFT schemes – Barnsley, Camden and Islington, East London, Manchester Salford and Trafford, Newcastle and North Tyneside and Sandwell – do reflect inner city targeting.[221] However, these schemes are a long way from completion. When we took evidence from Partnerships for Health, we were told that the projects were still at the development stage. Much of the current work concerned the physical assets of the LIFT scheme, and we were told that it would be some time before permanent solutions were reached.[222]

133. **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**

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214 Ev 8. Partnerships UK is itself a PPP: it is 51 per cent owned by the private sector and 49 per cent by the Treasury and the Scottish Executive. Its corporate objective is to facilitate the development of PPPs.
215 Ev 8.
216 Q760.
217 Q778.
218 Ev 8.
219 Q1091.
220 Ev 186.
221 Ev 8.
222 Q772.

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.

Value for Money

134. One of the prerequisites of the Department's use of PPPs and the private sector is that it should provide good value for money. The LIFT prospectus did not make it clear how value for money for LIFT schemes would be defined. Unlike PFI projects, there appears not to be a public sector comparator. The NHS Alliance saw this as a weakness, arguing that a detailed assessment of the first wave of schemes should be undertaken to establish value for money before LIFT was rolled out nationally.[223] We questioned Mr Goldstone about how value for money would be assessed. He told us that a number of safeguards were in place to protect the public purse:[224]

- there was a competitive process to determine the partner for the LIFT project and competition tended to yield good value for money
- rent levels would still need to be approved by district valuers within the existing statutory red book scheme, thus ensuring that rent levels were reasonable
- the fact that the public sector maintained a stake in the scheme ensured that Government had access to the accounts and a share of profits
- the LIFT scheme had the ultimate sanction of severing links with the private sector partner if that partner persistently failed to honour the contract.

135. While such mechanisms offer a degree of control, we were unconvinced that they would necessarily be sufficient fully to protect the public purse. Our witnesses from the BMA and the NHS Alliance were also unconvinced. Dr Stanton from the BMA expressed "a degree of honest scepticism" that this would ensure value for money while the NHS Alliance suggested that an independent body should appraise LIFT schemes "in terms of value for money, in terms of whether the premises meet the specifications and the needs of the community, whether the service charges are exorbitant or whether the services actually service the properties as they need to".[225]

136. We were also surprised to learn that the first six schemes were not pilot schemes and that the programme did not provide for a pause whilst these were evaluated.[226] However, the Secretary of State made his position clear: "They are not pilots. In fact I have announced the second wave today of 12 further initiatives. We are just getting on and doing this".[227] Our surprise was shared by the BMA who believed that "common sense would suggest that it might have been better to see the outcome of the first six before rolling out others".[228] The NHS Alliance also thought that LIFT should be "piloted in defined areas to begin with and rolled out nationally only when there is clear evidence that it can provide value for money, quality and equity".[229] Mr Coates explained that the first six schemes would be assessed and that "a standard business case assessment will look at both the numbers and the quality so that ultimately the prime test will be what numbers come out and whether they are providing value for money for the taxpayer".[230]

137. **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,**

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223 Ev 186.
224 Q787; Q789.
225 Q787.
226 Q784.
227 Q1078.
228 Q787.
229 Ev 186.
230 Q1088.

both in terms of value for money and service provision, though we recognise the urgent need to refurbish the primary care estate.

138. **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.**

VI PATHOLOGY AND PUBLIC PRIVATE PARTNERSHIPS

Pathology in the NHS

139. Our terms of reference extended to Public Private Partnerships. As we noted above, *The NHS Plan* outlined areas for further collaboration between the NHS and the independent sector. We chose to focus on pathology, one of the key areas where the Department anticipates growth.

140. The estimated total NHS expenditure on pathology services was £742 million in 2000-01, an increase of nearly £200 million on the figure for 1998-99.[231] The Royal College of Pathologists estimates that pathology consumes around 6% of the NHS acute services budget.[232] There are around 300 services in England, usually based in acute trusts, and about 1700 separate laboratories (principally haematology, microbiology, biochemistry, histopathology, immunology). Historically, pathology laboratories developed on-site in hospitals, serving local catchment populations. There are also approximately 250 private sector laboratories. There are a further 46 Public Health Laboratory services.[233]

141. Up to 70% of all diagnoses in NHS patients depend on laboratory tests, hence NHS pathology services are critical for the day to day evidence-based care of patients. Fewer than 5% of test requests ("hot tests") require a response within 24 hours. The NHS undertakes some pathology work for the independent sector, but very little NHS work is currently undertaken by the independent sector. In addition, the reprovision of laboratories has been included in a number of PFI projects. Only about 5% of pathology work undertaken in the UK is currently conducted by the private sector.[234]

142. In the light of new demands, in particular sophisticated new technology, a growing repertoire of high-technology tests, robotics and near-patient tests, there are growing pressures for pathology services to be organised to serve a larger population, perhaps equivalent to the strategic health authority size of around 1.5 million. The Royal College of Pathologists suggested that the status quo "hinders the optimal distribution of the pathology workforce, encourages duplication of expensive equipment in neighbouring institutions and fosters professional competition rather than collaboration".[235] The Doctors Healthcare Company, which owns The Doctor's Laboratory, the leading UK independent pathology services provider, suggested that pathology had suffered from "strategic neglect" in the NHS and argued that the NHS's laboratories "operate on a small scale, are fragmented, unmodernised, lack leadership attention, and find it difficult to change".[236]

143. Pathology is a rapidly expanding service, with a workload increasing at an annual rate of around 8%. In addition, the pressures of workforce shortages, as well as technology, are factors persuading some providers to look at the advantages of larger services. International comparisons suggest that UK laboratories are potentially inefficient, being too small to make effective use of new technology and improve labour productivity. The average NHS laboratory probably operates at only a fifth of the volumes of leading modern international facilities.[237] Technical advances in "near patient testing" and the introduction of desktop laboratories for GPs may significantly affect the traditional patterns of demand.

144. Over the last 20 years, capital investment in pathology has been poor as recognised by Audit Commission reports in 1991 and 1993 and the NHS Executive review in 1995.[238]

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231 Newchurch Limited estimate.
232 Ev 154.
233 *Official Report*, 23 April 2002, cols 249– 50w.
234 Q659.
235 *The Modernisation of Pathology: A Statement from the Royal College of Pathologists*, para 1.4.
236 Ev 161.
237 Figures from Newchurch Limited.
238 *Pathology Services and Management Review* 1991 and *Critical Path: An Analysis of Pathology Services* 1993.

In 1998, following the Comprehensive Spending Review, the Department initiated a ten year programme to modernise NHS pathology services but according to one of the largest private companies in this area, "the majority of NHS laboratories are still configured in the same way as they were 20 or more years ago".[239]

Modernising pathology services

145. The first indication of the Government's proposals to modernise pathology funds came in an announcement of a £20 million modernisation fund in 1998-99, and the establishment of a steering group to assess bids for funding.[240] A central instruction was issued to NHS Regional Offices to examine their pathology services and produce a co-ordinated plan to bring them up to date. These plans were returned by March 2001.[241] According to a Royal College of Pathologists' Discussion Paper, "central thinking in the Department was being shaped by policy makers in the Prime Minister's office and strategists from a variety of sources, including a Canadian company with much experience of configuring laboratory services in North America".[242]

146. In the first two years of the Programme (1999-2000 and 2000-01), 400 expressions of interest were received and £20 million was invested in 35 projects, looking at the adoption of advanced technologies in pathology and encouraging consolidation or reconfiguration of services. In 2001-2, a further £8 million is being spent supporting three or four larger reconfiguration projects exploring the development of managed clinical networks in NHS pathology services – moving from trust-based pathology services to those serving whole Health Economies, up to strategic health authority size (ie around 1.5 million). However, as Professor Lilleyman of the Royal College of Pathologists has noted, the modernisation programme has run into some difficulties.

> "First, initial bids showed just how un-modern some pathology services had become and that considerable investment was needed simply to bring them up to date. Second, the notion that capital might be more readily available from the private sector has not been greeted with universal enthusiasm. This is a disappointment to Government policy advisers who see public:private partnerships as an important part of the modern NHS - particularly in pathology. Finally, in late 2000, regional offices of the NHS Executive were each charged with producing a local modernisation strategy, and the perceived lack of consultation on this process has produced professional indignation in some parts of the county."[243]

147. We took evidence from two private sector pathology providers, Quest Diagnostics Limited and The Doctors Healthcare Company (TDHC), West Middlesex University Hospital (which had contracted its pathology services to Quest) the Royal College of Physicians and the MSF trade union.[244] We wanted to ascertain what the perceived advantages and disadvantages were of the contracting out of pathology services.

148. All our witnesses were agreed that pathology services in the UK were in need of reform and reorganization. Ms Gail Wannel, Chief Executive of West Middlesex University Hospital NHS Trust, told us that "economies of scale" were being lost because of the fragmented nature of the current provision of pathology.[245] Not only did larger networks of providers offer cost savings, they also facilitated the presence of specialized pathology teams, in contrast to the present situation where some senior technical and clinical staff were engaged in a variety of functions, including pathology. Professor

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239 Ev 348.
240 *The Modernisation of Pathology: A Statement from the Royal College of Pathologists.*
241 *Ibid.*
242 *The Modernisation of Pathology*, para 1.2.
243 *Bulletin of the Royal College of Pathologists*, October 2001.
244 Since we took oral evidence, Quest Diagnostics has lost its contract for all pathology services across West Middlesex Hospital Trust: West Middlesex's services will now be provided by Hammersmith Hospital Trust. See *The Health Service Journal*, 21 March 2002, p.9.
245 Q562.

Lilleyman for the Royal College of Pathologists drew attention to the problems caused by "pockets of unsatisfactory service due to chronic under investment" and workforce shortages. He backed the calls for reform of pathology along the lines of larger networks, which he felt should be managed at strategic health authority level,[246] but was open-minded as to whether this required greater private sector involvement.[247] Ms Wannell too felt that there was an opportunity for "a variety of models" but that the NHS could learn a lot from the private sector in terms of the development of specialist services and off-site laboratories for cold [non-urgent] testing.[248]

149. We asked our witnesses whether private pathology provision in the NHS gave good value for money. Ms Ward suggested that it was difficult comparing the costs of private provision with those obtaining in the NHS, owing to the complexity of accounting procedures within the NHS.[249] What she felt was indisputable was that the costs of provision by her company were more transparent and that this improved accountability. West Middlesex recorded that the costs of its pathology services had fallen by ten per cent since it had contracted out services.[250] Ms Ward told us that the purchasing power of the NHS would suggest it might obtain more favourable rates than private clients.[251]

150. We also wanted to establish how turn round times in the private sector compared with those in the NHS. Ms Ward of Quest cited the example of cervical cytology tests at West Middlesex, where the turn round time had been reduced from 16 weeks to seven working days following substantial investment by Quest. Dr Prudho-Chlebosz of TDHC assured us that there was no discrimination in turn round times as between tests carried out for NHS or private sector customers: "it is more expensive to discriminate between private pathology and NHS pathology than to ensure that the configuration of the department is such that all work is put through quickly".[252]

151. We were also concerned that quality might be compromised in the search for efficiency, and that control over procedures might move out of the hands of clinicians; West Middlesex University Hospital NHS Trust assured us that its pathology service remained consultant-led.[253] Urgent tests are analysed in a small laboratory on the hospital site while "cold" tests are conducted in an off-site laboratory. West Middlesex had found quality systems to be "robust", equipment was updated more frequently and pathologists were freed from routine administrative tasks and able to focus on clinical issues.[254] According to Ms Wannell:

> "The facility and environment are much enhanced. We were sited in four different laboratories, two of which were in a dreadful state of repair. The equipment is enhanced and we have IT systems significantly enhanced now. They link to the GPs so there is rapid response. People are not hunting around for results, it is a lot easier on that side. In the transport system, we had had a situation where sometimes pathology was being collected in laundry vans. Now we have dedicated transport. The whole service provision has been enhanced tremendously. I think the GPs would say that as well."[255]

152. Ms Wannell told us that a crucial aspect of the contract was that it was "clinically led", and that it had been clinicians who had determined the balance of tests to be conducted on and off-site. Mr Spiller of MSF acknowledged that his union's experience of the main private sector pathology providers had been that they provided work to a high

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246 Q557.
247 Q553.
248 Q564.
249 Q631.
250 Q573; Ev 345, Ev 348.
251 Q589.
252 Q589.
253 Ev 162.
254 Ev 164.
255 Q682.

quality standard, though he felt that similar improvements could be made within the NHS with adequate investment.[256]

153. Given the consensus over the need for substantial restructuring of UK pathology we wondered why so little had been done to date. West Middlesex recorded that a disadvantage of their public private partnership with Quest had been that pathologists valued the NHS ethos and wanted to remain in the mainstream of UK pathology.[257] Dr Prudo-Chlebosz of TDHC thought that the reason the NHS had not moved more quickly to more rational structures in pathology arose from the historical background of pathology, the fact that it had traditionally been constituted as a number of small disciplinary areas. People entered pathology out of an interest in providing a clinical service to a local set of needs, not to institute structural change.[258] Mr Spiller of MSF felt that the Pathology Modernisation Programme was severely under-funded and that the debate was hampered by the almost automatic assumption that rationalisation and reorganization entailed involving the private sector.[259]

154. **All sides to the debate 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.**

155. **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.**

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256 Q666.
257 Ev 164.
258 Q688.
259 Q690.

LIST OF CONCLUSIONS AND RECOMMENDATIONS

(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 (paragraph 17).**

(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 (paragraph 21).**

(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 (paragraph 23).**

(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 (paragraph 24).**

(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" (paragraph 25).**

(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 (paragraph 27).**

(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 (paagraph 28).**

(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 (paragraph 31).**

(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 (paragraph 33).**

(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 (paragraph 38).**

(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 (paragraph 39).**

(l) **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 (paragraph 40).**

(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 (paragraph 43).**

(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 (paragraph 45).**

(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 (paragraph 46).**

(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 (paragraph 53).**

(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 (paragraph 70).**

(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 (paragraph 77).**

(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 (paragraph 85).**

(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 (paragraph 90).**

(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 (paragraph 97).**

(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 (paragraph 97).**

(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 (paragraph 103).**

(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 (paragraph 108).**

(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).**

(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 (paragraph 112).**

(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 (paragraph 120).**

(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 (paragraph 123).**

(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 (paragraph 124).**

(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 (paragraph 133).**

(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 (paragraph 137).**

(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 (paragraph 138).**

(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 (paragraph 154).**

(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 (paragraph 155).**

PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT

Thursday 25 April 2002

Members present:

Mr David Hinchliffe, in the Chair

John Austin	Julia Drown
Andy Burnham	Sandra Gidley
Mr Simon Burns	Dr Doug Naysmith
Jim Dowd	Dr Richard Taylor

The Committee deliberated.

Draft Report (*The Role of the Private Sector in the NHS*), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 64 read and agreed to.

Paragraphs 65 to 69 read.

Motion made and question put, to leave out paragraphs 65 to 69. —(*The Chairman.*)

The Committee divided.

Ayes, 2	Noes, 3
Sandra Gidley	Jim Dowd
Dr Richard Taylor	Julia Drown
	Dr Doug Naysmith

Paragraphs 65 to 69 read and agreed to.

Paragraphs 70 to 83 read and agreed to.

Paragraphs 84 read, amended and agreed to.

Paragraph 85 to 123 read and agreed to.

A paragraph brought up, read the first and second time.—(*The Chairman.*)

The Committee divided.

Ayes, 3	Noes, 3
Julia Drown	Andy Burnham
Sandra Gidley	Jim Dowd
Dr Richard Taylor	Dr Doug Naysmith

Whereupon the Chairman declared himself with the Ayes.

Paragraph agreed to (now paragraph 124).

Paragraphs 124 to 154 (now paragraphs 125 to 155) read and agreed to.

Resolved, that the Report, as amended, be the First Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select committees (reports)) be applied to the Report.

Several papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman.*)

Several papers were ordered to be reported to the House.

[Adjourned till Wednesday 8 May at a quarter to four o'clock.

LIST OF WITNESSES
[Volume II]

Wednesday 24 October 2001

Monday 29 October 2001

Thursday 8 November 2001

Thursday 15 November 2001

Thursday 22 November 2001

Thursday 29 November 2001

Thursday 6 December 2001

Wednesday 9 January 2002

LIST OF MEMORANDA INCLUDED IN THE MINUTES OF EVIDENCE
[Volume II]

Memoranda and supplementary memoranda submitted by:

LIST OF APPENDICES TO THE MINUTES OF EVIDENCE

Memoranda submitted by:
[Volume II]

LIST OF UNPRINTED MEMORANDA

Memoranda have been received from the sources listed below. These have been reported to the House, but to save printing costs they have not been printed. Copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Record Office, House of Lords, and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London, SW1 (tel 020 7219 3074). Hours of inspection are from 9.30 am to 5.00 pm Mondays to Fridays.

Memoranda or supplementary memoranda submitted by:

Association of Community Health Council for England and Wales [PS 2B]
British Dental Association [PS 3]
CHF–A Federation of Charity Hospitals [PS 6]
George Monbiot [PS 10]
GMB (Annexes) [PS11]
Healthcare at Home [PS 12]
Institute of Directors [PS 14]
Nuffield Hospitals [PS 19]
Recruitment and Employment Confederation [PS 21]
Residents Action Group for the Elderly (RAGE) [PS 22]
The College of Optometrists [PS 28]
The SMAE Institute [PS30]
The Society of Chiropodists and Podiatrists [PS 31]
UNISON [PS 33B]
UNISON [PS 33C]
Voluntary Action Haringey [PS 34]
Newchurch Limited [PS 36]
Mr John Thornburn [PS 38]
Federation of Independent Nursing Agencies [PS 39]
North Durham Healthcare NHS Trust (Annexes) [PS40]
Jackie Stewart [PS 44]
Catalyst Healthcare Management Limited [PS 49A]
Catalyst Healthcare Management Limited [PS 49B]
Professor Allyson Pollock [PS 54]
The Royal Liverpool Children's NHS Trust, Alder Hey Hospital [PS 58]
NHS Alliance [PS 60A]
Partnerships UK [PS 61]
The Medway NHS Trust [PS 62]
Hansard Scholars Programme [PS 64]

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