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Summary

Defining the independent sector (IS):

- the independent sector encompasses individuals, employers, and organisations contributing to needs assessment, design, planning, commissioning and delivery of a broad spectrum of health and social care, who are wholly or partially independent of the public sector. This includes care homes, private hospitals and charities
- the sector is a complex continually evolving over time and this briefing captures the IS at a single point in time.

The independent sector in 2009:

- the IS always has, and continues to deliver both health and social care in England
- the IS includes charitable organisations, social enterprises and commercial organisations providing a wide range of services from

RCN View:

- the RCN passionately supports the NHS model whilst also recognising that members of the RCN work in both the NHS and non NHS sectors
- the RCN supports organisations who meet the RCN Principles of:

    - quality – which includes themes of safety, dignity and effectiveness
    - accountability – including transparency and trust
    - equality – which includes universality, equity and diversity
    - partnership – including representation and collaborative decision making.

Introduction

This briefing provides an overview of the diverse non-NHS sector that is playing an increasingly important role in shaping and delivering health and social care in England. It is intended to:

- suggest a refined definition of the sector
- provide basic facts about the range and extent of IS activity in health and social care in England
- a look forward at the sector and the implications for patients and nursing.

It is important to note that the sector is a complex and continually evolving over time and this briefing captures the sector at a single point in time.

Context

Whilst the RCN passionately supports the NHS model, we recognise that our members work both within and outside the NHS and that the IS is of a comprehensive provision of high quality health and social care services.

The RCN does not have any ideological objections to the involvement of the IS but does have a range of principles it uses to review all developments around the partnership between the NHS and the IS. Those principles are summarised below:[1]

- quality – which includes themes of safety, dignity and effectiveness
- accountability – including transparency and trust
- equality – which includes universality, equity and diversity
- partnership – including representation and collaborative decision making.

Government policy continues to emphasise the role of the IS as both a provider of care and as a support to commissioning of cq3pd8re. Where NHS services are deemed to have failed, commissioners have turned to the IS to provide mq3pd8nagement capacity and other expertise to improve patient care.

[1]RCN (2008) *RCN principles to inform decision making: what do I need to know?* Available at: www.rcn.org.uk/__data/assets/pdf_file/0009/78696/003034.pdf

RCN policy briefing 01/2010: The independent sector in health and social care in England in 2009 and prospects for the future

Use of the IS

There are a number of ways that public funds are being used in the IS. A summary is provided in the table below and covers separately:

1. delivery of health care (both primary and secondary care)
2. delivery of social and domiciliary care
3. financing of physical capacity (buildings and equipment)
4. strategy and commissioning support to the NHS.

It's also worth noting that it is difficult to assess the full scale of IS activity because local provision varies and statistics are not always centrally collated. Our members have suggested that there has been an increase in care being commissioned and provided in home care settings for adults and children as well as more complex care in a community setting.

The IS is increasingly providing strategy and commissioning support to the NHS as a result of wider policy drives to split commissioning and provision (so that there are separate agencies who consider needs and undertake contracting to those agencies who deliver care) and to increase competition in the NHS. IS support is one option to aid the development of world class commissioners.[8] ad

Table 1: Overview of use of IS by the public sector/NHS[9]

Activity and sector	Type of IS	Public sector use of IS	Rationale for public sector use	Scale
Delivery of health care				
Secondary care (e.g. hip operations)	Independent sector hospitals	1. Spot purchasing 2. DH central procurement of activity from existing IS hospitals[10]	1. To overcome short term capacity constraints 2. To deliver 18 week target using readily available capacity	1. £305m in 2007[11] 2. Unknown share of £270m in 2007[12]
Secondary care (e.g. hip operations)	Independent Sector Treatment Centres (ISTCs)	DH central procurement of activity	1. To increase the capacity available to treat NHS patients; 2. Offer patients a choice over where they are treated; 3. Stimulate innovation in the provision of health care.	Unknown share of £270m in 2007[13]
Secondary care (e.g. hip operations)	Independent Sector Extended Choice Network or Free Choice Network (IS ECN/FCN).	Patient choice includes IS	To provide choice to patients	£83m from April 2007 to December 2008[14]

[9] Appendix 1 provides the top 10 by value IS providers to the NHS.
[10] Department of Health (2006) *Independent sector treatment centres.* Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4128686
[11] Laing and Buisson (2008) *Self-pay private healthcare falls as economic slowdown bites but NHS spending supports growth for private hospitals.* Available from: www.laingbuisson.co.uk/Portals/1/PressReleases/Laings_Review_2008.pdf
[12] Laing and Buisson (2008) *Self-pay private healthcare falls as economic slowdown bites but NHS spending supports growth for private hospitals.* Available at: www.laingbuisson.co.uk/Portals/1/PressReleases/Laings_Review_2008.pdf
[13] Laing and Buisson (2008) *Self-pay private healthcare falls as economic slowdown bites but NHS spending supports growth for private hospitals.* Available at: www.laingbuisson.co.uk/Portals/1/PressReleases/Laings_Review_2008.pdf
[14] Department of Health (2008) *Independent sector extended choice network activity.* Available from: www.dhgov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098744.pdf

Specialist services (e.g. cancer care at the end of life)	For example, Marie Curie

frontline primary and
community care facilities. It is

In addition the DH will make use of the IS to inform their own work. In 2007/2008 the DH spent £132million on management consultants.[28]

It's important to place the scale of expenditure in context; the total expenditure on the NHS is £102bn for 2009/2010.[29]

Lessons from the Independent Sector Treatment Centres Programme

The ISTC programme began in 2002 directed by the Commercial Directorate, part of the Department of Health in England.[30] The DH wanted to:

- increase the capacity available to treat NHS patients;
- offer patients a choice over where they are treated;
- and stimulate innovation in the provision of health care.

Others suggest it was primarily as part of efforts to reduce waiting times in the NHS for planned operations and diagnostic tests.[31]

The ISTC programme is different to the use of the IS by the NHS over it's entire history by being a deliberate central policy and providing care only to NHS patients and not a mix of both public and private patients.

There has been considerable interest in ISTCs and their costs and benefits. A number of benefits have been cited including: [34]

- faster and more convenient treatment for patients
- innovation in both delivery and processes
- Value for money by lowering the spot purchase price from traditional private hospitals providing ad hoc services to NHS patients.

Patients have been reported to be very satisfied with their care.[35]

However, this has not necessarily been cheap. Media estimates suggest that ISTCs in the first wave were 'overpaid' by £927million (and the whole programme itself cost £5bn including purchasing of diagnostics and other activities).[36] This figure should be considered with caution though; the full details of activity delivered and payments are not clear. This estimate is based on one example in Scotland and applied across the UK. And estimates from the Kings Fund suggests that overall ISTCs account for less than one per cent of annual NHS expenditure. [37] Value for money is complicated because central purchasing is likely to drive down the cost of IS treatment compared to spot purchasing, patients seen in ISTCs are likely to be different to those seen in acute trusts, and there are different regulatory and accounting regimes making a straight comparison of costs difficult.

The overpayment stems from the potential for NHS funds to have been used to pay for activity which is not subsequently delivered. According to the media around 85 per cent of activity had been delivered up to September 2008.[38] Contracts signed by the DH with the independent sector however means that they will be paid for the full value of the contract even when activity is lower than planned. ISTCs are also paid more than the NHS would be via an uplift on tariff. The potential value of unused activity could be £350million. [39]

The programme has been scaled back; a third wave of procurement was cancelled in 2007, and some schemes under wave one and two were cancelled. [40] There are cost implications of this for both schemes where contracts were signed, and to compensate bidders who were awarded preferred bidder status but where the contract was stopped before it was awarded.

[34] Department of Health (2006) *Independent sector treatment sectors*

Key lessons from this programme include:

- centrally procured contracts may be cheaper than ad hoc purchasing, however the structure of the contracts can lead to payment when not all the capacity is actually used. The structure of contracts is therefore a crucial part of considering the overall value for money from use of the IS
- contracting should include comparable indicators on quality so that the IS and the NHS can be compared on a like for like basis
- delivery models should also be compared to the NHS to determine if they are innovative and if so, how best to import this back into the NHS.

We note in addition that there is a now an integrated regulator of health and adult social care which covers both the NHS and IS and from 2010 all providers will have to meet the same standard of care.

RCN members in the IS

A quarter of registrants on the NMC register work outside of the NHS. The RCN members' survey suggests 27 per cent of RCN members work outside of the NHS. This does not account for those who may hold second jobs within the IS.

The future of the IS

It is difficult to be confident about the future direction of the IS in the current economic climate and political uncertainties. However, some broad indicators suggest that the IS role will increase. For example:

- patient entitlements. Gordon Brown, Prime Minister, has announced a number of patient entitlements including hospital treatment within 18 weeks, access to a cancer specialist within 2 weeks, and free health-checks on the NHS for people aged 40-74.[49] If treatment is not available within the NHS, the media has suggested it might be provided by the IS.[50] It is also unlikely that a policy of choice could be rolled back to limit choice of provider

- divestment of provider services in the community (Transforming Community Services). It has been reported in the media that the move to separate commissioning and provision in the community could lead to more tendering for services. Depending upon who is successful in bidding, this could lead to greater IS involvement in the community. This market could be worth up to £10bn a year[51]

[49] Labour (2009) *Building Britain's future*. Available from: www.labour.org.uk/building_britains_future
[50]

- role of the IS in 'turnaround' circumstances. Under the policy of unsustainable providers, in the extreme management teams could be replaced with alternative managers. This could theoretically be IS

- cross border care. The degree to which patients will wish to travel to access care, and how often it will be paid for by the NHS, is unclear

- top ups. Although the number of patients is small, there is now explicit provision for patients to top up for those medicines which are considered cost ineffective.[52] There is a continuing debate on what should be available within the NHS and what is not affordable. This could mean a greater role for the IS to meet the demands of patients

Implications for nursing and patients

It is likely that there will be a greater role of the IS given the direction of travel of a number of policy initiatives. This has implications for nursing and for patients, including:

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Tell us what you think

This briefing is intended as a backgrounder on the IS in England and the Policy Unit would like to receive comments/feedback from as many members as possible on this important issue - policycontacts@rcn.org.uk.

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Additional resources

NHS Evidence (2009) *Independent sector providers (primary care)*. Available from:
www.library.nhs.uk/healthmanagement/ViewResource.aspx?resID=251437

Independent Health care Advisory Services. Available from: