Centre for Health and the Public Interest (CHPI) evidence to Module 3 of the COVID 19 Public Inquiry relating to the use of the private hospital sector to support the pandemic response.

CHPI | Centre for Health and the Public Interest

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CHPI evidence to Module 3 of the COVID 19 Public Inquiry

Contents

Introduction.

1. This note sets out the Centre for Health and the Public Interest's (CHPI) evidence to the COVID 19 Public Inquiry concerning the use of the private hospital sector to support the government's response to the pandemic during the first year of the pandemic.

2. It is based mainly on research carried out by the Centre between 2020 and 2023 which was funded by the Joseph Rowntree Charitable Trust. The research was published by the Centre and cited in a number of major publications including The Guardian, the British Medical Journal, and The Independent, and has been commented on supportively by senior Members of Parliament.

3. The research was carried out with the aim of understanding the nature of the contractual relationship between the NHS and the private hospital sector during the first year of the pandemic, including the amount of public money spent on the contract. We also sought to assess the role played by the private hospital sector in treating NHS patients at a time when many NHS hospitals were overwhelmed.

4. Despite assertions by government ministers and senior NHS leaders that the role of the private sector in supporting the pandemic response would be completely transparent we have faced significant difficulties in accessing the data and information needed to allow us to perform a detailed analysis of this subject.

5. As far as we are aware our research is the only attempt to examine this subject in depth and none of the parliamentary committees nor the National Audit Office have to date carried out an audit or investigation of the costs and benefits of this arrangement. This is despite the fact that the £2 billion spent by the government on the private hospital sector was the largest procurement of services from private companies during the pandemic.

6. Because of the difficulties in accessing data and the lack of a detailed inquiry by any other official body, many questions about the role played by the private hospital sector during the pandemic remain unanswered, and it is our hope that the COVID Inquiry will succeed in providing some answers.

The powers available to the Secretary of State for Health and Social care in relation to private sector provision during a public health emergency and the founding principles.

7. Our starting-point for analysing this issue is whether the actions taken by the government were consistent with the founding principles of the NHS, namely that comprehensive healthcare in the UK should be provided by the state on the basis of need, rather than ability to pay.

8. We consider it legitimate to assess whether the government's response to the pandemic was conducted in accordance with these principles because they are at the heart of the social contract between the state and the individual, and also because all major political parties since 1948 have repeatedly re-affirmed their commitment to them.

9. Any instances where the government deviated from these principles during its response to the pandemic should be treated as a major issue of concern.

10. Whilst recognising that the Secretary of State for Health and Social Care, along with other decision-makers in government and the NHS, were faced with very difficult decisions about how to allocate and prioritise access to healthcare during the pandemic, we consider that access should be based primarily on the needs of the patient and that healthcare services should be organised accordingly. We maintain that this is an uncontroversial approach to take.

11. We also argue that the Secretary of State was under a duty to act in this way. Section 47 of the Health and Social Care Act gives the Secretary of State significant powers to direct large parts of the health care infrastructure during a public health emergency including the hospitals, clinics and medical equipment which are owned and operated by private companies.[1]

12. In our view the Secretary of State was required to organise medical services to be consistent with his broader statutory duties which include those set out Section 1 of the Health and Social Care Act 2012. This Section, along with Section 4, places a duty on the Secretary of State to promote "a comprehensive health service" and to reduce inequalities.

13. When considering the use of the private hospital sector to support the pandemic response the focus should not solely be on how facilities and equipment were utilised but also on how the medical workforce was utilised.

14. There is one pool of medical consultants in the UK, and around 17,500 of them split their time working in the NHS and the private sector. Without this work-force private hospitals would not be able to deliver any forms of care.

15. Because the vast majority of these consultants are NHS employees, the Secretary of State and the NHS leadership had the legal power to determine what work they should undertake to support the pandemic response, whether in the private sector or in the NHS, and consequently whether they treated patients on the basis of need or on their ability to pay.

16. Moreover, the employment contract between the Department of Health and Social Care and NHS medical consultants contains clauses which prevent them from prioritising their private patient work over the interests of NHS patients or the NHS more generally.

17. In short, in a public health emergency the Secretary of State had the power to dictate how the hospitals, clinics and consultants working in the private hospital sector were used to meet the healthcare needs of the population. In our view he was under a legal duty to use these resources in such a way as to prioritise those in greatest need ahead of those with the ability to pay, and this should have determined how the government used the private hospital sector during the pandemic.

Summary of our findings in relation to the use of the private hospital sector during the pandemic and key questions which the Inquiry should seek to answer.

Finding 1: Despite the fact that NHS hospitals were overwhelmed, the government incentivised and encouraged private hospitals and NHS consultants to treat non-urgent privately-funded patients, almost certainly at the expense of seriously ill NHS patients.

18. Based on the evidence set out below we assert that the national contract between NHS England and the private hospital sector and the overall approach taken by the government did not give priority to patients based on need and that the resources available to the Secretary of State in the private hospital sector were not directed towards providing a comprehensive healthcare service for the population.

19. We also find that the Secretary of State and the leadership of NHS England permitted and encouraged NHS medical consultants to undertake the treatment of private patients, despite the impact that this had on potentially sicker NHS patients and the overall pandemic response.

20. Under contractual terms introduced by NHS England in the summer of 2020, private hospital companies which were covered by the national contract were provided with an incentive to increase the number of privately-funded patients that they treated. Limits were also placed on the amount of private hospital capacity which could be made available for use by the NHS.

21. This contractual limit on private sector capacity available to the NHS was especially strict in London, despite the fact that many of the NHS hospitals in London bore the brunt of the first and second waves of the pandemic.

22. The outcome of this policy overall was that less than half the patients treated in private hospitals between April 2020 and March 2022 were NHS patients, with the proportion of private patients being treated in private hospitals increasing from 55% to 62% as the pandemic progressed.

23. Had private hospitals been required to solely treat NHS patients on the basis of need rather than ability to pay we calculate - based on analysis of data from the Private Healthcare Information Network (PHIN) - that an additional 970,000 NHS patients would have received care.

24. The incentives to treat fee-paying private patients and the large amount of fee-paying activity being carried out in private hospitals in London also appear to have caused significant operational problems for NHS hospitals.

25. For example, in January 2021 at the peak of the second wave of the pandemic, the Medical Director for NHS England's London Region along with the Medical Directors of 5 London NHS Trusts and 5 London Clinical Commissioning Groups (CCGs) issued a public letter which was designed to "shame" their NHS consultants and the private hospitals into ceasing to treat non-urgent, fee-paying patients, and to turn their attention to the wider pandemic response.

26. The fact that such a letter had to be written by senior members of the NHS at one of the worst parts of the pandemic is strong evidence that the government failed to effectively utilise the private hospital sector to support the treatment of NHS patients.

Finding 2: Despite paying to cover the operating costs of the private hospital sector during the first year of the pandemic the NHS did not make full use of this capacity.

27. We also find that that the government failed to fully utilise the private hospital sector to treat NHS patients where capacity was available. Our research – based on official NHS data - found that the private hospital sector delivered less activity for the NHS during the pandemic than in the year before it.

28. Data provided to the Health Service Journal (HSJ) also found that only one third of private hospital capacity was being utilised by the NHS during the early months of the first year of the pandemic although their capacity had been set aside for NHS patient care.

Finding 3: Despite public assurances, it is likely that private hospital companies were able to generate profits out of the contract with the NHS during the first year of the pandemic.

29. Our research also raises significant questions about how public money was spent procuring services from the private hospital sector. The nature of the contract guaranteed private hospitals income to cover all their operating costs for the first 9 months of the pandemic, with no requirement on their part to treat a specified number of patients during this period.

30. The government and the Chief Executive of NHSE maintained that the companies were prohibited from generating a profit from this arrangement, although we cannot find any sections in the contracts with the private hospital sector which seek to enforce this policy.

31. Without access to the financial data of the companies involved, we are unable to say definitely whether any profits were generated from the income provided by the NHS during this period.

32. However, our research from 2023 found that for 17 of the contracted companies for which 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.

Finding 4: The well documented systemic patient safety issues in private hospitals are likely to have had an impact on patients, the taxpayer and the wider NHS response.

33. A further concern that the Inquiry should explore is whether all the hospitals which were enlisted to support the pandemic response were safe and suitable to treat the types of patients who needed assistance during the first year of the pandemic. This is especially the case for those hospitals which had not undertaken any NHS funded work before, including some whose normal business was to deliver cosmetic surgery.

34. Our research has identified one hospital which provided services under the contract which was not properly registered with the CQC and was found not to be testing patients and staff for COVID. In addition, there is evidence that in one private hospital company the number of patient safety incidents recorded almost doubled during the first year of the pandemic.

35. Despite the fact that the NHS was overwhelmed, around 6,600 patients were transferred from private hospitals to NHS hospitals during the first year of the pandemic, including 750 patients who were transferred at the peak of the second wave of the pandemic in January and February 2021. We assume that these transfers occurred because the private hospitals were unable to deal with complications which arose post-operatively. These figures are not dissimilar to the number of transfers which occur in most years and is likely to be the product of the large numbers of private patients being seen by private hospitals throughout the pandemic.

36. Such patients often require treatment in intensive care units, although we do not have any data on what happened to these particular patients or the reasons for their transfer during the pandemic. We are aware of at least one patient who died at the peak of the pandemic, most likely as a result of a transfer from the private hospital sector to an NHS hospital at a time when the health service was overstretched.[2]

37. If some of these patients transferred to the NHS were in need of intensive care and had been treated in private hospitals for non-urgent operations, this again raises questions as to why private hospitals were permitted to treat growing numbers of fee-paying patients.

38. Expecting the NHS to act as a safety net for the private sector when something goes wrong both endangers private patients and diverts vital resources away from critically ill NHS patients.

39. The issue of the safety of the private hospitals during the pandemic is also an issue for the taxpayer. As part of the arrangements with the private sector, the government introduced a statutory indemnity scheme for those private hospitals which were not part of the NHS clinical negligence scheme, known as the Clinical Negligence Scheme for Coronavirus (CNSC).

40. Unlike most other indemnity schemes in the NHS and the private sector, this scheme did not require a financial contribution from the private hospital companies which were members. In addition, the full liability for any harm caused to patients by the members of this scheme falls to the taxpayer – it is currently the case that NHS Resolution which runs this scheme has set aside £26.9 million to cover these liabilities.

41. It should be noted that whilst the government saw fit to provide free indemnity cover to the private hospital sector, no such scheme was made available to the care home sector in England, a decision which contributed significantly to their financial difficulties. This raises questions as to whether the private hospital sector received preferential terms compared to companies which were also enlisted to support the pandemic response.

Key questions about the use of the private hospital sector which the Inquiry should seek to answer.

42. Based on our findings and the evidence presented in this submission we consider that the Inquiry should seek to answer the following 6 questions:

Question 1:.Why did the government permit and actively encourage private hospitals and the NHS consultants working in them to carry out non-urgent operations on fee-paying patients when these resources could have been used to treat NHS patients who were in greater need?

Question 2: What was the impact of the policy of actively encouraging private hospitals to undertake fee-paying work in the middle of the pandemic on a) the pandemic response b) the growing backlog of NHS operations?

Question 3: How many NHS patients were denied access to care because available healthcare resources were being used to treat private patients and how many preventable deaths did this lead to?

Question 4: Why did the government not use the emergency powers available to it to bring the private hospitals and NHS consultants practising privately directly under the control of the NHS for the duration of the pandemic in order to support the pandemic response?

Question 5: Did the private companies involved in providing services to the NHS under the contract with the private hospital sector generate a profit, despite assurances given by the NHS that this would not happen?

Question 6: What were the implications for the NHS and individual patients of the large volume of patients transferred from the private hospital sector to the NHS during the pandemic?

Background information about the private hospital sector in the UK

43. According to market analysts Laing Buisson, going into the pandemic there were 197 private inpatient hospitals, 638 operating theatres, and 8,730 beds in the UK. In 2018 there were 364,875 inpatient admissions and 885,625 day admissions of which 694,500 are privately funded and 556,000 were funded by the NHS.[3]

44. The companies which operate most of these hospitals are owned by mainly overseas investors or companies and, with a few exceptions, operate on a for-profit basis. The distribution of private hospitals in the UK is centred around major cities with most being located in Greater London.

45. Private hospitals in the UK are substantially different from those in the NHS. In the first place, in most cases these hospitals were established to undertake high-volume low complexity elective activity such as hip operations or cataract surgery as well as diagnostic services.

46. The standard operating model for most private hospitals when undertaking treatment is for a patient to be under the care of a particular consultant, who in effect rents a room or operating theatre from the private hospital. The private hospital and the consultant bill the patient or the insurer separately and in most cases the consultant is not employed by the private hospital directly.

47. The consultant is usually an NHS consultant who undertakes work in the private hospital sector in their non-NHS hours on a free-lance basis. This arrangement is permitted by the national employment contract between the NHS and the medical consultants subject to the proviso that such activity does not impact their NHS work.

48. Once the consultant has completed the treatment they leave the patient in the charge of a resident medical officer, who in many cases is again not employed directly by the hospital but is instead employed by an outside recruitment agency.

49. This operating model means that private hospitals do not have the types of multi-disciplinary teams to cater for a wide range of illnesses or complications nor do the majority of them have the types of facilities and equipment available in NHS hospitals. Importantly most of them lack intensive care facilities and high dependency units. Because of these limitations e patients with more complex needs – including co-morbidities – are unsuitable for treatment in most private hospitals.

50. Whilst private hospitals refer to themselves as "independent" they are in fact highly dependent on the NHS both for income and staffing. Market analysts Laing Buisson have identified that around one third of the income of the private hospital

sector comes from the NHS, and our analysis from 2017 showed that around half of the inpatient beds in private hospitals are used to treat NHS-funded patients.[4]

51. This has occurred as a result of the fact that the NHS has relied upon the private sector to deliver greater volumes of elective activity since the start of the century, in part because of restrictions on the development of new clinics and facilities in the NHS. Without NHS income or the ability to use NHS consultants large parts of the private hospital sector would not be financially viable based on its current business model.

52. Whilst private hospitals do employ nurses and healthcare workers, including technicians and theatre staff, the resources which the private hospitals are able to provide to government in an emergency are mainly in the form of facilities and equipment – capital assets – rather than the provision of healthcare services. This is because the private sector does not have a separate pool of doctors, including medical consultants, to undertake care which is in addition to that which occurs in the NHS. Instead an estimated 17,500 NHS consultants undertake work on a free-lance, or self-employed basis in the private sector.[5]

53. The fact that there is only one pool of medical consultants in the UK is a key issue in the context of this Module of the Inquiry. This is because both government and the NHS leadership were in a position to determine how that vital resource was allocated between treating patients on the basis of need or ability to pay.

Systemic patient safety issues in private hospitals

54. In the month immediately prior to the pandemic, the inquiry into the Ian Paterson scandal identified a number of systemic patient safety risks associated with the private hospital sector in the UK and made a number of recommendations to address them.[6]

55. These risks had also been identified by the Care Quality Commission, the Secretary of State for Health and Social Care and also by a number of coroners' investigations into patient deaths in private hospitals. They have also been the subject of numerous investigations by BBC Panorama, BBC File on Four, and The Sunday Times.[7],[8],[9],[10]

56. Risks include the fact that the liability arrangements meant that it is difficult to hold private companies to account for the harm caused to patients in their hospitals, and the fact that the post operative care arrangements in private hospitals rely on unsupervised junior doctors working 168 hour shifts as well as on transferring patients to NHS intensive care units when something goes wrong.[11]

57. It has been documented that these risks have led to avoidable patient deaths and significant harm to patients.

58. It is important for the Inquiry to be aware of these known patient safety risks, since it is unclear whether government took these issues into consideration when it firstly contracted with the private hospital sector to deliver NHS funded care, or subsequently when it incentivised the delivery of increased volumes of privately funded care in the private sector as the pandemic progressed.

59. Put simply, any patient safety failing in the private hospital sector was likely to be an additional issue which the NHS would need to respond to, as the NHS acts as a 'safety net' for the private hospital sector.

The nature of the national contract between NHS England and the private hospital sector to support the pandemic response.

60. The procurement arrangements for the use of the private hospital sector during the first year of the pandemic are difficult to fully understand as, like many of the goods and services which were procured during this period, they did not follow standard procedures.

61. In addition, there was a lack of transparency about how agreements were struck between the government and different companies as well as the role played by the Independent Healthcare Provider Network (IHPN), the organisation which represents the interests of the UK's private hospital sector, and its participating members. Few of the contract documents were published in accordance with the usual reporting requirements; we only gained access to copies of the contracts through Freedom of Information requests.

62. These contracts were, however, the main policy lever used by the government to utilise the resources in the private sector. Below we set out our understanding of how these complex arrangements worked, what the key provisions of the contract involved and how and why these were amended between March 2020 and March 2021.

The original contract agreement between the NHS and the private hospital sector March to July 2020

63. On the 21st March 2020 NHS England issued a press release entitled "NHS strikes major deal to expand hospital capacity to battle coronavirus" stating that[12]:

"More beds, ventilators and thousands of extra healthcare staff will be made urgently available from next week to aid the NHS fight against coronavirus, thanks to a major deal agreed between NHS England and the nation's independent hospitals"

64. It contained quotations from the Secretary of State for Health Matt Hancock stating:

"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. "Open book" accounting and external auditors will verify the public funds being deployed."[13]

65. The Independent Healthcare Providers Network (IHPN) said:

"Independent hospitals are boosting emergency capacity to put at the disposal of the NHS over these coming weeks. We have worked hand-in-hand with the NHS for decades and will do whatever it takes to support the NHS in responding to this pandemic.

"This significant additional capacity across the country will be a major boost to the NHS's efforts to treat those patients that need hospital care over the coming period and the independent sector stands ready to maintain that support for as long as needed."[14]

66. In general, the impression was given that utilising the capacity in the private hospital sector was a major part of the government's health service response to the pandemic.

67. The agreement referred to in the press release was reached on 12 March 2020 between NHS England and the Independent Healthcare Provider Network (IHPN). This agreement sets out the key terms of the agreement before any contract was formally signed. [15]

68. The agreement 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. It is our understanding that the agreement was not formally signed until the 15th of May.

69. A letter from NHSE's Director of Operations and Delivery, outlining the arrangements to local NHS leaders, explained that it would 'secure a 'secure all available inpatient capacity and resource' – an additional 8,000 beds, 680 operating theatres, 10,000 nurses and over 700 doctors.[16]

70. He went on to say that the private hospitals were expected to deliver five main services:

- Inpatient respiratory care for COVID patients
- Urgent NHS elective care to ease COVID pressures in NHS hospitals
- Diagnostic capacity
- Inpatient non-elective care to free up capacity in NHS hospitals
- Making clinical and support staff available for redeployment

71. Twenty-six private hospital companies, all IHPN members, would become parties to the contract. They included large chains such as Spire, Circle Health, Ramsay,

Nuffield Health and HCA, some companies which operated single hospitals, such as the New Victoria Hospital and 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 and had never previously undertaken NHS work.

72. Between 23 March 2020 and 30 March 2020, the private hospitals were paid on a cost per case basis – i.e. they would receive payment according to the number of NHS-funded patients they treated.

73. From 30 March 2020 onwards providers would be paid for their full operating costs rather than a set amount of activity, and payments would be made 'on an oncost basis'. According to the contract private hospital sector could invoice the NHS for the following:

"[..]the aggregate of all costs incurred by the Provider to provide the Services and to operate, support and maintain the Provider's Premises, comprising Operating Costs, Rent, Capex Costs, Finance Costs, Infrastructure Cost and Decommissioning Costs" [17]

74. This meant that the government would in effect pay the costs of running the hospitals of the 26 companies which had signed up to the contract, including operating costs as well as finance costs, such as repaying loans.

75. During the period between 23 March 2020 and 14 April 2020 – known as the "escalation phase" – private hospitals were permitted to continue to treat private patients, although they had to make capacity available to deliver key services for the NHS.

76. After 15 April 2020– which was known as the "peak surge period" – the private hospitals were required to cease all routine non-elective care and had to ensure that 100% of their capacity was available to deliver the following services:

- inpatient oxygen, NIV (Non-invasive) and/or mechanically ventilated care services to Service Users referred to them
- non-elective inpatient care to Service Users
- urgent elective and cancer surgery and oncology treatment
- such other activity as requested by the Local NHS Lead[18]

77. From 15 May 2020– after the "peak surge period" was deemed to be over – it was expected that the private provider would have "unused capacity". The contract stipulated that *'where there is unused capacity, the hospital can resume routine elective care, where this has been expressly agreed in writing'* with the NHS. This

was known as the de-escalation phase and lasted until the contract agreement was terminated.

78. On 15 May 2020 the Health Service Journal reported that the de-escalation clause had been triggered and that the private sector had been given the 'green light' to resume treating private patients. At the time an NHS England spokeswoman said:

"Faced with an unprecedented global health pandemic, private hospitals were rightly used by the NHS to deal with any extra demand. Their focus can now switch to delivering other services including elective surgery and cancer treatments - ensuring people can get the treatment they need."[19]

The private patient offset

79. Those negotiating the contract between the NHS and the private hospitals appear to have recognised that large amounts of the capacity would potentially would not be used to treat NHS patients.[20]

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

81. However, allowing 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.

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

83. 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.

84. This was initially 85% of any net revenue from each private patient treated, allowing them to keep 15%. This was known as the 'private patient offset'.[21] 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'.

85. It could be argued that because the NHS had covered all operating costs – including staffing - 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 they delivered.

86. 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.[22]

Revisions to the original contract –July 2020 to January 1 2021

87. Our understanding is that due to concerns raised by the Treasury about the cost of covering the full operating costs of the private hospitals a number of revisions were introduced to the original contract in order to reduce the amount paid by the NHS to the private hospital sector. These changes included the following:

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- financial incentives for private hospitals to treat more fee-paying private patients
- contractual limits on the amount of capacity in private hospitals available to the NHS, except in extreme circumstances.
- A reduction in the number of private hospital companies which were covered by the contractual arrangements.

Financial incentives for private hospitals to treat more fee-paying private patients

88. It appears that the private patient offset which allowed private hospitals to keep 15% of the income they generated from treating private patients, was not a sufficiently strong incentive to encourage increased private patient activity. From the Treasury's perspective, increased private patient activity reduced the overall cost of the contract to the taxpayer as the taxpayer received a rebate each time a private patient was treated.

89. As a result, the initial contract was revised and from the 1st July 2020 onwards 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 they could keep 40%.

90. Put another way the more private patient activity that was undertaken by a private hospital under the contract, the higher the margin paid by the taxpayer.[23]

91. 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."[24]

Contractual limits on the amount of capacity in private hospitals available to the NHS, except in extreme circumstances

92. For the private hospitals to be able to meet their private patient activity targets, the contracts introduced a limit on the amount of capacity which was reserved to treat NHS patients from 1st July onwards. In relation to the London area, the contract states:

> *"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]

93. 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. [26] [27]

94. Outside 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%.[28]

95. By setting a maximum level for use by the NHS these clauses had the potential to reduce activity to levels even lower than what had been achieved in the early months of the pandemic, when proportionately very few NHS patients were being treated in private hospitals. 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."[29]

96. From July 2020 onwards, the contract states that the NHS could gain access to the full staffed capacity of the private hospitals, but only in extreme circumstances, which are described as the "surge clause". The incentives to treat private patients could be suspended and the NHS was entitled to access 100% of the capacity of the hospitals, but only when the COVID infection rates '*were so high that they necessitated 'the suspension of most or all routine elective care'*.

97. According to the contract, this 'Surge Clause' could be triggered by NHSE at a national, regional or local level.[30]

Reductions in the number of private hospital companies included on the contract with the NHS

98. By the time that the contract award notice for the revised contract was announced, the total number of companies which were part of the arrangement had reduced from 26 to 14.

99. Some reports suggest that the reason for this was that the government would not meet the price being asked, while others report that new contractual terms were not agreed with some companies because their hospitals were underutilised. The companies which were not included on the revised contract were mainly smaller providers – such as those that focused on cosmetic surgery – but it also included the large private US healthcare company HCA Healthcare.

100. Whilst these companies were not covered by the generic terms of the national contract, a number went on to secure separate individual contracts with NHS Trusts at a local level.

101. However this reduction in the number of providers on the contract removed the only contractual lever employed by to the government in relation to these companies which could be used to require them to provide capacity to support the pandemic response.

January 2021 to March 2021 – The interim contractual arrangement between the NHS and the private hospital sector.

102. It is our understanding that the government had originally planned to move away from the national Covid contract and onto a long-term contracting framework commissioned at the local level by 1st January 2021.

103. This arrangement would be similar to the type of contractual arrangement which existed between the NHS and the private hospital sector prior to the pandemic whereby hospitals would be remunerated on the basis of activity, rather than having their operational costs met irrespective of the amount of care they delivered.

104. However, we understand that this contracting arrangement was not ready in time and a three month 'stop-gap' contract was therefore agreed to run from January to March 2021 while new long-term relationship was being finalised.

105. The revised contract covering January 2021 to March 2021 sought to introduce a transition from the 'block contracting' arrangements which had previously been in place. The contract envisaged that the NHS and the private hospital companies would agree to a plan so that by 1 February 2021 the private hospital would only be required to deliver those services which the private hospital had in effect been commissioned to deliver by the NHS.

106. In total the actual volume of services which the private hospital was required to deliver until March 2021 was "equal or greater than the one month average for October and November 2020" under the previous version of the contract.

107. In effect, from January 2021 onwards the private hospitals' role in supporting the pandemic response in an emergency capacity was limited to those circumstances when the Surge Clause would apply, at which point the NHS could again require that 100% of the capacity in the private hospitals was made available to support the NHS. The contract states that the Surge Clause could only be initiated by the Director of Operations at NHS England.

108. It is our understanding that from 31 March 2021 onwards, this contractual arrangement came to an end and the use of the private hospital sector by the NHS reverted back to the contracting arrangements which were in place prior to the pandemic.

The impact of the contractual arrangements on the numbers of NHS patients treated in the private hospital sector during the first year of the pandemic

109. The detailed contract provisions outlined above had a real-world impact in terms of the numbers and types of NHS patients treated during the pandemic. Here we set out what is known about how the private hospital sector was used to treat NHS patients as part of the pandemic response.

The treatment of COVID patients in private hospitals during the first year of the pandemic.

110. 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. [31]

111. We identified 187 private hospitals belonging to the 26 providers which were signed onto the national contract. 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.[32]

112. 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).[33]

The treatment of non-COVID patients in private hospitals during the pandemic.

113. It is important to recall the extent to which the NHS was overwhelmed during the period when the arrangement was in place with the private hospital sector.

114. 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%. As a result of the increased number of acutely ill patients, the treatment of many other conditions had to be put off. [34]

115. 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.[35]

116. The contract with private hospitals created the expectation that it would help to 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.

117. In December 2020 the Health Service Journal (HSJ) published internal NHS documents which showed that only one third of the available capacity for the provision of day case and diagnostic services in the private sector was being used by the NHS.[36]

118. Our analysis of the official NHS Hospital Episode Statistics (HES) supports these reports of under-utilisation. They show that in the year prior to the pandemic, between March 2019 and February 2020, the private hospitals which were covered by 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.[37]

119. 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.[38]

120. 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.

121. However, the NHS appears to have coped far better in terms of the number of NHS patients treated, 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 private hospitals fell by 42.8%.[39]

122. 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 out patient consultations towards delivering elective procedures that the NHS was too stretched to deliver.

123. 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.[40]

Table 1 Comparison of different types of NHS-funded healthcare activity in the contracted private 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)

Data on the growth in the private hospital sector's focus on privately funded treatment during the pandemic potentially at the expense of NHS patients

124. Our analysis of the data produced by the Private Healthcare Information Network (PHIN), which records both NHS and privately-funded activity in the private hospital sector, found that over the first year of the pandemic the approximately 180 hospitals operated by the 6 largest private hospital companies in the UK were predominantly used to treat privately-funded patients. Thus between April 2020 and March 2021, 55% of the episodes of care which occurred in private hospitals were privately funded and only 45% were NHS patients (see Table 2).

Table 2 Percentage of activity in 180 private hospitals carried out on NHS or private patients

Year April to March	Private Episodes	NHS Episodes	Total Episodes	% Private Episodes
2019-2020	580,265	484,730	1,031,265	56
2020-2021	360,980	297,710	658,675	55
2021-22	608,145	365,750	973,915	62
2022-23	648,665	278,430	927,155	70

(Source: CHPI analysis of Volume and Length of Stay data from the Private Healthcare Information Network (PHIN)[41]

125. Moreover, after the first year of the pandemic when the contractual arrangements between the NHS and the private sector had ended, the proportion of the privately funded patients in private hospitals grew to 62%, a level which was

higher than the year prior to the pandemic and which has continued to grow since this point.

126. Whilst we recognise that it is a crude calculation, it could be argued that had the private hospital sector been solely focused on providing care to NHS patients – i.e. if private pay activity had been cancelled in private hospitals and instead made available to treat NHS patients – then an additional 970,000 episodes of care could have been delivered to support the pandemic response. Not only would this have reduced the burden on NHS hospitals it would also have meant that the very big backlog of NHS care which has developed since the pandemic would not have been so large.

127. When looking at particular types of elective activity, for example knee surgery it is again clear that capacity in the private sector was being increasingly set aside for those with the ability to pay ahead of NHS funded patients, with corresponding impacts on equitable access to health care.

128. Thus, in 2019 prior to the pandemic, 67% of patients who had knee surgery in a private hospital were NHS patients, by 2022 this had fallen to 56%. This decrease in the number of NHS patients being treated in private hospitals for knee replacements occurred during a period where this form of elective activity in the private sector increased by 23% between 2019 and 2022. (See Table 3 and 4)

129. Over the course of the pandemic, access to orthopaedic surgery became increasingly more dependent on an individual's ability to pay (either through out of pocket expenditure or using private health insurance) than it was prior to the pandemic.

130. Thus in 2019 13% of all knee surgeries were carried out on patients paying privately but by 2022 this had risen to 23%. In contrast, the total number of knee surgeries carried out on NHS patients fell by 16% over this period. (see Table 3 and 4).

131. Similar shifts can also be seen in the data reported to the National Joint Registry regarding hip replacements. Thus, by 2022 the private sector again increased the number of patients that it was treating for hip replacements (52 392 in 2022) by 13,799 compared to 2019 (38,593).[42] (see Table 5 and 6)

132. However, the proportion of these operations which were carried out on NHS patients fell from 60% to 48% during this period. Out of the additional 13,799 patients which were treated in the private sector for hip replacements in 2022 compared to 2019, just 1,736 were NHS patients. (See Table 5 and 6)

133. This shift occurred during a period when the capacity in NHS hospitals to undertake hip replacements on NHS patients had fallen from 67,327 a year in 2019 to 54,929 a year in 2022 a reduction of 12,398 – an amount which almost

corresponds to the growth in the number of hip operations being performed in the private sector over the same period. (See Table 5 and 6)

134. As noted above, given that it was NHS consultants undertaking surgery in private hospitals, it could be argued that this part of the workforce simply shifted its practice to private hospitals over the course of the pandemic. However, instead of treating NHS patients, they focused instead on fee paying private patients.

135. In general, these data shows that almost all of the additional capacity made available in the private hospital sector for orthopaedic surgery during the pandemic was used to treat those with private health insurance or those who had the ability to pay out of their own pockets.

136. Again it is difficult to reconcile these outcomes with the expressed intention by policy makers to use the private hospital sector to support the pandemic response. It is also clear that because of the strategy adopted in relation to the use of the private sector that certain forms of healthcare were determined more by ability to pay rather by need.

Table 3 volume of knee operations carried out in NHS and private sector hospitals and sources of funding 2019 to 2022

Calendar Year	2019	% change 19/20	2020	% change 20/21	2021	% change 21/22	2022	% change 2019 to 2022
Total number of knee surgeries	115,514	- 50	57,409	50	86,216	26	109,043	- 6
knee surgeries provided in NHS hospitals	68,258	- 57	29,293	33	38,947	31	51,045	- 25
knee surgeries provided in Independent Sector Treatment Centres (ISTC)	4,394	- 47	2,319	76	4,081	31	5,346	22
knee surgeries provided in private hospitals	42,862	- 40	25,797	67	43,188	22	52,652	23
Total number of knee surgeries funded by the NHS	100,424	- 54	45,751	43	65,587	29	84,413	- 16
Total number of knee surgeries funded by private pay or private insurance	15,494	- 25	11,658	77	20,629	19	24,630	59
Total number of knee surgeries in private hospitals funded by the NHS	28,738	- 49	14,789	62	23,951	24	29,688	3
Total number of knee surgeries in ISTC funded by the NHS	4,317	- 50	2,173	67	3,625	34	4,855	12
Total number of knee surgeries in private hospitals funded by private pay or private insurance	14,214	- 23	11,008	75	19,237	28	24,630	73

(Source National Joint Registry)

Table 4 percentage of knee operations carried out on NHS or privately funded patients 2019 to 2022

Calendar Year	2019	2020	2021	2022	% Change 2019 to 2022
% of All knee surgeries undertaken in NHS hospitals	59	51	45	47	- 12
% of All knee surgeries undertaken in the private sector (including ISTCs)	41	49	55	53	12
% of All knee surgeries carried out on NHS patients	87	80	76	77	- 10
% of All knee surgeries carried out on privately funded patients	13	20	24	23	9
% of All knee surgeries in private hospitals carried out on NHS patients	67	57	55	56	- 11

(Source National Joint Registry)

Table 5 volume of hip operations carried out in NHS and private sector hospitals and sources of funding 2019 to 2022

Calendar Year	2019	% change 19/20	2020	% change 20/21	2021	% change 21/22	2022	% change 2019 to 2022
Total number of hip surgeries (all settings)	106,629	- 40	63,747	50	95,607	18	112,525	6
Total number of hip surgeries provided in NHS hospitals	67,372	- 50	33,962	34	45,444	21	54,929	- 18
Total number of hip surgeries provided in Independent Sector Treatment Centres (ISTC)	3,709	- 39	2,275	86	4,234	23	5,204	40
Total number of hip surgeries provided in private hospitals	38,593	- 29	27,510	67	45,929	14	52,392	36
Total number of hip surgeries funded by the NHS	92,913	- 48	48,534	41	68,568	21	82,887	- 11
Total number of hip surgeries funded by private pay or private insurance	16,716	- 9	15,213	78	27,039	10	29,638	77
Total number of hip surgeries in private hospitals funded by the NHS	23,179	- 43	13,230	59	20,999	19	24,915	7
Total number of hip surgeries in ISTC funded by the NHS	3,639	- 43	2,066	86	3,842	16	4,464	23
Total number of hip surgeries in private hospitals funded by private pay or private insurance	15,414	- 7	14,280	75	24,930	10	27,477	78

(Source National Joint Registry)

Table 6 percentage of hip operations carried out on NHS or privately funded patients 2019 to 2022

Calendar Year	2019	2020	2021	2022
% of All hip surgeries undertaken in NHS hospitals	63	53	48	49
% of All hip surgeries undertaken in the private sector (including ISTCs)	40	47	52	51
% of All hip surgeries carried out on NHS patients	87	76	72	74
% of All hip surgeries carried out on privately funded patients	16	24	28	26
% of All hip surgeries in private hospitals carried out on NHS patients	60	48	46	48

(Source National Joint Registry)

Concerns raised by senior NHS staff about the use of the private sector to treat fee paying private patients at the expense of patients more in need.

137. In addition to the data showing that the private hospital sector did not provide significant support to the pandemic, there were also a number of contemporary press reports which revealed concerns that private hospitals and NHS consultants were prioritising private pay patients over NHS patients.

138. In January 2021 at the peak of the second wave of the pandemic, the HSJ ran a report highlighting the difficulties faced by NHS hospital Trusts as a result of their consultants working in private hospitals and treating fee paying patients instead of dedicating their efforts to treating seriously ill NHS patients.

139. The journal published a public letter issued by the Medical Director for NHS England's London Region along with the Medical Directors of 5 London NHS Trusts and 5 London Clinical Commissioning Groups (CCGs) which was designed to "shame" their NHS consultants and the private hospitals into ceasing to treat non-urgent, fee-paying patients and to turn their attention to the wider pandemic response. The letter included the following statement:

"We are in genuinely unprecedented times and the second wave of covid-19 is putting pressures on the service that only a year ago would have been unthinkable.

"In this context, with all but the most urgent elective activity postponed in the NHS in London, it feels profoundly uncomfortable to us that some elective work, that is not time critical, is continuing in the independent sector.

"We are asking colleagues to think very carefully about the appropriateness of this, and would like colleagues not to support delivery of such work in the independent sector for a period of time, a month from the date of this letter in the first instance, until vaccination and the current lockdown take effect and the pressure on NHS services eases."[43]

140. It is interesting that senior members of NHS England felt that it was necessary to write such a letter rather than relying on the contractual arrangements which had been put in place. These contract provisions supposedly enabled the NHS Director of Operations to enact a 'surge clause' which would enable the NHS to access 100% of the capacity of contracted private hospitals when the NHS had become so overwhelmed that it *"necessitates the suspension of most or all routine elective care to facilitate an expansion of NHS COVID care capacity".*

141. It appears that this situation had been reached in London, as the Medical Directors state in their letter that "*all but the most urgent elective activity [had been] postponed in the NHS in London"* , Yet the 'surge clause' does not seem to have been invoked by the NHS Leadership to mandate that private hospitals were used to treat NHS patients.

142. A similar issue occurred in Manchester. In January 2021 the HSJ reported that the Chief Operating Officer of Manchester University Hospital Foundation Trust had informed the Trust's board that private hospitals were *"pushing back on services they can provide from January and the volume of activity available to NHS trusts"*.[44]

143. Whilst these examples raise questions about the efficacy of this contractual clause there were other legal powers available to government to prevent this situation from arising. For example, the contract between the government and NHS consultants states that:

> *"The consultant is responsible for ensuring that the provision of Private Professional Services or Fee Paying Services for other organisations does not: result in detriment of NHS patients or services; diminish the public resources that are available for the NHS".*[45]

144. We would suggest that had the Secretary of State chosen to do so, he could have required NHS consultants who were practising privately at the peak of the

pandemic to cease doing so. This is because there was clear evidence that continuing to carry out private work caused detriment to NHS patients and services and that as a result they were potentially in breach of their employment contract.

145. The tension between using private hospitals for fee paying patients and NHS patients also occurred in clinical settings. A BMJ investigation published in February 2023 cited one hospital manager who:

> " *[…]described how one particular private surgeon at New Foscote Hospital, would regularly try to barge in on NHS colleagues who were still operating on NHS patients after 5pm. "We were saying: 'Hurry up! We've got private patients coming in at 5pm'. The [NHS] surgeons were saying: 'We can't hurry up! We've got a patient on the operating table*."[46]

146. In May 2023 the *Independent* published a news report based on a series of emails provided to them from 2020 which "showed some trusts raising concerns over private hospitals "limiting" NHS patient bookings and cancelling NHS operations at the last minute."[47]

Did the private hospital companies make any profit from the contract?

147. 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.

148. 'No profit' was emphasised by the then Secretary of State for Health and Social Care when the deal was announced stating that:

149. *"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]

150. The then Chief Executive of NHS England told the Public Accounts Committee that the contract "contains caps on the profits that can be paid in dividends and other aspects of what would be a normal cost structure for those providers."[48]

151. 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.

152. In the first place, 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.

153. 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 for which 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.[49]

154. The 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 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 – have led to the creation of a surplus.

155. 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 change 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."[50]

Patient safety concerns and covering the costs of patients harmed in private hospitals during the pandemic.

156. 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 as a result of clinical negligence whilst being treated under the terms of the contract.

157. This was particularly the case for the smaller private companies such as those working in the cosmetic sector - which 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 work.

158. This risk also applied to a lesser degree to the larger private companies, which reported that the risk profile of the NHS patients that they treated during the pandemic had 'higher acuity' – i.e. the cases were more complex and hence riskier to treat than those they had treated before.

159. This change in the risk profile of the patients treated in private hospitals can be seen in an increase in the prevalence of patient safety incidents in some of these hospitals.

160. 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 a total of 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.[51]

161. The potential for some NHS-funded patients who were treated in private hospitals to be harmed also increased as a result of the fact that one private hospital delivering services to the NHS was not appropriately registered with the CQC and was found by the regulator to have failed to carry out COVID tests on its staff, despite this being a basic safety requirement and a condition of the contract with the NHS. [52]

162. Under the terms of the contract, it was the NHS and the taxpayer-supported indemnity schemes which bore the financial risk of NHS patients being harmed as a result of clinical negligence.[53] 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.

163. 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 of these private companies increased because of the possibly higher risk profile of NHS patients who were treated during the pandemic under the contractual arrangements.

164. However, just 9 of the 26 companies on the contract were members of the CNST scheme prior to March 2020; companies which did not have this cover and did not have adequate commercial insurance to meet any clinical negligence claims, were able to join, free of charge, a new indemnity scheme which had been created by Parliament under Section 11 of the Coronavirus Act.[54] [55]

165. This scheme, 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 would be covered by the taxpayer.

166. 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 initially provided NHS Resolution with sufficient funds to cover claims under the CNSC of up to £92.4m, as of 2021/22.[56] The scheme also costs an estimated £236,000 to administer.[57]

167. In their latest accounts NHS Resolution report that it had reduced the amount set aside for to cover these liabilities to £26.9 million, presumably due an expectation that the scheme would pay out a lower number of claims than initially predicted. [58]

168. 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 which delivered state-funded healthcare services during the pandemic.

169. 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%.[59] This raises questions as to whether the private hospital sector received preferential terms

compared to other companies that had been enlisted to support the pandemic response

170. 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 of patients. Thus, at the peak of the second wave in January and February 2021 750 patients were transferred from private hospitals to the NHS. In total between March 2020 and April 2021 around 6,600 patients were transferred to the NHS after being treated in the private hospital sector.[60]

171. These figures are not dissimilar to the number of transfers which occur in most years and are likely to be due to the large numbers of private patients being seen by private hospitals throughout the pandemic.

172. Such patients often require treatment in intensive care units, although we do not have any data on what happened to these patients or the reasons for their transfer during the pandemic. However we are aware of at least one patient who died at the peak of the pandemic most likely as a result of a transfer from the private hospital sector to an NHS hospital at a time when the health service was overstretched.[61]

References and endnotes

[1] The explanatory notes for Section 47 of the Health and Social Care Act state: "The Secretary of State can direct the provider: about the provision of NHS services by the provider; to cease to provide services or to provide additional services. This ensures that the Secretary of State may give directions to both NHS bodies and providers of NHS services not only regarding their own activities but also to ensure coordination between bodies in exercising their activities in times of emergency." Given that the vast majority of private hospitals in the UK – with the exception of HCA Healthcare – are providers of NHS services, the Secretary of State arguably had powers of direction in relation to them. (Reference: https://www.legislation.gov.uk/ukpga/2012/7/notes/division/5/1/8/2)

[2] Jacqueline Lake Coroner's 'Report to prevent future deaths in the case of Barbara Hollis' 26 August 2022
https://www.judiciary.uk/wp-content/uploads/2022/10/Barbara-Hollis-Prevention-of-future-deaths-report-2022-0264_Published.pdf

[3] Laing Buisson 'Private Acute Healthcare UK market report, 5th edition 2019

[4] Centre for Health and the Public Interest 'No safety without liability: reforming private hospitals after the Ian Paterson Scandal' November 2017
https://chpi.org.uk/wp-content/uploads/2017/10/CHPI-PatientSafetyPaterson-Nov29.pdf

[5] David Rowland 'Pounds for Patients - Pounds for Patients? How private hospitals use financial incentives to win the business of medical consultants' Centre for Health and the Public Interest 2019
https://chpi.org.uk/wp-content/uploads/2019/06/FINAL-REPORT-POUNDS-4-PATIENTS-070619.pdf

[6]The Right Reverend Graham James 'Report of the Independent Inquiry into the Issues raised by Paterson' 4 February 2020
https://assets.publishing.service.gov.uk/media/5e3947ed40f0b6090e0b446b/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf

[7] Letter from Jeremy Hunt MP Secretary of State for Health and Social Care, 'Patient safety and acute care in the independent sector' May 2018 https://www.gov.uk/government/publications/patient-safety-letter-to-independent-healthcare-providers/patient-safety-and-acute-care-in-the-independent-sector

[8] BBC Panorama 'NHS Patients going private: What are the risks?' Broadcast April 2024
https://www.bbc.co.uk/programmes/m001y43c

[9] Shaun Lintern 'You can pay for private healthcare but can you trust it'? Sunday Times 10 September 2023 https://www.thetimes.com/uk/article/you-can-pay-for-private-healthcare-but-can-you-trust-it-csd0rsm8d

[10] BBC File on Four 'Paying the Price – Private Hospitals' October 2018
http://downloads.bbc.co.uk/rmhttp/fileon4/24_Private_hospital.pdf

[11] Centre for Health and the Public Interest 'No safety without liability: reforming private hospitals after the Ian Paterson Scandal' November 2017https://chpi.org.uk/wp-content/uploads/2017/10/CHPI-PatientSafetyPaterson-Nov29.pdf

[12] NHS England Press Release 'NHS strikes major deal to expand hospital capacity to battle coronavirus' 21 March 2020

https://www.england.nhs.uk/2020/03/nhs-strikes-major-deal-to-expand-hospital-capacity-to-battle-coronavirus/

[13] NHS England Press Release 'NHS strikes major deal to expand hospital capacity to battle coronavirus' 21 March 2020

https://www.england.nhs.uk/2020/03/nhs-strikes-major-deal-to-expand-hospital-capacity-to-battle-coronavirus/

[14] NHS England Press Release 'NHS strikes major deal to expand hospital capacity to battle coronavirus' 21 March 2020

https://www.england.nhs.uk/2020/03/nhs-strikes-major-deal-to-expand-hospital-capacity-to-battle-coronavirus/

[15] Agreement between the NHS England, the IHPN and its members

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886123/he01-independent-healthcare-providers-network-notified-9-april-2020.pdf

[16] NHS England, Letter to NHS Leaders, COVID-19: 'Partnership working with the Independent Sector Providers and the Independent Healthcare Providers Network' 24th March 2020

https://www.ihpn.org.uk/wp-content/uploads/2020/03/IHPN-Partnership-Letter-to-system-24-March-2020.pdf

[17] 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.

[18] Section 6 of the Main Contract

[19] Tom Horton ' NHS triggers 'de-escalation' clause to allow private providers to restart work' Health Service Journal May 15th 2020

https://www.hsj.co.uk/news/nhs-triggers-de-escalation-clause-to-allow-private-providers-to-restart-work/7027662.article

[20] 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.

[21] Section 2.14.1 of the Main Contract states "A deduction will be made in respect of 85% of the net revenue, (the total invoiced revenue excluding VAT and private consultant costs incurred in earning such revenue to the extent such cost is not itself a Qualifying Cost), earned by the Provider in the Block Booking Period in respect of all private patients, including long-stay, at all Provider's Premises in England which are involved in the provision of the Services."

[22] NHS England, Contract award to KMPG, Covid 19 Accounting Services IHPN 10th February 2021

https://www.contractsfinder.service.gov.uk/notice/58563604-d3fd-47c0-a8b3-f032acea66f5?origin=SearchResults&p=1

[23] The Variation Contract Sections 2 and 3

[24] Benenden Hospital Trust Annual Report and Financial Statement Year ending 31 December 2019 Page 37 (Available from Companies House)

[25] The Variation Contract, Section 6 – Release of capacity for Private Patient Activity.

[26] Public Accounts Committee 'Correspondence from Julian Kelly, NHS Chief Financial Officer, re Readying the NHS and social care for COVID-19, dated 18 September 2020'

https://committees.parliament.uk/work/345/readying-the-nhs-and-social-care-for-the-covid19-peak/publications/3/correspondence/

[28] The Variation Contract, Section 6 – Release of capacity for Private Patient Activity.

[29] 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.

[30] The second COVID wave straddled two iterations of this contract, which were 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.

[31] Centre for Health and the Public Interest 'For Whose Benefit? NHS England's contract with the private hospital sector in the first year of the pandemic' September 2021

https://chpi.org.uk/wp-content/uploads/2021/09/CHPI-For-Whose-Benefit_.pdf

[32] Centre for Health and the Public Interest 'For Whose Benefit? NHS England's contract with the private hospital sector in the first year of the pandemic' September 2021

https://chpi.org.uk/wp-content/uploads/2021/09/CHPI-For-Whose-Benefit_.pdf

[33] Centre for Health and the Public Interest 'For Whose Benefit? NHS England's contract with the private hospital sector in the first year of the pandemic' September 2021

https://chpi.org.uk/wp-content/uploads/2021/09/CHPI-For-Whose-Benefit_.pdf

[34] Centre for Health and the Public Interest 'For Whose Benefit? NHS England's contract with the private hospital sector in the first year of the pandemic' September 2021

https://chpi.org.uk/wp-content/uploads/2021/09/CHPI-For-Whose-Benefit_.pdf

[35] Centre for Health and the Public Interest 'For Whose Benefit? NHS England's contract with the private hospital sector in the first year of the pandemic' September 2021

https://chpi.org.uk/wp-content/uploads/2021/09/CHPI-For-Whose-Benefit_.pdf

[36] Rebecca Thomas 'Leaks reveal two-thirds of private hospital capacity went unused by NHS' Health Service Journal 1st December 2020

https://www.hsj.co.uk/finance-and-efficiency/leaks-reveal-two-thirds-of-private-hospital-capacity-went-unused-by-nhs/7029000.article

[37] Centre for Health and the Public Interest 'For Whose Benefit? NHS England's contract with the private hospital sector in the first year of the pandemic' September 2021

https://chpi.org.uk/wp-content/uploads/2021/09/CHPI-For-Whose-Benefit_.pdf

[38] Centre for Health and the Public Interest 'For Whose Benefit? NHS England's contract with the private hospital sector in the first year of the pandemic' September 2021

https://chpi.org.uk/wp-content/uploads/2021/09/CHPI-For-Whose-Benefit_.pdf

[39] Centre for Health and the Public Interest 'For Whose Benefit? NHS England's contract with the private hospital sector in the first year of the pandemic' September 2021

https://chpi.org.uk/wp-content/uploads/2021/09/CHPI-For-Whose-Benefit_.pdf

[40] The National Audit Office (NAO) and the Department of Health and Social Care have argued that it is not meaningful to use NHS Digital's Health Episode Statistics (HES) data to make a comparison between activity in the two years because of the different way in which data during the pandemic was recorded. The NAO specifically state that this comparison is not meaningful, because:

"The special national contracts [with the private sector] allowed the NHS to send patients for elective treatment in independent providers' facilities in the usual way, but they also allowed NHS providers to make use of independent provider staff, theatres and equipment as if they belonged to the NHS.[…] One consequence of this approach is that data on the use of the independent sector before the pandemic are not comparable with data on its use during the pandemic."

(https://www.nao.org.uk/wp-content/uploads/2021/07/NHS-backlogs-and-waiting-times-in-England.pdf#page=34)

In their report, the NAO instead rely on a dataset which was developed specifically to capture NHS-funded private sector activity during the pandemic, which has also been circulated to the media by the Independent Health Providers Network. We remain concerned as to both the origins of this data and also its validity, as we are unsure how the data was collected and by whom. We are also aware that it has not been audited by any independent body, a point we have raised with the NAO.

[41] The data analysed here is from the Private Healthcare Information Network. These datasheets contain information on the number of patient episodes delivered by private hospitals which are privately-funded and funded by the NHS. Private hospitals are under a duty to provide data to PHIN about the treatment of private patients under the Competition and Markets Authority 2014 Order. Our understanding is that NHS Digital provide data to PHIN in relation to NHS-funded patient episodes in private hospitals. In carrying out our analysis of this data we examined the private hospitals operated by the following companies Ramsay Heatlhcare, Practice Plus Group, BMI/Circle, HCA Healthcare, Nuffield Health and Spire Healthcare. The number of hospitals in the dataset varied marginally from year to year: Thus in 2019-20 the dataset contained180 hospitals for these 6 companies, 2020-21 176, 2021-22 182, and 2022-23 182. We do not consider that the difference in the number of hospitals in the dataset for each year substantially affects the overall figures that we have cited.

The full data can be accessed here: https://www.phin.org.uk/data/volume-and-length-of-stay-datasheets

[42] National Joint Registry Reports for Hip replacement surgery 2019 to 2022 'Procedure details by type of provider' available at https://reports.njrcentre.org.uk/

[43] Laurence Dunhill 'Medical leaders seek to 'shame' private hospitals and their staff into supporting NHS' Health Service Journal 10 January 2021

https://www.hsj.co.uk/news/exclusive-medical-leaders-seek-to-shame-private-hospitals-and-their-staff-into-supporting-nhs/7029276.article

[44] Laurence Dunhill 'Private sector 'pushing back' on NHS request to take more patients, says top trust' Health Service Journal January 2021

https://www.hsj.co.uk/private-sector-pushing-back-on-nhs-request-to-take-more-patients-says-top-trust/7029290.article

[45] NHS Consultant Contract 2003 Schedule 9 Section 2

https://www.nhsemployers.org/system/files/2022-03/Terms-and-Conditions-consultants-Mar-2022-v12.pdf

[46] Esther Oxford 'The NHS paid private hospitals £2bn in the pandemic: did taxpayers get value for money?' British Medical Journal 15 February 2023

https://www.bmj.com/content/380/bmj.p329

[47] Rebecca Thomas 'Why turning to the private sector won't save the NHS backlog' The Independent 10 May 2023

https://www.independent.co.uk/independentpremium/nhs-private-hospitals-covid-b2345004.html

[48] Sir Simon Stevens 'Readying the NHS and social care for the COVID-19 peak', Public Accounts Committee Oral evidence HC 405 Question 65 22nd June 2020

https://committees.parliament.uk/oralevidence/550/pdf/

[49] Centre for Health and the Public Interest 'The devil is in the detail: NHS England's contracts with the private hospital sector during COVID-19.' May 2023

https://chpi.org.uk/wp-content/uploads/2023/05/The-Devil-is-in-the-Detail-NHSEs-contract-with-private-hospital-sector-during-COVID-19-May-2023.pdf

[50] One Hatfield Hospital Limited Full annual accounts made up to 30 June 2021, available from Companies House

[51] Nuffield Health Quality Accounts 2020

https://www.nuffieldhealth.com/downloads/2020-annual-report-quality

[52] The CQC report into Burcot Hall, one of the hospitals delivering care under the original contract, found that: "At the time of our inspection Burcot Hall Hospital Ltd the registered provider did not employ any staff or provide any regulated services directly. All staff and support services were being provided by another provider".

For more details see this CQC report here: https://api.cqc.org.uk/public/v1/reports/65f51948-c01c-4fa1-824a-ad5508d0e3f2?20210701110001

[53] 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.

[54] NHS Resolution 'Factsheet 5 – trust and authority claims data 2020/21'

https://resolution.nhs.uk/resources/factsheet-5-trust-and-authority-claims-data-2020-21/

[55] "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)

https://assets.publishing.service.gov.uk/media/61fbfacc8fa8f538882511f3/dhsc-annual-report-and-accounts-2020-2021-web-accessible..pdf

[56] NHS Resolution Annual Report 2021/22 page 113

https://resolution.nhs.uk/wp-content/uploads/2022/07/NHS-Resolution-Annual-report-and-accounts-2021_22_Access.pdf

[57] NHS Resolution Annual Report 2021/22 page 60.

https://resolution.nhs.uk/wp-content/uploads/2022/07/NHS-Resolution-Annual-report-and-accounts-2021_22_Access.pdf

[58] NHS Resolution 'Annual Report and Accounts 2023-24'

https://resolution.nhs.uk/wp-content/uploads/2024/07/NHS-Resolution-Annual-report-and-accounts_23-24_Access.pdf

[59] Sarah Provan 'UK care homes face soaring insurance premiums, charity warns' Financial Times June 7 2022

https://www.ft.com/content/32ec9d47-dbc9-4429-b8d0-d7627d4dec2a

[60] Edward Agar MP response to Parliamentary Question "NHS: Private Patients UIN 141193", tabled on 16 March 2022 Hansard

https://questions-statements.parliament.uk/written-questions/detail/2022-03-16/141193/

[61] Jacqueline Lake Coroner's 'Report to prevent future deaths in the case of Barbara Hollis' 26 August 2022
https://www.judiciary.uk/wp-content/uploads/2022/10/Barbara-Hollis-Prevention-of-future-deaths-report-2022-0264_Published.pdf