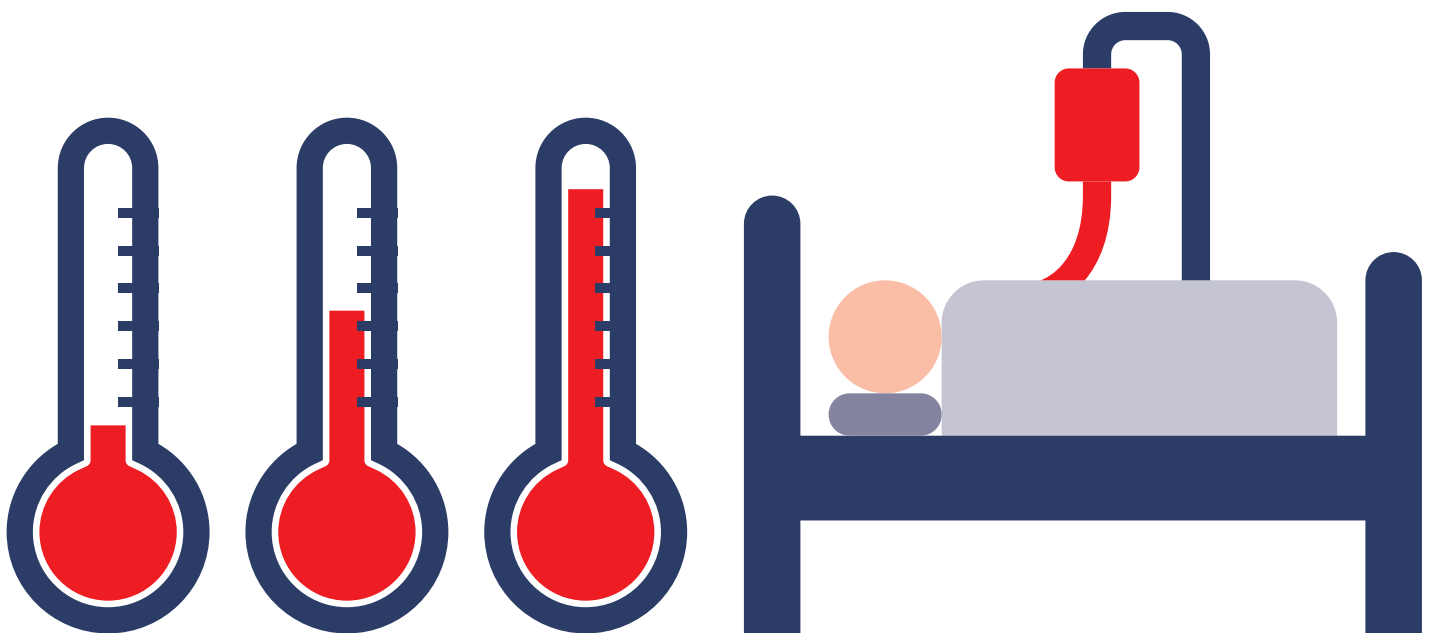


# Patient safety in private hospitals – the known and the unknown risks



**The Centre for Health and the Public Interest (CHPI) is an independent think tank committed to health and social care policies based on accountability and the public interest.**

**CHPI**

**Centre for Health  
and the  
Public Interest**

**The Centre seeks to frame the policy debate in a way that is evidence-based and open and accessible to citizens.**

## The authors

This report was produced by Professor Colin Leys and Professor Brian Toft.

### **Professor Colin Leys**

Colin Leys is an emeritus professor at Queen's University, Canada, and an honorary professor at Goldsmiths, University of London. Since 2000 he has written extensively on health policy.

### **Professor Brian Toft**

Educated at the Universities of Lancaster, Exeter, Cambridge and Cardiff Brian Toft is the Principal of Risk Partnerships, Emeritus Professor of Patient Safety at Coventry University, visiting Professor of Patient Safety at Brighton and Sussex Medical School, and holds several senior advisory positions including membership of the World Health Organisation's European Regional Advisory Council on patient safety and healthcare.

Brian was the first non-physician to chair an external inquiry into the death of a patient in the National Health Service. He was presented with the Royal College of Radiologists Glyn Evans Memorial Lecture Medal for his work on 'involuntary automaticity' and awarded an OBE for his services to healthcare in the 2010 Queen's Birthday Honours List.

Published by CHPI

Email: [info@chpi.org.uk](mailto:info@chpi.org.uk)

[www.chpi.org.uk](http://www.chpi.org.uk)

# Contents

.....	
<b>Executive summary</b>	<b>4</b>
.....	
<b>Introduction</b>	<b>8</b>
.....	
<b>What treatments do private hospitals provide to patients and what is the relationship between these hospitals and the NHS?</b>	<b>10</b>
.....	
<b>What is known about mortality rates and serious patient safety incidents in private hospitals?</b>	<b>13</b>
.....	
<b>What are the known risk factors in private hospitals?</b>	<b>15</b>
.....	
<b>What information is publicly available to patients and commissioners on the quality of care in private hospitals?</b>	<b>23</b>
.....	
<b>Conclusions and recommendations</b>	<b>26</b>
.....	
<b>References</b>	<b>29</b>
.....	

## Executive summary

---

There are 1.61 million admissions to private hospitals for surgical procedures each year in the UK. A quarter of these are now funded by the NHS. Yet little is known about the quality and safety of care provided to these patients, due to a dearth of independently verifiable performance data. The lack of reliable data means that regulators are unable to assess the risk of harm posed to patients in these hospitals, and patients are unable to make informed choices about where to receive their care.

This report sets out what is known about the risks, but also what remains unknown. Through a review of Care Quality Commission (CQC) inspection reports into private hospitals, data from national clinical audits, Freedom of Information requests and parliamentary questions we found the following:

### ***Admissions from private hospitals to the NHS***

- Private hospitals now receive 28% of their income from treating NHS patients. They also rely on NHS hospitals to treat many of those who develop complications whilst being treated in private hospitals. Around 6,000 patients a year are admitted to the NHS from private hospitals, although we have not been able to establish the reasons behind these admissions, nor the cost to the NHS.

### ***Unexpected deaths and serious injuries in private hospitals***

- Between October 2010 and April 2014, 802 unexpected deaths and 921 serious injuries were reported by private hospitals. Because of the limited reporting requirements for private hospitals we are unable to state whether these deaths and injuries should be a cause for concern. We do know that compared to NHS hospitals, private hospitals mainly treat patients who are 'low risk' patients – those who are less likely to develop complications following surgery.

### ***Size and facilities of private hospitals***

- Most private hospitals are significantly smaller than NHS hospitals and do not have intensive care beds to treat patients if complications arise. Less than half of the hospitals providing cosmetic surgery in 2010 – most of which were private – had a fully-equipped operating department. CQC reports on private hospitals often identify problems with facilities or equipment which pose risks to patient safety.

### ***Staffing arrangements in private hospitals***

- The consultant surgeons and anaesthetists who work at private hospitals tend to operate in isolation from other medically qualified colleagues. Unlike the situation in NHS hospitals there are no trainee surgeons present to observe their work and assist them, and they cannot rely on the potential support of any senior colleagues on the site. Post-operative care is normally the immediate responsibility of relatively junior Resident Medical Officers. Further, a 2012 investigation of the resuscitation of patients following in-hospital cardio-respiratory arrest found that out of the 132 private hospitals which responded to the enquiry, 14 had no dedicated resuscitation team.

### ***Record-keeping***

- There is also evidence from CQC inspection reports that some patient records are not always kept in the hospital where they are being treated but instead off-site with the consultant. This has been identified as poor practice and a risk to patients if something goes wrong.

### ***Clinical governance***

- Because private hospitals do not employ the surgeons and anaesthetists who operate at them a different type of clinical governance exists from that which operates in the NHS. A Medical Advisory Committee – whose members are drawn from, and usually elected by, the consultants who operate at the hospital – is responsible for ensuring that only surgeons who meet the required standards are granted ‘practising privileges’ to operate at the hospital. The constitution and responsibilities of Medical Advisory Committees are not set out in law, but they can remove the practising privileges of consultants if issues of concern come to light.
- Performing this role can be difficult given that there can be well over 100 different consultants who have practising privileges in a small 30 to 50-bed private hospital, and conflicts of interest can arise. The recent case of Ian Paterson, who performed potentially dangerous surgery on patients at two private hospitals, and one procedure he was not qualified to perform, raises serious questions about the efficacy of these clinical governance arrangements.

### ***Availability of performance data***

- The Competition and Markets Authority recently found that the data available on the performance of private hospitals for patients was ‘poor’ and ‘insufficient to promote competition between private healthcare facilities.’ The CQC has stated that it ‘currently has access to relatively little information that relates to private healthcare’. The information which is available is significantly less comprehensive than that which is available for NHS hospitals, and is collated and published by the private healthcare industry itself, rather than by an independent body.

- In compiling this report we sought to find on the NHS Choices website the published Quality Accounts (signed statements of the quality of care provided to NHS patients) for nine major private hospital providers. This is a legal requirement under the Health Act 2009 for all hospitals which treat NHS patients. However we were unable to do so for all of them, and we were unable to determine whether any regulations have been breached in failing to file these Accounts. Whilst NHS hospitals are required to have their Accounts independently audited, the same does not apply to private hospitals. The report also finds that concerns have been expressed about private hospital participation in national clinical audits.

## Recommendations:

In order to address the above risks and the lack of information the report makes eight recommendations.

**First**, private providers should be subject to exactly the same requirements to report patient safety incidents (including mortality data) as NHS trusts and foundation trusts. All of the information should be published in the same way as it is for NHS providers and this should be a requirement of registration with the CQC.

**Second**, private hospitals should be required to report on their performance in the same way as NHS providers. The Health and Social Care Information Centre, rather than the private healthcare industry, should be tasked with making this data available to patients and commissioners through NHS Choices or another dedicated patient information website. The requirements set out in Section 8 of the Health Act 1999 for all providers of NHS services to publish their Quality Accounts on the NHS Choices website should be properly enforced by the government and all Quality Accounts should be externally audited, not just those produced by NHS hospitals.

**Third**, the remit of the Parliamentary and Health Service Ombudsman should be extended to cover the whole private healthcare sector. The scope of the Freedom of Information Act should also be extended to cover private hospitals in respect of anything related to the treatment of NHS patients.

**Fourth**, given the failings detected by numerous CQC inquiries and the Paterson case, the clinical governance of independent hospitals needs to be subject to a wider review by the CQC to determine whether the current arrangements are effective in protecting patients. The review should cover the duties and powers of Medical Advisory Committees as well as the duties and powers of the hospital director in relation to patient safety. In addition, in order to reduce the potential for conflicts of interest between clinicians, owners, and patients, Medical Advisory Committees should have externally appointed clinical and lay members with no connection to the hospitals concerned. The responsibilities and constitution of Medical Advisory Committees should be made statutory.

**Fifth**, full participation in all national clinical audit and data collection programmes should be a requirement for registration with the CQC.

**Sixth**, it is important that patients are made aware of the different risk factors between being treated in a small private hospital and a much larger NHS hospital. For patient consent to be informed consent, the consent forms given to patients at private hospitals should detail not only the risks inherent in the procedure being offered but also any that stem from the distinctive nature of the facilities, equipment and staffing of the hospital.

**Seventh**, the regulations governing the provision of care in hospitals need to include some which are private hospital-specific and unambiguous. In particular there should be an on-site registrar-level surgeon or doctor qualified in each specialty for which patients are treated, and nurses with qualifications in the same specialties, and arrangements for an anaesthetist to be on call. It should also be a requirement that all patient records are kept on the ward.

**Eighth**, given that there are some 6,000 admissions to NHS hospitals from private hospitals every year a review should be carried out by the Department of Health of the nature and cost of these admissions.

Many of the recommendations made here have been made previously in other inquiries or reports, including by the House of Commons Health Committee and the NHS Medical Director, but have not been acted upon. Given what is now considered good practice, the lack of any clear picture of the risks to patients in private hospitals outlined in this report suggests that action on those recommendations is overdue.

# Introduction

Of an estimated 1.61 million admissions for surgical procedures in UK private hospitals in 2013, 420,000 were estimated to be funded by the NHS

1. The role played by private hospitals in the UK healthcare system has changed significantly in the last ten years, with greater reliance on private hospitals to provide surgical care and treatment for NHS patients. Since 2004 the amount spent by the NHS on treatment for patients in private hospitals has quadrupled, to the point where the NHS is now the second largest source of income for the private sector after private medical insurance. Of an estimated 1.61 million admissions for surgical procedures in UK private hospitals in 2013, 420,000 were estimated to be funded by the NHS.<sup>1</sup>
2. The sector is dominated by five major hospital chains, but unlike the private hospital sector in many other countries it is characterised by small facilities and relies on the NHS to provide the highly skilled healthcare professional needed to run its business. In 2013 there were 465 private acute hospitals in the UK. 201 of these had overnight beds enabling them to offer surgery requiring inpatient stays. Apart from central London, where there are eight private hospitals with an average of 137 beds each, private hospitals in the rest of the UK are very small, with between 30 and 50 beds each in 2013<sup>2</sup>. For comparison the number of beds in a typical NHS general acute hospital ranges from around 300 to over 1,000.<sup>3</sup> The greater part of the care provided in these hospitals is surgical. The surgeons and anaesthetists who do the surgery are normally not employed by the hospitals but instead are granted ‘practising privileges’ at them and work in a self-employed capacity. Almost all of them are consultants at nearby NHS hospitals, working privately in their non-NHS hours.
3. The available data on the performance and quality of care in private hospitals, however, are very limited compared to the data available for NHS hospitals. This lack of robust and reliable data has two main consequences. First, it prevents a proper assessment of the nature of risk in healthcare settings. As has been shown by recent investigations of failings at NHS hospitals (most notably the Francis Report on Mid Staffordshire NHS Foundation Trust and the Keogh review of 14 NHS trusts in 2013), accurate and accessible performance data are crucial if the risks to patients are to be addressed by commissioners and regulators of healthcare. This conclusion has been endorsed by the Berwick Review of patient safety.<sup>4</sup> Yet as the Care Quality Commission has pointed out, ‘The CQC currently has access to relatively little information that relates to private healthcare compared to some of the other sectors that it regulates’.<sup>5</sup>
4. Second, if patients, or commissioners acting on behalf of NHS patients, are to make informed choices about which hospitals offer good treatment they must have access to reliable performance data from authoritative sources. The ‘information asymmetries’ which exist in healthcare – the difficulty that patients and commissioners have in determining whether a healthcare provider is likely to provide high quality treatment at a reasonable cost – means that the availability of robust performance data produced by an authoritative source is a necessary condition for choice to be exercised, and for healthcare markets to work.



5. As there is very little literature on private hospitals anywhere in the UK this report aims to set out what is known about them, including their relationship with the NHS, and areas of risk that have been identified as being specific to the operation of private hospitals. It also seeks to outline what is not known. It uses data from the National Confidential Enquiry into Perioperative Deaths (NCEPOD) – the most authoritative source of survey data on the treatment of patients who have undergone surgery in the UK - and from inspection reports on private hospitals by the CQC in England, supplemented by responses to Freedom of Information requests and answers to Parliamentary Questions.
6. It reveals a number of specific risks for patients receiving care in private hospitals, compared to NHS hospitals, and makes a series of recommendations which health care regulators should consider when developing their approaches to the regulation of this sector. Some of these recommendations, such as that private hospitals should have to publish the same data as NHS hospitals, and have clinical governance arrangements underpinned by law, have been made by previous inquiries into patient safety in private hospitals, but they have yet to be implemented.
7. The report highlights the current lack of accurate and robust performance data for private hospitals which makes an assessment of the risks they present hard to establish. We make a number of recommendations to address this deficit.

## What treatments do private hospitals provide to patients and what is the relationship between these hospitals and the NHS?\*

8. As of June 2013 there were an estimated 1.61 million admissions a year for surgical procedures in UK private hospitals.<sup>6</sup> The range of treatments provided in these hospitals is significant, as Table 1 shows. Their strong emphasis on elective or planned surgery reflects one of the main reasons why people entitled to be treated by the NHS have historically chosen to be treated privately, namely to be treated more quickly (the other principal reasons being to be treated by a consultant of their choice, and to have a private room). Private patients who pay for themselves, or the insurers of those who have insurance, have a contract with the private hospital. NHS-funded patients treated at private hospitals remain the responsibility of the NHS.

**Table 1: Specialties offered by private hospitals in the UK**

Specialty	Share of hospitals offering the specialty	Share of total admissions (inpatient and day case)	Share of total revenue (inpatient, day case and outpatient)
Obstetrics and gynaecology	95.4	7.6	6.9
General surgery	93.5	13.5	9.5
Trauma and orthopaedics	93.0	27.0	30.5
Anaesthetics	93.0	2.3	0.9
Urology	91.6	6.7	4.1
Gastroenterology	88.9	6.1	3.0
Ophthalmology	88.8	5.8	2.3
Otolaryngology	88.4	3.6	2.2
Dermatology	86.5	0.3	0.6
Plastic surgery	86.5	4.0	3.1
Cardiology	85.6	1.3	4.5
General medicine	83.3	3.2	3.3
Neurology	82.8	0.3	1.1
Oral and maxillofacial surgery	80.9	3.2	0.8
Rheumatology	80.9	0.1	0.3
Clinical radiology	80.0	1.1	1.5
Total	N/A	86.1	74.6

Source: Competition and Markets Authority Private healthcare market investigation: final report April 2014 Table 5.2 page 5-12

\* Independent Sector Treatment Centres or ISTCs are not covered in this report because they operate on a different basis from private sector acute hospitals, employing clinical staff including surgeons and anaesthetists seconded from NHS hospitals, to which some of them are physically attached.

9. The relationship between the NHS and private hospitals has two aspects. First, the NHS relies increasingly on private hospitals to treat NHS patients. In the last ten years the number of NHS-funded admissions to private hospitals for elective surgery has increased from 19,620 in 2004–05 to 394,260 in 2012–13, primarily referred by NHS hospitals to meet the government’s waiting time target.<sup>7</sup> Over this period the NHS’s spending on privately-funded healthcare services has more than quadrupled in real terms; in 2012, it spent £1.195 billion on the treatment of NHS patients in private hospitals, and the NHS is now the second biggest source of revenue for private hospitals in England.<sup>8</sup> As the Competition and Markets Authority has put it, ‘the growth of NHS revenue has, to some extent at least, sheltered private hospitals from the weak state of the privately paid for healthcare sector.’<sup>9</sup>

**Table 2: Sources of funding of private acute healthcare at private hospitals 2012**

Source of funding	Percentage	Revenue
Private Medical Cover	55.1%	£2,397.9m
NHS	27.5%	£1,196.8m
Self Pay	14.5%	£631.0m
Overseas	3%	£130.6m

Source: Private Acute Medical Care 2013, Laing and Buisson, p.13

10. Because few private hospitals have facilities for high-risk patients, in most of them only low-risk NHS patients (up to ASA 2, i.e. with at most a mild systemic disease)<sup>10</sup> are accepted for treatment.<sup>11</sup>
11. The second aspect of the relationship is that patients who are treated in private hospitals are sometimes transferred to NHS hospitals. This usually happens where complications arise following surgery, or where certain forms of post-operative care or rehabilitation are not funded by the patient’s private medical insurance or from their own resources.
12. The data that are available, however, on how many patients are admitted to NHS hospitals following treatment in private hospitals, are limited to what is set out in Table 3. This suggests that on average around 6,000 admissions of this nature occur each year. As the data do not give the reasons for the admissions, or whether complications following surgery were the cause of the admission, or the age or health status of the transferred patients, it is difficult to know the cost of this, or its impact on NHS services. For example, the Government has recently admitted that no information is held centrally on the number of patients who are treated in NHS hospitals as a result of problems resulting from corrective laser eye surgery provided in private hospitals - data which would provide valuable information on the safety and efficacy of that procedure.<sup>12</sup>
13. It is also not possible to determine from the data in Table 3 the extent of the risks posed, or whether these trends ought to require NHS commissioners or regulators to take steps to prevent harm to patients.

**Table 3: Count of finished admission episodes for NHS providers where the source of admission was a non-NHS run hospital for the years 2003-04 to 2012-13 by admission method\***

Year	Elective	Emergency	Other	Total
2003-04	1,514	3,919	1,784	7,217
2004-05	1,562	3,541	1,622	6,725
2005-06	1,757	2,539	1,538	5,834
2006-07	1,637	2,647	1,466	5,750
2007-08	1,879	3,006	1,608	6,493
2008-09	1,868	2,445	1,661	5,974
2009-10	1,902	2,540	1,551	5,993
2010-11	1,502	2,158	1,531	5,191
2011-12	1,569	2,440	1,427	5,436
2012-13	1,697	2,622	1,748	6,067

Source: House of Commons Written Answer 6 February 2014 Hansard column 370W

14. Nonetheless the data do suggest that the NHS is used by private sector hospitals as a ‘provider of last resort’, raising the possibility that a form of ‘moral hazard’ may exist in that private hospitals and the consultants operating in them know that another part of the system will if need be deal with the consequences of any errors or shortcomings in their patients’ treatment. In his review of cosmetic surgery, for example, NHS Medical Director Sir Bruce Keogh, has commented that ‘it can be argued that the business model of cosmetic surgery providers relies to some extent on the NHS being there to act as a safety net to treat clinical complications.’<sup>13</sup> The NHS also bears significant costs as a result of this relationship, although a full audit of the costs has never been undertaken.<sup>†</sup>

\* Definitions in Table 3:

- *Finished admission episodes*: the first period of in-patient care under one consultant within one health care provider. Episodes are counted against the year or month in which the admission episode finishes. The same in-patient may have more than one admission within the period.
- *NHS providers*: one of the following: Care Trust, Foundation Trust, Primary Care Trust, NHS Hospital Trust, NHS Hospital Trust Treatment Centre.
- *Source of admission*: where the patient was immediately prior to admission for example patients admitted from home and patients transferred from another hospital provider or institution
- *Assessing growth through time (In-patients)* changes to the figures over time need to be interpreted in the context of improvements in data quality and coverage (particularly in earlier years), improvements in coverage of independent sector activity (particularly from 2006-07) and changes in NHS practice. For example, changes in activity may be due to changes in the provision of care.
- *Admission method* identifies how the patient was admitted to hospital. Elective admissions include where the patient was on a waiting list and where the admission was booked or planned. Emergency admissions include admissions via A&E via a GP, via Bed Bureau including the Central Bureau, via consultant out-patient clinic, and by other means. All admission methods which do not fit in to the above categories, including maternity related admissions, have been categorised as ‘other’.

Source: Hospital Episode Statistics (HES), Health and Social Care Information Centre

† The Keogh review cited some data on the costs borne by the NHS of treating patients whose cosmetic surgery had gone wrong; ‘surgeons at the Chelsea & Westminster Hospital in London showed that, over a 15 month period, 12 patients presented to A&E needing treatment for complications from cosmetic procedures. This resulted in 34 outpatient visits and 66 inpatient nights, costing a total of £43,000’ (para 3.22) [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/192028/Review\\_of\\_the\\_Regulation\\_of\\_Cosmetic\\_Interventions.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf)

## What is known about mortality rates and serious patient safety incidents in private hospitals?

---

15. One of the key indicators of the safety and performance of any healthcare setting is the number of serious injuries and unexpected deaths which occur in it each year. These data, when adjusted for the population from which patients are drawn, as well the case-mix of the patients treated (including their age, health status and deprivation scores), can be used to develop an indicator of safety and performance in that hospital. This indicator is known as a 'standardised hospital mortality indicator'.<sup>\*</sup> Recently these data - which are available for every NHS hospital in England - were used as the basis for the Keogh review into patient safety in 14 hospital trusts which the indicator showed had higher than expected deaths.<sup>14</sup>
16. NHS hospitals are required to report serious incidents (which include injuries to patients and patient deaths) to the CQC, Monitor, commissioners and the National Reporting and Learning System (NRLS), which makes these data publicly available on a hospital-by-hospital basis. Private hospitals are required to report all serious incidents to the CQC and Monitor, and for NHS-funded patients, to commissioners; but they are not required to report them to the NRLS. Although the CQC does not publish serious incidents reported by private hospitals we were able to obtain through the Freedom of Information Act the aggregate data for all private hospitals registered with the Commission which provided surgical treatment. This is set out below in Table 4.

---

\* 'The indicator is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.' Health and Social Care Information Centre, <http://www.hscic.gov.uk/SHMI>. See also Dr Foster Toolkit on standardised hospital mortality ratios <http://drfosterintelligence.co.uk/wp-content/uploads/2011/10/HSMR-Toolkit-Version-6-October-2011.pdf>

**Table 4: Notifications for death of service user and other incidents for independent hospital locations registered with the Care Quality Commission since 1st October 2010**

Year	Number of notifications from independent hospitals				Total
	Deaths of service users			Other Incidents	
	Expected death <sup>*</sup>	Unexpected death	Reason for death not stated	Serious injury	
2010	256	39	15	16	326
2011	988	220	18	130	1,356
2012	1,329	276	0	225	1,830
2013	1,088	197	5	403	1693
2014	242	70	1	147	460
<b>Total</b>	<b>3,903</b>	<b>802</b>	<b>39</b>	<b>921</b>	<b>5665</b>

Source: Freedom of Information request to CQC- data accessed on 17 April 2014†

It is not possible to state from these data whether these rates of death and serious injury are significant, as we do not know in which hospitals they occurred, the health status of the patients concerned, nor the types of treatment that were being provided

17. It is not possible to state from these data whether these rates of death and serious injury are significant, as we do not know in which hospitals they occurred, the health status of the patients concerned, nor the types of treatments that were being provided. It is also not possible to state whether the rates are unusually high or to be expected, nor whether the notifications to the CQC are complete and cover all deaths and serious injuries. A further shortcoming of the data is that most patients who develop life-threatening conditions in private hospitals are transferred to an NHS hospital where there are intensive care beds and specialist teams capable of treating them, so that if they die their deaths are recorded as deaths in the NHS hospital. This could mean that the mortality rates of private hospitals are actually higher than reported here, and the mortality rates for NHS hospitals could include deaths which were the result of procedures carried out in private hospitals.
18. The lack of information on the 802 unexpected deaths and the 921 serious injuries reported since 2010 thus reveals a general lack of knowledge about the performance and safety records of private hospitals, and the inability of the public, parliament and regulators to properly assess the risks posed.

\* When independent healthcare providers submit a notification advising the CQC of the death of a patient, they are required under the regulations to inform the CQC whether they consider the death was expected or unexpected. Regulation 16 of the Care Quality Commission Registration Regulations states that the death must be notified to CQC if it: ‘cannot, in the reasonable opinion of the registered person, be attributed to the course which that service user’s illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment’ [http://www.cqc.org.uk/sites/default/files/documents/care\\_quality\\_commission\\_registration.pdf](http://www.cqc.org.uk/sites/default/files/documents/care_quality_commission_registration.pdf)

† To avoid the risk of double counting we have excluded a handful of deaths and injuries that have been reported by provider companies rather than by the hospital where they occurred.

## What are the known risk factors in private hospitals?

19. The National Confidential Enquiry into Peri-Operative Deaths (NCEPOD)<sup>15</sup> does, however, provide some information about the nature of these risks, and some recent CQC inspection reports also provide an authoritative source of information. We set out below the various risk factors which have been identified in both these types of report. However, we are again unable to correlate these risk factors with either the deaths and serious injuries reported above, or the admissions to NHS hospitals from private hospitals, so as to build up an overall picture of risk across the sector. As Box 1 shows, the data published by the NCEPOD also suffers from some limitations because private hospitals have not always complied with requests to take part in NCEPOD enquiries. In addition, CQC inspections of private hospitals which have focused closely on safety issues have often been undertaken as a result of concerns brought to their attention through a complaint or a whistleblower, so there may be other risks which have not been detected.

### ***Box 1: Concerns about private hospital participation in national clinical audits***

There have been a number of instances where the lack of responses from private hospitals to NCEPOD surveys, and the quality of responses that have been received, have caused concern. For example:

The NCEPOD's 2003 overview report *Who Operates When?* noted that 'one large independent group informed NCEPOD before the study started that they were not willing to participate and this accounts for the majority [of the 51 non-participating independent hospitals].' 93% of NHS hospitals and 63% of independent hospitals participated.

The same report also noted that the responses showed that 'In the independent sector all staff had received resuscitation training within the past 12 months. However, in the plenary session some advisors expressed reservations about this figure... Of the 23 consultant surgeons and anaesthetists present at the plenary session, only seven (30%) had undergone resuscitation training within the previous 12 months.'<sup>16</sup>

For NCEPOD's 2010 enquiry into care received by the elderly, only 24% of private hospitals returned the organisational questionnaire.<sup>17</sup>

Commenting on the 2013 NCEPOD report on cosmetic surgery Sir Bruce Keogh noted that some providers had 'failed to meet their obligations to participate in confidential enquiries – only 32% responded to the questionnaire – suggesting that there is a general lack of understanding among some providers of the importance of such work in ensuring the patient's safety.'<sup>18</sup>

## Facilities and equipment

20. Even though private hospitals undertake some complex surgery their facilities can present risks to patients, particularly if things go wrong. The main risk is due to the fact that few of the 201 private hospitals in England with overnight beds have intensive care or 'level 3' beds. As Table 5 shows in relation to private hospitals in London – the best-resourced in the country – there are 85 level 3 intensive care beds out of a total of 1318 overnight beds. Forty of them belong to two hospitals.

**Table 5: Capacity in private hospitals providing inpatient services in central London, 2011**

Hospital	Overnight beds		Theatres		Consulting rooms		Critical care beds level 3	
	Number	%	Number	%	Number	%	Number	%
Aspen Highgate Hospital	28	1.8	3	3.8	12	2.8	0	0
<b>BMI</b>								
Blackheath	69	4.3	4	5	21	4.9	0	0
Fitzroy Square	16	1.0	1	1.3	7	1.6	0	0
London Independent	58	3.6	4	5	10	2.3	6	7.1
Weymouth	10	0.6	4	5	0	0.0	0	0
Total BMI	153	9.6	13	16.3	38	8.8	6	7.1
<b>HCA</b>								
Harley Street Clinic	104	6.5	4	5	51	11.9	20	23.5
Lister Hospital	74	4.6	4	5	31	7.2	2	2.4
London Bridge Hospital	111	7.0	7	8.8	56	13.0	8	9.4
Portland Hospital	87	5.5	4	5	39	9.1	3	3.5
Princess Grace Hospital	114	7.2	8	10	38	8.8	4	4.7
Wellington Hospital	226	14.2	11	13.8	20	4.7	20	23.5
NHS ventures UCLH	24	1.5	-	-	-	-	-	-
St John & St Elizabeth	49	3.1	5	6.3	36	8.4	0	0
King Edward VII's Sister Agnes	60	3.8	3	3.8	6	1.4	4	4.7
The Bupa Cromwell	118	7.4	5	6.3	29	6.7	7	8.2
The London Clinic	170	10.7	13	16.3	74	17.2	11	12.9
Total Private hospitals	1318	82.8	80		430		85	

Source: Competition and Markets Authority Private healthcare market investigation: final report April 2014

21. According to the NCEPOD, out of the 158 private hospitals which performed cosmetic surgery in 2010 only 24 had level 3 (intensive care) beds,<sup>19</sup> and out of 62 which did bariatric surgery (a treatment for those seeking weight loss) in 2012 only 17 had them.<sup>20</sup> A quarter of those doing bariatric surgery had no level 2 (high dependency) beds either. Outside London few private hospitals have any level 3 beds.
22. Again, according to the NCEPOD report into bariatric surgery more than half of all hospitals doing bariatric surgery in 2010 (of which 60% were private) did not have adequate imaging facilities for morbidly obese patients.<sup>21</sup> In the case of cosmetic surgery, which is mainly done in private hospitals, only 101 out of 226 hospitals (44.6%) had a fully-equipped operating department.<sup>22</sup>



23. As Box 2 shows, the CQC has found that the facilities and equipment in some private hospitals posed potentially serious risks to patients.

### ***Box 2: The safety risks from equipment in private hospitals***

At a private hospital in Worthing in 2012 the CQC found that a patient ‘sustained a serious injury because of obsolete equipment. Staff had raised concerns about the equipment several months before as it was outdated and spare parts were no longer made for it. The equipment had featured on the hospital’s risk register for several months however it had not been taken out of action until a person had been severely injured by it.’<sup>23</sup>

In the same year at a private hospital in Basingstoke the CQC reported that ‘hundreds of items’ of portable equipment had not been tested for over two years. ‘The untested items included equipment operated by hospital staff and used for the care and treatment of people using the services, and so presented a potential risk to the safety of both.’<sup>24</sup>

In another hospital a surgeon insisted, against the objections of the theatre staff, on performing surgery in an ambulatory care setting because of problems with the main operating theatre facilities, with the result that when the patient suffered a severe haemorrhage blood supplies could not be found in good time and there was a serious risk of this and other patients dying.<sup>25</sup> At the same hospital CQC inspectors reported that ‘a written statement from an anaesthetist showed that a patient had been put at very serious risk of death or brain injury because essential emergency equipment was not available in the operating theatres’.<sup>26</sup>

## ***Staff***

24. Another distinctive safety risk posed by surgery in private hospitals stems from the fact that they do not usually employ surgeons or anaesthetists themselves; for surgery they provide only theatre nursing staff. The surgeons, almost all of whom are current or retired NHS consultants, are responsible for finding consultant anaesthetists to work with them.
25. The first risk to which this gives rise comes from working alone. As the Royal College of Surgeons points out, there is a crucial difference between surgery done in private hospitals and that done in the NHS: ‘When a surgeon has patients under their care within the NHS, the patients tend to be looked after by a large team, including a variety of grades of trainees. Medical care in the private sector is generally delivered entirely by the consultant.’<sup>27</sup> The Association of Anaesthetists says the same: ‘Practising anaesthesia in private hospitals commonly involves working in isolation, often being the only anaesthetist in an operating theatre suite or in the whole hospital.’<sup>28</sup> This means that if a problem arises during an operation neither the surgical nor the anaesthetic consultant has a junior colleague in training to provide assistance, nor can they call for advice or assistance from another consultant, as would normally be the case in an NHS hospital where several others will typically be at work nearby.

26. Related to the fact of working without trainee surgeons in attendance is the risk that surgeons may not follow safe practice as conscientiously as they would when working with trainee colleagues in an NHS theatre. The CQC has found a number of instances where the WHO Surgical Safety Checklist was not being fully implemented in the private hospitals it inspected, even though its importance for reducing errors, when used properly, is well established.<sup>\*</sup> It has also identified a number of cases where surgeons have violated basic principles of safe practice, for example by failing to wash their hands or remove their watches or jewellery, even when asked by members of the theatre staff,<sup>29</sup> or failing to complete consent forms<sup>30</sup> or to ensure that there is a complete and accurate record of the operation.<sup>31</sup> A lax safety culture has been found to have developed in some private hospitals which can affect anaesthetists too. In one private hospital the CQC found that an anaesthetist had covered two theatre lists simultaneously, risking the lives of two sets of patients.<sup>32</sup>
27. Modern safe practice also emphasises the vital importance of team work, but in private hospitals a team culture, in which all the theatre staff feel equally part of the team, can be hard to build.<sup>33</sup> A small private hospital may have fifty or more surgeons with practising privileges, and an equal number of different anaesthetists, so the leadership of the team in any one of its theatres changes constantly.<sup>†</sup> Briefings before surgery begins, which are crucial for effective team work, can sometimes be perfunctory. One CQC report on a private hospital commented that ‘the team brief we observed was inadequate as the anaesthetist was not present and the only significant discussion from the surgeon was that the list order had changed.’<sup>34</sup>
28. Team work of another kind is particularly important in bariatric surgery, where good practice calls for Multi Disciplinary Team (MDT) meetings to determine whether surgery is appropriate. But NCEPOD’s 2012 enquiry showed that fewer than a third of private hospitals, in which most of this surgery is done, held MDT meetings.<sup>35</sup>
29. In order to be proficient and safe in a particular form of surgery it is necessary for surgical staff to have the opportunity to undertake the procedures involved on a regular basis.<sup>36</sup> For some private hospitals, however, this is not possible

\* Atul Gawande, *The Checklist Manifesto*, chapter 7; Charles Vincent, *Patient Safety*, Wiley/Blackwell and BMJ Books, 2nd ed., 2010, pp. 352-56. As in NHS hospitals, the five largest private hospital chains require the WHO checklist to be used in all their hospitals, but the extent to which they are used as intended is unknown. Private hospitals where the checklist and the NHS-recommended ‘Five Steps to Safer Surgery’ have been found not properly implemented include BMI Mount Alvernia Hospital, Guildford; BMI The Blackheath Hospital; Mount Stuart Hospital (Ramsay), Torquay; Spire Little Aston Hospital; and BMI The London Independent Hospital, where the CQC found that ‘In two cases the “time out” did not occur at the end of the procedure, although paperwork implied it had been done. In one instance a staff member found an anaesthetist in the recovery room/suite to check that everything on the checklist was correct. We found that the WHO checklist was not fully embedded with some clinicians as a post-surgery process.’ (CQC Report March 2014, p.11) [http://www.cqc.org.uk/sites/default/files/old\\_reports/1-128766965\\_BMI\\_The\\_London\\_Independent\\_Hospital\\_INS1-767233585\\_Scheduled\\_28-03-2014.pdf](http://www.cqc.org.uk/sites/default/files/old_reports/1-128766965_BMI_The_London_Independent_Hospital_INS1-767233585_Scheduled_28-03-2014.pdf)

† BMI’s 56 hospitals each have an average of 125 consultants with practising privileges. For example in 2012 BMI’s The Garden Hospital in north London had two operating theatres, 30 beds and over 150 consultants with practising privileges [http://www.cqc.org.uk/sites/default/files/old\\_reports/1-102643500\\_BMI\\_Healthcare\\_Limited\\_1-128766778\\_BMI\\_The\\_Garden\\_Hospital\\_20120224.pdf](http://www.cqc.org.uk/sites/default/files/old_reports/1-102643500_BMI_Healthcare_Limited_1-128766778_BMI_The_Garden_Hospital_20120224.pdf)

due to the low volume of some of the operations which they perform each year. The 2010 NCEPOD enquiry into cosmetic surgery, for example, found that 79 per cent of the centres doing cosmetic surgery performed fewer than 20 of the procedures they offered per year, while 84 centres were only doing between 1 and 10 breast reductions (a relatively complex procedure) a year.<sup>37</sup> As Sir Bruce Keogh noted in his 2013 report, these figures suggest that ‘some cosmetic surgical teams may be performing operations too infrequently to maintain competence, let alone excellence’.<sup>38</sup>

30. Once patients have recovered from surgery and have been returned to the wards it is important that they receive good post-operative care to aid rehabilitation and to ensure that no complications arise. \* To oversee this phase of care private hospitals employ Resident Medical Officers (RMOs), at least one of whom is on duty at any one time. These are relatively junior doctors, who must look after all the patients in the hospital. The patients will often have experienced a range of procedures undertaken by quite a large number of different consultants, who are usually no longer on site. RMOs also do not have specialty registrars (surgeons and physicians in training to become consultants) to turn to for supervision and advice, as a junior doctor would in an NHS hospital, if they are not sure whether to contact the consultant or the consultant is not immediately accessible.<sup>†</sup>
31. A further post-operative risk arises from the fact that in a small private hospital a high proportion of the staff must be able to provide resuscitation if needed. Out of 132 private hospitals that responded to a 2012 NCEPOD enquiry into the resuscitation of patients following in-hospital cardio-respiratory arrest, 14 had no dedicated resuscitation team.<sup>39</sup> In addition CQC reports into private hospitals have found cases where nursing staff fail to keep their training up to date, including training in resuscitation.<sup>‡</sup> In private hospitals where concerns have emerged, staffing levels have also sometimes been below what CQC inspectors consider adequate, with a relatively high reliance on agency staff being not uncommon.<sup>40</sup>

Out of 132 private hospitals that responded to a 2012 NCEPOD enquiry into the resuscitation of patients following in-hospital cardio-respiratory arrest, 14 had no dedicated resuscitation team

\* In the case of private patients the ongoing clinical responsibility may be limited by their contractual relationship with their surgeon and/or anaesthetist. The Association of Anaesthetists of Great Britain and Northern Ireland states that the post-operative period covered by an anaesthetist’s contract is ‘limited’ to a maximum of ‘24 to 48 hours’. Anything beyond this can be chargeable to the patient *Independent Practice*, April 2008, pp.6-7 [http://www.aagbi.org/sites/default/files/independent\\_practice\\_08\\_0.pdf](http://www.aagbi.org/sites/default/files/independent_practice_08_0.pdf)

† Specialty registrars are surgeons with two years of training in general surgery and up to 8 years of training in a specialty before being eligible to become consultants. The importance of good access by junior doctors and nurses to advice from senior clinicians when a patient’s condition deteriorates is one of the points stressed by Sir Bruce Keogh in his review of patient safety at 14 NHS trusts in 2013 *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*, p. 21, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>

‡ See for example CQC reports on: BMI The Park Hospital, Nottingham, 2014 and BMI The Highfield Hospital, Rochdale, 2012., where ‘although mandatory training was taking place, the majority of staff had not yet received mandatory training in key areas such as safety, health and environment, safeguarding, infection control, moving and handling, fire safety, equality and diversity and basic life support.’- [http://www.cqc.org.uk/sites/default/files/old\\_reports/1-102643500\\_BMI\\_Healthcare\\_Limited\\_1-128766862\\_BMI\\_The\\_Highfield\\_Hospital\\_20121207.pdf](http://www.cqc.org.uk/sites/default/files/old_reports/1-102643500_BMI_Healthcare_Limited_1-128766862_BMI_The_Highfield_Hospital_20121207.pdf)

## Clinical governance

32. Since the inquiry into the Bristol Heart scandal in 1995 it has been widely recognised that within a healthcare setting a system of oversight (known as clinical governance) needs to be in place to ensure that the performance of healthcare professionals and the overall system is able to deliver high standards of clinical care. In particular there needs to be one specific body which can be held to account for ensuring these standards, and for ensuring that clinical performance is audited, that procedures are effective, that risks are managed and that there is a culture of open reporting. The boards of all NHS hospitals are under a statutory duty to carry out these functions as well as to ensure that healthcare professionals keep their skills up to date.<sup>41</sup>
33. Within private hospitals the situation is different. While the manager of any hospital which is registered with the CQC is responsible for these measures, including ensuring that the necessary appraisals of all clinicians working at the hospital are up to date, he or she is expected to exercise these clinical governance functions on the advice of a Medical Advisory Committee (MAC), which has no statutory basis and is itself under no legal duties.\* The MAC is drawn from, and usually elected by, the consultants who have practising privileges at the hospital, often with one or more co-opted members from the management and the senior nursing staff.<sup>42</sup> There is thus a potential conflict between the interests of the professionals and those of patients, with no external member or representative of patient interests.† They usually meet once every two or three months.<sup>43</sup> MACs have no powers to enforce good clinical practice, short of advising the hospital management to suspend a colleague's practising privileges. However, there is an incentive for private hospitals not to take this action as there are financial implications not just for the consultant concerned, but also for the hospital which stands to lose the revenue that the consultant generates for them. This problem is familiar in the United States.<sup>44</sup>
34. The efficacy of the clinical governance arrangements in ensuring patient safety in private hospitals has been questioned in recent reports. Ian Paterson undertook dangerous breast surgery, and colonoscopies which he was not qualified to perform, at two private hospitals in Solihull, causing actual or potential harm to a significant number of patients. In March 2014 an independent review of the case found that the Medical Advisory Committee at one of the private hospitals 'was not able to identify any trends or whether

\* 'The overall hospital governance is the responsibility of the registered manager (i.e. the CEO). However, clinical and professional governance can only take place if managed and led by consultants... Clinical governance [...] will thus involve all clinical records, audits, reviews, clinical incidents, deaths and complaints. This is the professional responsibility of the MAC.'

(Federation of Independent Practitioner Organisations, *Guidelines for Medical Advisory Committee Chairmen and Members in the Independent Sector*)

† FIPO *Guidelines* para 3 state that: 'It is important to remember that the MAC has two major roles – one to advise hospital management and the other to represent professional (and thus patient) interests. There is therefore a potential for occasional conflicts and the Chairman needs to be sensitive to the balance.' The assumption that professional interests coincide with patients' interests is open to question when professionals have a financial interest that is not coincidental with that of patients.

consultants have a greater than expected number of adverse events’ because it only considered ‘adverse events which had been anonymised and [were] not attributable to individual consultants’.<sup>45</sup>

35. CQC reports into private hospitals from 2012 and 2013 have also found that some of the private hospitals that they inspected had not been vigilant in ensuring that consultants with practising privileges have up-to-date appraisals of fitness to practice or up to date legal indemnity.<sup>46</sup> In the case of the anaesthetist in a private hospital who covered two surgical lists simultaneously, the CQC found that the hospital had not put in place ‘effective interim measures’ to prevent the incident recurring and ‘no notification of the incident had been made to the General Medical Council [the professional regulator] or to other registered providers [i.e. hospitals] who used the services of the anaesthetist.’<sup>47</sup>

### ***Record-keeping***

36. Record-keeping is apt to be a problem at private hospitals because the consultants are mainly working off-site, including when seeing their private patients as outpatients, and because there is often no standardised form for records. The first problem was summarised in a CQC report on Ramsay’s Oaks Hospital, where the hospital management itself raised it: ‘There was no combined medical and clinical record for any private patients at the Oaks Hospital. [...] The [hospital management] stated that there was a lack of archive of private-outpatient consultant records due to custom and practice in the independent health care sector. Some consultants held their private outpatient practice information separate to the hospital in which they practiced. For example, the clinical note of a private consultation may not be held on the hospital site but held by the consultant’.<sup>48</sup> At another hospital ‘Staff told [the CQC inspectors] there was no one formally recognised system for doctor’s records; each doctor “did their own thing.”’<sup>49</sup> Poor record-keeping recurs as a theme in CQC reports.

## What information is publicly available to patients and commissioners on the quality of care in private hospitals?

37. As noted above the availability of data about private hospitals has two main consequences. It prevents regulators and commissioners from being able to identify any risks to patients in private hospitals but it also impedes the ability of patients to choose their healthcare provider.

### ***The Competition and Markets Authority investigation and the Private Healthcare Information Network***

38. The Competition and Markets Authority investigation into private healthcare providers looked at the availability of performance data about private hospitals and consultants from the perspective of consumers choosing in a competitive market. It recently came to the conclusion that information on the performance of private healthcare facilities has been poor in the past and below the standard of the information available on NHS hospitals and that the information that is currently publicly available 'is insufficient to promote competition between private healthcare facilities.'<sup>50</sup>
39. As well as not being under any requirement to report mortality data to the National Reporting and Learning Service, private hospitals are not required to publish the same data sets about themselves as NHS hospitals.
40. As part of the response to the Competition and Markets Authority investigation the private hospital sector has sought to address this information deficit by establishing a Private Hospital Information Network (PHIN). However, whilst NHS hospitals are expected to make available on the NHS Choices website a set of indicators, ranging from data about reporting of patient safety alerts and staffing levels to the incidence of healthcare-associated infections, the data available about private hospitals on the Private Healthcare Information Network (as of July 2014) is limited to the types of services which are provided at each hospital and data from the Friends and Family Test.<sup>51</sup>
41. Moreover, unlike the Health and Social Care Information Centre, an independent statutory body which collates and publishes data on the performance of NHS hospitals, the Private Healthcare Information Network is funded and overseen by members or former members of the private hospital sector.<sup>52</sup> This lack of independence has the potential to introduce a conflict of interest and a potential distortion of the published data. As Sir Robert Francis QC pointed out in his first report into Mid Staffordshire NHS Foundation Trust, 'It is particularly important that [healthcare performance] information should be available from unimpeachably independent and reliable sources.'<sup>53</sup>

Unlike the Health and Social Care Information Centre, an independent statutory body which collates and publishes data on the performance of NHS hospitals, the Private Healthcare Information Network is funded and overseen by members or former members of the private hospital sector

## ***Quality Accounts.***

42. Section 8 of the Health Act 2009 requires all providers of NHS services, including private providers, to publish Quality Accounts on the NHS Choices website by 30 June of each year. These accounts must be signed off by the most senior manager of the organisation who must be satisfied that the data are accurate, that he or she is aware of the quality of NHS services that the organisation provides, and what improvements are needed. The Quality Accounts provide information on how the healthcare provider measures how well it is doing, how it seeks to continuously improve the services it provides, and how it responds to checks made by regulators such as the CQC. Quality Accounts should also include a statement from the provider's main commissioner and a statement on what they have learned from national and clinical audits.<sup>54</sup>
43. Although NHS and NHS Foundation Trusts are required to have their Quality Accounts audited externally before they are published, this requirement does not apply to private providers, even when they provide NHS services.
44. NHS Choices have described Quality Accounts as providing 'additional accountability about the quality of an organisation's services'.<sup>55</sup> Sir Robert Francis QC, in his report on Mid Staffordshire, went further, seeing Quality Accounts as enabling the CQC to identify risks within hospitals.<sup>56</sup> He also recommended that it should be a criminal offence to publish false and misleading information in these accounts, and that they should no longer be confined to reports 'on achievements as opposed to a fair representation of areas where compliance has not been achieved'.<sup>57</sup>
45. In July 2014 we looked at the NHS Choices website to see if the nine major private hospital providers mentioned in the recent Competition and Markets Authority report on private hospitals had submitted and published their Quality Accounts in the past three years which we assumed were required by the Health Act 2009. We also checked this information with the Quality Framework Team at NHS England.
46. Given that the Competition and Markets Authority found that private hospital providers generate a significant amount of their revenue from treating NHS patients we would expect that the organisations listed in Table 6 would fall under the obligation to publish quality accounts on NHS Choices. However we cannot be sure of which of them are required to do so by the Health Act, which exempts providers which earn less than £130k NHS income per annum, and have less than 50 staff members. The exemption seems likely to apply only to HCA and the London Clinic, which the Competition and Markets Authority found did not receive significant revenues from the NHS, but information on how much revenue each provider generates from NHS contracts is protected by commercial confidentiality and NHS England do not hold a list of those

organisations which are required to comply with the regulations.\* The table shows that out of the nine private hospital providers listed only five did so in 2013-14, three in 2012-2013 and one in 2011-2012.

**Table 6: Quality Accounts filed by private hospital providers 2011-2014**

Provider	Quality Accounts filed on NHS Choices website		
	2013-2014	2012 - 2013	2011-2012
1. Aspen Healthcare	Yes	Yes	No
2. BMI Healthcare	No	No	No
3. Bupa Cromwell	No	No	No
4. Circle	Yes,	No	No
5. HCA	No	No	No
6. London Clinic	No	No	No
7. Nuffield Health	Yes	No	No
8. Ramsay Health Care UK	Yes	Yes	No
9. Spire Healthcare	Yes	Yes	Yes

Source: NHS Choices website, accessed 7 July 2014

\* According to Lang and Buisson by March 2013 NHS-funded work accounted for 70% of Ramsay's admissions, 32% of BMI's, 23% of Spire's, and 'the majority of Circle's revenues'. For HCA the NHS-funded figure was 'no more than 1%'; for The London Clinic 'only a few percent represents NHS-funded work'; and BUPA Cromwell was 'believed to carry out only a modest amount of NHS work' (Blackburn, *Private Acute Medical Care*, Figure 2.2 and pp 47-74). In relation to Nuffield, the Competition and Markets Authority found that between 2007 and 2011 'growth in the number of NHS patients offset[...] a decline in the number of private patients'



## Conclusions and recommendations

---

47. Patient safety in surgery has become a major concern only relatively recently. It developed in the 1990s with the realisation that surgical interventions have become so common that the average American will undergo seven in the course of his or her lifetime, with the average Briton probably not far behind;<sup>58</sup> that the rate of complications (generally estimated at 8-12% in advanced healthcare systems) is too high;<sup>59</sup> and that about half of these are preventable by systematic measures to prevent them.<sup>60</sup>
48. As this report shows, in the circumstances of most private hospitals in England such measures can be hard, and in some respects perhaps impossible, to enforce. The resulting risk to patients is reduced by admitting few higher-risk patients to these hospitals.\* But ‘all surgery is risky and dangerous wherever it is done’.<sup>61</sup> Even the healthiest individual can experience an adverse event during or after surgery, and the risk is heightened if the conditions under which the treatment occurs make it more likely that something will go wrong, or that remedial action will be less prompt and effective if it does.
49. To address the known and the unknown risks in private hospitals identified in this report we make a number of recommendations.
50. First, private providers should be subject to exactly the same requirements to report patient safety incidents (including deaths) as NHS trusts and foundation trusts. All of the information should be published in the same way as it is for NHS providers and this should be a requirement of registration with the CQC. This recommendation was made by George Osborne MP in 2003 when he introduced a private member’s bill to ‘require private hospitals to publish independently audited information on clinical performance and on complaints from patients on the same basis as that required of NHS hospitals’.<sup>62</sup> It was also made by Sir Bruce Keogh in relation to private providers of cosmetic surgery.<sup>63</sup> And Sir Ian Kennedy, in his review of the Ian Paterson case in Solihull in 2013, made the same recommendation, pointing out that this information is important for the safety of patients in NHS hospitals as well as in the private ones in which NHS consultants operate, since otherwise the data on any individual consultant’s work is incomplete and may be misleading.<sup>64</sup>
51. Second, private hospitals should be required to report on their performance in the same way as NHS providers. The Health and Social Care Information Centre, rather than the private healthcare industry, should be tasked with making this data available to patients and commissioners either through NHS Choices or another dedicated patient information website. Since the Private Healthcare

---

\* In 2003 fewer than 4% of patients undergoing surgery in private hospitals in England, Wales and Northern Ireland for whom an ASA status was recorded were higher than ASA 2. See the 2003 Report of the National Confidential Enquiry into Perioperative Deaths, Table 4.1, <http://www.ncepod.org.uk/pdf/2003/03full.pdf>

Information Network is not ‘unimpeachably independent’ (as Robert Francis put it in relation to Mid Staffordshire) from private hospital providers, there will always be questions about the data that it chooses to make available to patients. The requirements set out in Section 8 of the Health Act 1999 for all providers of NHS services to publish their Quality Accounts on the NHS Choices website should be properly enforced by the CQC and all Quality Accounts should be externally audited, not just those produced by NHS hospitals.

52. Third, as recommended by Sir Bruce Keogh in his review of the regulation of cosmetic surgery, the remit of the Parliamentary and Health Service Ombudsman should be extended to cover the whole private healthcare sector.<sup>65</sup> The scope of the Freedom of Information Act should also be extended to cover private hospitals in respect of anything related to the treatment of NHS patients.
53. Fourth, given the failings detected by numerous CQC inquiries and the Paterson case, the clinical governance of independent hospitals needs to be subject to a wider review by the CQC to determine whether the current arrangements are effective in protecting patients. The review should cover the duties and powers of Medical Advisory Committees, as well as the duties and powers of the hospital director in relation to patient safety. In addition, in order to reduce the potential for conflicts of interest between clinicians, owners, and patients, Medical Advisory Committees should have externally appointed clinical and lay members with no connection to the hospitals concerned. And, as the House of Commons Health Committee recommended in 1999, the responsibilities and constitution of Medical Advisory Committees should be made statutory.<sup>66</sup>
54. Fifth, as also recommended by Sir Bruce Keogh in relation to cosmetic surgery, full participation in all national clinical audit and data collection programmes should be part of CQC registration requirements.<sup>67</sup>
55. Sixth, it is important that patients are made aware of the different risk factors between being treated in a small private hospital and a much larger NHS hospital. For patient consent to be informed consent, the consent forms given to patients at private hospitals should detail not only the risks inherent in the procedure being offered but also any that stem from the distinctive nature of the facilities, equipment and staffing of the hospital.
56. Seventh, the regulations governing the provision of care in hospitals need to include some which are private hospital-specific and unambiguous. In particular there should be an on-site registrar-level surgeon or doctor qualified in each specialty for which NHS patients are treated, and nurses with qualifications in the same specialties, and arrangements for an anaesthetist to be on call. It should also be a requirement that all patient records are kept on the ward.
57. Finally, given that there are some 6,000 admissions to NHS hospitals from private hospitals every year a review should be carried out by the Department of Health of the nature and cost of these admissions.

58. Both the House of Commons Health Committee in 1999 and the recent Keogh review of cosmetic surgery recommended that if a patient who has received treatment in a private hospital subsequently needs treatment in an NHS hospital due to a failure by the private hospital, the NHS should have the power to recoup any costs.<sup>68</sup> Some recouping of costs to the NHS arising from ‘never events’ in private hospitals is already provided for in NHS policy.<sup>69</sup> Extending this policy to other cases where the NHS incurs expense after a private provider has failed a patient may also reduce the risk of ‘moral hazard’ whereby the ‘safety net’ provided by the NHS may encourage riskier behaviour in some private hospitals.
59. Many of the recommendations made here have been made previously by other inquiries or reports. Given what is now considered good practice, the lack of any clear picture of the risks to patients in private hospitals outlined in this report suggests that action on those recommendations is overdue.

# References

- 1 Philip Blackburn, *Private Acute Medical Care: UK Market Report*, Laing and Buisson 2013, p. 123.
- 2 Blackburn, *Private Acute Medical Care*, Table 3.2.
- 3 Health and Social Care Information Centre, *Hospital Estates and Facilities Statistics*, <http://www.hefs.ic.nhs.uk/ERIC.asp>
- 4 National Advisory Group on the Safety of Patients in England, *A promise to learn – a commitment to act: Improving the Safety of Patients in England*, August 2013. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/226703/Berwick\\_Report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf)
- 5 Care Quality Commission comments to the Competition and Markets Authority Investigation into Private Healthcare Market, September 2013 [https://assets.digital.cabinet-office.gov.uk/media/5329dd69ed915d0e60000151/130930\\_cqc.pdf](https://assets.digital.cabinet-office.gov.uk/media/5329dd69ed915d0e60000151/130930_cqc.pdf)
- 6 Blackburn, *Private Acute Medical Care* 2013, p.123. The total number of admissions (in-patient and day case) for elective surgery at all hospitals (NHS and private) in the UK was estimated in 2013 to be 10.38 million a year.
- 7 Blackburn, *Private Acute Medical Care* 2013 Table 2.4.
- 8 Blackburn, *Private Acute Medical Care* 2013, p.19.
- 9 *Competition and Markets Authority 'Private healthcare market investigation Final Report'*, para 2.35
- 10 The American Society of Anaesthesiologists physical status rating. ASA 1: Healthy patient. Localised surgical pathology with no systemic disturbance; ASA 2: Mild / moderate systemic disturbance (surgical pathology or other disease process); ASA 3: Severe systemic disturbance from any cause; ASA 4: Life threatening systemic disorder. Severe activity limitation; ASA 5: Moribund patient with little chance of survival.
- 11 Anne Mason, Marisa Miraldo, Luigi Siciliani, Peter Sivey and Andrew Street, 'Establishing a Fair Playing Field for Payment by Results', Centre for Health Economics, University of York, UK, July 2008, Table 9. [http://www.york.ac.uk/media/che/documents/papers/researchpapers/rp39\\_payment\\_by\\_results.pdf](http://www.york.ac.uk/media/che/documents/papers/researchpapers/rp39_payment_by_results.pdf)
- 12 House of Commons Written Answer 29 January 2014 *Hansard* Column 584W
- 13 Sir Bruce Keogh *Review of the Regulation of Cosmetic Interventions: Final Report*, Department of Health April 2013 paragraph 3.2.1 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/192028/Review\\_of\\_the\\_Regulation\\_of\\_Cosmetic\\_Interventions.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf)
- 14 Sir Bruce Keogh, *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report, 16 July 2013*, <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>
- 15 According to Lang and Buisson by March 2013 NHS-funded work accounted for 70% of Ramsay's admissions, 32% of BMI's, 23% of Spire's, and 'the majority of Circle's revenues'. For HCA the NHS-funded figure was 'no more than 1%'; for The London Clinic 'only a few percent represents NHS-funded work'; and BUPA Cromwell was 'believed to carry out only a modest amount of NHS work' (Blackburn, *Private Acute Medical Care*, Figure 2.2 and pp 47-74). In relation to Nuffield, the Competition and Markets Authority found that between 2007 and 2011 'growth in the number of NHS patients offset[...] a decline in the number of private patients'
- 16 <http://www.ncepod.org.uk/pdf/2003/03full.pdf>
- 17 *An Age Old Problem: A review of the care received by elderly patients undergoing surgery* [http://www.ncepod.org.uk/2010report3/downloads/EESE\\_fullReport.pdf](http://www.ncepod.org.uk/2010report3/downloads/EESE_fullReport.pdf)
- 18 Department of Health, *Review of the Regulation of Cosmetic Interventions*, 2013, p. 9
- 19 NCEPOD, *On the face of it: A review of the organisational structures surrounding the practice of cosmetic surgery*, Table 37. [http://213.198.120.192/2010report2/downloads/CS\\_report.pdf](http://213.198.120.192/2010report2/downloads/CS_report.pdf),
- 20 NCEPOD *Too Lean a Service? A review of the care of patients who underwent bariatric surgery*, Table 3.13 [http://www.ncepod.org.uk/2012report2/downloads/BS\\_fullreport.pdf](http://www.ncepod.org.uk/2012report2/downloads/BS_fullreport.pdf)
- 21 NCEPOD, *Too lean a service?* p. 35
- 22 NCEPOD, *On the face of it*, p. 39. At Ramsay's Oaks Hospital in Colchester, in 2012, for example, 'due to the low levels of cosmetic surgery at the hospital... theatres had limited numbers of cosmetic specific instrument sets. However, staff could get additional sets where needed from Springfield Hospital in Chelmsford or the sterile services hub if necessary.' (CQC report)
- 23 BMI Goring Hall Hospital, CQC report April 2013, p.9. [http://www.cqc.org.uk/sites/default/files/media/reports/1-102643500\\_BMI\\_Healthcare\\_Limited\\_1-128766799\\_BMI\\_Goring\\_Hall\\_Hospital\\_20130420.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/1-102643500_BMI_Healthcare_Limited_1-128766799_BMI_Goring_Hall_Hospital_20130420.pdf)
- 24 BMI The Hampshire Clinic, CQC report December 2012, p.10, [http://www.cqc.org.uk/sites/default/files/media/reports/1-102643500\\_BMI\\_Healthcare\\_Limited\\_1-128766820\\_BMI\\_The\\_Hampshire\\_Clinic\\_20130103.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/1-102643500_BMI_Healthcare_Limited_1-128766820_BMI_The_Hampshire_Clinic_20130103.pdf)
- 25 At BMI Mount Alvernia, CQC report June 2013, pp. 10-11. [http://www.cqc.org.uk/sites/default/files/media/reports/1-128767043\\_BMI\\_Mount\\_Alvernia\\_Hospital\\_INS1-571177028\\_Responsive\\_-\\_Concerning\\_Info\\_15-06-2013.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/1-128767043_BMI_Mount_Alvernia_Hospital_INS1-571177028_Responsive_-_Concerning_Info_15-06-2013.pdf)
- 26 BMI Mount Alvernia Hospital, CQC report June 2013, p. 24.
- 27 Royal College of Surgeons, *Surgical Careers: Private Practice* <http://surgicalcareers.rcseng.ac.uk/surgeons/practising-as-a-surgeon/independent-practice>, accessed 4 July 2014
- 28 The Association of Anaesthetists of Great Britain and Ireland, *Independent Practice*, 2008, [http://www.aagbi.org/sites/default/files/independent\\_practice\\_08\\_0.pdf](http://www.aagbi.org/sites/default/files/independent_practice_08_0.pdf), accessed 4 July 2014

- 29 For example at BMI Mount Alvernia, BMI The London Independent Hospital, and Spire Little Aston, Solihull.
- 30 For example at The Yorkshire Clinic, Bingley (Ramsay) and BMI the Saxon Clinic, Milton Keynes.
- 31 For example at BMI The Saxon Clinic (CQC report January 2013) and BMI The Goring Hall Hospital (CQC report April 2013). From several CQC reports it would appear that responsibility for this is often left to the theatre nursing staff.
- 32 This happened at BMI The Priory Hospital Birmingham in December 2012: CQC report February 2013, p. 9. [128767127\\_BMI\\_The\\_Priory\\_Hospital\\_20130301.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/1-128767127_BMI_The_Priory_Hospital_20130301.pdf)
- 33 It is hard enough in major hospitals, even though the vital importance of team work for patient safety in surgery is stressed by all authorities. For the views of a pioneer of patient safety see e.g. Peter Pronovost and Eric Vohr, *Safe Patients, Smart Hospitals*, Penguin Books, 2011, Chapter 4.
- 34 CQC report on BMI The Blackheath Hospital, December 2013, p.10, [http://www.cqc.org.uk/sites/default/files/media/reports/1-128758547\\_BMI\\_The\\_Blackheath\\_Hospital\\_INS1-556168760\\_Scheduled\\_24-12-2013.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/1-128758547_BMI_The_Blackheath_Hospital_INS1-556168760_Scheduled_24-12-2013.pdf)
- 35 NCEPOD *Too lean a service?* Figures 3.3 and 4.3.
- 36 Keogh, *Review of the Regulation of Cosmetic Interventions*, para 3.18
- 37 NCEPOD, *On the face of it*, p. 5.
- 38 Keogh, *Review of the Regulation of Cosmetic Interventions*, 2013, para 3.4.
- 39 NCEPOD, *Time to intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardiorespiratory arrest*, Table 2.2, [http://www.ncepod.org.uk/2012report1/downloads/CAP\\_fullreport.pdf](http://www.ncepod.org.uk/2012report1/downloads/CAP_fullreport.pdf)
- 40 See CQC reports on e.g. Nuffield Health North Staffordshire Hospital, 2014, where there was a shortage of theatre staff, with some staff doing procedures they were not certified competent to do [http://www.cqc.org.uk/sites/default/files/media/reports/1-115574639\\_Nuffield\\_Health\\_North\\_Staffordshire\\_Hospital\\_INS1-649347358\\_Scheduled\\_20-02-2014.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/1-115574639_Nuffield_Health_North_Staffordshire_Hospital_INS1-649347358_Scheduled_20-02-2014.pdf); and BMI The Clementine Churchill Hospital, 2014, pp. 18-19, [http://www.cqc.org.uk/sites/default/files/media/reports/1-128758653\\_BMI\\_The\\_Clementine\\_Churchill\\_Hospital\\_INS1-664782319\\_Scheduled\\_01-05-2014.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/1-128758653_BMI_The_Clementine_Churchill_Hospital_INS1-664782319_Scheduled_01-05-2014.pdf);
- 41 Health Act 1999, Section 18.
- 42 FIPO *Guidelines* para 28: 'It is generally agreed that the MAC comprises "elected" consultants and co-opted management, nursing or other consultant members.'
- 43 FIPO *Guidelines Appendix 2, citing the Care Standards Act 2000*, 'The MAC meets quarterly as a minimum and formal minutes are kept of meetings.'
- 44 Suzanne Gordon, Patrick Mendenhall and Bonnie Blair O'Connor, *Beyond the Checklist*, London: Cornell University Press 2013, pp. 199-200.
- 45 Verita, *Independent review of the governance arrangements at Spire Parkway and Little Aston hospitals in light of concerns raised about the surgical practice of Mr Ian Paterson*, para 1.78, referring to the MAC at Spire Parkway. ' <http://www.spirehealthcare.com/Documents/Corporate%20docs/Spire%20-%20Executive%20summary%20and%20recommendations.pdf>
- 46 CQC reports on Spire Wellesley, May 2012 ; on Spire Leicester, November 2012; on BMI The Saxon Clinic, July 2013.
- 47 CQC report on BMI The Priory Hospital, Birmingham, February 2013, p. 12-13, [http://www.cqc.org.uk/sites/default/files/media/reports/1-102643500\\_BMI\\_Healthcare\\_Limited\\_1-128767127\\_BMI\\_The\\_Priory\\_Hospital\\_20130301.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/1-102643500_BMI_Healthcare_Limited_1-128767127_BMI_The_Priory_Hospital_20130301.pdf)
- 48 CQC report on the Oaks Hospital (Ramsay), Colchester, February 2012, p.19, [http://www.cqc.org.uk/sites/default/files/media/reports/1-102643458\\_Ramsay\\_Health\\_Care\\_UK\\_Operations\\_Limited\\_1-128733050\\_Oaks\\_Hospital\\_20120213.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/1-102643458_Ramsay_Health_Care_UK_Operations_Limited_1-128733050_Oaks_Hospital_20120213.pdf)
- 49 CQC report on Spire Portsmouth, inspected Feb 2013.
- 50 Competition and Markets Authority, *Private healthcare market investigation: Final Report* , 2 April 2014, para 9.82 and para 9.83 [https://assets.digital.cabinet-office.gov.uk/media/533af065e5274a566000023/Private\\_healthcare\\_main\\_report.pdf](https://assets.digital.cabinet-office.gov.uk/media/533af065e5274a566000023/Private_healthcare_main_report.pdf)
- 51 NHS Choices 'About the indicator facts you can see on NHS Choices' <http://www.nhs.uk/Scorecard/Pages/HospitalFacts.aspx> For comparison see Private Healthcare Information Network <http://www.phin.org.uk/> (Accessed June 30 2014)
- 52 The Board of Directors at PHIN: <http://www.phin.org.uk/About.aspx>
- 53 Robert Francis QC, *The Mid Staffordshire NHS Foundation Trust Inquiry: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*, Volume I para 59. [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_113447.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113447.pdf)
- 54 The National Health Service (Quality Accounts Regulations) 2010, the National Health Service (Quality Accounts) Amendment Regulations 2011, and the National Health Service (Quality Accounts) Amendment Regulations 2012, set out prescribed information that must be included within Part 2 of the Quality Accounts. (NHS Choices 'About Quality Accounts')
- 55 NHS Choices Website <http://www.nhs.uk/Pages/HomePage.aspx>
- 56 *Mid Staffordshire NHS Foundation Trust Public Inquiry* Volume 2: recommendation 49. <http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%202.pdf>
- 57 *Mid Staffordshire NHS Foundation Trust Public Inquiry* Volume 2: recommendation 37. <http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%202.pdf>
- 58 Atul Gawande, *The Checklist Manifesto*, pp. 31 and 87.
- 59 Charles Vincent, *Patient Safety*, p. 57.
- 60 '...at least 30-50% of major complications for patients undergoing surgical procedures are thought to be avoidable' (Vincent, *Patient Safety*, p.57).
- 61 Gawande, *The Checklist Manifesto*, p. 145.
- 62 Commons *Hansard* 8 May 2002, col. 157. <http://www.publications.parliament.uk/pa/cm200102/cmhansrd/vo020508/debtext/20508-04.htm>

- 63 Recommendations 3 and 10. The government's response ignored this specific recommendation. *Government Response to the Review of the Regulation of Cosmetic Interventions*, Cm 8776, February 2014, pp. 5-6, [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/279431/Government\\_response\\_to\\_the\\_review\\_of\\_the\\_regulation\\_of\\_cosmetic\\_interventions.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279431/Government_response_to_the_review_of_the_regulation_of_cosmetic_interventions.pdf)
- 64 *Review of the Response of Heart of England NHS Foundation Trust to Concerns about Mr Ian Paterson's Surgical Practice; Lessons to be Learned; and Recommendations*, paras 14.72-73, <http://www.heartofengland.nhs.uk/wp-content/uploads/Kennedy-Report-Final.pdf>
- 65 Keogh Review of the Regulation of Cosmetic Interventions, p. 8 and recommendation 34 [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/192028/](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/). The Government's response accepted the principle of 'a single, independent point of redress for all privately funded healthcare complaints' but stopped short of agreeing to extend the role of the Ombudsman to achieve this *Government Response to the Review of the Regulation of Cosmetic Interventions*, Cm 8776, February 2014, p.16. [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/279431/Government\\_response\\_to\\_the\\_review\\_of\\_the\\_regulation\\_of\\_cosmetic\\_interventions.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279431/Government_response_to_the_review_of_the_regulation_of_cosmetic_interventions.pdf)
- 66 Commons Health Committee, *The Regulation of Private and Other Independent Healthcare*, Fifth Report, 1999, Paras 126-7. <http://www.publications.parliament.uk/pa/cm199899/cmselect/cmhealth/281/28113.htm#a27>
- 67 Keogh *Review of the Regulation of Cosmetic Interventions*, Recommendation 9. The government's response ignored this recommendation *Government Response* pp. 6-7 [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/279431/Government\\_response\\_to\\_the\\_review\\_of\\_the\\_regulation\\_of\\_cosmetic\\_interventions.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279431/Government_response_to_the_review_of_the_regulation_of_cosmetic_interventions.pdf)
- 68 Commons Health Committee, *The Regulation of Private and Other Independent Healthcare*, Fifth Report of Session 1998-99, para 130; Keogh Review of the Regulation of Cosmetic Interventions, recommendation 38. The government response to the Keogh Review expressed sympathy with this recommendation and undertook to explore it. <http://www.publications.parliament.uk/pa/cm199899/cmselect/cmhealth/281/28114.htm#a28>
- 69 'Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers' Department of Health, *The never events policy framework* 2012, pp.22-3. <http://webarchive.nationalarchives.gov.uk/20130107105354/https://www.wp.dh.gov.uk/publications/files/2012/10/never-events-policy-framework-update-to-policy.pdf>





Registered charity number 1157077

[www.chpi.org.uk](http://www.chpi.org.uk)