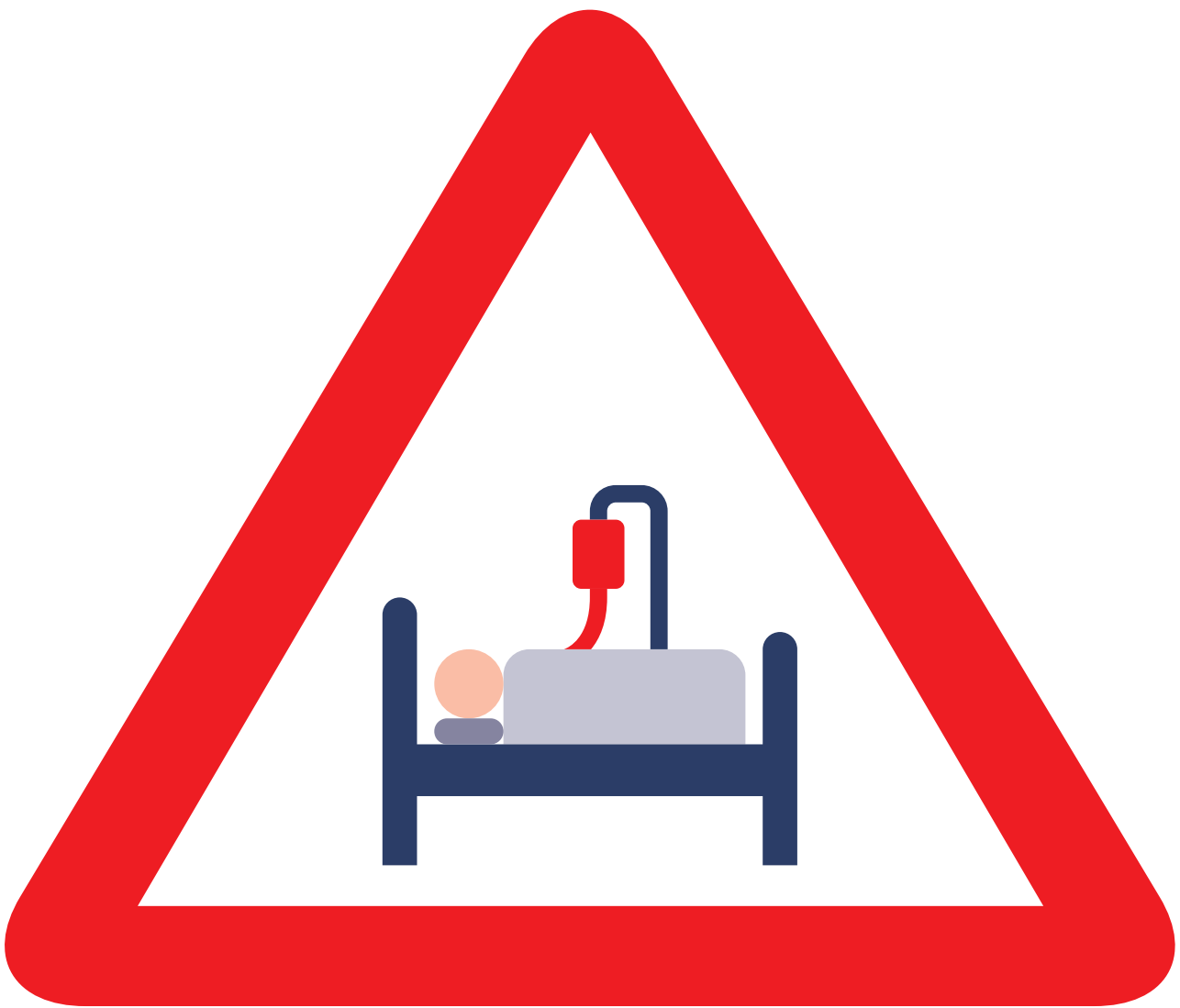


No safety without liability

reforming private hospitals in England after the Ian Paterson scandal



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.

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

This report has been written by the CHPI research team.

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Executive summary

1. This report sets out a series of recommendations to reform the private hospital sector in England following the Ian Paterson scandal which left over 500 women who underwent unnecessary breast surgery in two private hospitals maimed and injured.
2. As we have shown in two previous reports, there are a number of systemic patient safety risks which are specific to the private hospital sector. The reaction by both the regulator the Care Quality Commission and the private hospital sector to the Ian Paterson scandal highlights the extent to which those risks remain and will continue to do so unless extensive reforms are introduced.
3. Based on an extensive review of the CQC inspection reports of 177 private hospitals in England this report provides evidence which identifies the characteristics of the private hospital business model which make it susceptible to exploitation by ill-meaning or incompetent surgeons.
4. The report shows that these systemic risks stem from one central flaw. Unlike any other type of hospital the great majority of private hospitals seek to transfer the risk and the liability for something going wrong to the NHS or other companies.
5. The refusal by private hospital companies to accept full responsibility for what happens in their facilities means that patients will always be at risk. Or put another way, there can be no guarantee of patient safety in private hospitals without full liability.
6. Further, the regulatory regime which covers private hospitals does nothing to address this central weakness and has in many cases ignored or overlooked the extent to which patients have been put at risk.
7. The report makes the following 5 recommendations to reform the private hospital model in order to make these hospitals truly safe for patients and to avoid a repetition of the Ian Paterson case.
8. **First, private hospital companies should directly employ the surgeons and anaesthetists who work at their hospital facilities and should take responsibility for monitoring their activities and appraising their performance.** The failure by the two private hospitals to accept the liability for the actions of Ian Paterson was not an isolated case, but is central to how the private hospital business model operates. Allowing hundreds of NHS trained and employed surgeons to carry out operations in small private hospitals, but without having a direct contract of employment with them, prevents the private hospitals from being able to effectively monitor their performance.
9. Further, if private hospitals are not liable for the activities of the surgeons operating in them, they lack a crucial incentive to monitor their performance and activities.

10. In addition, this report shows that in hundreds of cases the failure by private hospital companies to employ surgeons directly means that it is entirely possible that a surgeon will not have performed an operation in a given private hospital for over a year but would be allowed to do so tomorrow. This poses direct risks to patients as the surgeon is unlikely to be familiar with the hospitals procedures, facilities and staff.
11. This report also shows that those hospitals with the highest number of surgeons who are granted the right to practise within a hospital tend to have above average rates of adverse incidents for patients. It also shows that some private hospital businesses allow surgeons to be **45 minutes away from the hospital** after they have carried out an operation and so are not on site to deal with any post-operative complications. This has been found to be a key factor in the avoidable deaths of patients at private hospitals and is contrary to the Royal College of Surgeons Standards on Unscheduled Surgical Care, which require consultants to be no more than 30 minutes away. Despite this risk the regulator of the private hospital sector permits this practice to occur.
12. **Second, private hospitals will not be truly safe unless they have adequate facilities to deal with situations where a patient’s life becomes endangered following an operation and where the hazardous transfer of patients to NHS hospitals ceases.** Currently, the great majority of private hospitals transfer patients to the NHS when complications post-surgery arise. We estimate in this report that this **reliance on NHS** hospitals could have **cost** as much as around **£250m** over the course of the last three years, with no evidence that private hospital companies have paid anything to cover these costs. Whilst the safety net for private hospitals provided by the NHS saves lives, its existence is an impediment to a true patient safety culture in private hospitals. If the private hospital company does not have to deal with the consequences of post-operative complications it has no incentive to prevent things from going wrong in the first place.
13. **Third, private hospital companies must end their reliance on a single junior doctor (a Resident Medical Officer), working extreme shift patterns, to provide post-operative care for patients.** This report shows that most private hospitals have only **one junior** doctor in charge, irrespective of the number of patients in the hospital, with some being responsible for up to **96 beds**. In addition, the current working patterns of these junior doctors are incompatible with the European Working Time Directive, with many doctors working shifts of 24 hours a day (**168 hours per week**) for one or two weeks at a time.
14. Instead of relying on an outside agency to employ these doctors – which again allows the private hospital business to seek to avoid liability if the doctors are not properly trained or vetted – the hospitals should employ them directly. **There is no good clinical reason why the current Resident Medical Officer model should continue to be used to provide post-operative care to patients in private hospitals.**

15. **Fourth, as we have stated before, private hospitals should be required to adhere to the same reporting requirements as NHS hospitals in order to enhance the possibility that the risk of harm to patients can be more easily detected.** This report shows again that the notification of some adverse patient safety incidents, such as unplanned patient transfers or readmission rates, to the CQC is haphazard, and the quality of the data is unreliable – private hospitals are not required to provide regular returns to the CQC covering these incidents and currently only 63% do so.
16. What data is available shows that there is a huge variability in the occurrence of patient safety incidents across private hospitals but that despite this the CQC does not have the ability to determine where potentially dangerous practices are occurring. Instead where patient **transfer rates are 4 or 5 times the national average** the CQC has deemed these to be of no concern and has often rated these hospitals as **‘good’ or sometimes even ‘outstanding’**.
17. The private hospital companies have argued that the data which they have been required by the Competition and Markets Authority to provide to the Private Hospital Information Network (PHIN) address the concerns about data transparency. However, despite the misconception that these data are focussed on patient safety they are of limited value. It is also information which has yet to be fully collected and published by private hospitals, despite this now being a legal requirement. The organisation which has been set up to publish and validate this data is **funded by and governed by representatives from the private hospital businesses**.
18. **Fifth – The legislation governing private hospitals should be amended to make clear that all those which are registered with the CQC should be fully liable for all the services which are provided within them, including the actions of surgeons and other healthcare professionals.** The Health and Social Care Act 2008 sets out requirements for private hospitals to ensure that they employ properly trained and competent surgeons and other healthcare professionals. However, the difficulties that the victims of Ian Paterson have had in gaining compensation and redress for the harm caused to them shows that this legislation is either unclear or inadequate. The fact that the requirements of the existing legislation have not been properly enforced by the CQC raises the question whether the Paterson scandal could have been prevented had the regulator intervened at the time. **A simple amendment to the Health Service Safety Investigations Bill currently before Parliament could easily rectify this issue.**¹
19. **Finally this is an issue for the NHS as much as for private funded patients.** The risks posed by the current private hospital model do not only affect patients who are funding their treatment themselves or through private insurance. The analysis set out in this report shows that **almost half of all inpatients treated in private hospitals are funded by the NHS**, as are a third of outpatients. There are now **82 private hospitals** in England where the majority of patients are funded by the NHS. This puts the NHS and the Department of Health in a very strong position to require changes to the private hospital business model in order to ensure the safety of NHS patients.

Key facts about private hospitals in England

500 + – the number of women on whom Ian Paterson carried out unnecessary breast surgery in two private hospitals.

£250m – the estimated cost to the NHS of treating patients who have been transferred from private hospitals.

45% – the percentage of inpatients in private hospitals who are funded directly by the NHS.

32% - the percentage of outpatients in private hospitals who are funded directly by the NHS.

82 – the number of private hospitals where more than 50% of patients are funded directly by the NHS.

104 – the number of patients who died following a transfer from a private hospital to an NHS hospital.

168 hours – the typical weekly shift of a Resident Medical Officer in a private hospital.

32 – the average number of beds for which a single Resident Medical Officer is responsible in a private hospital.

868 – the number of consultants who have the right to practise at the Harley Street Clinic, a hospital with 100 beds.

45 minutes – The duration, in travelling time, for which a consultant is allowed to be away from a considerable number of registered private hospitals in the event of one of their patients becoming unwell.

Introduction

1. This report sets out a series of recommendations for fundamentally reforming the private hospital sector in England in the light of the Ian Paterson breast surgery scandal. As has been widely reported in the press, Mr Ian Paterson was convicted of wounding with intent for carrying out unnecessary breast surgery on women in 2 private hospitals – Spire Parkway in Solihull and Spire Little Aston in Birmingham. In addition, Ian Paterson carried out unorthodox, unsafe and inappropriate surgery in the NHS Heart of England NHS Foundation Trust.
2. Since his conviction, Spire Healthcare, the private hospital company which owns and runs the two hospitals where Paterson worked, has agreed to pay compensation to the women who were harmed and maimed by his actions after initially refusing to do so.² However, the difficulties faced by the victims of Ian Paterson in gaining compensation from the private hospital has been in stark contrast to the experience of the patients who were harmed by him in the NHS hospital where he worked, and who were able to get compensation from the NHS Litigation Authority.
3. The denial of liability by the private hospital company, and the difficulties which many affected patients have experienced in gaining redress, have raised fresh questions about the provision of private hospital services in England and the ability of the current regulatory framework to adequately protect patients.
4. Prior to the last general election, the Secretary of State for Health, Jeremy Hunt, promised to hold a public inquiry into the Paterson scandal in the event that the Conservatives were returned to government.³ However, at the time of writing no such inquiry has been announced. Nor has the CQC set out any proposals to apply a different regulatory model in the light of the scandal.
5. A Freedom of Information request for the minutes of the meetings held by the CQC to develop a new inspection approach, after the facts of Paterson's actions were known, revealed that the case was not discussed nor used to inform how private hospitals would be inspected in the future. Instead the CQC was keen to apply the same regulatory model to private hospitals as applies to the NHS, despite there being significant and known differences between the two forms of hospital provision. The membership of the Expert Advisory Group, whose role was to “make recommendations about design” of the new inspection approach, was made up exclusively of representatives from the private hospital sector, with no input from patient groups.⁴
6. This report builds on our previous reports from 2014 and 2015.⁵ It starts from the premise that the Paterson scandal has revealed some of the central flaws in the way the private hospital sector is run in England and sets out reasons why radical reform of the private hospital sector is necessary.

Whilst new forms of regulation could be introduced to better police the existing provision of private hospital services, the business model of many of the current private hospital companies contains a number of endemic patient safety risks which need to be addressed by policy-makers.

7. The report is based on an analysis of the data contained within 177 CQC inspection reports conducted under the CQC's new model of inspection, as well as Freedom of Information requests to the CQC for the data it holds on some categories of patient safety incidents in private hospitals. It also uses data obtained through Freedom of Information requests to 123 NHS hospital trusts in England relating to patients transferred from private hospitals to NHS hospitals.
8. The report is structured around five recommendations for changes we consider need to be introduced in order to prevent the possibility of similar harm being experienced by patients in the private hospital sector in future.
 - **Recommendation 1** – Private hospitals should directly employ the surgeons and other consultants who work in their hospitals
 - **Recommendation 2** – Private hospitals will not be truly safe unless they have adequate facilities to deal with situations where a patient's life becomes endangered following an operation, ending the hazardous transfer of patients to NHS hospitals.
 - **Recommendation 3** – Private hospitals must end their reliance on a single junior doctor (a Resident Medical Officer) working extreme shift patterns to provide post-operative care for patients.
 - **Recommendation 4** - Private hospitals should be required to adhere to the same patient safety reporting requirements as NHS hospitals in order to enhance the possibility of detecting any risk of harm to patients.
 - **Recommendation 5** - The legislation governing private hospitals should be amended to make clear that all those who are registered with the CQC should be fully liable for all the services which are provided within them, including the actions of surgeons and other healthcare professionals.
9. Finally, we would like to thank those people who have been affected by the Ian Paterson case who have shared their experiences with us and improved our understanding of how the private hospital sector can be reformed.

Recommendation 1: Private Hospital companies should directly employ the surgeons, anaesthetists and physicians who work at their hospitals and should take responsibility for monitoring their activities and appraising their performance.

The private hospital is “under no obligation to provide competent surgeons to perform breast surgery at the hospital”

(Letter from Spire’s legal representatives to one of Ian Paterson’s patients, 30 April 2105)

“Spire is alleging that the [NHS] trust is responsible for Mr Paterson’s private practice [...] Spire argues that its role was essentially to provide facilities from which seemingly competent doctors could practise. [...] Spire also argues that while it had in place some clinical governance safeguards, it relied on the NHS, as the primary employer of such clinicians, to tell it whether doctors were competent or whether there were patient safety concerns.”

(NHS HEFT spokesperson, HSJ 9 August 2017)

“The very large number of consultants with practicing privileges posed a risk that they would see patients and provide treatment in an unfamiliar environment where they were not used to the equipment and did not know the local policies”

(CQC inspection report into Kent Institute for Medical Services)

The “practising privilege” model of employing surgeons and anaesthetists – how it works.

10. The employment status of Ian Paterson was one of the main reasons why he was able to carry out harmful and unnecessary surgery at two private hospitals. Whilst his main employment was with the NHS Heart of England Foundation Trust in Birmingham – where he was subject to formal, if inadequate, clinical governance arrangements – he was also granted the right to perform surgery at two local private hospitals.⁶ It was at these private hospitals that the nature of his work remained undetected and where he was found guilty of carrying out unnecessary breast surgery on women. These same employment arrangements are at the core of the way private hospitals in England function.

11. The great majority of surgeons who carry out operations in private hospitals are not directly employed by the private hospitals but instead are granted “practising privileges” by the hospital to work there. An individual patient who funds their own care or has it paid for by a health insurance company has two contracts – one directly with the hospital to cover the hospital facilities (such as the hospital bed and nursing) and a separate contract with the surgeon to carry out the operation.
12. In most cases the surgeons who work in private hospitals also work for the local NHS hospital and so they undertake surgery in the private hospital outside their contracted NHS time. They are often responsible for bringing work to the private hospital and so are an important source of revenue for it. The decision to allow a surgeon to practise at the hospital is taken by the hospital’s Medical Advisory Committee, which is made up of consultants who already have practising privileges at the hospital.
13. There are a number of significant systemic risks associated with this mode of employment which raise serious questions about whether it should be allowed to continue. These are set out below.

The difficulty of monitoring the work of a surgeon who is not directly employed.

14. First, the typical “clinical governance” arrangements in most private hospitals are significantly challenged by the way consultants with practising privileges carry out work in their facilities. Clinical governance is the way in which hospitals can ensure that the work of surgeons and other medical professionals is of high quality – it requires monitoring and oversight of what happens in operating theatres as well as regular audits of the outcomes of surgery for patients.
15. The Independent Review into the Paterson case found that these clinical governance arrangements had failed to detect the fact that Ian Paterson was carrying out unnecessary surgery and harming hundreds of women. The review found that:
 - The Medical Advisory Committee (MAC) at the private hospital where he worked did not discuss the reviews of Ian Paterson’s work at his NHS hospital which had previously identified serious concerns.
 - The two hospitals did not collect all the clinical activity and performance data captured about surgeons with practising privileges, including adverse clinical events, complaints, appraisal information, scope of NHS practice, and any documented areas of concern. The MAC at neither hospital reviewed any of the individual performances of any of their consultants.
 - The MAC only considered adverse events that had been anonymised and were therefore not attributable to individual consultants. The MAC was therefore not able to identify any trends or whether consultants had a greater than expected number of adverse events. The

information about adverse events was not used effectively as a means of identifying consultants who might be a cause for concern at Parkway.⁷

The lack of direct employment means that the private hospital can claim that it is not responsible for the actions of the surgeon when things go wrong.

16. Second, the hospital does not directly employ the surgeons, anaesthetists and other consultants who work in their facilities and relies on third parties to provide assurances that these medical professionals are suitable and fit to carry out surgery. As detailed in various CQC inspection reports, the private hospitals rely almost entirely on the assessments by the NHS to determine an individual consultant’s suitability to operate in their hospital.¹ This puts the hospitals one step removed from knowing whether a surgeon is indeed suitable to perform surgery in their hospital – for example, the NHS may deem that the surgeon is safe to practise one type of surgery, but the surgeon may then choose to carry out another type of surgery in his private work.
17. This reliance on others to assess the suitability and competence of the surgeons with practising privileges has allowed private hospitals to claim that they are not liable when things go wrong and patients are harmed. Spire Healthcare, which owns the private hospital where Ian Paterson worked, used this argument in bringing legal proceedings against the NHS on the basis that the NHS was negligent in not carrying out an effective assessment of Paterson’s practice and for not conveying concerns about his practice to their private hospitals.⁸ At the time of writing this report this legal case has yet to be resolved.
18. The fact that private hospitals do not directly employ consultants was also used as a reason to deny liability for any of the harm caused by Ian Paterson. The lawyers for the private hospital company where Paterson worked informed one of his victims that they were under no legal obligation to provide a competent surgeon as part of their contract with her.⁹ When the victims initially sought to gain compensation for the harm caused to them by Paterson the hospitals denied liability for his actions on the basis that the patients had a contract directly with the surgeon and not the hospital.

i “All consultants received an annual appraisal which provided a review of their performance. This was usually completed by the consultant’s responsible officer or a trained consultant appraiser in their employing NHS Trust. We spoke to a consultant who confirmed they had received a 360 feedback and appraisal of their practice with their substantive NHS employers. The Spire biennial review involved checking the NHS appraisals.”
(CQC Inspection Report into Spire Murrayfield Hospital).

The very large number of consultants who have practising privileges within a small hospital poses a patient safety risk.

19. Third, unlike an NHS hospital where the doctors all work on site, in a private hospital having a large number of doctors entitled to look after patients is not beneficial for patient safety. This is because having a large number of consultants who may practise at a small hospital at any given time is likely to mean that not all of them practise at the hospital with the necessary frequency to be able to practise safely. It also means that it is more difficult for the hospital to keep track of the surgeons' work.
20. A high number of consultants with practising privileges means that individual surgeons are likely to practise in the hospital on a limited number of occasions. For example, in the case of the BMI hospital Clementine Churchill the CQC found that over half of the 462 consultants with practising privileges had not carried out any episodes of care over the course of a year, and this was by no means an isolated finding across the private hospitals that the CQC looked at. As **Box 1** shows, in another inspection report the CQC identified the high number of consultants and the lack of frequent work within the hospital as a clear patient safety risk.

Box 1 – Patients put at risk by large numbers of consultants contracted to work at the hospital.

“The organisation has more than 250 consultants working with practicing privileges. The number of consultants with practicing privileges was of concern as most did not work regularly at [the hospital]. These consultants had an initial look around the premises but were unfamiliar with the policies and practices at [the hospital]. They would not necessarily be familiar with the equipment. This posed a risk to patient safety. We saw an incident report where a patient had suffered a burn as a result of a surgeon being unfamiliar with equipment. [...] The very large number of consultants with practicing privileges posed a risk that they would see patients and provide treatment in an unfamiliar environment where they were not used to the equipment and did not know the local policies”
(CQC inspection report into Kent Institute for Medical Services)

21. Despite identifying this systemic risk, the CQC has not challenged more generally the practice of having large numbers of consultants at particular hospitals, although there is some evidence within the data collected by the CQC to suggest that it may be associated with worse outcomes for patients.
22. From an analysis of the data presented in the CQC inspection reports we found that for every consultant with practising privileges the average number of inpatients treated in a year was 35. The higher the ratio of consultants to patients, the less likely it is that any given consultant will practice frequently at that hospital, with the potential that the risks identified by the CQC above will materialise.

Table 1 – Hospitals with a high ratio of consultants to inpatients treated and the possible association of this with adverse patient incidents.

Hospital	Inpatients per consultant with practising privileges	No. of consultants	Number of inpatients	Returns to Theatre per 1000 inpatients	Readmission rate per 1000 inpatients	Transfer to NHS per 1000 inpatients	CQC rating
The Harley Street Clinic	8	868	7,044	1.8	5.8	0.7	Outstanding
BMI Hendon Hospital	8	167	1,391	0.7	2.2	4.3	Good
Kent Institute of Medicine and Surgery (KIMS)	10	250	2,583	0.8	N/A	1.5	Requires improvement
Spire Cambridge Lea Hospital	11	231	2,466	1.2	2.8	3.6	Good
BMI Coombe Wing	11	97	1,106	2.7	0.9	0.9	Good
The Portland Hospital for Women and Children	13	598	7,483	0.8	2.1	0.1	Good
Harley Street at Queens	13	110	1,438	0.0	0.0	0.0	Good
The Wellington Hospital	14	907	12,733	2.1	4.1	0.2	Good
The McIndoe Centre, part of Horder Healthcare	14	116	1,680	10.7	6.5	1.2	Good
BMI The Priory Hospital	15	553	1,680	3.0	2.5	8.9	Requires improvement

(Our analysis of the data contained within the CQC inspection reports found that the average returns to theatre post surgery per 1000 inpatients = 1.3; the average number of patients readmitted within 28 days per 1000 inpatients = 1.7 and the average number of patients transferred to NHS per 1000 inpatients = 1.4 Red indicates higher than average)

23. As set out in **Table 1** the CQC data shows that there appears to be a higher than average rate of adverse patient safety incidents for hospitals with a high ratio of consultants to inpatients. This indicates (although it does not confirm) that there may be a link between having a high number of consultants with practising privileges at a hospital and increased patient safety risks, and is an area which the CQC should examine further to see if there is any correlation.

Consultants with practising privileges are often away from the private hospital after surgery has been performed

24. Fourth, the fact that the surgeons with practising privileges are not employed directly by the hospital means that there is no requirement for them to remain on site after an operation has been completed. This means that in the event of a post-operative complication a junior doctor – the Resident Medical Officer – and staff nurses are left in charge. In most cases,

the hospital requires the surgeon to be no more than 30 minutes away from the hospital in order to be able to attend to any emergency, and to ensure that cover by another consultant is available.

25. Any delay in reaching a surgeon or anaesthetist can prove critical when dealing with a serious post-operative complication. Because the surgeons who practise at private hospitals work primarily in the NHS they may be engaged in providing surgery in the NHS when they are needed to look after a patient with complications in a private hospital. The impact of a delay in getting a consultant surgeon to attend to a seriously ill patient was identified by the internal review into the death in 2010, at the BMI Clementine Churchill Hospital, of Mr Hughes, which initially led to the surgeon David Sellu being found guilty of manslaughter with negligence. The internal review found that when Mr Hughes, a post-operative patient, suffered severe abdominal pain from what proved to be a perforated bowel, there was a delay of twelve hours before he was seen by a general surgeon (Mr Sellu). Furthermore, it found that when an emergency operation was seen to be needed Mr Sellu first completed his outpatient appointments, and this was followed by a further delay when the surgeon's chosen anaesthetist was delayed by another case.¹⁰
26. The great majority of private hospital companies require their surgeons to be no more than 30 minutes away from the hospital. This is the requirement set out in the Royal College of Surgeons guidance on emergency surgery.¹¹ However, CQC inspection reports into the private hospitals of Spire Healthcare found that the requirement of this company is that the surgeon must be no more than 45 minutes away from the hospital after an operation has been performed.ⁱⁱ No comment has been made by the CQC about the risks posed to patients by this deviation from the Royal College guidance.

Conclusion

27. The practising privileges model of employment appears to be beneficial for NHS surgeons and other consultants who are able to top up their NHS salaries by working privately. It also works well for the private hospital companies which do not have to directly employ and monitor a number of highly skilled and costly medical personnel. However, there is no evidence to suggest that it is a model of employment which has benefits for patients or is clinically appropriate for the operation of a modern hospital which puts patient safety at its core. Instead there are a number of critical patient safety risks associated with this practice and the Ian Paterson case is just one, if extreme, example of its failings.

ii *"The consultant handbook stated that that consultants must live within an appropriate distance of the hospital and if they lived further than 45 minutes away from the hospital, a risk assessment must be undertaken to ensure that consultant cover if the event of an emergency was adequate."*
(CQC report into Spire Manchester Hospital)

Recommendation 2: Private hospitals will not be truly safe unless they have adequate facilities to deal with situations where a patient's life becomes endangered following an operation and where the hazardous transfer of patients to NHS hospitals ceases.

28. As we have noted in previous reports, the lack of intensive care beds in most private hospitals means that private hospitals can only be deemed safe operating entities if they are able to transfer seriously ill patients to local NHS hospitals to be cared for. Sir Bruce Keogh in his report into the regulation of Cosmetic Surgery described the role played by the NHS in looking after transferred private patients as a “safety net” for the private hospital industry.¹² If this safety net was taken away, only a very few private hospitals in England would be permitted to operate.
29. There are two dimensions to the safety net provided by the NHS. The first is the financial impact it has on NHS hospitals. The public are strongly against the NHS picking up the tab for mistakes made in private hospitals and believe that the private hospitals should be required to pay for the costs of their mistakes.¹³ Research into public opinion in this area with regard to cosmetic surgery in March 2013 found that:

“There was unanimous rejection of the NHS bearing responsibility for providing care for procedures conducted privately that have gone wrong. While some members of the public and all practitioners recognised that it might be necessary to turn to the NHS in the event of serious health issues following an intervention, they insisted that the first port of call should be the practitioner/provider company. In the event that they cannot deal or do not wish to deal with the problem, then they should be liable for the cost to the NHS.”
30. However, since 2001, little or no evidence has been available about the extent of the cost to the NHS of transferring patients to the NHS, although a study in 1999 found that the cost the NHS of treating emergency patients transferred from independent hospitals was estimated to be £2.6m.¹⁴ There are some data on the numbers of patients admitted into the NHS from private hospitals recorded by NHS Digital, but the actual cost to the NHS of treating these patients has not been calculated.
31. As a result, we made Freedom of Information Requests to all NHS Trusts in England seeking information on the numbers of patients who had been transferred in from private hospitals, using the data codes from the NHS

Digital Hospital Episode Statistics Data dictionary as well as the outcomes of the treatment for the patients transferred and their average length of stay, going back to 2011. We received 65 responses out of 123 NHS Trusts contacted.

- 32. **Table 2** sets out the findings from this research. In total, using 2015/16 average reference costs calculated per bed day, we have developed a crude estimate that the cost of treating patients transferred from private hospitals to the NHS could have cost up to £254m in the past 3 years, with the average length of stay being 11.8 days for emergency patients transferred. One additional cost which we were not able to identify, but which is incurred by the NHS as a result of these arrangements, is the cost to the NHS ambulance service.
- 33. We recognise that there are imperfections in the calculation of these totals and it is unclear how much, if any, of each patient’s stay was privately funded. As such it represents the likely maximum cost of transfers, but indicates that the NHS is picking up a significant cost which should be borne by the private hospital industry. The recording of admissions from private hospitals by NHS hospital trusts also requires further scrutiny.

Table 2 – Estimated cost to the NHS of treating patients transferred from private hospitals 2013 – 2016

Year	Average length of stay in NHS hospital (Days)	Patients Transferred 2013-14	Cost of patients transferred 13- 14 (£m)	Patients Transferred 2014-15	Cost of patients transferred 2014 -15	Patients Transferred 2015-16	Cost of patients transferred 2015 -16	Total £m
Elective	17.96	1,898	£35.8m	2,134	£40.2m	2,610	£49.1m	£125.1m
Emergency	11.81	4,328	£29.2m	3,341	£22.5m	3,070	£20.7m	£72.5m
Other	17.96	1,802	£18.5m	1,979	£20.3m	1,753	£18m	£56.8m
Totals	17.96	8,028	£83.5m	7,454	£83.1m	7,433	£88m	£254.5m

- 34. It should be noted that many of the patients who have been transferred from private hospitals to NHS hospitals will be patients whose care in the private sector has been funded by the NHS in the first place. This is because, as **Table 3** shows, **45% of inpatients treated in private hospitals, and 32% of outpatients, are NHS funded.** Out of the 172 CQC inspection reports where data on the percentage of NHS funded patients was recorded we found that in 37 private hospitals 80% or more of the inpatients were NHS patients, whilst in 115 hospitals more than one third of the inpatients were funded by the NHS. This means that the NHS is potentially paying twice for the care of a transferred patient.

Table 3 Percentage of inpatients and outpatients treated in private hospitals funded by the NHS over the course of 1 year. ⁱⁱⁱ

Total Number of Inpatients	Total NHS Funded	% NHS Funded
1,161,957	522,939	45%
Total Number of Outpatients	Total NHS Funded	% NHS Funded
5,487,187	1,759,226	32%

35. Many CQC reports state that private hospitals have Service Level Agreements with local NHS hospitals in order to ensure that patient transfers from private hospitals take place safely. We surveyed NHS hospital trusts to see if they had such agreements in place and if they covered financial payments for patients transferred. We received 74 responses to the FOI request out of a total of 123 Trusts and found that only 15 were able to confirm that they had such a formal agreement in place, whilst 59 said that they had no such agreement.
36. The second dimension to private hospitals relying on the NHS to care for their seriously ill patients is that it poses a significant risk for patient safety. In the event that a patient is deemed to be so unwell that transfer to a critical or intensive care facility is required, any delay is potentially detrimental to their chances of survival and recovery. In addition, the actual fact of transporting patients in this condition using an ambulance is hazardous to the patient’s health. Studies of inter-hospital patients transfers show that between 30% and 70% resulted in adverse patient safety incidents.¹⁵
37. In our requests for data from NHS Trusts we asked whether the transferred patient died or was discharged from hospital. In total, out of the 5,991 emergency admissions between 2011/12 and 2016/17 on which we received data, 104 or 2% ended in the patient’s death.
38. As we have noted previously, it is impossible to say whether the rates of transfer for patients from private hospitals is higher or lower than it should be, given the categories of patients who are being treated, due to the limitations of the data. However, as we have also stressed, because most private hospitals do not have intensive care or even, in many cases, high dependency facilities, they ought to restrict admission to their hospitals to patients who are deemed to be relatively well and not suffering from serious co-morbidities. As a result any unplanned transfer ought to be treated as a significant patient safety incident.
39. What we do find within the CQC data is a high rate of variability amongst private hospitals in the number of transfers which take place per 1000 patients treated. Thus the average number of patients transferred to NHS

ⁱⁱⁱ Each CQC inspection report contains data on the number of inpatients and outpatients treated in a year and the percentage of these funded by the NHS. This data is a sum of all the patients treated in the private hospitals for one year, however, due to the fact that hospitals were inspected at different points over the past 3 years this data does not represent any one particular calendar year.

hospitals from private hospitals is 1.4 for every 1000 inpatient, but as **Table 4** shows, in seven hospitals the number of transfers per 1000 patients is more than 4.

Table 4 Private hospitals where patients transferred to NHS is higher than 4 per 1000 inpatients

Hospital	Patients transferred to NHS hospital (per 1000 inpatients)	% of inpatients NHS funded	CQC rating
New Hall Hospital	5.6	59%	Good
Nuffield Health Hereford Hospital	5.5	49%	Good
North Downs Hospital	4.6	75%	Good
Horder Healthcare	4.4	94%	Outstanding
BMI Hendon Hospital	4.3	57%	Good
BMI The Esperance Hospital	4.1	57%	Requires improvement
BMI Bath Clinic	4.0	47%	Requires improvement

(Based on 172 Private Hospitals where data is recorded in CQC inspection reports)

Conclusion

40. The extent to which the private sector relies on the NHS to treat patients with post-operative complications is neither safe nor cost-efficient for the taxpayer. A more effective way of protecting patients and removing a significant government subsidy to the private hospital industry is to require private hospitals to put in place the necessary critical care facilities to look after patients when things go wrong.

Recommendation 3: Private hospital companies must end the reliance on a single junior doctor (a Resident Medical Officer), working alone on extreme shift patterns, to provide post-operative care for patients.

41. The vast majority of private hospitals rely on a single junior doctor known as a Resident Medical Officer (RMO) to look after patients on behalf of the consultants who admit them. Since surgery accounts for 77% of all the treatments given in private hospitals, RMOs are mainly concerned with post-operative care. The RMO usually stays in the hospital facilities and takes responsibility for patients once the consultants have carried out the surgery and left the premises. Our analysis of CQC private hospital inspection and coroners' reports into the death of patients in private hospitals reveals a number of key patient safety risks which demonstrate that significant reforms are necessary in this way of staffing private hospitals. These risks are as follows:

The large number of private hospital beds per RMO

42. Recent research by Professor Brian Jarman of Imperial College shows that there is a strong correlation between the number of doctors employed for each bed in a hospital and the number of deaths in that hospital – the fewer the doctors the more patient deaths.¹⁶ Our analysis of the CQC inspection reports shows that in the great majority of private hospitals **only one** RMO is on duty, irrespective of the number of patients whom the hospital treats at any one time.
43. But while the average ratio is one Resident Medical Officer to 32 beds, **Table 5** shows that there is a significant range across all private hospitals, with one RMO being responsible for as many as 96 beds. In none of the CQC inspection reports that we examined was the ratio of RMOs per bed raised as an issue by the inspectors.
44. Because of the single-handed nature of the RMOs role, there is always the possibility that an RMO will be required to deal with more than one emergency at a time, or will be affected by illness which prevents them from carrying out their duties adequately. And this risk is, of course, increased, if the number of patients that they are required to look after at any one time is very large.

Table 5 The ratio of Resident Medical Officers per bed in private hospitals in England

Average	Lowest	Highest
32 beds	12 beds	96 beds

The extreme working conditions of Resident Medical Officers at private hospitals

45. Our review of the CQC inspection reports shows that the working conditions of the vast majority of Resident Medical Officers are incompatible with the European Working Time Directive. In general it appears that most RMOs work 24 hours 7 days a week for a week at a time, with some working 24/7 for two weeks at a time. The Working Time Directive was introduced in order to protect both the safety of patients and the safety of workers such as doctors and nurses. It requires that doctors work no more than 48 hours in a week (calculated over a period of 26 weeks) with a period of 11 hours continuous rest each day, and a day off each week, or two days off in every fortnight.¹⁷
46. Following a European Court of Justice ruling in 2000 – known as the SIMAP ruling – it was confirmed that the hours in which a doctor is on call or on site, even if they are sleeping, counts towards the time which is protected under the Directive.¹⁸ Despite this, in those inspection reports in which the CQC refers to the EWTD they incorrectly assume that Resident Medical Officers working 24/7 shifts are doing so in line with the Directive.¹⁹
47. **Box 2** sets out the typical working pattern of a Resident Medical Officer which is derived from the CQC reports, as well as some concerns raised by CQC inspectors about the effect of these working patterns on patient safety. These hours of work are clearly extreme for any type of worker, but in the context of a single-handed doctor in a hospital, they pose a potential risk to patient safety. The risk associated with the lack of sleep and the lack of rest periods for doctors was identified by the General Medical Council when it undertook a review of the Directive, citing evidence that doctors who were on a 48 hour working week made 33% fewer medical errors compared to those who worked a 56 hour rota.²⁰
48. Under the Directive, medical professionals like all workers are given the right to opt out of the working time requirements and this also occurs in the NHS, usually to facilitate shift working to cover emergencies or to enable junior doctors to get the necessary exposure to training. However, it is unclear why – from a clinical perspective – it is necessary for private hospitals to require junior doctors to work under such extreme working conditions on a routine basis, when private hospitals only undertake elective, rather than emergency, care. Yet the agencies which employ these doctors and supply

them to private hospitals are clear that opting out of the Directive is a pre-condition for undertaking this type of work.^{iv}

Box 2 Examples of Resident Medical Officers working patterns

“Resident Medical Officers (RMO) covered the hospital seven days a week through a rota system and were able to be called overnight. RMOs worked for seven-day stretches and handed patient care over on a Monday lunchtime to the next RMO. We reviewed the RMO rota and saw between October 2016 and December 2016 there were a number of occasions where RMOs were working 48-hour shifts. On one occasion, an RMO worked a 24-hour shift, a night shift and a 48 shift over consecutive days. Between 14 November 2016 and the 11 December 2016, one doctor was rostered to work six 48-hour shifts over the period.”

(CQC Inspection report on Bupa Cromwell Hospital)

“The RMO’s worked seven 24-hour shifts in a row, with facilities on site for them to sleep over night. [...] There was no auditing of how many times the RMO was woken during the night. Concerns were raised over the ability for the RMO to work the following day if they had been awake for long periods during the night.”

(CQC inspection report on Spire Norwich Hospital)

“The risk register in July 2016 identified a risk that when one of the two RMOs was away, the other RMO could work 24/7 for a month which would have been potentially unsafe.”

(CQC report into Spire St Anthony’s Hospital)

Reliance on an outside agency to ensure that the Resident Medical Officer is suitable and properly trained.

49. As is the case with the consultants with practising privileges who operate at private hospitals Resident Medical Officers tend, in the vast majority of the CQC inspection reports that we have assessed, to be employed by an outside agency and supplied to the hospital under a contract between the hospital and the agency. This leaves the odd situation whereby most private hospitals do not directly employ any doctors.

^{iv} See RMO International (the supplier of RMOs to a number of private hospitals) website which states “Most doctors who join us elect to opt out of the 48 hour working week contained in the Working Time Regulations as it allows them to structure their lives around a one week on and one week off rotation” <https://rmointernational.co.uk/package> .

Also, Spire Healthcare who rely on NES Healthcare to provide their RMOs, have the following statement regarding 24/7 working in their 2012 handbook for the management of RMOs which is available on the University of Edinburgh Medical School website: “Is this legal from the perspective of the European Working Time Directive? Yes, provided that all doctors employed on these shifts have voluntarily signed the Opt-Out. This enables them to work longer hours than those laid out by the EWTD. NES Healthcare gives its doctors the freedom to choose the rotation they wish to work and provides them with the information to allow their decisions to be well informed” <http://recruitment.mvm.ed.ac.uk/Clinical%2018%20-%20RMO%20Handbook.pdf>

50. As is the case with the consultants who work in private hospitals, this lack of direct employment by the hospital means that the hospital relies on a third party to ensure the suitability, training and competence of Resident Medical Officers.²¹ It also allows for the potential that the private hospital company will be able to pass the liability to another body if things go wrong.
51. Under these arrangements, the outside agency becomes responsible for checking RMOs' qualifications and for ensuring that they have ACLS and APLS (advanced cardiac and paediatric life support) qualifications.²² These qualifications are required because a critical role of an RMO is to lead the resuscitation team for any patient in cardiac arrest. RMOs are, however, not required have any actual experience of resuscitation (the life support certificates can be earned through relatively short classroom courses, which some recruiting agencies advertise that they will provide). As a result RMOs are not always competent in practice even though they may have the necessary training.
52. In some instances, this reliance on 3rd party employment agencies to ensure that the RMO is properly qualified and experienced fails. For example, in one case the relevant and legally required background checks on the RMO had not been completed by the employment agency.
53. But when the agency supplying the RMO fails to ensure that the doctor is safe the private hospital company is able to claim that the responsibility for the failure lies with the recruitment agency. For example, the coroner's court found that the attempt by an RMO 'of unclear experience' to resuscitate a patient at BMI Mount Alvernia Hospital in Guildford in 2014 was 'chaotic and ineffective'.²³ Yet the hospital did not acknowledge that the lack of training was an issue for them to address, and appeared to disavow any responsibility for the RMO's lack of experience, passing this back to the agency. In their response to the coroner BMI stated:
- 'RMOs are provided to the hospital by an agency [...] on the basis that they are able to work within the clinical requirements specific to the hospital, including GMC registration, a current Advanced Life Support Certificate and European Advanced Paediatric Life Support Certificate and experience in cancer care. This was the case for the RMO on duty that day'.²⁴*
54. The fact that there are no doctors employed directly by the private hospital also means that supervision for these junior doctors is apt to be weak. In a number of CQC reports, it was identified that there was a lack of clarity about who was responsible for the clinical supervision of, and advice for, RMOs. In one case the hospital Matron – a nurse, rather than a senior doctor or consultant - was seen to fulfil this role.²⁵

The reliance on doctors trained outside the UK to fulfil the RMO role

55. A final risk associated with relying on outside agencies to provide RMOs is the fact that some of them specifically recruit junior doctors from outside the UK to fill these roles.²⁶ Because of the nature of the European Directive on the Mutual Recognition of Professional Qualifications, it is possible for a doctor who has trained in another European country to practise in the UK without the General Medical Council testing their skills and competence – they automatically become registered to practise in the UK as long as they have a medical degree in their home country.
56. This has been identified by the GMC as a major risk to patient safety – not just because of the differences in training, but also because of the lack of familiarity with the UK health system. Indeed doctors trained outside the UK have double the rate of fitness to practise sanctions against them (disciplinary sanctions by the regulator) compared to UK-trained graduates.²⁷
57. This reliance on doctors trained outside of the UK was identified by the appeal judge in the criminal prosecution relating to the death of Mr Hughes in 2010. He noted that the RMO who was in charge of Mr Hughes and 40 other patients at the Clementine Churchill Hospital had been in England barely a month, had worked at the hospital for just three weeks, and had been unable to communicate effectively with the deceased patient.²⁸ In such circumstances the fact that RMOs have no support from any on-site senior doctor, and do not necessarily feel free to consult any other consultant who may happen to be at the hospital when problems arise, is particularly problematic.

Conclusion

58. The above data shows that the use of Resident Medical Officers is an outdated and potentially hazardous way of staffing a hospital. The fact that the RMO tends to be sole doctor on duty overnight, irrespective of the number of patients, is a significant cause for concern. Added to this, are the extreme working conditions which these junior doctors, often recruited from outside the UK, are required to endure. Neither of these aspects of the RMO model can be justified from a clinical or patient safety perspective.

Recommendation 4: Private hospitals should be required to adhere to the same reporting requirements as NHS hospitals in order to improve the chance of harm to patients being detected.

“The development and publication of comprehensive, reliable and clearly understood, statistically based information about the performance of hospitals is clearly vital [...].It is therefore particularly important that such information should be available from unimpeachably independent and reliable sources”

(Sir Robert Francis Inquiry into Mid Staffordshire NHS Foundation Trust)

59. As we have noted previously, the private hospital sector is not under the same requirements as the NHS to publish patient safety data.²⁹ This means that unlike NHS hospitals it is not possible to identify which private hospitals pose a risk to patients by conducting a statistical analysis of patient outcomes as a result of particular surgical interventions or other forms of treatment.
60. However, access to this data by regulators and the commissioner of services is crucial for patient safety – for example, it was a statistical analysis of the mortality data in Mid Staffs NHS Foundation Trust which uncovered the very low standards of healthcare at the hospital.
61. It is unclear whether the recording and reporting of patient outcome data would have enabled the private hospital regulator the CQC to detect the harm caused by Ian Paterson. However, the fact that the private hospital sector has not been placed under further requirements to report on patient safety data to the regulator means that it is possible that another systematic perpetrator of abuse could avoid detection. It is also unclear whether the CQC has a system of regulation which is able to identify patient safety risks from the data which are available to them.

The reporting of patient safety data to the CQC – what the available data tells us

62. Whilst private many hospitals do submit data to the Care Quality Commission this is not a mandatory requirement except in the event of a patient death or where a patient is seriously harmed. According to the CQC only around 63% of private hospitals which are registered with them make voluntary returns on a regular basis.

63. We were given access through a Freedom of Information request to the data submitted to the CQC by private hospitals on a quarterly basis. We also analysed the data on hospital activity and patient safety incidents which is contained in the published CQC inspection reports on private hospitals.
64. From this we sought to understand the extent to which the numbers of patient safety incidents for each hospital were higher or below average compared to all private hospitals. We did this because the CQC reports make judgments about the safety of a hospital based on whether or not these rates are above or below average or are similar to what the inspectors expected.
65. The key patient safety indicators that were held by the CQC included unexpected deaths, serious clinical incidents (such as ‘never events’), patient transfers to NHS or other hospitals, returns to operating theatre and readmission within 28 days of treatment. We chose to look at patient transfers, returns to operating theatres and readmissions within 28 days of treatment, as these were the most common patient safety incidents recorded in the inspection reports we looked at.
66. If a patient is transferred unexpectedly to an NHS hospital, or has to return to the operating theatre, or is readmitted, then something serious is likely to have happened. This is usually as a result of a healthcare intervention at the hospital. No hospital or healthcare procedure is entirely safe and so instances of harm are, unfortunately, unavoidable. However, it is important to identify the frequency of patient safety incidents to be able to build up a picture of the overall safety of a hospital.
67. Thus, a hospital which has a high proportion of adverse patient safety incidents for the number of patients that it treats is likely to pose more of a risk than a hospital with a lower proportion of incidents.
68. Our analysis identified the following issues. In the first place, there was a wide variance in the numbers of adverse patient safety incidents across all the private hospitals regulated by the CQC. For example, across 142 hospitals where the data was available the average number of patients who were returned to theatre - for every 1000 inpatients treated - was 1.3.^v However, there was a number of hospitals where the rate was significantly higher than this, with one hospital having 10 times the average number of transfers, as **Table 6** shows.

^v This average is based on the 142 private hospitals where data on return to theatre rate is recorded in CQC inspection reports.

Table 6 hospitals where returns to theatre post surgery is greater than 4 per 1000 inpatients.

Average returns to theatre across 142 private hospitals = 1.3 per 1000 patients		
Hospital	Inpatients per 1000 returned to theatre post surgery	CQC rating
The McIndoe Centre, part of Horder Healthcare	10.7	Good
New Hall Hospital	4.9	Good
King Edward VII's Hospital	4.0	Requires improvement
Spire Bristol Hospital	4.0	Good

- 69. We also looked at those hospitals which had the highest combined rate of patient safety incidents: that is, those hospitals with highest risk of either being transferred to an NHS hospital, being readmitted to the hospital, or being returned to the operating theatre, to see how these were rated by the CQC. This is set out in **Table 7**.
- 70. As can be seen, the ratings given by the CQC for each private hospital do not accord well with the data on the rates of patient safety incidents which are recorded in the inspection reports. Thus out of the 9 hospitals which have the highest rates of significant patient safety incidents, 6 of these are rated as either good or outstanding.

Table 7 Hospitals with the highest number of significant patient safety incidents per 1000 inpatients treated.

Hospital	Number of patients subject to either transfer, readmission or return to theatre per 1000 inpatients	CQC rating
The McIndoe Centre	18	Good
New Hall Hospital	15	Good
King Edward VII's Hospital	12	Requires improvement
BMI Foscote Hospital	10	Good
Park Hill Hospital	10	Requires improvement
Nuffield Health Hereford Hospital	9	Good
Spire Southampton Hospital	9	Good
The Harley Street Clinic	8	Outstanding

- 71. We also found that the CQC inspection reports made judgments about the rates of these adverse patient safety incidents without being clear about what the average rates of patient safety incidents were across all private hospitals. As **Table 8** shows, with some consistency, those hospitals which have the highest number of patient transfers to NHS are described by the CQC as being “not high” compared to the rates at other private hospitals. This raises questions about the basis on which the CQC were issuing ratings to the private hospitals which they had inspected.

Table 8 CQC comments on rate of transfer to NHS hospitals in inspection reports

Average rate of transfer to NHS hospitals across 172 private hospitals = 1.4 per 1000 patients		
Hospital	Patients transferred to NHS hospital (per 1000 inpatients)	CQC inspection report comments on rate of transfer
New Hall Hospital	5.6	<i>“This is not high when compared to a group of independent acute hospitals that submitted performance data to CQC.”</i>
Nuffield Health Hereford Hospital	5.5	<i>“This was not high when compared with other independent acute hospitals”</i>
North Downs Hospital	4.6	<i>“We undertook a review of the unplanned transfers and given the nature and volume of operations undertaken, all were appropriate and there were no common themes or concerns”</i>
Horder Healthcare	4.4	<i>“The assessed rate of unplanned transfers (per 100 inpatient attendances) is not high when compared to a group of independent acute hospitals which submitted performance data to CQC.”</i>
BMI Hendon Hospital	4.3	<i>“The number of unplanned transfers was not high when compared to other independent acute hospitals”</i>
BMI The Esperance Hospital	4.1	<i>No comment</i>
BMI Bath Clinic	4.0	<i>No comment</i>

72. In addition, we found that there was a discrepancy between the data which was being recorded in the CQC inspection reports by the hospital inspectors, and the data which was being sent to the CQC by private hospitals as part of their quarterly data returns, as the example in **Table 9** shows. This is a particular concern as it is important that any data provided by private hospitals can be relied upon by the regulator for its robustness.

Table 9 Discrepancies between data recorded in CQC quarterly returns and data reported in inspection process

Hospital: BMI Alexandria	CQC Quarterly Returns	CQC Inspection reports
Number of unplanned returns to operating Theatre	39	17
Numbers of transfers to NHS hospitals	18	8

(Reporting Period: April 2015 – March 2016)

The publication of data by the private hospital sector – The Private Hospital Information Network (PHIN)

73. The Private Hospitals Information Network (PHIN), established in 2014, has been represented as a satisfactory response to data deficit in the private hospital sector. PHIN claims to be independent and to be bringing private hospital standards of data quality and transparency ‘in line with the NHS’.³⁰ There are however two key features of PHIN which undermine this claim.
74. First, the data which PHIN is mandated to provide is not aimed at ensuring that hospitals are safe. PHIN was not set up by the Department of health but by the Competition and Markets Authority (CMA), following a two-year enquiry into the competitiveness of the private healthcare market.³¹ The CMA concluded that ‘the information available to people considering private healthcare was inadequate. Patients do not have sufficient information available to understand and compare their options to help them make informed choices.’³²
75. The list of information the CMA ordered to be published is therefore concerned with patient choice, and while it includes items that are important for safety it does not include others that are very important for safety, such as whether a hospital has level 3 intensive care beds, or an on-call anaesthetist rota.
76. Second, while PHIN is independent of any one private provider, it is not independent of the private hospital sector. Unlike NHS Digital, it is financed and governed solely by representatives of the private hospital sector, and there is no external validation of the data provided by it. All providers of private health care, including NHS providers, are members of PHIN and pay for it, but only the private hospital groups that founded PHIN, private medical insurers, and organisations representing consultants are Voting Members.³³ Because it is not a public body it is not subject to the Freedom of Information Act and to the extent that it is accountable, this is to a competition authority (the CMA) rather than the Department of Health or Parliament.
77. An example of what this means in practice is the way PHIN has treated one of the only two previously unpublished items of information it has so far produced, on volumes of procedures and length of stay. Although PHIN was formally established in December 2014, by September 2017 it had published only four of the first eleven items of information required by the CMA, for just over half of the estimated 500 hospitals covered by the CMA’s order. Two of the four items – the results of the ‘friends and family test’, and CQC ratings – were already published by the CQC.
78. On the volumes of each procedure undertaken in a hospital, which is relevant to the level of expertise developed there, PHIN does not give the numbers which the CMA’s order might appear to call for.³⁴ Instead a hospital is said only to do ‘more than average’, ‘about average’ or ‘fewer than average’ volumes of each procedure, with no indication of what the average is.

79. It is also not made clear that the information on volumes given for NHS providers relates only to the number of procedures carried out on private patients. As an indicator of the amount of experience an NHS hospital has with a given procedure this can be very misleading, since NHS hospitals perform most procedures many times more often than a typical private hospital. PHIN thus does not offer an acceptable response to the lack of transparency in private hospitals.

Conclusion

80. The chances of detecting a major patient safety incident - such as the activities of Ian Paterson - are significantly increased if there is a legal requirement placed on private hospitals to report the full set of patient safety data to the CQC and the NHS. The introduction of mandatory reporting and verification of patient safety indicators in a way which is comparable to the NHS should be a central part of the reform of the private hospital sector in the wake of the Paterson scandal. The CQC should also use the data available to it on major patient safety incidents to develop a more sophisticated profile of the patient safety risks in private hospitals.

Recommendation Five: The legislation governing private hospitals should be amended to make clear that all hospitals registered with the CQC should be fully liable for all the services which are provided within them, including the actions of surgeons and other healthcare professionals.

81. The Health and Social Care Act 2008 sets out the regulatory framework for all registered health and social care services in England. It is the legislation which created the Care Quality Commission and it introduces a number of generic requirements for all those organisations which are required to be registered with the CQC, whether these be NHS hospitals, private hospitals, or care homes for older people. These requirements range from requirements about the safety of the facilities to infection control procedures and safeguarding.
82. Included amongst these is the requirement for any registered organisation to employ only people with the “necessary qualifications, skills and experience to carry out the regulated activity” (Regulation 19). The CQC also requires all registered organisations to ‘operate robust recruitment procedures, including undertaking and relevant checks. They must have a procedure for ongoing monitoring of staff to meet the requirements, and they must have appropriate arrangements in place to deal with staff who are no longer fit to carry out the duties required of them.’³⁵
83. The difficulty with the application of this legislation to private hospitals is that, as stated above, the vast majority of private hospitals do not directly employ the consultants who work there. Those who drafted the legislation recognised this and in the context of the private hospital the regulations describe “employment” as including those who are granted “practising privileges”. This is re-iterated by the guidance issued by the Association of Independent Hospital Organisations which states:

*“It is intended that those with practising privileges come within the meaning of ‘employment’ or ‘staff’ in term of compliance with the relevant regulations and guidance of the appropriate system regulator, for example in terms of consent, record keeping, hand hygiene etc.”*³⁶
84. However, the fact that the private hospital company where Ian Paterson worked went to such lengths to deny that they were liable for the actions of the surgeon who was granted practising privileges – on the basis that he was

not an employee of the company – shows that this legislation is insufficiently clear to create certainty about where liability rests. Indeed, not only did the hospital deny liability for Paterson’s action on this basis, but prior to the Paterson scandal the CQC were not adequately checking whether private hospitals were effectively monitoring the performance and behaviour of their surgeons.

85. Thus the CQC carried out inspections of the two private hospitals where Paterson had worked 18 months after he had been suspended, but the inspection reports make no mention of any attempts by the inspectors to discover whether the hospitals had procedures in place for monitoring the work of the consultants who practised in them.
86. Instead the CQC’s focus at the time was solely on the other healthcare staff who were directly employed by the hospital, such as the ward nurses and theatre staff.³⁷ Had the CQC focused its efforts on checking whether the hospitals were effectively monitoring the work of the surgeons there might have been an opportunity to prevent Paterson from continuing to perform unnecessary surgery.

Conclusion

87. As noted at the start of this report, unless private hospitals have full legal liability for all the actions which take place in their facilities there can be no guarantee that they are safe places for patients to be treated. With legal liability comes an incentive to make sure that patient safety incidents are reduced and to ensure that those who work in the hospital are safe and fit to practise.
88. At first glance the Health and Social Care Act 2008 and subsequent regulations appear to impose legal liability on private hospitals for the actions of the surgeons who work in them, but this legislation needs to be updated to make it clear that the hospitals are liable for all the activities that take place within them.
89. Parliament’s current focus on preparing for Brexit means that the opportunity for introducing legislative change to rectify this lack of clarity in the law is limited. However, the current draft Health Services Safety Bill 2017 which is before Parliament provides an opportunity for the existing CQC regulations to be amended to put the liability and responsibility of private hospitals beyond doubt.
90. Any legislative change would not be intended to take away the duty of surgeons and other consultants to meet their professional standards, but is necessary to provide assurance to patients and the public that private hospitals are taking active measures to deliver safe care.

Overall Conclusion

91. The Ian Paterson scandal represents a major failing of the private hospital business model and exposes the ineffective way that private hospitals in England are regulated. Whilst Ian Paterson is both professionally and criminally culpable for carrying out unnecessary surgery on hundreds of women we would argue that the way in which private hospital care is delivered in England permitted these abuses to occur. This, in itself, requires a public policy response from government and at the very least an independent inquiry to the provision of private hospital services.
92. It is made more urgent by the increasing number of state-funded NHS patients who are being treated in private hospitals and who currently have none of the safeguards available to them in NHS hospitals. Without change to the private hospital business model there is no reason to believe that a similar tragedy will not occur in the future. We hope that the recommendations set out in this report and the evidence to support them will contribute to a better understanding of how to move forward with this pressing issue.

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