The devil is in the detail: NHS England's contracts with the private hospital sector during COVID-19.

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Introduction and Executive Summary

Key Facts:

£2.05bn - the total amount said to have been paid by the NHS to private hospitals during the first year of the pandemic.
£92m – the amount set aside by the taxpayer to cover any medical negligence claims against the private sector when treating NHS patients
£22,000 – average unit cost of one episode of healthcare activity delivered one of the private hospital companies contracted to provide NHS services
£72m – the estimated amount of furlough payments made to the private hospital companies during the pandemic.
£65m – the aggregate increase in operating profits for 11 of the companies who were signatories to the contract.
£29m – dividend payments made by some of the companies who were signatories to the contract and their subsidiaries.
6,600 – the number of patients who were treated in private hospitals who were later admitted to NHS hospitals.
791 days – the period during which NHSE financial transparency data has been unavailable.

Introduction and executive summary

1. This briefing note is a follow up to our September 2021 report ‘For Whose Benefit? NHS England’s contract with the private hospital sector in the first year of COVID’. Following a number of requests to NHS England under the Freedom of Information Act (FOI) for the basis of the contractual arrangements with the private sector, we were eventually provided with the main contract documents and also more detail on the volume of services which were provided by the contracted parties. This has allowed us to understand more about the nature of the contractual arrangements which underpinned this deal with the private sector and to analyse further the extent to which the contract was in the public interest.

2. When the COVID 19 pandemic began in March 2020 NHS England struck a remarkable deal with the private hospital sector. To support the pandemic response, NHS England purchased the entire capacity of 26 private hospital companies, practically the whole sector, but it quickly transpired that buying healthcare ‘capacity’ (beds and facilities) is not the same as buying healthcare ‘activity’ (operations, and procedures).

3. Our September 2021 report showed that despite the significant amounts of money paid to the private hospital sector during COVID, elective activity in the private sector fell by 45%, a shortfall of 235,000 operations compared to the year before the pandemic. At most, the 8,000 private sector beds cared for just 78 COVID patients on a single day in April, and for 59% of the 375 days this contract lasted no more than one COVID patient was being cared for. [1]

4. At the time, there were widespread reports that large amounts of vital healthcare capacity were going to waste during the pandemic. The issue was raised by the Public Accounts Committee as early as June 2020, and in December 2020 leaks to the Health Service Journal showed two-thirds of private sector capacity went unused by the NHS.[2]

5. If NHS England had taken the standard approach for contracting with private providers, paying the NHS tariff rate for each consultation, diagnostic test, day-case procedure or surgery, this wasted capacity would not have been such a problem from a value for money perspective. But that wasn't the contract NHS England signed.

6. Instead, NHS England bought the entire capacity of these hospitals as a back-up option - all their beds, doctors, nurses equipment and administrative support - and in return agreed to pay almost all their operating costs associated with running them. This deal meant it was impossible for the 26 private hospitals to lose money for the duration of the contract but made it inevitable that the taxpayer would foot the bill for wasted healthcare capacity in the event that this back-up wasn't utilised.

7. The arrangement under which the NHS would cover almost all the operating costs of private hospitals was a lifeline for the sector which had been plunged into financial uncertainty by the pandemic. It was also an arrangement which was made more favourable to their interests because of specific clauses within the contracts which provided them with incentives to continue their core business of treating private patients. We understand that these clauses were written into the contract to allow the NHS to reduce the overall costs of the arrangements to the taxpayer.

8. The result, however, was that although most private hospitals during the pandemic were assumed to be at the 'beck and call' of the NHS, there was an incentive built into the contract for them to focus on increasing the volumes of private patients treated in their facilities. Press reports highlighted that the NHS struggled to use private hospitals to treat NHS patients and in January 2021, at the peak of the second wave of the pandemic, NHS Medical Directors in London issued a public plea to their consultants working in the private hospital sector to assist them in treating seriously ill NHS patients rather than favouring potentially less urgent, fee-paying patients.[3],[4]

9. Whilst we remain concerned about the value for money of these arrangements for the taxpayer, the central question which the public inquiry into the COVID 19 pandemic will need to consider is whether the UK government put all the available resources in the private hospital sector at the disposal of treating NHS patients on the basis of clinical need, or whether these resources

were allowed to be used to treat fee paying patients who were able to access care based on their ability to pay.

10. Based on our analysis of the contracts and hospital activity data which have been released under FOI as well as an analysis of companies house accounts and other public data sources we seek to answer the following 4 questions:

- **Why were private hospitals not used to treat more NHS patients during the first year of the pandemic?**
- **Did the private hospitals make any profit from the contract?**
- **Who paid for the additional capital expenditure and infrastructure costs under the contract?**
- **Who covered the costs if any patients were harmed under the contract?**

11. The main recommendation from our September 2021 report was greater transparency about these contractual arrangements. But despite promises of transparency by ministers, the NHSE Chief Executive and the trade-body for private hospitals at the time the contract was announced, this has not happened.

12. As a result, it has taken numerous Freedom of Information requests before NHS England was willing to release copies of the contracts themselves, albeit with all financial details redacted. In addition, the failure by NHS England to publish its required financial transparency data for more than 2 years means that we are still unable to say how much this contract cost the taxpayer. We set out in *Annex A* the process and efforts by which we have sought greater transparency and we have also made available the documentation which has been disclosed to us on our website.

Why were private hospitals not used to treat more NHS patients during the first year of the pandemic?

13. One of our key findings from our 2021 report into the arrangements between the NHS and the private hospital sector during COVID was that despite the stated policy aim to use the private hospital sector to support the pandemic response, there were fewer NHS patients treated in private hospitals compared to prior to the pandemic.

14. This was despite the fact a) the NHS was paying large sums for this capacity and b) the private sector was able to treat growing numbers of fee-paying private patients in their facilities, so that by the end of the first year of the pandemic in most private hospitals more fee-paying private patients were treated than NHS patients. This suggests that the reasons why comparably, so few NHS patients were treated under the contract is not to do with the operational difficulty of the private hospitals providing care during the pandemic.

15. A more detailed examination of the released contract provisions now enables us to explain how this potentially perverse outcome occurred. There were two key clauses in the revised contracts which drove these changes – a) contractual incentives for private hospitals to treat more fee-paying private patients b) contractual limits on the amount of capacity in private hospitals available to the NHS, except in extreme circumstances.

Contractual incentives to private hospitals to treat private patients (the private patient offset)

16. Those negotiating the contract between the NHS and the private hospitals appear to have recognised that large amounts of the capacity would potentially go un-used to treat NHS patients.[a]

17. The private companies were also keen to return to their core business of treating private patients as soon as possible. The contract therefore included a provision to allow private hospitals to treat private patients in any capacity which was not being used by the NHS.

18. However, allowing the private hospitals to receive income from treating private patients at the same time as they were also being paid for their full operating costs created a double-payment problem.

19. In effect, when a private hospital treated a fee-paying private patient under the original contract, they would be being paid twice for their facilities; first by the NHS which covered all their operating costs, and then by a private insurer which would also pay for using the same private hospital facilities already paid for by the NHS.

[a] Sections 5-7 of the Main Contract detail what is expected of the providers at each stage of the contract. Section 5.5 says: "The Parties acknowledge that the Provider may have some unused capacity before or after 15 April 2020 which the Provider is expected to use for mobilisation and staff training.". A similar note is included in Section 7.4 of the main contract outlining the De-Escalation Phase, 15th May to 31st December, but there appears to be no expectation of unused capacity during the Peak Surge Phase as described in Section 6.

20. To avoid this double-payment problem the revised contract stipulates that the companies were not allowed to keep all the income they received from treating private patients and instead had to pay a proportion of this back to the NHS. This was initially 85% of any net revenue from each private patient treated, allowing them to keep 15%. From the Treasury's perspective, this arrangement also sought to reduce the overall costs to the NHS as this would provide the NHS with a 'rebate'.

21. It could be argued that because the NHS had covered all operating costs, the 15% of the income which the private hospitals were allowed to keep was effectively a 15% margin or surplus on each privately funded operation.

22. It appears however, that 15% wasn't a sufficiently strong incentive to encourage increased private patient activity, and so from the 1st July 2020 the incentive to treat more private patients was ratcheted up - if private hospitals could meet certain private patient activity targets, then instead of keeping 15% of any private patient revenue they could keep 30%, and if a further target was reached 40%. Or put another way the more private patient activity which was undertaken by a private hospital under the contract, the higher the margin paid by the taxpayer.[b]

23. It appears from a review of the accounts of some of the companies on the contract, that these private patient activity targets were not difficult to meet. This was because the baseline for activity was calculated during the early part of the pandemic when there were very few private patients being treated. As one provider noted in their annual report in relation to these revised contracts:

    "*A favourable aspect of the new contract is that the level of the private patient income offset [the amount which has to be paid back to the NHS] is reduced from the original 85% to 70% and then to 60% according to which the level exceeds base level activity in June [2020]. With a low base level of private patient activity in June, this delivers an improved return to the Hospital.*" [5]

Contractual limits on the overall amount of capacity available to the NHS

24. For the private hospitals to be able to meet their private patient activity targets a limit was placed on the amount of capacity which could be reserved to treat NHS patients from 1st July onwards.[c]

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[b] The Variation Contract Sections 2 and 3

[c] The Variation Contract, Section 6 – Release of capacity for Private Patient Activity, states that "The agreement of a maximum NHS Capacity Limit or London Area NHS Capacity Limit or the Inner M25 Area NHS Capacity Limit from time to time is designed to protect sufficient capacity during core hours for private work to maintain the ability of the Provider to deliver private work in support of commitments to the Minimum Private Patient Offset Amount"

25. Although the Finance Director of NHS England wrote to the Public Accounts Committee stating that the NHS would be able to access no less than 75% of private hospital capacity from July 2020 onwards the contract reveals that this varied across England, and that it was likely to be much less than 75% overall.[6] Outside of London the NHS was guaranteed access to 75% of private hospital capacity, but in the South East of England - which is where most private hospitals in the UK are situated – in the Outer London Area it was 70% and within the M25 area it was a maximum of 60%.

26. This meant that despite the guarantees of funding provided under the contract, by setting a maximum level for use by the NHS these clauses had the potential to reduce activity to levels even lower than had been achieved in the early months of the pandemic when proportionately very few NHS patients were being treated (see Figure 5). This risk is acknowledged in the contract where it states "*It is recognised that agreeing a maximum [..]for each of the Provider's Premises may limit capacity for NHS work to a level below the current actual activity level.*"[d]

27. From July 2020 onwards, the contract did permit the NHS to gain access to the full staffed capacity of the private hospitals but only in extreme circumstances. The incentives to treat private patients could be suspended and the NHS was entitled to access 100% of the capacity of the hospitals on the contract, but only when the COVID infection rates *'were so high that they necessitated 'the suspension of most or all routine elective care'*. This 'Surge Clause' could be triggered by NHSE at a national, regional or local level, but it is not clear whether they were ever invoked.[e]

28. Overall, despite the large sums of money being paid to private hospitals to cover their operating costs, it appears that the contract provisions had the intention of increasing the number of private patients who could be treated in private hospitals and except in extreme circumstances providing a limit on the amount of NHS care which could be provided.

29. Whilst this would both meet the business needs of the companies involved, as well as the demands from the Treasury to reduce the costs to the taxpayer, from a public health perspective we found no corresponding incentives in the contract to increase the volumes of NHS patients being treated in private hospitals during the pandemic, despite NHS waiting lists growing throughout the pandemic and NHS hospitals being overwhelmed.

30. Nor is it clear that these provisions were actually successful in reducing the costs of this contract. Because of large front-loaded payments the initial cost per month does fall rapidly after April 2020. But once costs stabilise the average monthly payments to providers in May and June 2020, before renegotiation was £155.1m. After renegotiation in July to September

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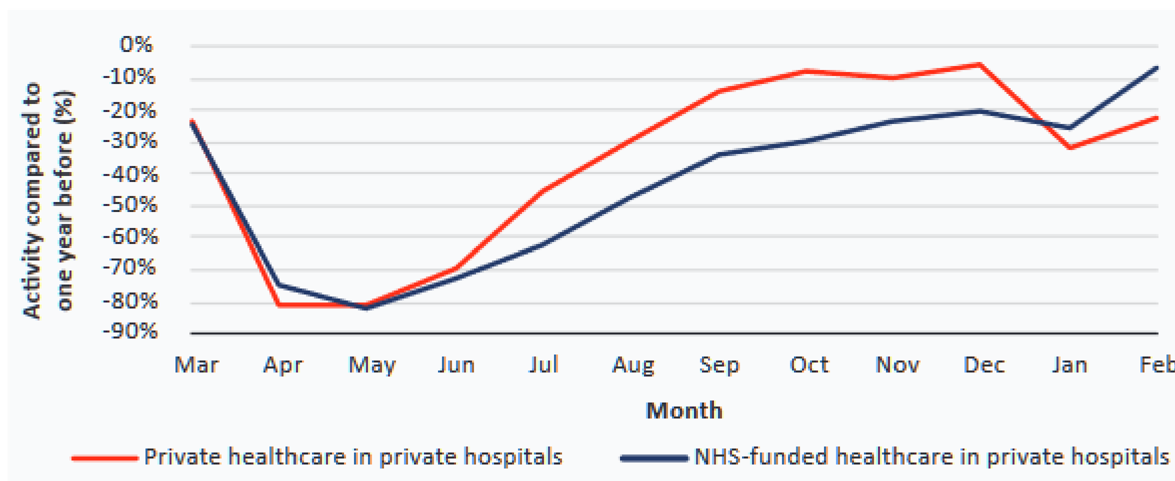
[d] This quotation is from Section 6 - Release of capacity for Private Patient Activity within the Variation Contract. The quoted section is from the third paragraph on Page 7.

[e] The Variation Contract, Section 7 - Commissioner may trigger return to Peak Surge, dictates the circumstances whereby NHSE could override the NHS capacity limits and providers must "ensure that 100% of its capacity at the named Provider's Premises is available to be fully applied to the delivery of the (NHS) Services (but not care for COVID-19 infected Service Users needing high dependency respiratory support on oxygen therapy, NIV therapy, or mechanical ventilation)."

the average monthly cost was £139.3m and in the last three months of this iteration of the contract, October to December 2020, the average monthly cost was £143.5m.

31. Overall we consider it likely that these contract provisions were the reason why so few NHS patients were treated in private hospitals during the first year of the pandemic compared to the previous year and why private patient activity almost returned to pre-pandemic levels by Autumn 2020. (as Figure 1 below shows)

Figure 1: Private Hospital Activity during the Pandemic



(Sources: This graph is reproduced from the CHPI's 2021 report 'For Whose Benefit', Figure 5. NHS Funded Healthcare Activity in blue is compiled from NHSE's Hospital Episode Statistics, and Private Healthcare Activity is from the Private Hospital Information Network's data. Both sets of figures are expressed as a percentage of activity performed in the year prior to the pandemic.)

32. This financial incentive to prioritise privately funded patients over NHS patients is also likely to have a significant impact on whether urgent NHS patients received timely care within NHS hospitals. As noted in the introduction to this report, in January 2021 when London's NHS Hospitals were being overwhelmed at the height of the second COVID wave, NHS Medical Directors for London Trusts along with NHS England's London Regional Medical Director wrote to their consultants asking them to stop doing private work so that severe capacity shortages in the NHS could be resolved.[7]

33. These senior NHS leaders point out in their letter that *"all but the most urgent elective activity [had been] postponed in the NHS in London"*. This suggests the threshold for NHSE requesting a return to 'peak-surge' had been reached – allowing the NHS take control of 100% of private hospitals to aid the pandemic response. It is not clear whether NHSE took steps to secure this surge capacity from private hospitals. And if so, how it was able to enforce compliance given Medical Directors felt more needed to be done.[f]

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[f] The second COVID wave straddled two iterations of this contract, which switched on the 31st December 2020. During 2020 the private providers were on the Main Contract and the amendments set out in the Variation Contract. The Main Contract's Section 6 appears to only allow for a single 'Peak -Surge Period' from 15th April to 15th May but the Variation Contract, Section 7, effective from the 1st July adds a clause to allow NHSE to re-trigger this higher level of provision. The Extension Contract, Section 6, describes to the triggering of a 'Peak Surge Period and was effective from 1st January 2021 until the 31st March 2021.

34. It is because of the potential impact on access to healthcare, based on need rather than ability to pay, that we consider that the UK-COVID 19 Inquiry should investigate these contract provisions in more detail.

Did the private hospitals make any profit from the contract?

35. The arrangement with the private hospitals for use of its capacity was stated to be on the basis that the private sector would make 'No profit' on the deal – it was only supposed to cover costs.

36. 'No profit' was emphasised by Matt Hancock when the deal was announced stating that: *"Under the agreement, the independent sector will reallocate practically its entire national hospital capacity en bloc to the NHS. It will be reimbursed, at cost – meaning no profit will be made for doing so."* [8]

37. Simon Stevens also told the Public Accounts Committee that the contract *"contains caps on the profits that can be in dividends and other aspects of what would be a normal cost structure for those providers."* [9]

38. However, an analysis of the contracts themselves, and the financial accounts of the participating private hospital companies makes it difficult to find anything to support the claims that no profits were made from the contracts and that no dividends were paid.

39. In the first case, in the copies of the contracts which have been disclosed to us there are no provisions which explicitly state that no profits can be made from providing services under the contract, nor are there any clauses which prohibit the payment of dividends to shareholders.

40. Second, we analysed the accounts of the companies which filed profit and loss accounts for at least 9 months of the financial year 2020-21 the period covering the contract. This shows that for the 17 companies where data was available, 11 companies saw their aggregate operating profits increase by a total of £65 million. In addition, we identified that companies which received funding from the NHS under the contract including their subsidiaries paid out dividends worth £29m.

41. The exact relationship between the COVID contracts and the profits made by the companies on the contract is difficult to establish due to the lack of precise financial data. As noted in the previous section, the private hospital companies were also increasingly incentivised to treat more private patients out of which they would have been able to generate a profit. However, because of the complexity of the contract arrangements it is not possible to identify which income streams – either taxpayer or private funding – which may have led to the creation of a surplus.

42. However, a review of the financial accounts reveal that some companies do attribute an increase in operating profits to the support received from the NHS. Thus, one company which saw its prior year operating loss of £1.49 million increase to an operating profit of £2.5 million

in the financial year 2020 attributed this *"mainly due to operating under a Public Health England (sic) contract for 9 months which covered most operating costs"*[10]

43. The extent to which some companies were likely to have benefitted financially from the contracts with the NHS can be seen in the amount of revenue they received per patient treated. This measure can also provide some indication of whether the overall contract was value for money to the taxpayer.

44. Although the activity data provided to us by NHSE under the contract is difficult to validate as it does not provide sufficient information on the nature of the healthcare activity performed by private hospitals and it is difficult to reconcile this with data published by some of the private companies in their statutory quality accounts, when combined with the payments provided to each company it is possible to show that there was a wide variation in the amount of income received in relation to activity undertaken.[9]

45. In total, NHSE's data shows that the 27 companies on the contract delivered 3.26m inpatient stays, daycases, chemo/radiotherapies, diagnostics and outpatient appointments. However, two thirds of this activity, 2.15m, was outpatient appointments, a proportion of which may have been carried out remotely (for example over the telephone) as guidance at the time recommended that unnecessary hospital visits should be avoided.[11]

46. Although a crude figure, by dividing the amount of activity NHSE has recorded (3.26m) by the total cost (£2.05bn) we can arrive at an average cost-per-activity of £628.

47. For reference, the 2022 NHS Tariff prices for outpatient appointments, which made up 66% of the activity, average £226 for a first attendance, or £109 for a follow-up. Operations and procedures are highly dependent on type and complexity, but for example, a minor cornea procedure has a tariff rate of £144 while an intermediate hip procedure has a rate between £2900 and £7,000 depending on patient risk factors.[12]

48. While the average cost-per-activity was £628, there was significant variation between providers with some companies generating significant amounts per activity performed. The highest cost-per-activity based on the data provided by NHSE was £22,372. This company is said by NHSE to have received £8 million from the NHS and performed no outpatient activity, and 371 inpatient, day case and diagnostic treatments. A hospital company operating solely out of London received £25.6 million from the NHS and recorded 2772 units of activity of which 19% were outpatient appointments at a cost of £9,247 per unit of activity. Another company, paid £153m, provided 40,000 units of activity of which 67% were outpatient appointments at an average cost-per-activity of £3,830.

49. While some of this variation might be explained by a focus on higher-complexity care, some appears to result from the high levels of payments made relative to the low levels of activity

[9] The data here is the NHS England Spend over £25k data for the period March 2020 to April 2021 and the COVID 19 contract activity data provided by NHS England under a Freedom of Information release.

delivered. Without further detail of what kinds of care were carried out by these providers a more detailed assessment of value-for-money is not possible.

50. Finally, as we have pointed out previously, the ability for companies to generate a profit out of the contract was not limited to those companies who had a direct contract relationship with NHSE. Those companies which leased properties and equipment to the private hospital companies as well as those who provided them with loans were guaranteed a return on their investment as the contract explicitly provides for the NHS to cover off any interest and associated costs of any loans, rent, mortgages and other borrowing.[h]

Who covered the costs of patients being harmed under the contract?

The indemnity and liability cover for the private hospital sector under the contract

51. One of the major challenges faced by the private companies which were included on the contract was clinical negligence cover for NHS patients who were either harmed accidentally or due to clinical negligence whilst being treated under the terms of the contract.

52. This was particularly the case for the smaller private companies such as those working in the cosmetic sector - who had not previously undertaken work as complex and risky as the type of work they were expected to perform to assist the NHS. This meant that it was unlikely that their existing commercial insurance or indemnity policies would cover this type of work.

53. This risk also applied to a lesser degree to the larger private companies, who reported that the risk profile of the NHS patients that they treated under the COVID contracts had a 'higher acuity' profile – i.e they were more complex and hence risky to treat than those they had treated before.

54. This change in the risk profile of the patients treated in private hospitals under the COVID contract can be seen in an increase in the prevalence of patient safety incidents in these hospitals.

55. For example, there was a significant increase in the number of patient safety incidents relating to NHS funded patients at Nuffield Health during 2020, whereby the total number of patient safety incidents relating to NHS patients increased by 840 on the previous year to 1587 an incidence of 2.28% of all patient episodes, with 77 NHS patient deaths and 5 cases of severe harm. This was compared to 4 NHS patient deaths and 2 cases of severe harm in the previous year. [13]

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[h] The Main Contract, Schedule 3B – Payment, outlines the costs private providers could bill under this contract and begin in detail at Section 2.4. Payments for rent are covered in Section 2.5, and finance costs in Section 2.8.

56. Under the terms of the contract, it was the NHS and the taxpayer supported schemes which bore the financial risk of NHS patients being harmed as a result of clinical negligence.[i] Those companies which had contracts to treat NHS patients prior to the pandemic had been able to join the NHS's clinical negligence scheme (known as the Clinical Negligence Scheme for Trusts or CNST) and were able to rely on this cover during the pandemic.

57. The CNST is a contribution-based scheme run by NHS Resolution, whereby both NHS Trusts and private companies treating NHS patients pay into the scheme according to an assessment of the risks associated with their activity. It is unclear, however, whether the membership contributions for these private companies increased because of the possibly higher risk profile of NHS patients which were treated during the pandemic under these contractual arrangements.

58. However, just 9 of the 27 companies on the contract were members of the CNST scheme prior to March 2020 and so for those companies who did not have this cover and did not have adequate commercial insurance to meet any clinical negligence claims, they would be able to join, free of charge, a new indemnity scheme which had been created by Parliament under Section 11 of the Coronavirus Act. [j] [14]

59. This scheme known as the Clinical Negligence Scheme for Coronavirus (CNSC) was a non-contributory scheme, whereby all the costs associated with litigation resulting from harm caused to NHS patients in private hospitals was to be covered by the taxpayer.

60. Although it is not possible to know exactly how much the state will ultimately be required to pay out to those NHS patients who were harmed in private hospitals under these contractual arrangements, the Department of Health and Social Care has provided NHS Resolution with sufficient funds to cover claims up under the CNSC of up to £92.4m as of 2021/22.[15] The scheme also costs an estimated £236,000 to administer.[16]

61. In addition to providing most private hospital companies with free indemnity cover for NHS patients, the NHS continued to offer a 'safety net' to private hospital companies in the event that something went wrong in their treatment. Thus, between March 2020 and April 2021 around 6,600 patients were transferred to the NHS after being treated in the private hospital sector.[17]

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[i] The Main Contract, General Conditions, Section GC11 sets out liability and indemnity provisions. Under these terms it is stated that NHSE must 'indemnify and keep the provider indemnified' against and loss, damages, costs, [or] liabilities … in respect of the Provider's, any Sub-Contractor's, or any Staff's clinical negligence … but only if and to the extent that:' such losses are not already covered by the provider's clinical negligence indemnity arrangements (GC11.1A)These clinical negligence indemnity arrangements include the CNST run by NHS Resolution – a contributory scheme – and CNSC – a non-contributory scheme also run by NHS Resolution which was established specifically for the pandemic and also commercially provided indemnity cover.

[j] Any clinical negligence liabilities arising prior to or after this date from these coronavirus-related NHS activities are covered by CNSC by direction from Secretary of State under Section 11 of the Coronavirus Act 2020 or, prior to the commencement of that section, under general powers to provide indemnity for clinical negligence. (Department of Health and Social Care Annual Report 2020/21)

62. It could be argued that the private hospital sector was provided with highly favourable terms regarding indemnity cover under this contract relative to other private companies who delivered state funded healthcare services during the pandemic.

63. For those private companies providing care home services for state funded residents during COVID (including those receiving NHS funded nursing care) no additional indemnity cover was provided by the state. Because of the high risks associated with looking after care home residents during the pandemic, this led to many care home companies seeing their insurance premiums rising by 300%.[18]

64. Where the government did provide indemnity cover for the private care home companies this was only in the very limited instances where they established special facilities to look after COVID positive patients who had been discharged from NHS hospitals. The total estimated cost of this scheme (known as the Coronavirus Temporary Insurance Scheme) is £2.01m.

Who paid for the additional capital expenditure and infrastructure costs of the private hospitals under the contract?

65. In addition to almost all operating costs being covered by the government, the private companies on the contract could invoice the NHS for any additional capital expenditure required to provide the services under the contract.[k]

66. This might include reconfiguring wards to accommodate social distancing, buying new equipment or converting facilities. They could also bill the NHS for any decommissioning costs to restore their premises back to how they were.[l]

67. In September 2021 the CHPI requested copies of the forms NHSE asked private providers to use when requesting capital expenditure, and NHSE provided the information in September 2022. The spreadsheet provided showed a total of 8 applications for capital funding, one of which was an error, one which was withdrawn and resubmitted, and one which was approved but never went ahead, leaving five applications for a total of £121,000. All applications were approved.

68. This included £30,000 to the King Edward VII hospital for the hire of equipment and a further £20,000 for its repair and decommissioning. £28k was paid to Kinvara Private hospital for hire of a 'stack system' for gynaecological procedures, and £5,000 to the New Foscote for plumbing works to re-establish an en-suite bedroom which had previously been converted to an office.

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[k] The Main Contract, Schedule 3B – Payment, Section 2.6 says capital expenditure payments from 30th March to 31st December 2020 ' incurred in order to implement and carry out the Services, including acquisition of capital equipment, and necessary alterations or improvements to freehold or leasehold buildings' are covered by NHSE. Section 2.6.2 goes further, to include 'any reasonable capital expenditure' incurred prior to the contract starting in order to mobilise the provider.

[l] The Main Contract, Schedule 3B – Payment, Section 2.10, describes decommissioning costs, covering 'the reasonable costs incurred … in restoring the provider's premises … to their prior condition.

69. The largest approved application £178,000 for Care UK's St Mary's Treatment Centre would have supported conversion to a 42 bed inpatient facility for additional healthcare capacity, but this project did not proceed due to a 'change of plan with the NHS'.

70. However, we were concerned that NHSE had not provided a full picture of capital payments under the contract. [m] We asked directly if there was further information on capital expenditure we would need to request, and NHSE would only 'confirm there is other capital expenditure information related to the contracts' without explaining what that might be.

Infrastructure Costs

71. The contract also allows providers to claim for 'infrastructure costs' which is an extra payment to cover any 'normal wear and tear' and 'all other costs related to the services' not covered elsewhere in the contract. Clause 2.9 of the contract states *"Infrastructure cost" is an additional amount, to be paid in respect of normal wear and tear on property equipment and in respect of all other costs of the Provider related to the [provision of services] calculated as 8.6% of the total pre-tax amount of Operating costs"*[n]

72. This 'infrastructure cost' is calculated as a flat 8.6% of whatever the companies bill under 'operating costs'. A company which paid a total of £1m in operating costs, staffing, goods and services, support costs and overheads, would receive an additional £86,000 for 'infrastructure costs'.

73. As we understand it 'wear and tear' might often be recognised as depreciation of an asset. But 'depreciation, amortisation or any other non-cash cost' is listed elsewhere in the contract as an 'excluded cost', and so is not part of this contract.

74. Whilst it is possible to argue that a contract designed to cover the operating costs of running these hospitals should include recognition of wear and tear, these provisions do stray away from compensating the companies for their actual costs and paying them for the hypothetical replacement of facilities and equipment in the future.

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[n] The Main Contract, Schedule 3B – Payment, Section 2.9 describes the 'infrastructure costs'.

Conclusions and recommendations:

Conclusions

75. To date, outside of our analysis there have been no attempts to assess the efficacy and value for money of the contractual arrangements between the NHS and the private hospital sector during the first year of COVID. Whilst significant claims about the support provided by the private hospital sector have been made, there is a lack of clarity about the actual cost to the taxpayer of these provisions, the total number of NHS patients treated and the policy intention behind the arrangements.

76. Given that the NHS went into the COVID pandemic with fewer hospital beds per head of population than most of its European counterparts, an effective response to the public health emergency required that all healthcare assets at the disposal of Secretary of State for health, including in the private sector, were put towards treating patients on the basis of their clinical need. This overarching principle – which lies at the heart of the National Health Service – is even more compelling during a pandemic when access to treatment is restricted due to hospitals being overwhelmed by patients affected by the virus.

77. Because the emergency powers granted to the Secretary of State permitted him to direct the private hospital sector in which ever way was necessary, the NHS was in a very strong bargaining position when it came to striking a contract with the private sector. However, as we have detailed above and in previous reports, private hospital facilities treated fewer NHS patients during COVID than prior to the pandemic and overall, during the first year of the pandemic, more fee-paying patients were treated in most private hospitals than NHS patients. This suggests that ability to pay determined access to treatment in these facilities rather than clinical need. Quite what impact this is likely to have had on the patient care of individuals during the pandemic and the impact on the subsequent growth in NHS waiting lists remains unclear.

78. In addition to permitting the private hospital sector to carry on and build its core business during the pandemic, it was also provided with favourable terms from a financial perspective. Because of a lack of transparency regarding the finances of this contract, the full cost remains unknown. However, based on the activity data provided to us by NHS England (which we should stress we have been unable to validate) some private hospital companies appear to have provided very few procedures or treatments in return for millions of taxpayer funds. The accounts of the companies involved also show that many companies made profits over the first year of the pandemic, although it is not possible to say whether this was due to the contractual arrangements with the NHS or from treating private patients.

79. The contract disclosed to us reveals that there were also hidden costs. In most cases, the taxpayer underwrote for free the indemnity and liability costs of treating NHS patients and companies were also permitted to claim for capital expenditure and also infrastructure costs.

Recommendations

80. Based on our analysis we recommend the following:

- **Efficacy of the arrangements in the face of a public health emergency.** The public inquiry into the COVID 19 pandemic should examines the impact of these contractual arrangements on the overall pandemic response, including whether private hospital facilities were used effectively and whether patients were granted access on the basis of clinical need rather than ability to pay.

- **Transparency.** NHS England should publish all financial data relating to the contract, including the rebates received from the private patient offset, as well the background documents relating to the development of the contract and the policy intentions behind it.

- **Value for money.** The National Audit Office and the Public Accounts Committee should examine the full costs of the contract – including any hidden costs and liabilities not previously considered - and undertake a full value for money assessment of the arrangements, including whether any company on the contract made a profit from contract and the exact amount of healthcare activity which was undertaken for the NHS by the private hospital sector during the first year of COVID 19.

Annex A –Access to information behind the contractual arrangements between the private hospital sector and the NHS.

1. NHSE has not lived up to the promises of transparency which it made at the outset of this contract. The only information which it has released pro-actively regarding these contracts are its spending records, which are out of date and incomplete. This has left the CHPI pursuing several Freedom of Information requests over the last two years.

2. Those requests are now beginning to clear the Information Commissioner appeal stage, and enter the Information Tribunal appeal stage. While NHSE has released some limited information, it refuses to disclose the information we have requested in full citing: the cost of finding the information, commercial sensitivity of the information, confidentiality clauses written into the contract, harm to its policy-making processes and the risk of fraud should it disclose invoices submitted by the private providers. The CHPI has consistently argued that the risks of disclosing this information are exaggerated and there is an overwhelming public interest in transparency.

3. Nevertheless, we have now obtained redacted copies of many of the key documents relating to this contract, namely:

   a. The contract itself – Which is comprised of four separate documents detailing the different iterations of this contract:
      i. The Heads of Terms - agreed on the 20th March 2020 outlining the rough shape of the deal
      ii. The Main Contract - formalising the Heads of Terms and covering the period 23rd March to 31st December 2020
      iii. The Variation Contract - which made a number of adjustments to the key payment mechanisms, and was effective from the 1st July 2020
      iv. The Extension Contract – Covering January-March 2021 this new contract no-longer paid the private providers for their entire capacity, but instead paid each provider per NHS procedure they carried out

   b. Records of payments – The CHPI has requested each step of the payment process for two of the largest providers, what these providers billed, NHSE's auditors analysis of what was and wasn't deemed a valid cost and then what was actually paid to each provider. The only information NHSE has released are final payments, which are already within its Spend over £25k records.

   c. Records of healthcare activity – NHSE disclosed a spreadsheet outlining healthcare activity for each of the providers, broken down into inpatient, outpatient, daycase, chemo/radiotherapy and diagnostics. However this data is difficult to validate and it is unclear where this data came from, what units it is counting or if it has been audited.

   d. Records of capital expenditure – NHSE has provided some limited information about payments for capital expenditure, but admits that this is not the full picture.

4. Further requests for records of meetings and correspondence between NHSE and the private hospital sector have been refused in their entirety.

5. We have also made use of NHSE's monthly 'Spend over £25k' records, although these records only go as far as March 2021 and have not been updated in over a year, since October 2021. Although the period for which spending records are available maps to the lifespan of the contracts, this is still unlikely to be the full picture. NHSE has indicated that throughout 2021 it was engaged in 'reconciliation and arbitration' with an undisclosed number of the private providers, therefore this final 'settling of the bill' is unaccounted for.

6. Contrary to the Information Commissioner's guidance, NHSE does not publish the results of Freedom of Information requests to the general public. We have therefore provided links on our website to the primary documents we have obtained in the footnotes to this report and above.

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[11] NHSE's 'Guidance on Payments to Consultants by IS Providers', included in NHSE's Operational Update dated 3rd July 2020
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