CHPI | Centre for Health and the Public Interest

CHPI evidence to the inquiry into Ian Paterson

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About the Centre for Health and the Public Interest (CHPI)

1. The CHPI is an independent charity which produces research aimed at promoting the public interest in health and social care. The current Director of the CHPI David Rowland has spent over a decade working in the healthcare regulatory sector with a focus on patient safety and public protection.

Our work in relation to Patient Safety in Private Hospitals

2. The Centre has produced a number of reports into patient safety in private hospitals with the patient safety expert Professor Brian Toft and has also produced and commissioned blogs from relevant experts.

3. Our work has been cited by the Care Quality Commission and was relied upon by the Coroner who reported on the death of Peter O Donnell who tragically died following treatment in a private hospital. The intervention by the Coroner in this case led to a Report on the Prevention of Future Deaths being sent to the then Secretary of State for Health Jeremy Hunt with a recommendation that many of the concerns that we had raised be addressed. This subsequently led to the Secretary of State writing to the private hospital sector asking them to improve standards in the sector.

4. We have also worked with the Association of Victims against Medical Accidents and also with patients who have been affected by the Ian Paterson case as well as the family members of those who have died following treatment in private hospitals.

5. The CHPI's reputation in this area is based on the robust nature of the evidence and data that we have collected and it is our objective to identify relevant issues of concern from a public interest perspective and to make relevant recommendations.

6. This is done with the intention of increasing the public's understanding of the issues of this area which is not widely understood within government nor covered by other health policy think-tanks. We are not involved in campaigning for any changes in the law but we hope that our research will provide the basis for a considered response from policy makers to the problems that we have identified.

7. We set out below a series of concerns which we consider that the Inquiry should take note of in its review of the Ian Paterson case.

Issues of concern which we are relevant to the Inquiry into Ian Paterson.

The risks associated with the current private hospital business model

8. The private hospital sector in the UK (and also in the US) is almost entirely reliant on medical consultants to bring business to their hospitals. This reliance inevitably skews the relationship between the hospitals and medical consultants and it has been stated by both the Verita report into the Ian Paterson case and also by the CQC that the consultant rather than the patient is "promoted corporately as the primary customer" of the business. [1]

9. We would argue that the activities of Ian Paterson in providing unnecessary care were, in part, a product of this reliance on consultants as the main drivers of revenue to private hospitals. Put very crudely, from a private hospital's business perspective the provision of overtreatment or unnecessary care to patients, whilst a significant reputational risk, is also additional revenue. And we would argue that the financial incentives which run through the current system weigh against any of the current measures designed to prevent this.

10. In this respect it is useful to consider the value of an individual consultant to a private hospital operating in the UK today. According to LaingBuisson, at HCA Healthcare UK's hospitals in London an individual consultant brings, on average, revenue of 380 thousand pounds a year to the hospital.[2] It should be noted that this figure is an average, with some consultants likely to bring to a hospital many times more than this. Anecdotally, some consultants in London bring millions of pounds worth of revenue to a hospital through the patients which they refer and then treat at the hospital.

11. The failure to win the business consultants is identified as a risk to the financial success of the companies which own the hospitals. For example, HCA Healthcare (which is the largest provider of private hospital services in the UK) noted in its returns to the US stock exchange that:

    "physicians are often not employees of the hospitals at which they practice [and] Such physicians may terminate their affiliation with our hospitals at any time.[..] If we are unable to provide adequate support personnel or technologically advanced equipment and hospital facilities that meet the needs of those physicians and their patients, they may be discouraged from referring patients to our facilities, admissions may decrease and our operating performance may decline." [3]

12. The nature of this reliance on consultants to bring income to the hospital places the consultant (and sometimes groups of consultants) in a very powerful bargaining position with private hospitals. It could be said that this arrangement also provides the hospital with little incentive to engage in robust monitoring of their activities. This is very different to those situations where clinicians are directly employed by a hospital and where the hospital is not dependent on clinicians to bring in revenue.

The use of financial incentives to win the business of medical consultants

13. Because of this need to win the business of consultants, private hospitals are said to be engaged in "fierce" competition with each other to attract consultants to practise at their hospitals and they have developed a number of strategies accordingly. [4]

14. When it undertook its study into the private healthcare market in 2012 the Competition and Markets Authority (CMA) documented a wide range of financial incentive schemes designed to reward consultants for carrying out work at their hospitals and found that these schemes were widespread.[5]

15. These schemes included a number of private hospital companies making payments to consultants based on the amount of revenue that the consultant had generated for the hospital.[6]

16. Whilst the CMA Order of 2014 prohibits these schemes and prevented private hospitals from using financial incentives to induce patient referrals from consultants it is unclear how robustly this prohibition is monitored and enforced. [7] The CMA also permitted some financial incentive schemes to continue such as share ownership in private hospital facilities, the provision of corporate hospitality, ownership of equipment and the provision of consulting rooms and other facilities.

17. We have recently carried out a study of the investment that large private hospitals have made in attempting to win the business of consultants through the provision of corporate hospitality.[8] Using the declarations made by private hospitals on corporate hospitality – as is required by the CMA Order 2014 – we estimate that 7 private hospital companies have invested almost £1.5 million in corporate hospitality in the 2 years 2017 and 2018, with the vast majority of this £977k being provided by one private hospital company. [9]

18. Many of these instances of corporate hospitality clearly breach the NHS England statutory guidance on conflicts of interest which limit the value of corporate hospitality for NHS employees (which are the vast majority of the consultants who practise in private hospitals) to £75.[10] For example, we have identified individual instances of corporate hospitality given by one private hospital to its referring consultants to be worth over £1,200. The nature of this type of corporate hospitality is again is an indication of the extent to which the consultant is seen as the main customer within the private hospital business model and there are questions as to whether or not the provision of non-monetary benefits are compliant with the Bribery Act.

19. We have also identified that 637 consultants who practise privately own shares in the private hospitals to which they refer patients or own equipment in these hospitals, for which a number 77 receive a fee from the hospital each time their equipment is used to treat a patient.[11]

20. It is not clear whether patients are made aware beforehand of the existence of their consultant's financial interest in the facilities or equipment which will be used for their treatment even though such declarations are required to be made on the websites of private hospitals. We have identified that it is difficult to find these declarations on the private hospital websites and that for some private hospital companies there is no evidence that these public declarations have been made.[12]

21. In itself, the fact that consultants have a financial stake in the healthcare facilities to which they refer and treat them creates a conflict of interest between their own financial interests and the best interests of their patients. In addition, research shows that where clinician's own or have a stake in medical facilities and equipment patients receive more treatment than in facilities where clinicians do not have a financial stake.[13] In short, owning a

financial stake in a healthcare facility whilst practising at it poses, at the very least, a theoretical risk of harm to patients through the potential for overtreatment.

22. In the US, such practices are prohibited under a number of statutes and a number of healthcare companies whose subsidiaries currently operate in the UK have paid multi-million dollar fines for breaching these laws.[14] The UK system – which is overseen by a competition authority (the CMA), rather than a health regulator – has no sanctions attached to it. In addition to the fact that the CMA has no remit with regard to patient safety, we are unclear how it identifies and tackles any breaches of its regulations. [15]

The financial dimension to the Paterson case – how much did the private hospital company and Paterson make out of the unnecessary treatment of patients?

23. No independent financial assessment has been undertaken of the value of Ian Paterson's work to the private hospital company over the period when he was practising at its hospitals and we would urge the Inquiry to undertake such work.

24. Even on a rudimentary analysis, we consider that the amount generated by Paterson and by the private hospital is likely to be significant. We do not know the exact number of patients affected by Paterson, although we do know that the private hospital company has compensated around 750 individuals. Nor do we know the exact types of interventions which were carried out on these patients, although the press reports suggest that many of them were treated as cancer patients. On this basis it is possible to make some rough calculations based on the limited data available to us.

25. According to LaingBuisson, each individual oncology patient is worth £4000 to a private hospital in London.[16] If we assume that all of Paterson's patients were oncology patients and were either charged themselves or their insurance companies at similar prices to those who receive private oncology treatment in London, then it is possible to estimate that the revenue generated by the private hospital company as a result of Ian Paterson's work would be in the region of £3m.[17] This is in addition to the amount which Paterson himself generated from carrying out the unnecessary work.

26. Even on the basis of this rough calculation it is clear that Paterson generated a significant amount of revenue for the hospital for those cases where he provided unnecessary treatment. The ultimate compensation package paid out to the patients affected – reported to be in excess of £27 million - should also be viewed in the light of the revenue that the private hospital company generated from its work.

27. This type of analysis is pertinent to the Inquiry as it provides a further potential explanation behind the monitoring and assessment of Paterson's work as well as a potential motivation for his own actions which remain unclear following his criminal conviction.

28. We have also commissioned advice from a Professor of Financial Crime to consider whether the financial gains made from his actions should be viewed as the proceeds of crime and treated as such under the Proceeds of Crime Act.[18]

The adequacy of the regulatory framework to address the risks associated with the private hospital sector's business model.

29. We note with some concern that since the Paterson scandal nothing has changed substantially in the private hospital business model to make such an extreme incident of overtreatment and harm from happening again. In addition, we have identified that the regulatory framework which is intended to protect patients and the public is inadequate in the face of such powerful financial incentives.

Clinical governance arrangements within private hospitals – The Medical Advisory Committee

30. We have documented elsewhere that the Medical Advisory Committees which exercises the clinical governance function in private hospitals is made up of consultants who practise at the hospital. These committees have no statutory duties imposed upon them with regard to patient safety or quality assurance and the consultants who fulfil these roles are not employees of the hospital but are themselves responsible for bringing patients (and hence revenue) to the hospital. [19]

31. As a result, the membership of these committees means that there is no system of oversight for the delivery of clinical services at a private hospital which is wholly independent from the consultant workforce who provide services at the hospital. This has the potential for significant conflicts to arise. It is unclear whether the consultant members of a Medical Advisory Committee would have a strong incentive to undertake robust scrutiny of the activities of their peers when they themselves would be required to submit to the same level of scrutiny.

32. An example of the weakness of the MACs to provide an effective clinical governance function is their inability to mandate compliance with national clinical audits. For example, the Royal College of Anaesthetists (RCoA) recently undertook a national audit of the study of anaphylaxis related to anaesthesia and surgery.[20] The authors of the report suspect that about a third of all cases of perioperative anaphylactic shock may be expected to occur in private hospitals. Despite this there was a very poor response rate to the Royal College's survey from the private hospital sector. The RCoA wrote on multiple occasions to all 304 private hospitals, and the President of the RCoA had written twice to the chief executives of the hospital companies, many hospitals failed even to reply, and only 13% agreed to participate.

33. In a number of instances the reason for non-participation in the survey was due to the commercial environment in which the hospitals were operating. The report's authors found that :

"Several independent sector respondents noted that they had concerns about reporting data that might be considered 'competitive'. It is difficult to understand why the sharing of information about adverse incidents in a national audit such as NAP6 can be deemed to be commercially or competitively sensitive."

34. This suggests that the attitude towards clinical audit within private hospitals requires substantial improvement.

The CQC's model of regulation of the private hospital sector.

35. We have examined in a number of reports the CQC's approach to regulating the private hospital sector. Their declared starting point is to subject the private hospital sector to the same standards as those which they apply to the NHS.[21] We consider this to be an inappropriate way of regulating a fundamentally different type of health care provision. This is for the following reasons.

36. In the first place, the fact that many private hospitals do not directly employ any doctors but instead either contract with them on a "freelance" basis or employ them through an agency means that a private hospital is in essence a facility which rents out its facilities in return for a fee. The patient (or their insurance company) pays the private hospital separately for the use of their facilities and services and then pays a separate fee to the consultant and their anaesthetist for their treatment. This is fundamentally different to an NHS hospital which takes responsibility for all aspects of patient care and is required to approach all aspects of the running of the organisation with this in mind.

37. In addition, patients who receive treatment in private hospitals should meet certain criteria as set out by the American Society of Anaesthesiologists (ASA) before being admitted with a general rule that most private hospitals are unable to treat patients above ASA score II (i.e. those with mild systemic disease.)[22] This is because the great majority of private hospitals do not have intensive care facilities available in the event that post complications arise either during or after an operation. Again this is fundamentally different to most NHS hospitals who admit the full range of patients.

38. Our review of over 170 CQC inspection reports shows that inspectors occasionally note the ASA criteria used by the hospital as the basis for admitting patients. However, there is nothing in the regulations or the licensing of private hospitals by the CQC which specify that they are only safe for a distinct category of patients. From what we are able to ascertain, it is the admitting consultant who makes the final decision on whether the patient should be admitted. Again, given the financial incentives that we have outlined above this is a potential risk to patient safety and there has been one patient death that we are aware of which has occurred after an unsuitable admission.[23]

39. Multi-disciplinary team working which is seen as a key component of safe surgical practice is common place within an NHS hospital but is almost entirely non-existent in private hospitals. As the Association of Anaesthetists in Great Britain and Northern Ireland (AAGBI) notes: "Practising anaesthesia in independent hospitals commonly involves working in isolation, often being the only anaesthetist in an operating theatre suite or in the whole hospital."[24]

40. In addition to the fact that those working in a private hospital may not work with each other on a day to day basis it is possible that the operating consultant, the consultant anaesthetist and the wider healthcare team might not have met each other prior to the day of an operation. As the AAGBI also notes:

"*Staffing at so many [private] providers is frequently transient, with large numbers of bank and agency staff covering regular, ad hoc sessions and isolated sites. With the buildings themselves rarely being built for purpose, this can lead to a lack of essential knowledge.*"[25]

41. This means that a patient in private hospital faces different risks to those in NHS hospitals due both to the lack of availability of a range of healthcare professionals to deal with all potential complications and the lack of familiarity within the wider healthcare team.

42. As we have noted in our 2014 report the data reporting requirements for private hospitals are substantially different to NHS hospitals which are required to provide significant amounts of data to a whole range of bodies from NHS Improvement to NHS Digital and the National Reporting and Learning Service.

43. We examined the data provided by private hospitals to the CQC as part of their annual returns to identify the extent to which they would provide an indicator of risk factors to inform their inspection and regulatory processes and we identified a number of issues of concern. In the first place, we identified significant inconsistencies between the data reported by the inspectors and the data provided to the CQC in advance of the inspection. This raises concerns about the reliability of the data collected by some private hospitals, particularly when this data is being submitted to the national regulator.

44. Secondly the CQC told us the provision of data returns from private hospitals was not mandatory and they took the decision 2017 to cease data collection directly from providers and to rely instead on data provided to the Private Healthcare Information Network (PHIN) as required under the CMA Order 2014.

45. As the Inquiry will be aware, Private hospitals subject to this Order were required to provide data to PHIN in order that it could be published to better inform patient choice between competing private hospitals. It was not intended as a data set designed to identify patient safety risks and we have expressed concern that the CQC have chosen to rely on this data for regulatory purposes.[26]

46. As the Inquiry will no doubt be aware PHIN is a not a public body created under statute – for example, it is not subject to the Freedom of Information Act 2000 – nor is it independent from the private hospital companies which operate private hospitals in England as these companies sit on the board of the organisation and are responsible for its funding.

47. This arrangement runs counter to one of Sir Robert Francis' recommendations in his first report into Mid Staffordshire NHS Foundation Trust which was that the collection and publication of data relating to a hospital's performance should be "unimpeachably independent" from the hospital in order that it could be relied upon.[27]

48. In addition the returns to PHIN from private hospitals still fall way short of the requirements set out in the CMA Order 2014 despite the fact that the private hospital sector has been required by law to provide this information since 2015.[28] It is again a concern that the CQC would choose to rely on this incomplete data set as the basis for identifying potential risks within private hospitals.

49. For all of these reasons we would argue that the CQC needs to develop a distinct regulatory model for addressing the patient safety risks which result from the particular nature of the private hospital operational model.

The role of the Competition and Markets Authority in the regulation of the private hospital sector

50. As we have noted above the CMA now plays a significant role in the regulation of the private hospital market. It has issued regulations relating to the provision of information relating to hospital performance and has mandated the creation of the Private Healthcare Information Network (PHIN). It has also issued regulations prohibiting the use of financial incentives to attract business and referrals from consultants within the private hospital sector.

51. We are concerned that the CMA has been given this role as it does not have any remit with regard to patient safety. It's interventions with regard to the provision of information to patients are designed to facilitate patient choice between private hospital providers in order to foster more effective competition. Similarly, its interventions regarding financial incentives are designed to ensure that private hospitals compete on a level playing field and that financial incentives are not used to distort competition between private hospital companies.

52. The CMA like all competition bodies is established in law as independent from government in order to ensure that it can take decisions based on a purely technical assessment of the nature of competition. It is not answerable to the Department of Health and Social Care for its interventions and as such has no formal place within the overall patient safety framework and does not develop its approach in conjunction with the Care Quality Commission, the Health and Safety Executive or any of the healthcare professional regulators. We therefore consider that it is inappropriate for a competition body to be undertaking any regulatory role in the healthcare sector which may have an impact on patient safety. It does not have sufficient resource to focus on this area, nor does it have the necessary legal powers to enforce compliance with its regulations.

The risks associated with the practising privileges model of employment and the reliance on Resident Medical Officers for post-operative care.

53. As we have documented in our 2017 report, there are some private hospitals in London who have over 1000 medical consultants with practising privileges who carry out work in them.[29] This situation poses a number of risks to patient safety. In the first place, the ability of a small hospital to monitor the activities and the quality of care of so many consultants is likely to be difficult to achieve without significant investment by the hospital.

54. In addition, the fact that so many consultants have the right to practise at the hospital means that there is a possibility that some consultants will only carry out operations at the hospital very infrequently. Infrequent practise within a particular hospital means that the consultant is likely to be unfamiliar with the procedures and equipment at the hospital and this has been identified by the CQC as a patient safety risk.[30]

55. Our research shows that there is a possible association between the number of consultants with practising privileges at a hospital and a higher than average number of transfers from

private hospitals to NHS hospitals for emergency treatment – a key patient safety indicator. Due to the poor quality of the data available on patient safety indicators within private hospitals we are not able to establish any direct correlation here between patient outcomes and the numbers of those with practising privileges but this is something which we consider ought to be explored further.[31]

56. A further risk emerges as a result of the fact that once a consultant has concluded an operation in a private hospital the care of the patient becomes the responsibility of a Resident Medical Officer (RMO) and the consultant will often be "off-site" during the post-operative recovery period when complications can occur. The fact that the responsible consultant was off site or unavailable has been cited in relation to one patient death that we are aware of.[32]

57. Whilst the CQC reports that most private hospitals require their consultants to be no more than 30 minutes travelling time away from the hospital (which is in line with the recommendations of the Royal College of Surgeons) there is no way of ensuring that this is the case in practice and there is no evidence from the CQC reports that this is consistently adhered to.[33] Again, the large number of consultants with practising privileges who operate out of some private hospitals makes adherence with this requirement even more difficult. In addition, it should be noted that one private hospital company was identified by the CQC as permitting consultants to be 45 minutes away from the hospital after they had performed an operation or a procedure, although the CQC did not identify this as an issue of concern.[34]

58. In the absence of the consultant being available for post-operative care of the patient the responsibility for this lies with the RMO who is a junior doctor often recruited from outside the UK. As we have documented, in the large majority of cases, the RMO is not directly employed by the hospital but is instead supplied by an agency. The RMO typically works a shift of 168 hours week, which means they are on duty at all times when in the hospital's facilities even when they are supposed to be sleeping or resting.[35]

59. Such extreme employment conditions are deemed to be a patient safety risk under EU and UK law and they are only permitted due to the fact that these doctors choose to opt out of the European Working Time Directive as a condition of their employment. Again, as far as we are aware this practice is uncommon in the NHS.

60. Our review of the CQC reports also identified that the number of RMOs available for post-operative care in private hospitals was not related to the number of patients which were being treated in the hospital at the time or the number of beds which the hospital was licensed by the CQC to provide.[36] We are unclear why no patient-to-staffing ratios have been introduced by the CQC or the private hospital sector to deal with this potential risk to patients.

61. The practising privileges model of employment also raises issues regarding the private hospitals responsibility for the actions of consultants with practising privileges. The CQC regulations describe consultants operating with practising privileges in private hospitals as "employees" and as a result seem to require the hospital to ensure that activities of the consultants operating in their facilities are safe and competent to do so.[37] However, the extent to which private hospitals remain responsible for any issues relating to the fitness to practise of their consultants or any issues relating to misconduct or malpractice remains a moot point.

62. The denial of liability for Paterson's actions by the private hospital company and the attempt to transfer responsibility to the NHS was one of the issues which led to a delay in Paterson's patients receiving compensation and which also caused significant distress to the patients affected.[38] We were provided with a letter to one of the patients harmed by Paterson which stated that the private hospital is "under no obligation to provide competent surgeons to perform breast surgery at the hospital" [39]

63. In addition, we have heard of other cases involving harm caused to patients in private hospitals where the private hospital companies have refused to admit any liability on the basis that the consultants practising in their hospitals are operating on a "freelance basis" and are not employed directly.

64. Whilst the regulatory system operated by the CQC provides some measure of assurance for patients and the public it is only one part of the regulatory framework. The law of Tort which ensures that those injured by private individuals or companies to seek damages is an important element in ensuring the safety of the public in a whole range of situations. The potential damages that a company may have to pay out in the event that an individual is harmed is a key impediment to undertaking risky practices and provides a strong incentive to ensure that safety requirements are observed.

65. The fact that the liability of private hospitals for the actions of the consultants who operate in their facilities remains in doubt suggests that a key part of the overall public safety framework is either missing or ineffective. We would argue that the law needs to be clarified in order for patients and the public to have confidence in the private hospital sector.

The reliance on the NHS as a "safety net"

66. Because of the fact that the large majority of private hospitals do not have intensive care units to deal with those situations where patients become seriously ill following an operation or procedure the sector relies on its ability to transfer these patients to local NHS hospitals. This causes a number of risks to patients.

67. In the first place any transfer of a seriously ill patient from one hospital facility to another poses patient safety risks and so should be avoided where possible. Our research shows that around 7,433 patients were transferred from private hospitals to the NHS in 2015-16.[40]

68. In addition, our survey of NHS Hospitals shows that there is a lack of awareness within the NHS of the formal transfer arrangements which are said to be in place with private hospitals. In the case of Peter O'Donnell – an NHS patient who was treated in a private hospital and who died following a transfer to a local NHS hospital – the CQC inspection report stated that the transfer arrangements were in place, however the coroner's inquest found that this was not the case.[41]

69. A further issue with the reliance on the NHS to provide a safety net for when things go wrong is that it has the potential to create a "moral hazard". If the private hospital knows that it can rely on a third party to address any short comings in its patient safety regime it has a limited incentive to avoid mistakes or eliminate risky behaviour.

70. This moral hazard is compounded by the fact that the NHS bears the full cost of treating patients from private hospitals which are transferred to NHS hospitals. We have estimated that the costs borne by the NHS as a result of patient transfers from private hospitals is in the region of £70m a year.[42] If the private hospital sector was required to meet these costs it might have a further incentive to address the reasons why patients develop post-operative complications and may also cause them to place a greater focus on the criteria for determining which patients should be admitted for treatment.

Conclusion

71. Our research has raised a number of systemic patient safety risks associated with the private hospital business model, its model of employment and the efficacy of the current regulatory regime. We have made a number of recommendations to address these concerns many of which have been reflected in reports by the CQC, the Coroner's report into the death of Peter O' Donnell and more recently in the letter which was sent by the former Secretary of State to private hospitals requiring an improvement in standards.[43]

72. To date we have yet to see any substantial changes in either the private hospital business model or the regulatory regime following the Secretary of State's letter. Given the nature of the harm caused by Ian Paterson we would have expected to see a step change in the provision of private hospital services in the UK in the same way that the Inquiry into the failings at Mid Staffordshire NHS Foundation Trust brought about a fundamental review of patient safety within the NHS.

73. Our understanding of the development of the CQC's regulatory approach to private hospitals is that it did not identify the Paterson case as evidence of systemic problems within the private hospital sector and so it did not develop a response designed to ensure that a similar incident would never happen in the future. [44] Similarly, the Competition and Markets Authority Order of 2014 was developed in absence of any of the issues relating to the Paterson case, in part because it has no remit with regard to patient safety.

74. Finally, we would argue that despite the many advances in the understanding of patient safety risks that have occurred over the past few decades the systemic issues which we have identified in recent years are no different to those identified by the Health Committee in its 1999 report into the private hospital sector. [45]

75. We hope that the Inquiry will produce a set of recommendations which will bring about fundamental changes in both private hospital provision and its regulation which we consider are necessary to ensure patient and public confidence in private hospital care in the UK.

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