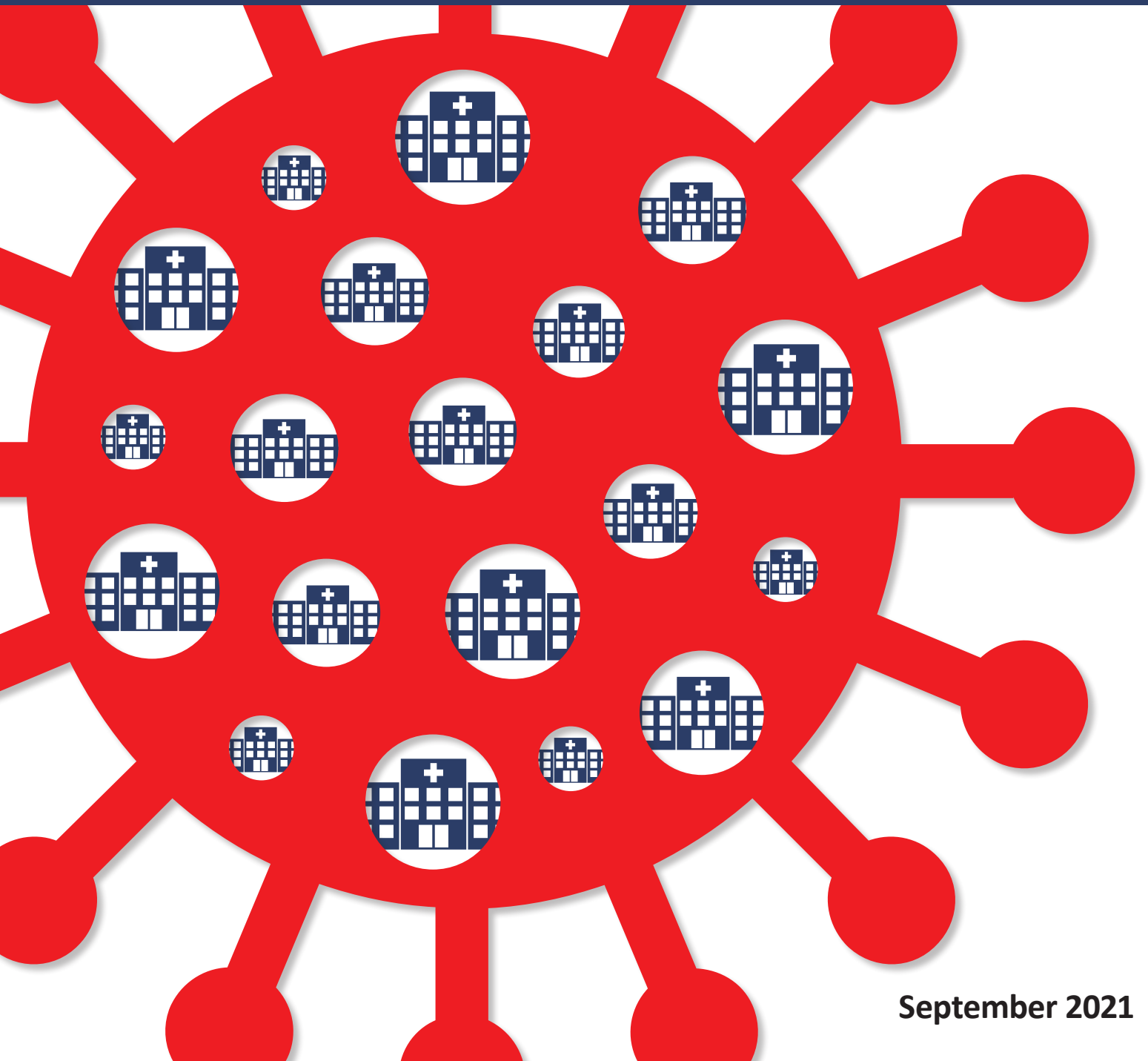


For Whose Benefit?

NHS England's contract with the private hospital sector in the first year of the pandemic



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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Executive Summary

1. This report analyses the government's use of the private hospital sector in England as a strategy for alleviating the burden on the NHS during the first year of the COVID 19 pandemic. It uses publicly available information to examine the nature of the contracts between the NHS and the private sector, the potential costs of these contracts and the extent to which NHS patients benefitted from this approach.

Background

2. Over the past two decades the NHS has used the private hospital sector to deliver mainly routine elective care, such as hip replacements and cataract operations, to a growing number of NHS patients. This work is largely carried out by NHS consultants in their non-NHS hours, as very few private hospitals employ their own surgeons or anaesthetists. Primarily for the same reason only a few private hospitals, mainly in London, have intensive care beds.
3. In March 2020 NHS England signed a contract with the private hospital sector whereby in return for the NHS covering all their operating costs the private hospital companies would make 100% of their facilities available to the NHS to help it cope with the pandemic.
4. Much of the information about this contract – the amounts paid to the private hospitals, and the amount of healthcare activity undertaken in them in return – has not been disclosed by the government or NHS England. The required financial data relating to expenditure by the NHS on private companies have not been published since March 2020. Parliamentary questions and Freedom of Information requests seeking information on the contract have also been refused, and the text of the contract has yet to be made public.
5. The findings in this report are based on the government's COVID SITREP data, NHS Digital's Hospital Episode Statistics, official statements, company accounts and informed media sources.

The contract

6. In August 2020 the contract was revised to reduce the NHS's purchase of private hospital capacity to 'no less than 75%' of their facilities. At the same time most of the private hospitals in London, where 24% of private hospital beds are located, exited the contract. In January 2021 the contract was changed again: from January to March 2021 the remaining hospitals would be paid a sum based on a guaranteed minimum number of treatments.

7. The total cost of the contract is unknown. For the first period of the contract, from March to July 2020, estimates by government ministers and unofficial inside sources range from £200m a month to more than £500m a month. Government estimates put the total cost for the period March 2020 to March 2021 at £2bn. NHS and industry sources suggest that the total figure could be more than double this.

Findings

8. Very few Covid patients were treated in private hospitals. In the 187 private hospitals for which official data are available (out of the 193 in England which have overnight beds), on 39% of the days from March 2020 to March 2021 no bed was occupied by a Covid patient, and on 20% more days, only one bed was occupied by a Covid patient. In total, the 187 private hospitals accounted for 0.08% of the national total of 3.6m Covid bed-days.
9. It was expected that the cancellation of much urgent elective care for NHS patients, due to the influx of Covid patients, would lead to an increase in NHS-funded elective care in private hospitals. Instead, the amount of NHS-funded elective care carried out in private hospitals fell by 45%, a shortfall of 291,000 procedures, compared with the twelve months before the pandemic.
10. The under-utilisation of the private hospital sector by the NHS is likely to have numerous causes, including the fact that few private hospitals have intensive care beds. As regards non-Covid patients, a key factor is likely to have been the fact that at various stages during the pandemic, NHS surgeons and anaesthetists were re-deployed to assist the wider response to COVID in NHS hospitals. Without this key staffing resource, private hospitals could not treat more NHS patients.
11. While the overall picture is one of under-utilisation of the private hospitals in the contract, the successive revisions of the contract reduced the proportion of private hospital resources available to the NHS during the second wave of the pandemic when the NHS was placed under the greatest strain. This was especially the case in London, where most of the private hospitals had exited the contract in August 2020. At times some private hospitals were treating non-urgent private patients in preference to urgent NHS patients. This led to the medical directors of several London trusts appealing to their colleagues not to do this while the pressure on the NHS continued.
12. Whereas the contract did not lead to private hospitals treating more NHS patients during the first year of the pandemic compared to the previous year, it provided them with a guaranteed income stream which enabled them to avoid the financial losses that would have been caused by the pandemic. After a brief initial ban on the treatment of any non-urgent cases, the contract allowed private hospitals to treat less urgent private patients, and also put them in a position to capitalise on the growing demand for private healthcare caused by the lengthening waiting times for NHS care.

Conclusion

13. The contract appears to have benefited the private hospital sector more than it did the NHS, although it is not possible to say this with certainty due to the lack of information available. It is therefore a matter of public importance that all the evidence relating to the strategy and implementation of the contract with the private hospital sector in 2020/2021 is made public, enabling the following questions to be answered:
 - a. Exactly how much was spent by the NHS on purchasing services from private hospitals during the first year of the pandemic, and what did the NHS receive in return?
 - b. Why were the private hospitals allowed to continue performing non-urgent elective care when the NHS was under the greatest strain, and why was the amount of purchased capacity reduced before the widely predicted second wave of the pandemic?
 - c. To what extent did the contract protect the interests of the private hospital companies rather than those of the NHS?
14. This is all the more important because under a new National Increasing Capacity Framework the NHS in England is expected to spend an estimated £2.5bn a year over four years on new contracts with private hospitals – £1bn a year more than in the years before the pandemic. To be able to assess how far purchasing more healthcare from the private sector, rather than expanding the NHS's own capacity, is a good use of public money, a full account of the 2020-21 contract is required.

Introduction

15. On the 21strd March 2020, two days before the first national lockdown was announced, NHS England (NHSE) made a contract with most of the private hospitals in the country, which gave it access to all their facilities, staff and equipment in order to deal with the COVID-19 pandemic. As summarised by the Secretary of State for Health Matt Hancock: ‘the independent sector will reallocate practically its entire national hospital capacity en bloc to the NHS.’¹
16. Significant amendments were made to the contract in August 2020 and in January 2021, and it came to an end on the 31st of March 2021. For much of this period, in return for making their resources wholly available to the NHS, the private hospitals were paid their full operating costs, minus the cost of any capacity the NHS agreed to release to them for treating private patients.
17. What the national COVID contract entailed, how it worked in practice, and what it meant for the NHS and NHS patients can only be understood in the context of the way the 193 private hospitals in England with overnight beds work, and how they related to the NHS before the pandemic.²
18. Apart from a few large private hospitals, almost all in London, the typical private hospital is very small, with between 30 and 50 beds, predominantly occupied by private patients recovering from routine elective surgery, almost all of which is performed by NHS surgeons and anaesthetists in their non-NHS hours. The hospital typically employs its own nursing staff; while routine postoperative medical care is provided by agency-supplied Resident Medical Officers (RMOs), usually with just one RMO on duty for a week at a time.³
19. By the same token, only a handful of private hospitals, most of which are in London, have Intensive Care Units (ICU). On average 7000 patients are transferred each year from private hospitals to the NHS at an estimated annual cost of £85 million.³
20. The main business of private hospitals is private patients, but since 2002 a growing share of the treatment of NHS patients for routine surgery has been outsourced to private hospitals, where these patients too are treated by NHS surgeons and anaesthetists working privately in their non-NHS hours. In July 2019, before the pandemic, an estimated 31 per cent of total private hospital revenues came from the NHS.⁴
21. In this context it is not obvious how NHSE envisaged private hospitals helping the NHS to cope with the pandemic. As the great majority of private hospitals have no ICUs, and are highly dependent on NHS consultants, they could only care for people severely ill with COVID if NHS staff were redeployed to their facilities. They may have been able to treat COVID patients who did not need intensive care, or non-COVID patients who could not be treated in NHS hospitals due to COVID-related pressures, but even in these scenarios, they would still have needed input from consultants already employed in the NHS.

22. Given the large sums of money involved, and the potential long-running consequences for patients and the NHS, this report seeks to answer the following questions:
- What was the structure and mechanism of the contract?
 - What benefits did the NHS receive from the contract?
 - What was the cost to the NHS?
 - What benefits did the private hospital companies receive from the contract?
 - What accounts for the under-utilisation of the private hospitals under the contract?
23. We have tried to answer these questions as best as we can. But it is important to highlight that the government has failed to publish the contract documents, key datasets are missing or incomplete, and parliamentary questions and freedom of information requests about the contract have not been responded to. This makes a full evaluation of the contract difficult, and also raises significant issues of transparency and accountability.

What was the structure and mechanism of the contract?

24. The first indication of the national contract between the private hospital companies comes in the form of an agreement between NHS England and the Independent Healthcare Provider Network (IHPN), the organisation which represents the interests of the UK's private hospital sector, and its participating members.⁵ Dated the 12th March, this agreement sets out the key terms prior to the deal being formally signed.⁶ The deal was to include 'Provision of full hospital capacity and services including acute bed capacity, facilities, diagnostics, staffing, management and full organisation capability' with 'full cost of provision to be funded centrally by NHS England and NHS Improvement', and would supersede all existing contracts between the NHS and these companies.
25. The national contract was announced just a week later on the 21st March, although it was not formally signed until the 15th May.⁷ A letter from NHSE's Director of Operations and Delivery, Neil Permain, outlining the deal to local NHS leaders, explained that it would 'secure all available inpatient capacity and resource' – an additional 8,000 beds, 680 operating theatres, 10,000 nurses and over 700 doctors.^{8, i} He went on to say that the private hospitals were expected to deliver five main services:
- a. Inpatient respiratory care for COVID patients
 - b. Urgent NHS elective care to ease COVID pressures in NHS hospitals
 - c. Diagnostic capacity
 - d. Inpatient non-elective care to free up capacity in NHS hospitals
 - e. Making clinical and support staff available for redeployment.
26. The additional capacity was intended help achieve the government's 'flattening the curve' strategy, providing a buffer in case of emergencies and allowing NHS healthcare disrupted by the pandemic to carry on in the private hospitals.
27. Twenty-six private hospital companies, all IHPN members, would become parties to the contract. They included large chains such as Spire, Circle Health and HCA, some single hospital providers such as the New Victoria Hospital or medical insurer BUPA's Cromwell Hospital, and smaller providers such as Transform or Kinvara Private Hospital, both of which had previously focused only on cosmetic surgery.ⁱⁱ

i Given that private hospitals do not generally employ their own consultants, we have to assume that most of these 700 doctors are Resident Medical Officers.

ii One company states in their accounts that by virtue of being an IHPN member, they were 'automatically included in the Heads of Terms' (the initial agreement between the IHPN and NHSE dated the 12th March). This raises the question whether, because this contract was negotiated primarily by the IHPN on behalf of its members, the government were presented with the choice between accepting all the private hospital companies, no matter their size or specialisation, or being able to access none.

28. Providers would be paid for 100% of their capacity, rather than a set amount of activity, and payments would be made ‘on an at cost basis’. This meant that the 26 companies would not charge a profit margin, but that government would pay the operating costs of running their hospitals including the costs of staffing, consumables and administration. However, sources describing the detail of the deal differ on whether other costs such as rent, interest payments on corporate debt, executive pay and dividends were included.ⁱⁱⁱ We have not found any indication that performance targets, or penalties for non-performance were included in the contract.
29. However, while the NHS had the potential to access to 100% of private hospital capacity, the private hospitals were allowed and expected to use any unused spare capacity for treating private patients.⁹ This private work would generate a profit for the providers, and a rebate system would save the corresponding part of the cost for the government. Without publication of the contracts we cannot know the precise mechanism of the rebate system, but we understand that the operating costs of the resources used for private activity would be deducted from the final bill to the government.
30. In order to administer this complex system of accounting for the operating costs of the private hospitals, and the cost-rebate system for private work, the private hospitals would be subject to open-book accounting, and the government signed an £11m contract with KPMG to audit and reconcile the payments.¹⁰ David Hare, the chief executive of the IHPN, told the *Health Service Journal* that ‘all providers had agreed to a fully transparent approach’.¹¹
31. When the contract was signed, it was stipulated that all private providers would be barred from providing non-urgent elective care, for both NHS and private patients, in order to prioritise the most pressing healthcare needs. This rule only lasted a month until the 15th May when ‘de-escalation clauses’ were triggered and providers were again free to perform non-urgent elective care.¹²
32. Companies were also given the option to refuse certain patients whom they felt unable to treat. Given the private hospitals, dependence on NHS consultants and ICUs highlighted above, this constrained the number of patients the NHS could send to be treated there. Furthermore, according to one private hospital company’s annual accounts, the capacity purchased by the NHS was limited to ‘core working hours’.¹³ However, we do not know if such an arrangement existed for any other private hospitals in the contract.

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iii Payment of interest on corporate debt and dividends was question 65 in the Public Accounts Committee’s witness evidence for its report ‘Readying the NHS and social care for the COVID-19 peak’. Simon Stevens, former NHS England Chief Executive, assured the committee that the payments would be ‘totally transparent’ and the contract has caps on bonuses, executive pay and dividends, whereas interest on debt is not discussed. The accounts and annual reports of the 26 companies which have been published to date contain several subtly different interpretations of what costs are included within the terms of the contract, and then there is the problem of accounting for a private patient rebate. Payments under the contract were made weekly in advance, and disputes over reconciliation are ongoing after 18 months.

33. There are conflicting reports about how long the initial phase of the contract was to run for, but the contract underwent significant revisions in August 2020.^{iv} The main change was that rather than purchasing 100% of available capacity, NHSE would henceforward purchase ‘no less than 75%’ of the capacity of the contracted private hospitals. The government would still pay ‘at cost’ for this capacity, but they would only be liable to pay for 75% of total capacity, although in the event of extreme pressure, the government could request a return to purchasing 100% of capacity by triggering surge clauses.¹⁴
34. The other major change in the second phase of the contract was that a number of private hospitals exited the contract. Some reports suggest that the reason for this was that the government would not meet the price being asked, while others report that the companies were removed because their hospitals were underutilised.^{15, 16} A list of which private hospitals left the contract at this stage has not been disclosed, but they have been described as being ‘mostly London-based’ and included one of the largest national providers, HCA. Several of these companies, however, went on to secure separate individual contracts with NHS Trusts at a local level.
35. The government had originally planned to move away from the national Covid contract and onto a long-term contracting framework run at the local level by 1st January 2021. However, this ‘National Increasing Capacity Framework’ was not ready in time, and a three month ‘stop-gap’ contract was therefore agreed to run from January to March 2021 while the long-term framework was being finalised.^{17, 18}
36. Under this final iteration of the national contract with private hospitals, companies would no-longer be paid ‘at cost’, and instead would be paid a fixed sum for a set amount of activity equivalent to what had been carried out in October/November 2020. Leaks to the *Health Service Journal* suggest that between June and September 2020 only around a third of day case, outpatient and diagnostic capacity was being used, rising slightly month on month.¹⁹ In-patient capacity and occupancy data for this period have not been released for the private hospitals under the contract so we can’t say how much of their total capacity the final iteration of the contract gave the NHS access to, but it seems likely that the activity levels in October/November 2020 accounted for less than 75% of private hospital capacity.

iv The Contract Award Notices list end dates specific to each provider, between the 15th May and 6th June. Several letters from NHSE state the end-date was the 31st June. And in a confusing account Minister for Health Edward Argar told the House of Commons ‘no contracts have been extended’ and the contract ends on the 31st December. There is further confusion about the dates of renegotiation, with NHSE telling the Public Accounts Committee that changes were ‘operationalised’ on the 12th August. However, one provider notes in their accounts that this revision was only agreed in principle in August, not formally signed until October and the terms were back-dated to the 1st July.¹⁷

37. In sum, the key feature of the national contract is that up to January 2021, the NHS purchased hospital *capacity* rather than healthcare *activity*. Capacity was purchased ‘at cost’. There were successive protracted renegotiations of the terms, each one reducing the cost to government but decreasing the capacity available to the NHS, in favour of delivering private healthcare.

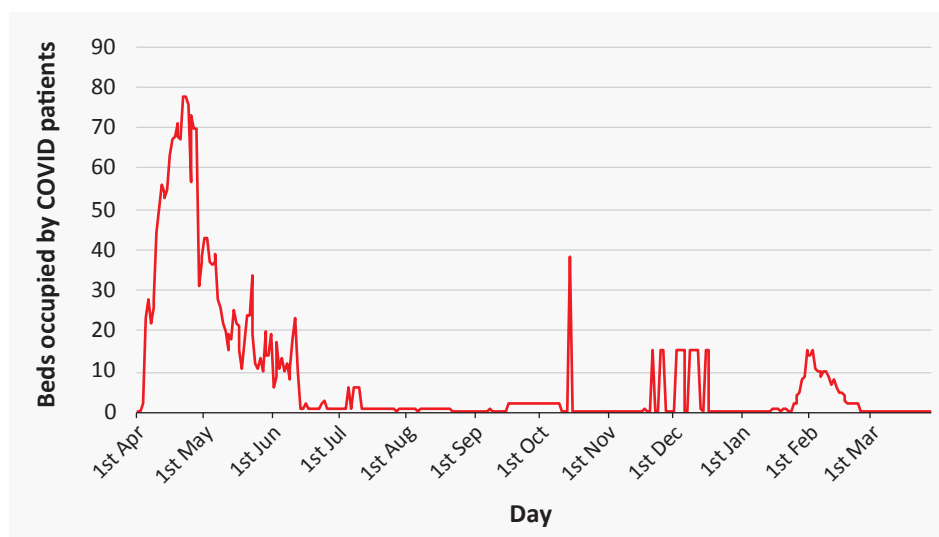
Phase 1: Escalation	Phase Two: De-escalation	Phase Three: Stop-gap	Current and future
March to July 2020	August to December 2020	January to March 2021	April 2021 to 2025
The contract makes 100% of the contracted private hospitals capacity available to the NHS	Purchased capacity is reduced from 100% to ‘no less than 75%’	The contract switches from making a defined proportion of private hospital capacity available, to a set amount of healthcare activity.	The national contract with private hospitals ends, and CCGs and Trusts outsource healthcare through the National Increasing Capacity Framework
Payments are made ‘at cost’ to 26 companies. Private activity is allowed to continue. A ban on non-urgent care from April to May.	One of the largest national providers and several London based hospitals exit the contract. No restrictions on performing non-urgent private healthcare.	Payment to the 14 remaining companies is no longer ‘at cost’, but a fixed sum based on a guaranteed minimum level of activity.	Payments are based on national tariffs, with prices and contract terms set at a local level.

What benefits did the NHS receive from the contract?

How many COVID patients were treated in private hospitals under the contract?

38. Treating patients with COVID was listed as the first goal of the national contract with the private hospitals. During the pandemic both the NHS and private hospitals were required to report the numbers of beds occupied by COVID patients each morning in the COVID Situation Report (SITREP) dataset, which covers the period 20th March 2020 to the 26th March 2021. We identified 187 private hospitals belonging to the 26 providers which were signed onto the national contract.
39. Including all these hospitals, on 142 of the 362 days in the dataset (39%), no bed was occupied by a COVID patient, and on 71 of the 362 days (20%), only one bed was occupied by a Covid patient. The largest number of the 8,000 private hospital beds occupied by COVID patients on any one day was 78, on April 21st and 22nd.

Figure 1: Total COVID Occupied Beds across the 26 contracted private hospital companies



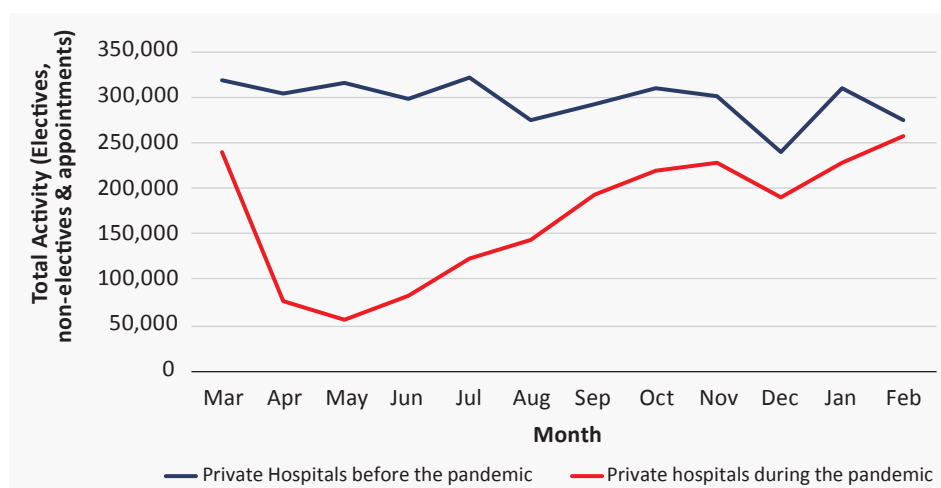
(Source: CHPI analysis of COVID SITREP data, daily sum of COVID occupied beds in the contracted private hospitals)

40. On average, there were 8.1 COVID patients in private hospitals on any given day across the entire period. In contrast, the NHS cared for a daily average of 9,977 COVID patients between March 2020 and March 2021. In total, the 187 private hospitals accounted for 2,937 or 0.08% of the total 3.6m COVID bed-days. A 'COVID bed-day' means a bed occupied by a COVID patient for one day.

How many non-COVID NHS patients were treated in private hospitals under the contract?

- 41. During the first wave of the pandemic, around 20% of all NHS hospital beds were occupied by COVID patients. During the second wave, the impact was even greater: in all regions at least 30% of beds were occupied by COVID patients, while in London and the South East the figure was over 50%.²⁰
- 42. As a result of the increased number of acutely ill patients, the treatment of many other conditions had to be put off. During the pandemic there were 2.9 million (34%) fewer elective inpatient admissions, 1.2m (21%) fewer non-COVID emergency inpatient admissions, and 17.1m (22%) fewer outpatient appointments in the NHS than in the year before the pandemic.²¹
- 43. The contract with private hospitals was expected to have helped reduce the scale of growing unmet need by scaling up the number of NHS patients treated in the private sector. In fact, far fewer NHS patients were treated in the private sector than in prior years.
- 44. The Hospital Episode Statistics (HES) show that in the year prior to the pandemic, between March 2019 and February 2020, the private hospitals under the national contract recorded a total of 3.5m NHS-funded electives, non-electives and hospital attendances, compared to just 2m during the same period during the pandemic – a 42.8% decrease in total activity.^v

Figure 2: Total NHS-funded activity of the 26 contracted private hospital companies before and during the pandemic



(Source: CHPI analysis of the Hospital Episode Statistics, the monthly sum of elective, non-elective, 1st appointments and subsequent appointments in the contracted private hospitals, for one year before and during the pandemic)

^v The Hospital Episode Statistics (HES) is the only publicly available dataset recording healthcare activity in both NHS and private hospitals on a monthly basis, and records four main types of activity: Electives (broken down into ordinary and day-case), non-elective, first attendances and subsequent attendances. Throughout this report we have referred to the sum of all these categories as ‘Total Activity’, and use ‘outpatient appointment’ rather than ‘attendance’.

45. Focusing on the short period between April and July 2020, before the contract was renegotiated and when all the private hospitals' resources were available to the NHS, we see a 73% reduction in total NHS-funded healthcare activity, from 1.2m electives, non-electives and outpatient appointments in the same period before the pandemic, to 336,000 during the pandemic.
46. While some of the reduction in private hospital activity can be explained by service disruption caused by the pandemic itself as well as NHSE's prohibition of non-urgent care between April and May, one might have expected to see an increase in NHS-funded activity overall given the aim of the contract and the fact that the NHS was paying for a large proportions of the costs pf the hospital in the contract. Instead, during the first year of the pandemic, March 2020 to February 2021, private hospitals delivered 2.39% of total NHS-funded activity, compared to 3.28% in the same period the year before.
47. Furthermore, considering that, unlike the NHS, private hospitals were not treating significant numbers of COVID patients, we would expect their normal service provision to have been less impacted by the pandemic. However, the NHS appears to have coped far better, with total activity in NHS hospitals falling by 21.5% compared to the year before the pandemic, while the equivalent NHS-funded activity in the contracted hospitals fell by 42.8%.

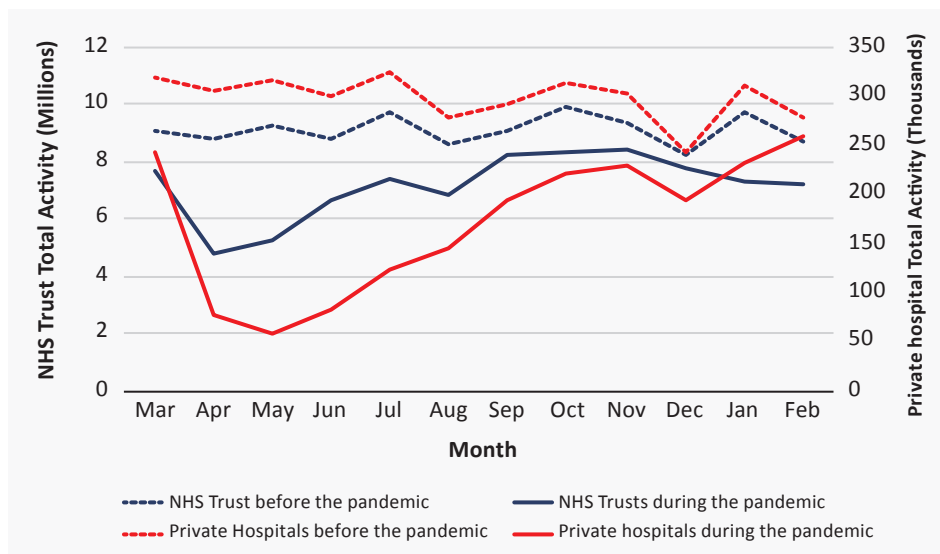
Table 1: Total NHS-funded activity in NHS hospitals compared to private hospitals

	Before pandemic (March 2019– Feb 2020)	During pandemic (March 2020– Feb 2021)	Percentage Change
Total activity in NHS Trusts	108,596,190	85,251,350	-21.5%
Total NHS-funded activity in contracted private hospitals	3,564,735	2,039,855	-42.8%

(Source: CHPI analysis of the Hospital Episode Statistics, sum of elective, non-elective, 1st appointments and subsequent appointments in the contracted private hospitals and in NHS Trusts, for one year before and during the pandemic)

48. NHS-funded activity in both the NHS and the contracted private hospitals are compared in Figure 4 below, showing that although both sectors suffered a reduction in activity, especially at the outset of the pandemic, the NHS was less severely impacted in the initial shock, quicker to recover, and saw less of an overall reduction in activity. Note that the graph uses two vertical scales, with NHS activity on the left and the contracted providers on the right.

Figure 3: Healthcare activity in the NHS and NHS-funded activity in private hospitals, before and during the pandemic



(Source: CHPI analysis of the Hospital Episode Statistics, the monthly sum of elective, non-elective, 1st appointments and subsequent appointments in the contracted private hospitals and in NHS Trusts, for one year before and during the pandemic)

- 49. While there was a significant reduction in total activity, one might also have expected to see some change in the type of activity carried out. For instance, the private hospitals could have shifted their focus away from consultations towards delivering elective procedures that the NHS was too stretched to deliver. However, this is not what happened: there was a reduction in activity almost across the board. The provision of NHS-funded elective care in private hospitals, the secondary objective of the contract, fell by 44.7%, from 526,000 between March 2019 and February 2020, to 291,000 between March 2020 and February 2021.

Table 2: Comparison of different types of NHS-funded healthcare activity in the contracted hospitals before and during the pandemic

	Before Pandemic March-February 2019/20	During Pandemic March-February 2020/21	Difference in Activity	Percentage Change
Elective total	526,330	291,000	-235,330	-44.7%
Ordinary elective	91,010	61,355	-29,655	-32.6%
Day case elective	434,520	228,435	-206,085	-47.4%
Non-elective	90	340	250	277%
First outpatient appointments	809,515	410,875	-398,640	-49.2%
Follow-up outpatient appointments	2,228,800	1,337,640	-891,160	-40.0%

(Source: CHPI analysis of the Hospital Episode Statistics, elective, non-elective, 1st appointments and subsequent appointments in the contracted private hospitals and in NHS Trusts, for one year before and during the pandemic)

50. The only type of healthcare activity which saw an increase was non-elective care, the fourth stated objective of the contract. Although 250 extra non-elective cases was nearly triple the amount of such activity out carried before the pandemic, in the context of the 5.2m such procedures carried out in the NHS over the same period, it was hardly significant. Diagnostic capacity was another service listed under the contract, and while these procedures are not distinguished from general ‘attendances’ in the HES data, reporting by the HSI indicated that between June and September 2020, only between 13% and 41% of diagnostic capacity in the private hospitals was being utilised.
51. If the private sector had been treating NHS patients at the same rate as in previous years, 526,000 elective procedures would have been carried out between March 2020 and February 2021, whereas the actual figure was 291,000, a shortfall of 235,000 procedures. Overall, despite ‘full organisational capability’ having been purchased from the private hospitals for the benefit of NHS patients, less of that capability was used for NHS patients during the first year of the pandemic than in the year before it.^{vi}

Did the capacity purchased under the contract match the pressures caused by the pandemic?

52. While we have looked at the amount of healthcare delivered by the private hospitals overall, we should ask to what extent the contract was able to address a fundamental risk of the pandemic, i.e. that spikes in COVID admissions would overwhelm the NHS completely. Was the contract suitable to address the often localised pressures of the pandemic? And how well did the contract prepare for the second wave?
53. The first issue to note is that private hospital beds are highly concentrated in London, the East and the South East, with 54% of all private sector beds, with some regions which experienced very high levels of infection, such as the North East, having just 1.6% of all private hospital beds.²²
54. Secondly, while the government initially purchased 100% of capacity from the private sector this was successively reduced, with the result that during the worst of the second wave of the pandemic, from October 2020 to March 2021, the NHS had access to the least amount of private hospital capacity.

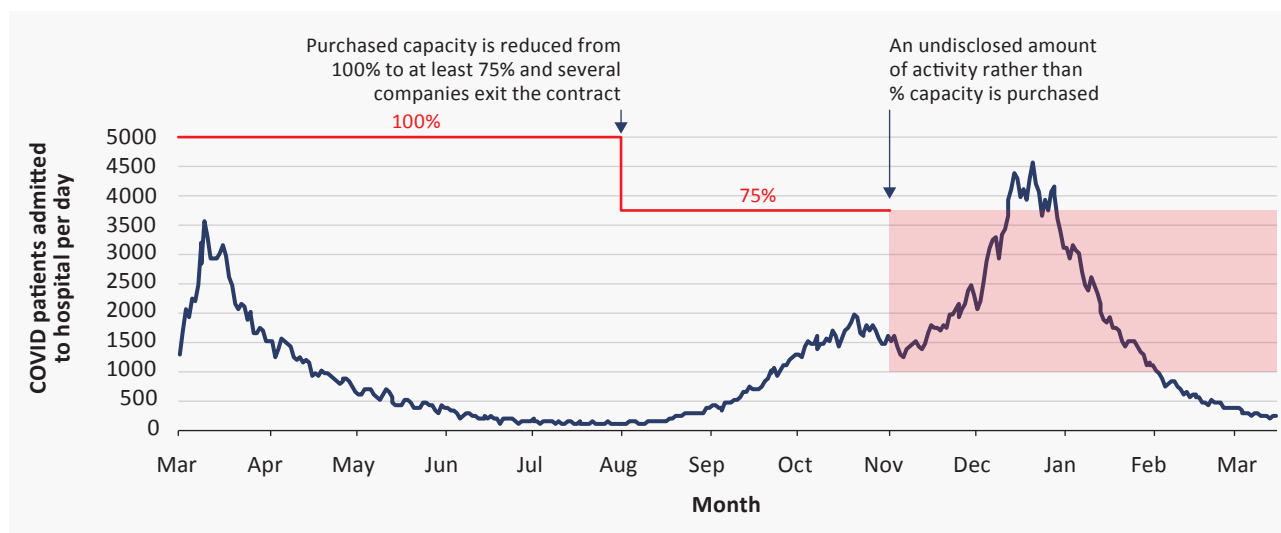
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vi The figures we have produced from the official datasets do not always accord with those published elsewhere, including the IHPN’s March 2021 report ‘Working Together during COVID-19’. Their headline figure of three million ‘operations, consultations, scans and tests and chemotherapy sessions’ is significantly higher than our analysis which shows 2m ‘electives, non-electives and attendances’. We believe this is due to a difference in definitions of activity, whereby one ‘attendance’ in the HES data is broken up into several components by IHPN.

Furthermore 12 of the 26 hospital companies show some gaps in monthly reporting of NHS activity, or report healthcare activity that doesn’t appear through our analysis, or their hospitals do not appear to be within the HES database. When the CHPI contacted each of these companies, two responded to say all necessary data had been submitted correctly and did not highlight any errors in our analysis. In any event, data issues tended to affect smaller companies, and the dataset is dominated by six hospital chains rather than single hospitals, so we would expect any missing data to represent only a few percent of total activity.

- 55. Figure 6 maps a rough estimate of the amount of capacity purchased by the NHS from private hospitals during the pandemic against the number of COVID hospital admissions. During the first wave of the pandemic, when a maximum of 18,600 beds were occupied by COVID patients, the NHS had access to 100% of the private hospitals' capacity. In August 2020, when Covid infections were at their lowest, the amount of purchased capacity was reduced to 'no less than 75%'.

Figure 4: Amount of private hospital capacity purchased against COVID admissions



(Sources: Gov.uk COVID admissions data, overlaid with percentage capacity purchased from private hospitals)

- 56. The final phase of the contract, running from January to March 2021, reduced the access to private hospitals even further. The new contract would no longer give the NHS access to a fixed percentage of total private hospital capacity, but to amounts of activity equivalent to what each Trust had actually used in October and November 2020. The new deal was negotiated and finalised in the final weeks of December,²³ when 15,000 NHS beds were occupied by COVID patients and numbers were rising, but it only guaranteed NHS Trusts access to what they had used in a relative quiet period of the pandemic.
- 57. As a result of this reduction in purchased capacity, and the exit of many London-based providers from the contract, the NHS had less access to the back-up capacity during the second wave of the pandemic than had been available earlier in the year. The *Health Service Journal* ran a number of articles in over the winter of 2020/21 outlining the pressure on the NHS, and how badly NHS Trusts needed extra capacity to provide urgent elective care such as cancer treatments.
- 58. On the 13th January Manchester University Foundation Trust reported to their board that their local private hospitals were 'pushing back' against requests for them to take more NHS patients, with the Hsj additionally reporting that there was a lack of clarity over how much private sector capacity could be accessed under the new deal.²⁴

59. When the number of patients in hospital with COVID rose 39% in a week just before Christmas, London NHS hospital trusts reported that if theatre space set aside for cancer operations were to be commandeered for ventilated Covid patients, surgical procedures for non-Covid patients, including urgent cancer operations, would have to be halted. In theory, some of these urgent non-Covid operations could have been conducted in private hospitals by NHS consultants. But an NHS London source told the *Health Service Journal*: “This is a real and imminent threat to London’s ability to perform cancer surgery. The reality was that NHSE offered something and these private companies simply did not respond, as they had better income streams”.²⁵
60. On the 4th January, NHS England’s regional medical director, together with five NHS Trust medical directors and the chairs of five CCGs, sent a letter to all acute Trust medical directors. They said they felt ‘profoundly uncomfortable’ about the scale of private non-urgent elective work being carried out, and were ‘asking colleagues to think very carefully about the appropriateness of this, and would like colleagues not to support the delivery of such work’ until pressure on the NHS had eased.²⁶
61. Another way in which the private hospitals were expected to respond to the pressures of the pandemic was by redeploying staff to the NHS. Data are lacking on to what extent the 10,000 nurses and 700 doctors available in private hospitals were similarly redeployed, but the available evidence suggests that it was on a small scale.^{vii} In the first and second waves of the pandemic both junior NHS hospital doctors and medical students supported overstretched nurses on Covid wards.
62. Thus, on the one hand the contract involved purchasing large amounts of capacity that was never used, while on the other private sector resources were not available when most needed. As NHS hospitals became overwhelmed with COVID patients, especially during the winter of 2020/21, urgent elective care had to be cancelled and could not be diverted to the private sector thus contributing to the NHS elective waiting lists which sits at 5.3m as of August 2021.

vii The IHPN’s March 2021 report ‘Working Together During COVID-19’ features case-studies from eighteen of the private hospital companies signed onto the national contract, but only four mention any redeployment of staff and some companies make reference to staff redeployments in their annual accounts. Ramsay, a chain with 33 hospitals, reported in its annual accounts that 200 staff had worked in NHS ICUs and Nightingale Hospitals. Nuffield said in the IHPN report that 60 employees were seconded to the NHS.

What was the cost of the contract to the NHS?

63. The total amount paid under the contract has not been disclosed. Numerous questions from MPs and journalists have not been answered, the CHPI's FOI requests for contracts and invoices have not been answered,^{viii} and normal financial transparency procedures have been suspended.^{ix} Estimates of the cost range between £168m and £543m per month over the one-year period between March 2020 and March 2021.
64. The only official documents describing the cost of the contract are the Contract Award Notices. The first notice appears to cover the period from 23rd March to 31st December 2020, and was published in October 2020.^x The second notice covers the period 1st January to 31st March 2021. Combined, the figures in these notices total £2bn, implying an average monthly cost of £168m. However, the listed 'contract values' were only estimates, and are unlikely to account for the renegotiation mid-way through the period of the initial contract, or the complex rebate system.
65. Thirty-one MPs have asked questions about these contracts in the House of Commons, many asking specifically for the cost of the contracts.²⁷ The questions have not elicited the information sought but two official statements do refer to the cost. On the 27th October 2020 Mr Edward Argar, Minister of State for Health, said that an estimated £1bn had been paid between the 30th March and 30th August 2020,²⁸ and on the 2nd December he said that £1.4bn had been paid from August until the 23rd November.²⁹ This implies average monthly costs of £200m and £175m per month, respectively.
66. However, senior NHS sources speaking to journalists have put the cost at double or even triple these figures. Both the Guardian and Health Service Journal's NHS sources put the cost of the deal at £400m per month.³⁰ Meanwhile, industry sources speaking to the Financial Times put the costs

viii When the contract ended on the 31st March the CHPI submitted FOI requests to NHS England for the contracts, invoices and reconciliation reports. The requests were refused after long, unexplained delays. Both refusals cited the commercial sensitivity of contracts and invoices as a reason for withholding them, in light of the ongoing reconciliation and settlement of payments under these contracts, and that most of the private hospital companies will be currently engaged in some degree commercial negotiations with local CCGs and NHS Trusts. The reconciled expenditure under these contracts was withheld under FOI because NHS England intended to release it 'soon'.

ix Almost all government bodies are required to publish monthly records of expenditure over £25k. This dataset would have shown the payments being made to each of the 26 private hospital companies on a monthly basis, however NHSE has failed to publish to this dataset in 18 months. Publication of this dataset would have made FOI requests unnecessary. NHS Trusts, although often a few months delayed, have continued to publish the same datasets on a regular basis, and have been helpful in their FOI responses.

x A judicial review found the Department of Health to have broken the law in relation to late publication of Contract Award Notices for PPE, which are supposed to be publicly available one month after signing the contract. NHSE published the initial Contract Award Notice after five months, but as a statutory body rather than government department it is not subject to the same time-limits.

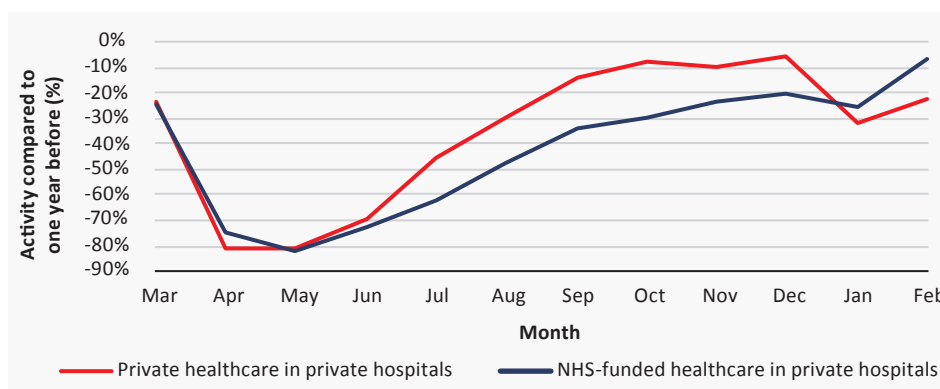
at between £430-540m per month.³¹ When contacted, the journalists reporting these stories have all stood by the figures their sources supplied.

67. While payments under the contract were made in advance, the government expected to recover some of that expense through reviewing the operating costs the companies charged and through the private patient rebate. This means the true cost of the contract is still in dispute, with one provider noting in its accounts that payments from NHS England are subject to arbitration,³² and ongoing settlement and reconciliation cited as a reason for refusing disclosure of financial records under FOI.
68. What is certain is that the Treasury was concerned about the cost of the contract. The *Guardian* reported in June 2020 that the Treasury had initially blocked the extension of the initial contract. An NHS source aware of the plan stated: 'They weren't going to cover that £400m a month based on evidence they thought was flimsy and a bit scant. The DHSC submitted only a short piece of paper and didn't put any detailed analysis into it. It didn't outline how many operations the taxpayer would get in return for the money.'³³

What benefits did the private hospital companies receive from the contract?

- 69. The government’s contract with the private hospitals, guaranteeing their operating costs for the first few months of the pandemic, and no less than 75% in the second phase, was a significant benefit to a sector that was financially vulnerable to the effects of the pandemic, including restrictions on international travel which cut the demand for private healthcare from foreign patients.
- 70. Many private hospital companies operate highly leveraged business models, requiring consistent income in order to repay debt obligations. Previous analysis by the CHPI showed that in 2017/18, the four largest private hospital companies had an average debt to equity ratio of over 300%.³⁴ At the outset of the pandemic Spire Healthcare risked breaching banking covenants on a £425m debt facility, but the contract with the NHS ‘removed the near-term risk of financial viability’ and a waiver was agreed with their bank.³⁵
- 71. In addition to receiving secure income, paid weekly in advance³⁶ under the contract, the private hospitals were allowed, except in April/May 2020, to continue delivering private healthcare in whatever portion of their capacity was in excess of the NHS’s needs. Data on private healthcare episodes shows that although the private hospitals’ treatment of private patients dropped steeply at the outset of the pandemic, it recovered faster than NHS-funded work in the private sector.
- 72. This is shown in Figure 5 below, plotting the percentage change in activity during the pandemic compared to the year before, for both private healthcare episodes as reported by PHIN,³⁷ and NHS-funded healthcare in the private hospitals, based on HES data.

Figure 5: NHS Funded and private healthcare activity in private hospitals as a percentage of activity prior to the pandemic



(Sources: The red line refers to PHIN’s estimated count of private healthcare episodes, and the blue line represents Total NHS-funded Activity in the contracted hospitals. Both are expressed as a percentage of activity compared to the same month one year before the pandemic, with 0% representing the provider delivering the same amount of healthcare as the previous year.)

73. Contract modifications in August 2020 led to most of the small private hospitals in London and the large national hospital company HCA Healthcare, exiting the contract, further enabling the private hospital sector to cater to the pent-up demand for elective care caused by the NHS's inability to provide elective care to large numbers of patients during the pandemic.
74. The *Financial Times* reported in January 2021 that HCA was performing twice as many self-pay hip surgeries, cataracts and abdominal operations as it had carried out in the previous year.³⁸ Spire Healthcare, one of the largest private hospital chains in the country also reported higher private activity, with inpatient and day-case admissions for self-pay patients were higher than in the previous year by January 2021.³⁹
75. Moreover, the Covid contract gave the private hospital companies what appears to be a more comprehensive form of support through the pandemic than was made available to private companies in other sectors of the economy.
76. That 'no profit will be made' by private hospitals on the contract was a point often emphasised by ministers, NHSE and the IHPN. Whether this proved to be the case cannot be verified at present, but it should be noted that the costs of staff provided by recruitment agencies, interest on debt, and rent paid to healthcare property management companies all include a profit margin.
77. The private hospital companies appear to have come out of the first year of the pandemic in a strong position. A September 2020 survey by IHPN reported that private hospital companies felt 'reasonably bullish' about the state of the market, with companies expecting to capitalise on the unprecedented backlog of healthcare, both by treating private patients seeking to avoid waiting for NHS-funded care, and by contracting with directly with NHS Trusts to treat their backlog of NHS patients.⁴⁰ xi

xi Several of the companies released from the national contract in August later made contracts with NHS Trusts at a local level. Monthly financial records show Barts Health NHS Trust making payments of £1.5m in February 2020 to three private hospital companies which left the national contract in August. These separate contracts began in between October 2020 and January 2021 and are set to be extended to September 2022. These contracts form part of an £80m 'Interim London Clinical Services Agreement', a joint venture between several NHS Trusts and private hospitals which was put to tender the day after the August renegotiation was concluded.

Why were the private hospital facilities so under-used by the NHS?

78. Several of the more obvious reasons why the private hospitals included in the contract were under-used, and in some respects not used at all, have already been alluded to. Social and physical distancing measures required to reduce the risk of Covid transmission may also have been a factor. But one of the key reasons is likely to have been the fact that the senior NHS doctors, surgeons and anaesthetists on whom private hospitals rely were already under acute pressure in NHS hospitals.
79. Another reason for the under-utilisation was the tension in the contract, between the permission to treat private patients from which the private hospitals made a profit, and the provision of care for NHS patients which would only cover their costs. In the first phase of the contract, even when the NHS was paying for the 'full capability' of these companies, private healthcare was not prohibited so long as a cost rebate was paid to the NHS.
80. Announcing the renegotiated contract in August 2020, NHS England's Director of Operations and Delivery said the reduction in the amount of capacity the NHS purchased would 'release a defined amount of capacity for private patient activity and enable private patients who have been waiting to receive care.' Spire Healthcare's annual report commented that the revised contract with the NHS meant that the private hospital sector was given an 'incentive for delivery of private work'.

Conclusion

81. None of the five services under the contract appear to have delivered the major boost to the NHS as intended:
 - a. **Intensive care for COVID patients** – For most days of the year, private hospitals cared for one or no COVID patients.
 - b. **Urgent elective care** – NHS funded elective care in the private hospitals fell by 44.7% compared to the previous year.
 - c. **Diagnostic capacity** – While data on diagnostic services have not been disclosed, it has been reported that between June and September 2020 only a third of diagnostic capacity was used.
 - d. **Non-elective care** – This activity increased during the period of the contract, but only amounted to an additional 250 procedures.
 - e. **Redeployment of staff** – Reported instances of private hospital staff being redeployed to support staff in NHS hospitals are few.
82. The under-utilisation of purchased capacity is likely to have been due to a mixture of reasons, one being that most private hospitals have no doctors other than their agency-supplied RMOs, while many of the NHS consultants who work in private hospitals in non-NHS hours were putting in extra hours in their NHS hospitals, and may also have been reluctant to provide non-urgent care in private hospitals while their NHS colleagues were being overwhelmed by the influx of Covid patients.
83. It is not clear why in August 2020 some private hospitals (mostly in London) were allowed to leave the contract, and why the capacity available to the NHS was reduced in those which remained. In both cases this enabled private hospitals to increase their private patient work. During the peak of COVID hospitalisations in 2021 the medical directors of NHS Trusts in London felt compelled to plead with their own consultants to stop doing non-urgent private work. The exit of some private hospitals from the contract appears to have come as a shock to NHS Trusts in London, which then had to negotiate their own deals.
84. Overall, the contract appears to have been more beneficial to the private hospitals than to the NHS, which raises questions about the government's approach. Seemingly large – but as yet undisclosed - sums of public funds were used to buy additional healthcare capacity at a time when the NHS was being overwhelmed and when NHS waiting times were rising. But much of this purchased capacity appears to have been under used.
85. From the private hospital sector's perspective, the national contract provided them with a guaranteed income stream which enabled them to avoid potential losses caused by the pandemic. It also allowed them to continue to treat less urgent, but profitable fee-paying patients even when the NHS was under great strain. The financial support from government has

also put the industry in a position where it can capitalise on the growing demand for healthcare caused by the pandemic. This includes winning new NHS work and marketing their services to the growing numbers of patients in need of urgent care who are willing to pay privately.

86. Despite the problems highlighted in this report the government seems set on relying even more on the private sector in the future through the a new 'National Increasing Capacity Framework', which came into force in April 2021, with an estimated cost of £2.5bn a year over four years. This represents a significant increase on the £1.5bn NHS Trusts spent on purchases from the private sector in previous years.⁴¹
87. Moreover, although NHS Trusts are under increasing pressure to drive down waiting lists, the government is scaling back the hospital building programme,⁴² indicating that the long-term squeeze on capital expenditure in the NHS will continue.⁴³ This suggests that the NHS will not get the additional facilities it needed before the pandemic, let alone the additional capacity required to address the healthcare backlog produced by the pandemic.
88. The most obvious requirement arising from the findings of this report is for the government to make public all evidence relating to the strategy and implementation of the contract, and provide the data required to allow independent scrutiny and answer the following questions:
 - a. Exactly how much was spent by the NHS purchasing services from private hospitals during the first year of the pandemic, and what did the NHS receive in return?
 - b. Why were the private hospitals allowed to continue performing non-urgent elective care when the NHS was under the greatest strain, and why was the amount of purchased capacity reduced before the widely predicted second wave of the pandemic?
 - c. To what extent did the contract protect the interests of the private hospital companies rather than those of the NHS?

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