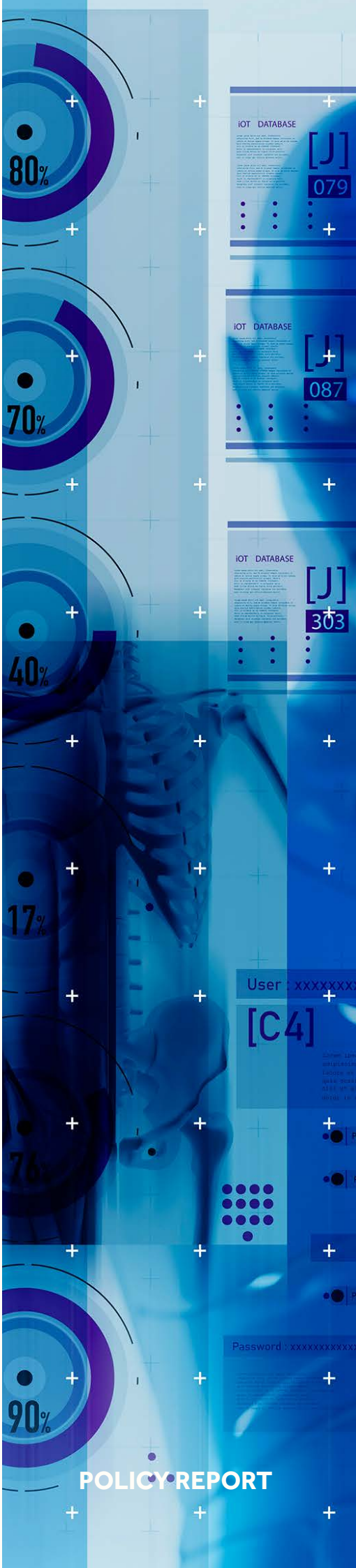
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Working together?

Quality and safety in NHS and private hospitals

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POLICY REPORT



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Executive summary

The quality and safety of healthcare provided by NHS and private hospitals is a very important concern for many people – health professionals, policymakers, senior leaders in both the NHS and the independent sector, the media – and of course patients and the public.

But there have been very serious problems in the past. For example, in 2020, the Paterson Inquiry report examined the practice of Ian Paterson, a breast surgeon in Birmingham who did unapproved and entirely unnecessary operations, many of which were botched, on hundreds of patients across both the NHS and private hospitals in the West Midlands between 1993 and 2011. It made a series of recommendations for reforms to the systems for assuring the quality and safety of care and protecting patients and the public, which were largely accepted by the government.

This report is based on research funded by the National Institute for Health Research and carried out by a team from Manchester, York and Birmingham universities. We have focused on how NHS and private hospitals work together and what differences there may be in the quality and safety of care and we have examined the implementation of the Paterson Inquiry recommendations. We aim to contribute research and evidence to inform future policy and practice.



Our key findings are

Systems for assuring the quality and safety of care in NHS and private hospitals exist within organisations but they do not work well between organisations. They rely too much on consultants themselves choosing to share or provide information about their performance or any concerns. The arrangements for gathering data and sharing information about quality and safety between organisations are not fit for purpose.

There are some longstanding concerns about the performance of private hospitals and the effect of private hospitals on the NHS which have not been supported by our empirical research. Our findings support the existing literature that indicates the quality of care in NHS and private hospitals is pretty similar on the whole, and differences are largely explained by differences in the populations they serve, with private hospitals predominantly providing less complex treatments to patients with fewer comorbidities, and not undertaking emergency work.

Data sharing has been hampered by an overcautious approach to information governance, GDPR concerns and a limited statutory basis to provide senior doctors and others holding clinical governance responsibilities with the assurance that they can share data – and, indeed, that to do so is an obligation when there are patient safety concerns.

Using two years of data, we found no evidence that when doctors work in dual practice, across both NHS and private hospitals, it has any adverse effect on either the quantity or quality of their work for the NHS. Future research needs to draw upon data over longer time periods to establish how entering and leaving private practice impacts quantity and quality of consultant care in NHS hospitals.

The operation of consultant appraisal and revalidation, and particularly the role and function of Responsible Officers, need reform to make a reality of whole scope of practice review and to create a duty on Responsible Officers and clinical governance leads to share information and to work in more formalised networks.

Liaison between NHS and private hospitals where there is shared care or a patient pathway which crosses between them needs to be improved, so that patients are informed about arrangements for ongoing care and patient records are transferred or accessible across the pathway.

It remains challenging to examine performance across whole consultant scope of practice in the public and private sectors as integrated and linked datasets are not available for clinical governance leads, regulators, and researchers. A pilot programme showed it was feasible to do so, but it has been shelved.

The arrangements for commissioning by Integrated Care Boards do not take account of the increasingly diverse provider market. Effective commissioning is hampered by patient choice and "any qualified provider" rules, and by a lack of capacity and capability in ICBs to monitor and manage contracts effectively. The NHS tariff system, based on NHS hospital cost returns, does not work well for specialist private providers and can create opportunities for windfall profits.

Based on these findings, our main recommendations to government are

The existing Responsible Officer regulations need to be revised and updated to strengthen Responsible Officers' statutory powers and duties, and to make it mandatory that they and others responsible for clinical governance share information about concerns about doctors with other organisations where they work.

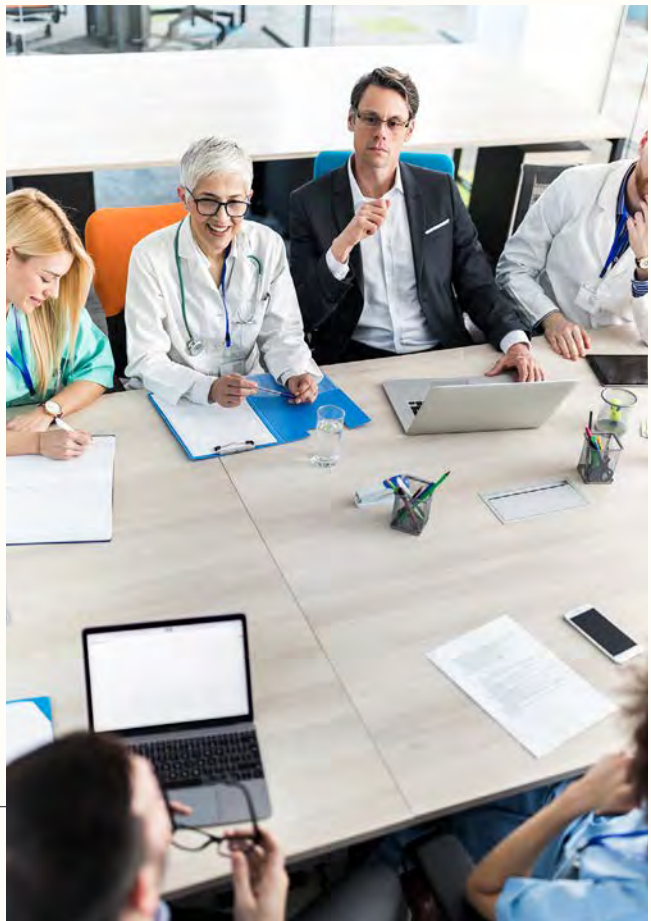
The existing guidance to organisations on appraisals and revalidation from the General Medical Council and NHS England does not have statutory force and while it makes clear that consultants and hospitals should share data about scope of practice and performance for appraisals and should ensure that appraisal and revalidation processes and outcomes are shared with every organisation where a doctor works, there is no mechanism to check or enforce this. This could be incorporated into future CQC inspections.

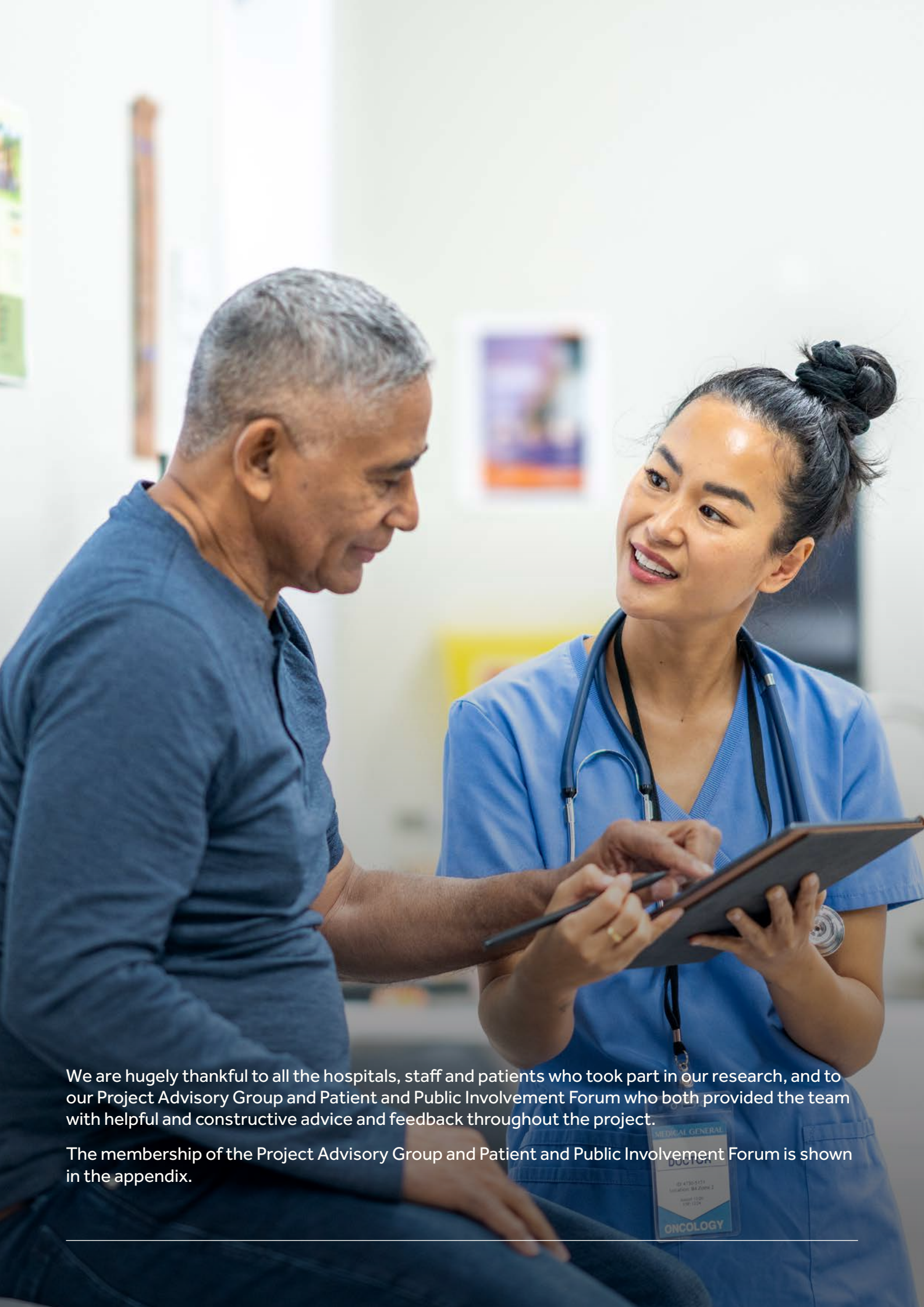
Government should move at pace to implement the first recommendation of the Paterson Inquiry report, using its existing legal powers to create a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data, which will be accessible for all those involved in clinical governance, and to patients and the public. That repository should include retrospective data from HES and PHIN.

In future, DHSC should use its powers under the Health Act 2022 to collect data from all NHS and private hospitals and to extend that data collection beyond admitted patient care. PHIN could continue to act as the data processor or DHSC could collect this data directly as it does for NHS hospitals and NHS funded care provided in private hospitals already.

The arrangements for commissioning acute healthcare from private hospitals should be reviewed, to consider whether Integrated Care Boards have the capacity and capability to commission effectively, and to put in place more robust arrangements which ensure effective contract monitoring and enforcement.

The NHS Payment Scheme should be reviewed to consider whether it is fit for purpose for contracting with NHS and private hospitals and to explore other ways of setting the reimbursement schemes for providers.





We are hugely thankful to all the hospitals, staff and patients who took part in our research, and to our Project Advisory Group and Patient and Public Involvement Forum who both provided the team with helpful and constructive advice and feedback throughout the project.

The membership of the Project Advisory Group and Patient and Public Involvement Forum is shown in the appendix.

1

Introduction

The quality and safety of healthcare provided by NHS and private hospitals is a very important concern for many people – health professionals, policymakers, senior leaders in both the NHS and the independent sector, the media – and of course patients and the public.

Some patients choose to go private and increasingly, some patients get offered the choice of whether to have their NHS funded care in an NHS hospital or in a private hospital. They want to know what that means for how long they may have to wait for treatment, how far they might have to travel, the quality of care they will receive, and what happens if there are any problems or complications.

The quality and safety of care in NHS and private hospitals is a contentious topic, on which some people and organisations have strong views. Organisations like Keep Our NHS Public[1] and the Centre for Healthcare in the Public Interest[2] see private, for-profit healthcare providers as a threat to the NHS, and argue that they put their profits before patients and the quality of care. But the Independent Healthcare Providers Network[3] asserts that private hospitals offer high-quality care, with good facilities and quicker access to treatments than many NHS hospitals.

In reality, the UK healthcare system has always been a combination of public and private provision, and while most healthcare is publicly funded, there has always been some private funding from patients paying for their own care or from health insurance. But the public/private healthcare debate has often been heated and perhaps driven more by rhetoric and ideology than by good evidence and data.

This report is based on research funded by the National Institute for Health Research and carried out by a team from Manchester, York and Birmingham universities. It is important to note that this research is mainly on planned or elective surgical services provided by NHS and private hospitals – in specialties like orthopaedics, general surgery and ophthalmology for example – because this is where most private hospital activity is found.

Private hospitals do not generally provide emergency or urgent care, obstetric care, or medical specialities like general medicine, care of the elderly, paediatrics, etc. We also do not cover private hospitals providing inpatient psychiatric services, or the private healthcare sector in other areas like primary care.

We have focused on the facts and the data to ask how NHS and private hospitals work together and what differences there may be in the quality and safety of care. We aim to contribute research and evidence to inform future policy and practice.



1 https://keepournhspublic.com/

2 https://www.chpi.org.uk/

3 https://www.ihpn.org.uk/



This report is structured into five main sections:

Background – which sets out why concerns about the quality and safety of hospital care have arisen over the last decade or longer – in both NHS and private hospitals. It explains what reforms or initiatives have been introduced and how they have worked, and how the healthcare system has changed in ways that have increased the interactions between NHS and private hospitals.

Systems for governance of quality and safety – how NHS and private hospitals track and manage quality through things like complaints, incident reporting and consultant appraisal and how they share information especially when there are concerns or problems about a doctor.

Information about quality and safety – what data is collected by both NHS and private hospitals, how it is shared or accessed, and who can see what it tells us about doctors' performance and other key quality issues.

Comparing quality and safety – what we know about how quality and safety varies across NHS and private hospitals, including areas like access, equity, waiting times, activity, complications and clinical outcomes and workforce issues.

Commissioning for quality – how NHS-funded care is commissioned (or purchased) from NHS and private hospitals, and how the arrangements for setting and monitoring contracts, giving patients a choice of hospitals, and paying hospitals for the activity they undertake work may affect quality and safety.

The report concludes by making some recommendations for changes which we think would lead to improved quality and safety for patients and better value for money for the NHS.

2

Background:
why quality in NHS and private hospitals matters

Since the inception of the NHS in 1948 as a publicly funded and provided healthcare system, there have also been private hospitals (run by either for-profit companies or in some cases not-for-profit charities or mutual organisations).

They have largely focused on providing elective surgical services – operations like hip and knee replacements, cataract surgery, hernia repairs and the like – and have been funded mostly either by patients paying directly for their care (who are sometimes called self-payers) or by health insurance that patients take out for themselves or get through their employer. Some NHS hospitals also have private patient units within the hospital, where patients funded privately can be treated. Over the last two decades, private hospitals have been providing a growing share of NHS-funded elective surgery, often to reduce waiting lists and waiting times for NHS patients or to give them a choice of hospitals .[4]

How has the share of NHS and private hospitals changed?

Figure 1 shows the balance of NHS funded care versus privately funded elective inpatient care and NHS hospital versus private hospital care delivery in 2020. You can see that the great majority (88%) of elective inpatient care is NHS-funded and delivered in NHS hospitals (quadrant A in the diagram). But just under 6% of care is NHS-funded but delivered in private hospitals (quadrant C), and another just under 6% is privately funded and delivered in private hospitals (quadrant D). Very little care (under 1%) is privately funded but delivered in NHS hospitals (quadrant B).

Figure 1 The funding and provision of elective inpatient care in England in 2020

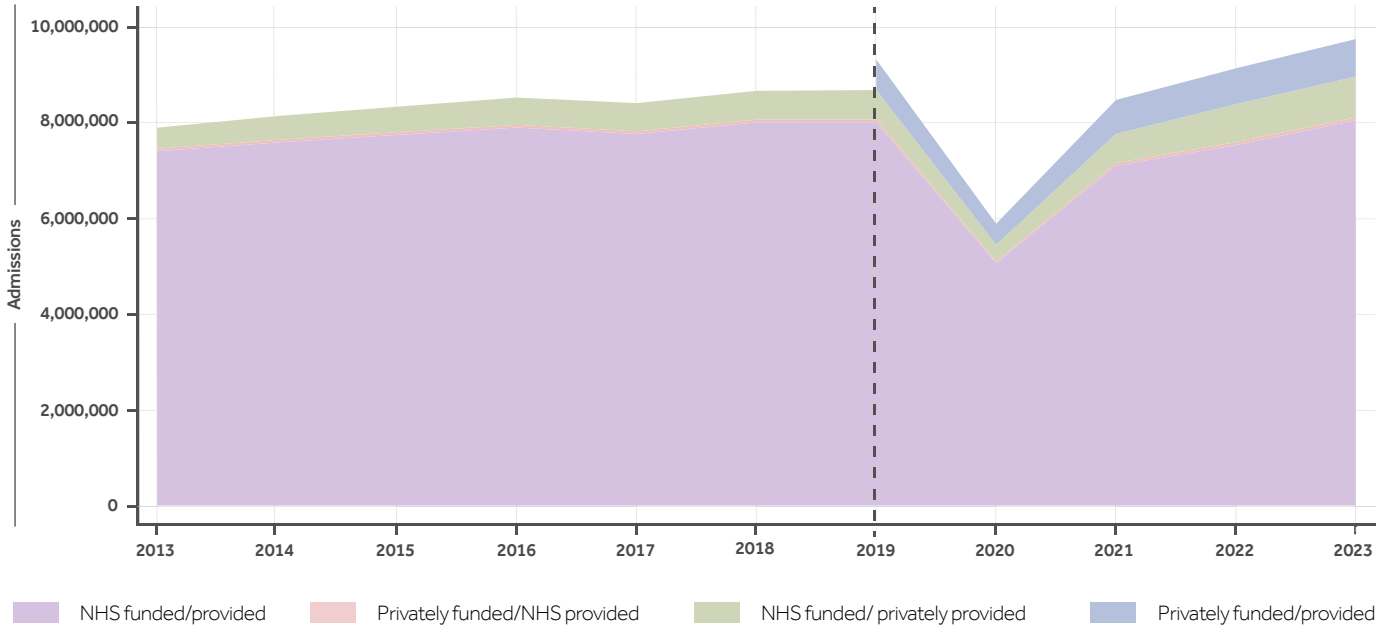
	NHS funded	Privately funded
NHS hospitals	**A** (88%)	**B** (0.6%)
Private hospitals	**C** (5.6%)	**D** (5.8%)

There are two main reasons why the role of private hospitals in the NHS is often somewhat contentious. The first is that over the last decade or longer, the amount of NHS-funded care they provide has been growing (from about 5.5% of all NHS-funded elective care in 2013, to 9.6% in 2023).

This is shown in **figure 2** below. The amount of NHS-funded care provided by private hospitals is quite small in absolute terms, but it has grown steadily. The sharp drop in all elective inpatient care in 2020 was of course due to the pandemic. Data on privately funded/privately provided care has only been available since 2019 which is why the blue area starts from then.

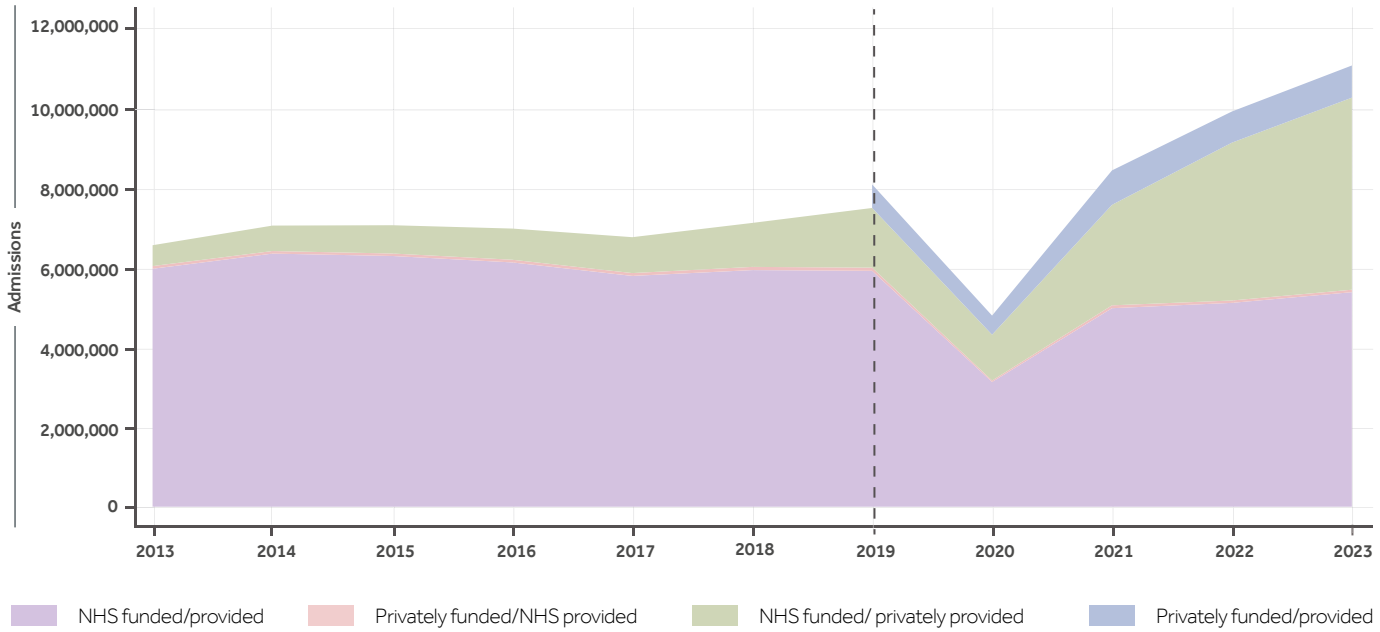
4 https://www.nuffieldtrust.org.uk/news-item/how-has-the-role-of-the-private-sector-changed-in-uk-health-care

Figure 2 Elective inpatient admissions in England 2013 – 2023



In a few areas – like cataract surgery – the private sector has grown dramatically. **Figure 3** shows all elective admissions in ophthalmology from 2013 to 2023.

Figure 3 Elective admissions for ophthalmology in England 2013-2023.

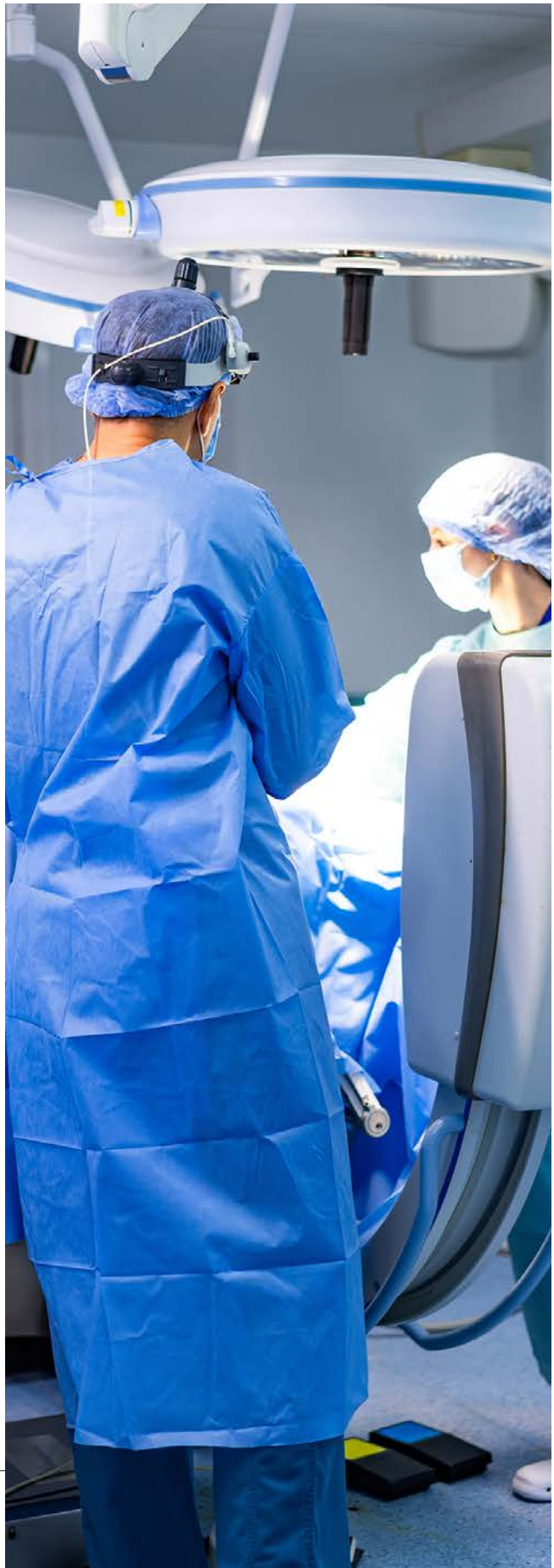


The changes in ophthalmology are largely driven by cataract surgery. The annual volume of NHS-funded cataract operations in England has gone from 416,691 cases in 2018/19 to 649,886 in 2023/24 (a 56 per cent rise). Private hospitals went from doing 22.4% of these operations in 2018/19 to doing 56.8% in 2023/24. The numbers of cataract operations in NHS hospitals actually fell over this period.

This kind of growth in private hospital provision has led some people to argue that the NHS is being privatised, that private hospitals cherry-pick the easier or simpler patients to treat and make too much profit, and that this is damaging to the NHS. Others argue that private hospitals help tackle long waiting times and lists, give patients more choice, stimulate competition, and increase overall system capacity.

This leads to the second point of contention – the medical workforce. Doctors work in both NHS and private hospitals. The great majority of consultants work for the NHS, but some (especially in surgical specialties) also work in the private sector. A small number of consultants only work in the private sector, often after a career in the NHS.

However, because the supply of doctors is limited, and because doctors can earn more in private hospitals than they can in the NHS, some people assert that private hospitals take doctors away from the NHS, and do not increase overall system capacity but weaken NHS provision. They also argue that because private hospitals do not generally contribute to the training of doctors and other healthcare professionals, they place the burden of workforce training on the public healthcare system.



Quality and safety: some key developments

These concerns go back a long way – pretty much to the start of the NHS – but they have grown in recent years, partly because of the increasing involvement of private hospitals in delivering NHS-funded care. They have also grown because of a number of reviews and reports which have raised questions about the quality and safety of care in both NHS and private hospitals, and some reforms designed to improve oversight of clinical performance.

For example:

In 2012, a system of revalidation for doctors was introduced by the General Medical Council (GMC), to check their continuing fitness to practice, in response to several past high-profile inquiries into problems with doctors' performance[5]. It was founded on the mandatory annual appraisals for doctors that already existed and required a senior doctor at their employer (termed a "Responsible Officer") to make a recommendation to the GMC every five years on whether the doctor should be revalidated. Because the great majority of hospital doctors worked in NHS trusts, their Responsible Officer was usually the medical director of the NHS trust. Importantly, that Responsible Officer was required to review performance across the whole scope of practice of the doctor, including any work in other hospitals – so for the first time a legal requirement for the oversight of doctors working in private hospitals was introduced.

In 2014, the Competition and Markets Authority published a critical report on the private healthcare market, which found that market power was concentrated in a small number of suppliers, that there was limited information available to patients and their GPs on which to base decisions, and that limited competition led to higher prices for patients and insurers. It used its powers to mandate the collection of information about all inpatient care from all private hospitals in the UK, and a charity called the Private Healthcare Information Network (PHIN) was set up for this purpose. It started collecting data in 2017, including activity data and patient reported outcome measures (PROMs) and over the last few years has steadily improved the coverage and accuracy of the data it collects on privately funded inpatient care. The dataset collected broadly matches that collected by the NHS from all NHS hospitals. In 2026, PHIN announced that it fulfilled its mandate from the CMA.

In 2018, DHSC and PHIN established a pilot programme (called the Acute Data Alignment Programme or ADAPt) to join up the data they held on all inpatient care on NHS and private hospitals. The pilot showed this could be done, but no further action has resulted and the programme was retired by NHS England in 2026[6] .

In 2019, the Care Quality Commission published a report based on its inspections of over 200 private hospitals. It found "concerns around the safety and leadership of some services, often as a result of a lack of safety checks and poor monitoring of risks. Too often, safety was viewed as the responsibility of individual clinicians, rather than a corporate responsibility supported by formal governance processes. In particular, we found that monitoring of medical governance such as scope of practice of individual consultants was not consistently robust".

5 https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/revalidation-resources
6 https://digital.nhs.uk/services/acute-data-alignment-programme

Also in 2019, the Independent Healthcare Providers Network (IHPN) produced and published its Medical Practitioners Assurance Framework which set out guidance for private hospitals on systems for medical governance. This was updated in 2022 and a further update will be published in 2026. It sets out how private hospitals should have systems for granting practising privileges to doctors, defining their scope of practice, monitoring and reviewing their performance regularly, and dealing promptly with any concerns that arise.

In 2020, the Paterson Inquiry published its report into the practice of Ian Paterson, a breast surgeon in Birmingham who is currently serving a 20-year prison sentence for intentionally wounding patients through unapproved, and unnecessary medical procedures, many of which were botched. Operating across both the NHS and private hospitals in the West Midlands between 1993 and 2011, he harmed hundreds of patients. The inquiry report opens by saying: "This report is not simply a story about a rogue surgeon. It would be tragic enough if that was the case, given the thousands of people whom Ian Paterson treated. But it is far worse. It is the story of a healthcare system which proved itself dysfunctional at almost every level when it came to keeping patients safe, and where those who were the victims of Paterson's malpractice were let down time and time again." It makes a number of recommendations for improving oversight of clinical performance which we explore below.

In 2022, the Cumberlege report into the safety of medicines and medical devices highlighted major failings in the oversight of safety across both the NHS and the private sector which had harmed thousands of patients. It recommended new databases of all devices to be mandatory across both NHS and private hospitals and that all data should be shared for consultant appraisal and revalidation.



In 2022, the Health Services Safety Investigation Body published a report on surgical care of NHS patients in private hospitals which highlighted the risks of acutely unwell patients being cared for in private hospitals without necessary diagnostic and clinical facilities, and recommended better information about capacity and capability be shared with NHS trusts and commissioners, and rapid transfer of deteriorating patients from private hospitals to NHS hospitals when it is needed, accompanied by full clinical records.

The Paterson Inquiry: fundamental reforms recommended

The Paterson Inquiry report was a watershed for both the NHS and for private hospitals. In the government response to the report, the then Secretary of State for Health wrote: *"The personal tragedies set out in the report of the inquiry were compounded by what the inquiry found to be the failure of a regulatory system that was well resourced to prevent such abuse, but that did not respond to the signals or 'join the dots' – to devastating effect. The inquiry also found that there were a series of failures across the entire healthcare system... This had devastating consequences for patients."*

The inquiry report made 15 recommendations, 13 of which were accepted in full by the government. It published its response to the inquiry report in 2021, and a further update in 2022. There have been no updates published since then. We list in **figure 4** some of the Inquiry recommendations which relate particularly to the way that NHS and private hospitals work together, and we will return to these recommendations in our discussion and conclusions.

Figure 4 Some key recommendations from the Paterson Inquiry report

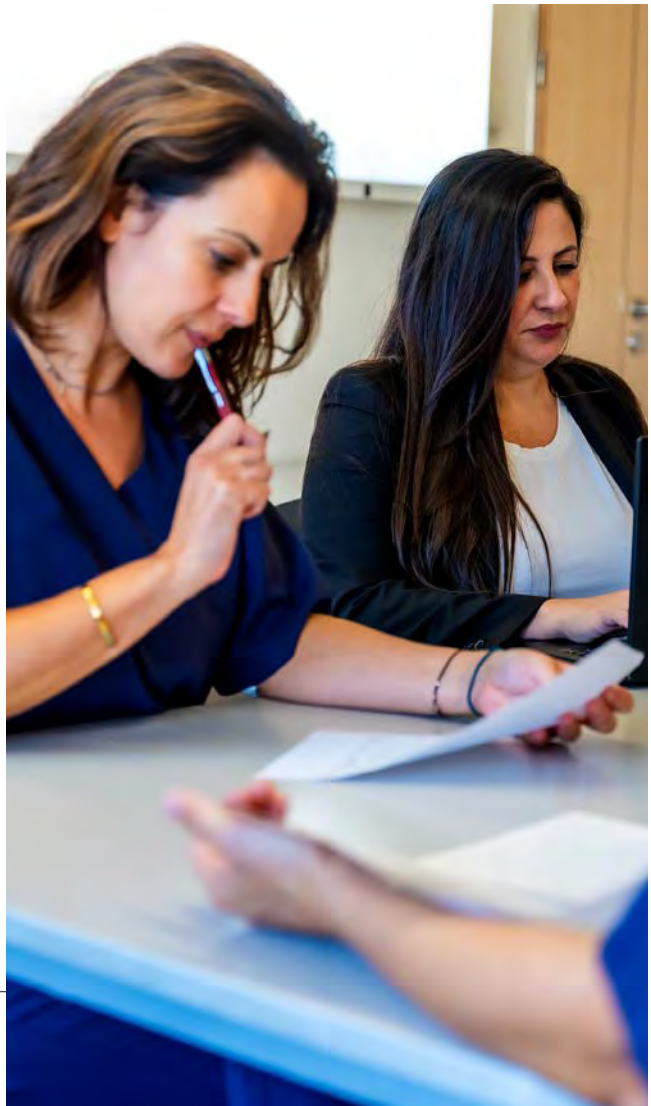
1	We recommend there should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data – for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and the independent sector.
3	We recommend that the differences between how the care of patients in the independent sector is organised and the care of patients in the NHS is organised is explained clearly to patients who choose to be treated privately, or whose treatment is provided in the independent sector but funded by the NHS. This should include clarification of how consultants are engaged at the private hospital, including the use of practising privileges and indemnity, and the arrangements for emergency provision and intensive care.
10	We recommend that the government should, as a matter of urgency, reform the current regulation of indemnity products for healthcare professionals in light of the serious shortcomings identified by the inquiry and introduce a nationwide safety net to ensure patients are not disadvantaged.
12	We recommend that if, when a hospital investigates a healthcare professional's behaviour, including the use of an HR process, any perceived risk to patient safety should result in the suspension of that healthcare professional. If the healthcare professional also works at another provider, any concerns about them should be communicated to that provider.

13	In the NHS, consultants are employees and the NHS hospital is responsible for their management, and accepts liability when things go wrong. The situation is very different in the independent sector where most consultants are self-employed. Their engagement through practising privileges is an arrangement recognised by CQC. However, this recognition does not appear to have resolved questions of hospitals' or providers' legal liability for the actions of consultants. We recommend that the government addresses, as a matter of urgency, this gap in responsibility and liability.
15	We recommend that, if the government accepts any of the recommendations concerned, it should make arrangements to ensure that these are to be applicable across the whole of the independent sector's workload (meaning private, insured and NHS-funded) if independent sector providers are to be able to qualify for NHS-contracted work.

Since the Paterson case, there has been widespread media coverage of a number of other high-profile examples of doctors whose practice has caused serious concerns and resulted in harm to many patients. Often, there have been investigations or reviews by NHS England, Royal Colleges, or independent investigators. Some have resulted in full scale statutory public inquiries. These ongoing failures in care seem to suggest that despite some reforms, "the failure of a regulatory system that was well resourced to prevent such abuse, but that did not respond to the signals or 'join the dots'" noted by the Secretary of State for Health in 2021 has continued.

Since the pandemic, the involvement of private hospitals in delivering NHS-funded care has continued to grow, particularly in some specialties, but there has also been a rapid development of new models of care in which private organisations deliver staffing and other services to provide care on NHS premises with NHS facilities. Often termed "insourcing", these newer private organisations (which are often consultant owned private for-profit limited companies) are responsible for the clinical governance of the services they deliver and usually do so under a contract from an NHS trust, but patients may not be aware they are being treated by a private provider and the activity is not distinguishable in the statistics from cases where the whole treatment is provided by the NHS itself.

Overall, we are seeing new and complex models of care emerge in which patient pathways from referral to diagnosis, treatment and discharge may cross a number of organisational boundaries in both the NHS and the private sector. The need for effective interorganisational clinical governance may never have been greater.



About our research

This report draws mainly on research funded by the National Institute for Health Research and carried out by a team from Manchester, York and Birmingham universities[7]. We set out to answer four main research questions:

1. What are the characteristics of the patient population and the care provision in NHS and private hospitals in England, and what differences are observed by funding type (NHS or private), care setting (NHS or private), specialty, procedure and geography and over time?

2. Can we map and measure the overall scope of practice of doctors providing care in both NHS and private hospitals, and explore how well those organisations understand and oversee that scope of practice through the separate and shared arrangements for clinical governance that they have in place?

3. How does the quality and safety of care provided in NHS and private hospitals vary and what hospital, consultant, or other characteristics are associated with such variations?

4. How have the practice and working arrangements between NHS and private hospitals changed during and after the COVID19 pandemic, and what effects have those changes had on clinical governance and the quality and safety of care?



The project methodology is full described in the project protocol on the NIHR website[8], and there is further information on our project website, including links to all project publications[7]. We are hugely thankful to all the hospitals, staff and patients who took part in our research, and to our Project Advisory Group and Patient and Public Involvement Forum who both provided the team with helpful and constructive advice and feedback throughout the project – details of both can be found in the appendix to this report.

7 https://www.alliancembs.manchester.ac.uk/research/funded-projects/quality-safety-and-clinical-governance-in-nhs-and-independent-hospitals/

8 https://njl-admin.nihr.ac.uk/document/download/2046327

3

Systems for governance of quality and safety and how they work across NHS and private hospitals

Both NHS and private hospitals have systems to monitor and oversee the quality and safety of care, and to deal with any problems which arise. They are all inspected by the Care Quality Commission against the same standards and regulations. But they are quite different as healthcare provider organisations.

There are around 700 NHS hospitals in England (run by around 135 NHS trusts) on average with around 500 beds though some are much larger than that. These hospitals usually deal with both emergency and planned care, treat a wide range of surgical and medical specialties, have many operating theatres, extensive onsite diagnostic facilities, and critical and intensive care units. Medical care is provided by large teams of doctors around the clock – consultants and doctors in training grades – and they are often also involved in teaching doctors and in research.

There are around 200 private hospitals in England, on average with about 40 beds. They generally only provide planned/elective care – mostly surgical operations of fairly low complexity for patients who are low risk. They may have limited diagnostic facilities on site and most of them do not have critical or intensive care units. Medical care is provided mostly by consultants (who usually have their main job in the NHS but work part-time in the private hospital) and resident medical officers who provide out of hours cover.



We found that NHS and private hospitals have different approaches to clinical governance, and different challenges in monitoring and overseeing the quality and safety of care and dealing with any problems which arise.

For example:

NHS hospitals directly employ their consultant medical staff (and doctors in training) and have full legal responsibility for their performance. They are also responsible for the appraisal and revalidation of those consultants. They generally have whole departments dedicated to clinical governance with teams dealing with complaints, incident reporting, quality improvement programmes, medical staffing, continuing professional development, and so on. They are large organisations, often employing hundreds of doctors, so a lot of responsibility is often devolved to clinical directorates or departments, which will have their own structures like multidisciplinary team (MDT) meetings, mortality and morbidity reviews, etc.



Private hospitals do not generally employ consultants – they are engaged as independent contractors who are legally responsible for their own clinical practice. Consultants have to apply to have practising privileges (permission to admit patients) from private hospitals, and these are reviewed by a medical advisory committee of senior doctors who work at the hospital which makes recommendations to the hospital management. Private hospitals also collect clinical data and can conduct their own appraisals, contributing information to consultant appraisals and revalidation carried out in the NHS hospital where the consultants are employed if the consultant requests it, but they are not generally involved in those processes in the NHS or in any follow-up. Many private hospitals do not run their own MDTs, and while private patients can be discussed at NHS MDTs, this relies on consultants referring the cases to the MDT and MDT members being able and willing to offer advice. Private hospitals usually have a small management team dealing with clinical governance and other responsibilities, though hospitals which are part of a larger group will often have some support from the group headquarters. Because they are generally small organisations with a limited range of services, private hospitals have the potential to monitor clinical activity quite closely.

This section sets out to explore those differences, and how NHS and private hospitals work together in practice. It draws on a national survey we did of both NHS and private hospitals, and on 84 interviews with staff in NHS and private hospitals.

Clinical governance at the interface between NHS and private hospitals

We found that interorganisational clinical governance relied heavily on senior doctors and others with governance responsibilities building and maintaining personal relationships with their counterparts in other hospitals, and this was usually easier to do in places like provincial towns where there was just one main NHS hospital and one private hospital. It was harder to do in larger towns and cities where there were multiple NHS and private hospitals.

> *The two main private hospitals nearby, we have reasonable relationships. I made an effort as CMO to reach out to all local private hospitals, with varying degrees of success. It is all very ad hoc. ...the flow of information and collaborative working needs to improve."*
>
> *(Chief Medical Officer, NHS)*

> *Inconsistent - some are excellent and others less so. Regular meetings and shared learning happens between some hospitals and their local NHS trust. In some localities this is even broader with good relationships across all providers in the ICB region. Some hospitals really struggle to get good collaboration with the local NHS trust."*
>
> *(Chief Clinical Officer, Private Sector)*

Only about 20% reported that they had any kind of formal written agreement with their counterpart hospital and, while some had regular meetings, others said they only met ad-hoc when problems arose. The asymmetry in size between NHS and private hospitals also played a part – and the fact that private hospital groups could be dealing with many different NHS hospitals, so building relationships was difficult.

> *I think the systems are reliant on personal honesty and transparency. If a consultant had practicing rights in [a large private hospital chain] for instance we may not know that. Locally the private hospitals are small and so it would be harder for folks to go under the radar."*
>
> *(Clinical Lead, NHS)*

> *It is quite dependent on the individuals involved and the relationships they have. Our organisation has more than 30 hospitals, leading to conversations with RO's in potentially many more trusts. It is difficult to build an effective relationship across this number."*
>
> *(Chief Clinical Officer, Independent Sector)*

> *It is not a two-way street - we inform but we are not often informed. This may be because it may be unknown where a consultant has their private practice as not held centrally anywhere (or validated)."*
>
> *(VP of Quality, Private Sector)*

Understanding and monitoring doctors' scope of practice

One crucial issue that emerged from our research was how hospitals define and oversee what is termed the scope of practice of doctors – the range of conditions, treatments or operations they are competent to perform. In the NHS, all consultants should have a job plan, which sets out their commitments to clinics, ward rounds, operating theatre sessions and so on. But this does not define the content of what they do, and we heard from some interviewees that job plans were not monitored:

> *And, again, I think in many organisations, including my own, there has been a palpable reluctance to police job plans, so that individuals, who are not where they're supposed to be, can be identified and the disciplinary problems that that generates addressed. And I know of two instances, simply within the last couple of years, where individuals have been not where they're supposed to be, because they've been at the private sector, when they're being paid to be undertaking NHS work, it took two years to deal with one of those problems"*
>
> *(Consultant, NHS)*

In the consultant's annual appraisal in the NHS, there should be details recorded of their NHS scope of practice, but this is not always the case, and in any case the appraisal is not usually shared with other organisations where the consultant works such as private hospitals. The appraisal should contain details of their private practice, including data on complications, incidents or complaints; but again this relies on doctors declaring where they work and providing details of their scope of practice and appropriate clinical data. ROs and other senior doctors undertaking appraisals need the power to require this information to be presented before appraisal takes place.

> *At point of revalidation, we get a statement of no concerns from each IS organisation listed in scope of practice at appraisal. It does not tell us in detail if they do the same procedures as in the NHS."*
>
> *(RO, NHS)*

> *I would write to the RO equivalent at the independent hospital if this is not clear in an appraisal process. Often a log is provided by a consultant though this does rely on probity."*
>
> *(Consultant Surgeon, NHS)*

> *My colleagues, in my experience, don't mention their private work at all and aren't challenged on it or they just say, well, I do a session a week at the local private hospital, but they don't provide any further detail about their activity, they don't provide, in my experience, information about complications resulting or complaints resulting from their private practice and, of course, because there's this firewall, between the two, there is no way than an appraiser would know to ask necessarily about that and compel someone they were appraising to provide that information. So I think it often just slips under the radar."*
>
> *(Consultant Surgeon, NHS)*

> *It's not. My experience is it's not and never has been. Whenever I've done job plans, and I've done it for 30 years, they will tell me that they work in the private sector and they'll tell me, and they will tell the clinical director, everything is going great. They won't tell us if anything has gone [wrong]... And the private sector won't volunteer that information either. Because they're under a separate contract, aren't they? "*
>
> *(Interim Chief Operating Officer, NHS)*

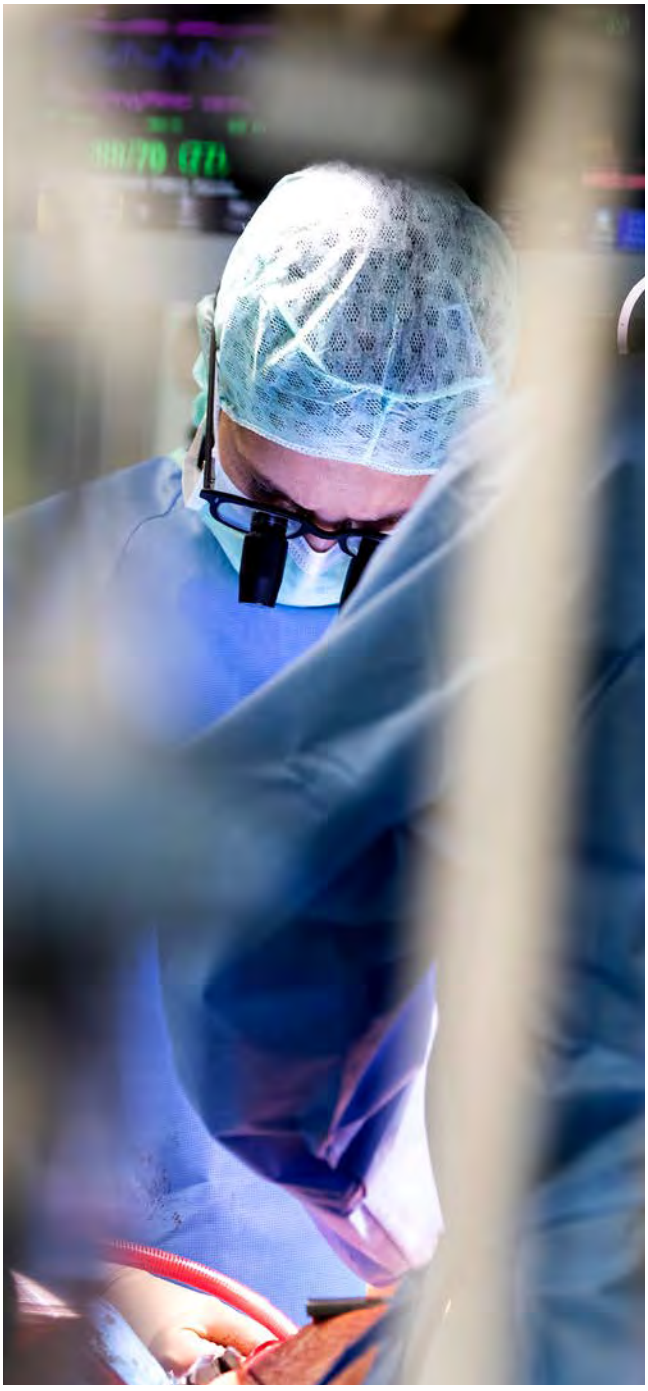
In private hospitals, scope of practice is usually more clearly defined when practising privileges are granted, and some hospitals go as far as to list the operations that the consultant is permitted to perform. But private hospitals generally allow doctors to do in the private hospital what they do in their NHS practice and, as already noted, that can be poorly defined, and they may be reliant on doctors themselves to tell them.

> *For some specialties the consultant is requested to get their scope of practice countersigned by their NHS Clinical Director. But compliance is variable - some NHS Clinical Directors are reluctant to engage."*
>
> *(Chief Executive, Private Sector)*

> *To be honest we get it from the consultant as part of PPs and you are trusting the consultant that they are telling the truth. We probably don't recheck scope of practice as much as we should."*
>
> *(Hospital Director, Private Sector)*

> *It is easy for somebody to just stop doing certain cases in their NHS practice. We're entirely reliant of them either telling us that, or if they've been stopped doing it, the ROs picking up the phone to speak to each other. And so, effectively, it's...without a formal mechanism to back it up, and without the evidence of an annual appraisal, you are relying on trust. ...we shouldn't be relying on trust, it should be something that is formal, transferable, able to be looked up by anybody, the patient, us as one of the employers, because the impact is significant."*
>
> *(Clinical Director, Private Sector)*

We heard many concerns from interviewees that these current arrangements provided inadequate protection for patients against some doctors working outside their scope of practice, or undertaking unconventional, inappropriate or incompetent surgery.



> *...there are smaller places where the scope of practice... and people go beyond their scope of practice because they've got to keep that place running, they have to... You know, so where there are owner clinics, which are smaller and have no supervision because whoever owns the clinic actually is the surgeon and, you know, then you start having problems and they will extend their scope of practice to doing things that will keep them commercially viable."*
>
> *(MAC Chair and Consultant, Private Sector)*

> *... most doctors who are difficult usually know how to use the system, they're able to use the system. I expect in [private sector organisation], it was commercially driven, I don't know. But you've got a big breast surgeon doing lots of work...bringing in lots of revenue, are you going to upset him? Are you going to pull him aside for bad behaviour. I can imagine how it happened, I'm not condoning it..."*
>
> *(MAC Chair, Private Sector)*

> *That is another area where when you are working in the independent sector you should only be doing the easy stuff, the stuff that you are doing on a really regular basis. You shouldn't be pushing your envelope... because you don't have the back up equipment, the facilities. Then you get other people coming in and the private hospitals get excited when they hear, oh, Mr so and so is doing this procedure that nobody else does. You think, oh, hang on a minute, are the alarm bells not going off."*
>
> *(Consultant, NHS and Private Sector)*

Appraisal and revalidation

As explained earlier, reforms to the regulation of doctors introduced in 2012 created a requirement for every doctor to undergo revalidation every five years – where a senior doctor in the organisation where they are employed, called the Responsible Officer, makes a recommendation to the General Medical Council that they remain fit to practice. This is built on the system of mandatory annual appraisals which already existed, and guidance from NHS England and the GMC set out the supporting information that doctors needed to collect for their appraisals and revalidation.

Crucially, appraisal and revalidation cover the doctors' performance across their whole scope of practice – so doctors who work in more than one organisation (such as in an NHS hospital and one or more private hospitals) have to provide information to their Responsible Officer from everywhere they worked. For the first time, data about doctors' whole practice should be reviewed in one place, and there is a senior doctor – the Responsible Officer – who has a set of statutory powers and responsibilities set out in regulations to provide oversight of doctors' performance. This is the only formal system for interorganisational clinical governance.

In reality, we found it was difficult for Responsible Officers to fulfil their responsibilities for a number of reasons. Firstly, there is no central database of where doctors work, so the Responsible Officer is entirely reliant on the individual doctor disclosing their work at other hospitals. Secondly, some private hospitals just provide a "letter of good standing" for their consultants to pass to their Responsible Officer as part of their appraisal, but this typically only states there are no ongoing investigations, restrictions on practice or exclusions in place. They may provide more information than that, but there is no obligation upon them to do so. Thirdly, private hospitals often get little or no feedback from the NHS hospital after the appraisal which is important especially if there are any actions arising from the appraisal. Fourthly, it was often not clear with whom in a private hospital the Responsible Officer should or could share information.

For private hospital groups, there is generally no Responsible Officer at a hospital level but one Responsible Officer at national level for the whole group – who may have to liaise with Responsible Officers in dozens of different NHS trusts. Fifthly, and perhaps most importantly, sharing data about performance with other hospitals is not mandatory for Responsible Officers, or for other people involved in clinical governance.

We heard many calls for a more systematic approach to providing data for whole scope of practice appraisal:

> *It would be ideal to have sufficient detail documented for all NHS consultants that could be shared with independent sector, and vice versa. Collecting, verifying, documenting and sharing this information would require systems and process we currently do not have."*
>
> *(Chief Medical Officer, NHS)*

> *Improvement should involve a bidirectional interface - full NHS scope of practice can come from the Director of Service (DoS) for consultants and last 5 years of practical experience. This could be replicated by private providers. It is not just the scope of practice, rather the complications that are managed and clear understanding of outliers is useful."*
>
> *(Assistant Medical Director, NHS)*

> *A centralised data repository which includes case numbers across a consultant's NHS and private practice, which was the intention with PHIN (but it has not delivered yet)."*
>
> *(Chief Executive, Private Sector)*

> *So, when we're pulling incidents...it might look okay to us but if you extrapolated that to their NHS work, which we don't get to see, is there then a problem? We're not joining up in that respect. So, no one I don't think has got a picture of a consultant's performance and safety other than that consultant themselves. They're the one that holds all of that information. "*
>
> *(Head of Risk Management and Clinical Governance, Private Sector)*

When revalidation was first introduced, a nationally advised standard medical appraisal form with associated guidance was provided. But the work of establishing information systems to manage appraisal information was left to the market in England, with the result that a number of commercial systems were established and used by different NHS trusts and information is siloed and not easily shared. In contrast, both Wales and Scotland established single information systems for appraisal which were used by all Responsible Officers and are therefore much better placed to share information when needed.

Dealing with concerns about medical performance

We heard from interviewees that one of the most difficult roles for senior doctors in both NHS and private hospitals was dealing effectively with concerns when they are raised about a doctor's performance. Interviewees discussed the challenges of balancing the need to take concerns seriously and respond effectively with the potential reputational and relational harm that investigations can cause to doctors, colleagues, and themselves, emphasising the importance of ensuring that any investigation was proportionate to the concerns raised:

> *It's difficult and there's a bit of a dark art to it... there has to be a bit of a fine line, but really, it's about evidence, triangulation, records...it's using your experience... but it has to be evidence based."*
>
> *(Director of Governance, NHS)*

> *We take written concerns much more seriously than verbal concerns. There's often in medicine some professional jealousy, people fall out; so you occasionally get people saying, oh, I think you need to look at X, Y and Z. I usually ignore that sort of tittle-tattle and encourage if people do have genuine concerns about a person's practice or capability, et cetera, then they need to write it down."*
>
> *(Chief Medical Officer, NHS)*

> *...they don't like to comment on each other's work officially. They'll do it unofficially very vocally but they don't like to do it officially. And trying to get that engagement and get them to do what they need to do so that we can get the right professional opinion or information can be difficult.*
>
> *(Clinical governance lead, NHS)*

Some interviewees thought that concerns about doctors were too often dealt with informally and confidentially, and that could mean that the ability to take action and to share information (within and across NHS and private hospitals) was constrained.

> *... the doctor seems to get a slap on the hand and off you toddle, carry on. And that is very much the feeling on the ground, because it's all behind closed doors. I know you've got to keep stuff confidentiality, it's difficult, but... There's still this very old gentleman's handshake kind of understanding that goes on so you really don't know... it's like the Old Boys' club, isn't it ...."*
>
> *(Clinical governance lead, NHS)*



NHS and GMC guidance makes it clear that when there are concerns about a doctor's practice, or an ongoing investigation, or any temporary restrictions on practice or suspension from practice, in any NHS or private hospital, then this information should be shared with all hospitals where the doctor works. This was a recommendation of the Paterson inquiry which the government accepted in principle though it qualified this by saying "It is important that providers retain some judgement regarding when best to flag concerns to other providers as they will be taking on responsibility to ensure this information is appropriate and accurate" and referred to obligations to the consultant under GDPR regulations concerning sharing of personal data.

In practice, we found that the sharing of concerns was problematic for reasons already outlined above – knowing where a consultant worked, knowing who to communicate those concerns to, and knowing whether anything had been done about it. There was a cultural reluctance to tackle performance issues and avoidance was rationalised. Once again, there was a reliance on the doctor themselves telling other organisations about the situation which seems problematic in the circumstances.

"

When it's severe enough to warrant a restriction and they can happen quite quickly once concerns are raised. The RO restricts clinical practice and when that happens, then the restricted person is told that they should inform the RO's or the CEOs or any other institution they work in. We don't directly inform those ourselves; we ask the doctor to do it and the doctor is made aware of the very severe, more severe even disciplinary offence to continue working in one institution when you are restricted from those roles in another."

(Responsible Officer, NHS and Private Sector)

"

What's happened to me more, at least I can think of two occasions, is when the independent sector haven't contacted me about something I think they should have told me about. So if they've stopped someone operating around behaviour, for instance, or restricted them, not renewed their admitting rights for two weeks or made any...they should contact me about that because that's change in scope of practice. If that's a big enough step to do there, gosh, it's important that we know about that."

(Chief Medical Officer, NHS)

"

I think where the interface is more difficult...if we did have a concern about a consultant...and they have a job in the NHS and therefore they're a trust employee, the only way that we can talk about their practice is through our RO. So, we'd take it to our medical director and say, Mr X has got an increase in infections, we've done investigations, we've looked at trends, it would be really interesting to know if he has this problem elsewhere. The only way we can do that is to go through the RO to RO and I still think that's a bit of a protected, I still think that's a bit of an issue."

(Chief Nurse, Private Sector)



"

What happens at RO level is not something that's generally understood or recognised, certainly within the rest of the NHS organisation. Now, it may well be that our RO is having those kind of conversations all the time, with their counterparts in other parts of the healthcare system, including the private sector, but, if they are, that information is not being shared more widely and maybe that's right, maybe it shouldn't be shared more widely, given the nature of that information, but, certainly, that's, frankly, above my pay grade in governance terms."

(NHS, Consultant Surgeon)

Conclusions about clinical governance

In conclusion, many NHS and private hospitals have generally well-established systems for clinical governance within their organisations. They may not always work as intended, and there is still a very strong medical club culture which can get in the way of dealing fairly and effectively with issues of performance, but there are systems in place.

The same cannot be said of inter-organisational clinical governance. The only formal, statutory system is the network of Responsible Officers and the requirements for appraisal and revalidation, but we have outlined the shortcomings and limitations of that system and described the reliance placed instead on informal professional networks and relationships among senior doctors in both NHS and private hospitals, and on consultants to share or provide information about their own performance at other organisations.

While these may work sometimes, they are not an adequate safeguard for patients, and the continuing series of high-profile cases of problem doctors illustrates this vividly. There is a need for further reforms, which we turn to in our final section.

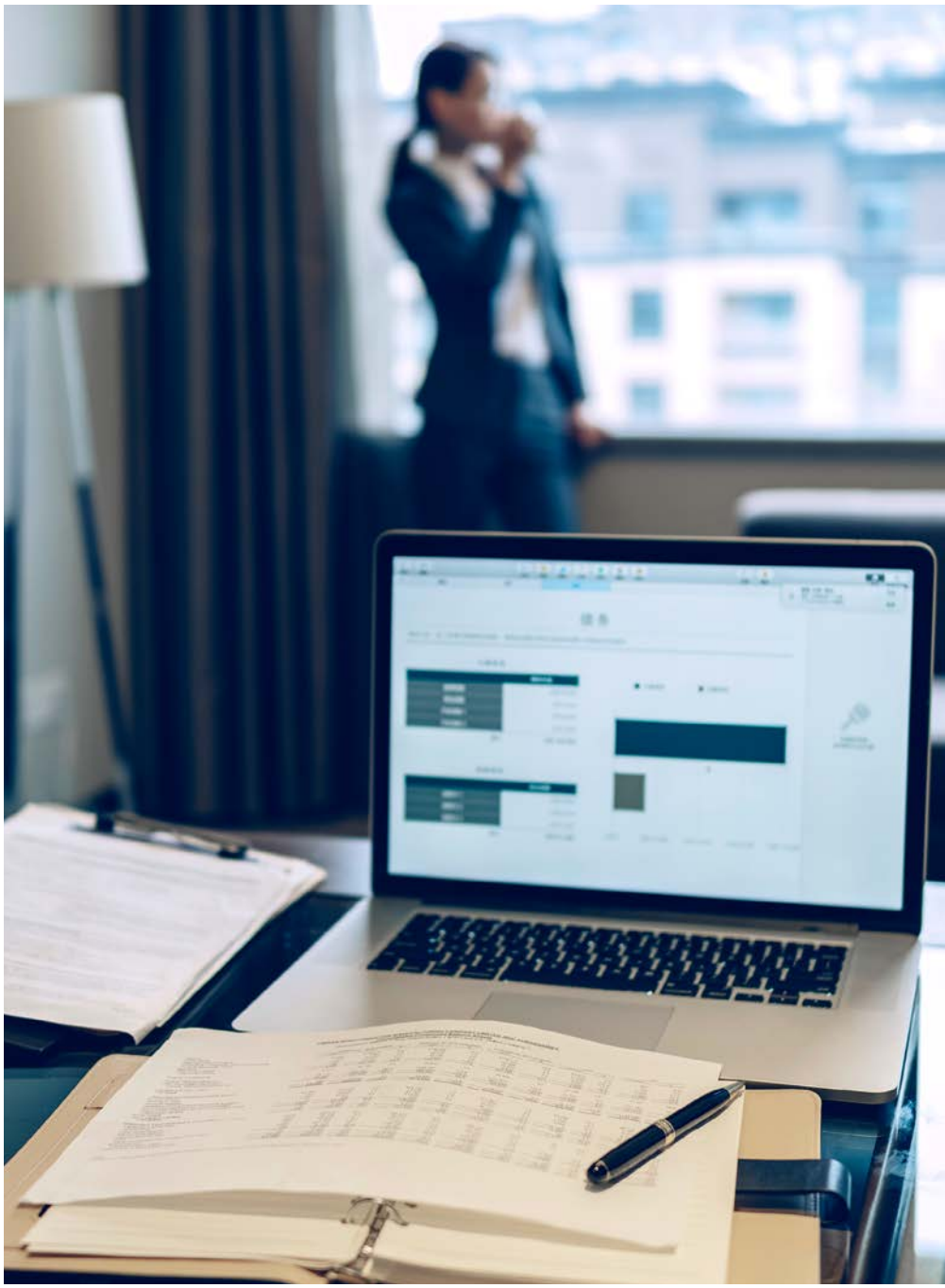


4

Collecting, managing and accessing information about quality and safety in elective inpatient care

It has already been noted that the first recommendation of the Paterson Inquiry report was that "there should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data – for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and the independent sector."

Six years later, despite this recommendation being accepted by government in 2021, it has not happened. In this section we examine the data about consultant performance that is available and describe our efforts to use it in our research – and some of the ways it could be used to monitor and manage quality and safety at the interface between NHS and private hospitals.



Information about elective inpatient care: what data exists

It may help to start by outlining some of the data sources which currently exist, what they cover, and how they can be accessed, using the four quadrants diagram in **figure 1**. That splits all elective inpatient care into four areas - NHS-funded and delivered in NHS hospitals (quadrant A in the diagram); privately funded but delivered in NHS hospitals (quadrant B); NHS-funded but delivered in private hospitals (quadrant C); and privately funded and delivered in private hospitals (quadrant D).

Figure 5 Elective inpatient care - data sources and coverage

	Data coverage			
Data source	**A -** NHS funded/ NHS provided	**B -** privately funded/ NHS provided	**C -** NHS funded/ privately provided	**D -** Privately funded/ privately delivered
NHS Hospital Episode Statistics (HES) – collected by NHS England from all NHS trusts and providers of NHS funded care	✓	✓	✓	✗
Private Healthcare Information Network – collected by PHIN from all providers of privately funded care	✗	✓	✗	✓
Healthcare Quality Improvement Programme (HQIP) national audits and outcome registries	?	?	?	?
National Consultant Information Programme (NCIP) – uses data from HES linked to ONS death records, GMC consultant data and NHS electronic staff records	✓	✓	✓	✗
Acute Data Alignment Programme (ADAPt) – pilot which used data from both HES and PHIN	✓	✓	✓	✓
National Outcomes and Registries Programme (ORP) established to provide a single registry for data about medical devices used in procedures	?	?	?	?

While as **figure 5** shows, there is some data available which covers all inpatient elective care in England, whether publicly or privately funded and provided, there are a number of shortcomings in these data sources which limit their utility in monitoring and managing the quality and safety of care across NHS and private hospitals.

Hospital Episode Statistics – are the longest established and most complete record of all elective admissions which are funded by the NHS. This dataset is complex and very widely used in research and management – alongside other datasets that NHS England collects. Access for researchers is via the Data Access Request Service (DARS). But the process for applying for and securing access is very slow (it took our project 8 months from first applying to receive data, and it can be longer for requests which require some bespoke data manipulation). There are some concerns about the accuracy of clinical data in HES, and it should be noted that while each admission is attributed to the consultant in charge, much NHS care is delivered by the wider medical team.

Private Healthcare Information Network – has been collecting data from both NHS and private hospitals on all privately funded elective inpatient care since 2017 as authorised by the CMA under the Private Healthcare Market Investigation Order 2014[9], though it has taken some time to get all hospitals to contribute data and the completeness of coverage is still a concern. PHIN publishes some aggregated data on its website[10], but it has no mechanism for allowing researchers or other third parties to access or use the patient-level dataset which it holds. Our research project began with PHIN's then Chief Medical Officer as a co-applicant, but it turned out that PHIN's board was not able to allow us access to any patient level data for our research, because of concerns that it did not have legal authority to do so under the CMA Order or other legal provisions. In the end, all we could access was aggregated data, largely that which is published on the PHINI website, subject to small number suppression rules, and which was of quite limited utility.

Healthcare Quality Improvement Programme (HQIP)[11] commissions a wide range of national audits and outcome registries (such as the National Joint Registry and the National Ophthalmology Database) on behalf of the Department of Health and Social Care, many of which are operated by bodies such as Royal Colleges and specialty societies and involve the collection of specialist datasets about particular operations or conditions. Participation is mandated in the national NHS contract but in practice varies widely in both the NHS and private hospitals. Some audits require hospitals to pay to participate. Participating doctors and hospitals get feedback in the form of various audit reports, and some audits provide information aimed at the public/patients. In most cases, these national audits are standalone datasets which cannot be (or have not been) linked to HES. Access for researchers varies for each audit but generally researchers can apply to access the data.

National Consultant Information Programme (NCIP)[12] is a programme within NHS England which uses HES data linked to some other datasets to provide consultants, clinical directors, medical directors and Responsible Officers with dashboards of indicators on surgical activity and outcomes for 13 specialties. Access is restricted to those roles (there is no public access) and it does not cover quadrant D.

9 https://www.gov.uk/government/publications/private-healthcare-market-investigation-order-2014

10 https://www.phin.org.uk/

11 https://www.hqip.org.uk/

12 https://gettingitrightfirsttime.co.uk/associated_projects/ncip/



Acute Data Alignment Programme (ADAPt)[13] was a programme set up jointly by NHS England and PHIN to link the HES and PHIN datasets through common patient identifiers to provide a single integrated dataset of publicly and private funded and provided elective care. It ran a series of successful pilot exercises to show that this was technically feasible, and in March 2025 DHSC was about to issue a formal legal direction to allow the dataset to become a routine data collection which could then be made available through DARS when the programme was paused apparently because of information governance concerns and it has subsequently been retired. Information about the ADAPt programme pilots is no longer available on the NHS England website.

National Outcomes and Registries Programme (ORP)[14] was established to provide a single unified registry for data about medical devices used in procedures, as recommended by the Cumberlege report. It is still being set up though formal directions for data collection have been issued and should cover data in all four quadrants. There is some potential overlap with some HQIP national audits and registries.

13 https://digital.nhs.uk/services/acute-data-alignment-programme

14 https://www.england.nhs.uk/outcomes-and-registries-programme/

Data quality: completeness and comparability between NHS and private hospitals

One of the fundamental challenges in using data to make comparisons of quality and safety between different hospitals is to make sure your comparisons are fair and take account of the differences between those hospitals – we have already observed that NHS hospitals and private hospitals treat different specialties and conditions, and have very different facilities, and have different medical staffing arrangements.

So even when we are comparing like with like (inpatient elective care) in NHS and private hospitals we need to be aware of potential differences in the patient populations they serve and the way they are organised.

To explore this, we undertook some detailed analysis of HES data (which covers all NHS-funded elective inpatient care in NHS and private hospitals) in two specialties – orthopaedics and ophthalmology – where there is substantial private hospital activity - to see what differences existed in their patient populations and in the data that NHS and private hospitals collected, and some of the results are shown in **figure 6** below.

Figure 6 Patient characteristics, data completeness and clinical coding for ophthalmology and orthopaedics in NHS and private hospitals 2017/18-2023/24

	Ophthalmology			Orthopaedics		
	NHS hospitals	Private hospitals	p-value	NHS hospitals	Private hospital	p-value
Age (mean (SD)) (completeness (%))	69 (18.2) (100%)	74.6 (9.6) (100%)	<0.001	55.9 (20) (100%)	60.4 (14.8) (100%)	<0.001
Deprivation (mean IMD (SD))** (completeness (%))	20.7 (14.9) (100%)	19.7 (14.8) (100%)	<0.001	21 (15) (100%)	18.3 (13.7) (100%)	<0.001
Gender (% female) (completeness (%))	54.2% (100%)	58.3% (100%)	<0.001	54.8% (100%)	55% (100%)	<0.001
Ethnicity (% white) (completeness (%))	88.5% (88%)	93% (59.6%)	<0.001 <0.001	91.4% (88.2%)	95% (65%)	<0.001 <0.001
Number of diagnosis codes (mean (SD))	5.1 (3.5)	3.8 (2.3)	<0.001	4.8 (3.6)	4.3 (2.7)	<0.001
Number of operation codes (mean (SD))	5.1 (3.5)	3.8 (2.3)	<0.001	4.8 (3.6)	4.3 (2.7)	<0.001
Charlson comorbidity index (mean (SD))	0.80 (1.19)	0.41 (0.83)	<0.001	0.53 (0.97)	0.39 (0.74)	<0.001
Elixhauser comorbidity index (mean (SD))	1.21 (1.25)	0.65 (0.93)	<0.001	1.18 (1.30)	1.11 (1.15)	<0.001
CC score (mean (SD))	1.79 (1.55)	1.75 (1.63)	<0.001	1.35 (1.84)	1.13 (1.37)	<0.001
Waiting times in days (mean (SD))	132.1 (183)	76.4 (88)	<0.001	183 (173.7)	143.1 (147)	<0.001

The table shows that private hospitals treat patients who are slightly older and from less deprived areas than those treated in NHS hospitals. One key finding is that private hospitals are much worse at recording patients' ethnicity than NHS hospitals (which matters when it comes to comparing or adjusting for casemix). Hospitals record patients' diagnoses (using ICD10 codes) and operations (using OPCS procedure codes) and the table shows that private hospitals use fewer of these codes than NHS hospitals – though of course private hospitals may not have had access to the full medical records of patients they treat. The Charlson and Elixhauser indexes are both measures of the wider health of patients – the higher the index, the more other health problems they have. It can be seen that in both specialties private hospitals tend to treat patients who are relatively healthy, while NHS patients treat patients who have more health problems.

The CC (co-morbidities and complications) score in the table is an NHS England measure used to determine how much the hospital is paid by the NHS for treating the patient – broadly it is meant to distinguish between less complex and more complex cases and to fund the latter cases more generously.

It is worked out from a list of other diagnosis codes that NHS England specifies in its tariff guidance. We were surprised to see that in ophthalmology, NHS and private hospitals had similar mean CC scores even though the Charlson and Elixhauser indexes suggested that NHS hospitals treated patients who were more unwell and had more comorbidities.

This is illustrated more clearly in **figures 7** and **8** below. In these graphs for two procedures – hip replacements and cataract surgery - each hospital is a single bar, and all hospitals are shown in increasing order of their mean CC score, with NHS hospitals in blue and private hospitals in red. You can see that in orthopaedic hip replacements, as we would expect, private hospitals are treating less complex patients and have lower mean CC scores. But in cataract surgery, the reverse is true – private hospitals have higher mean CC scores than NHS hospitals.

Figure 7 All hospitals ranked by mean CC score for hip replacement admissions, 2023

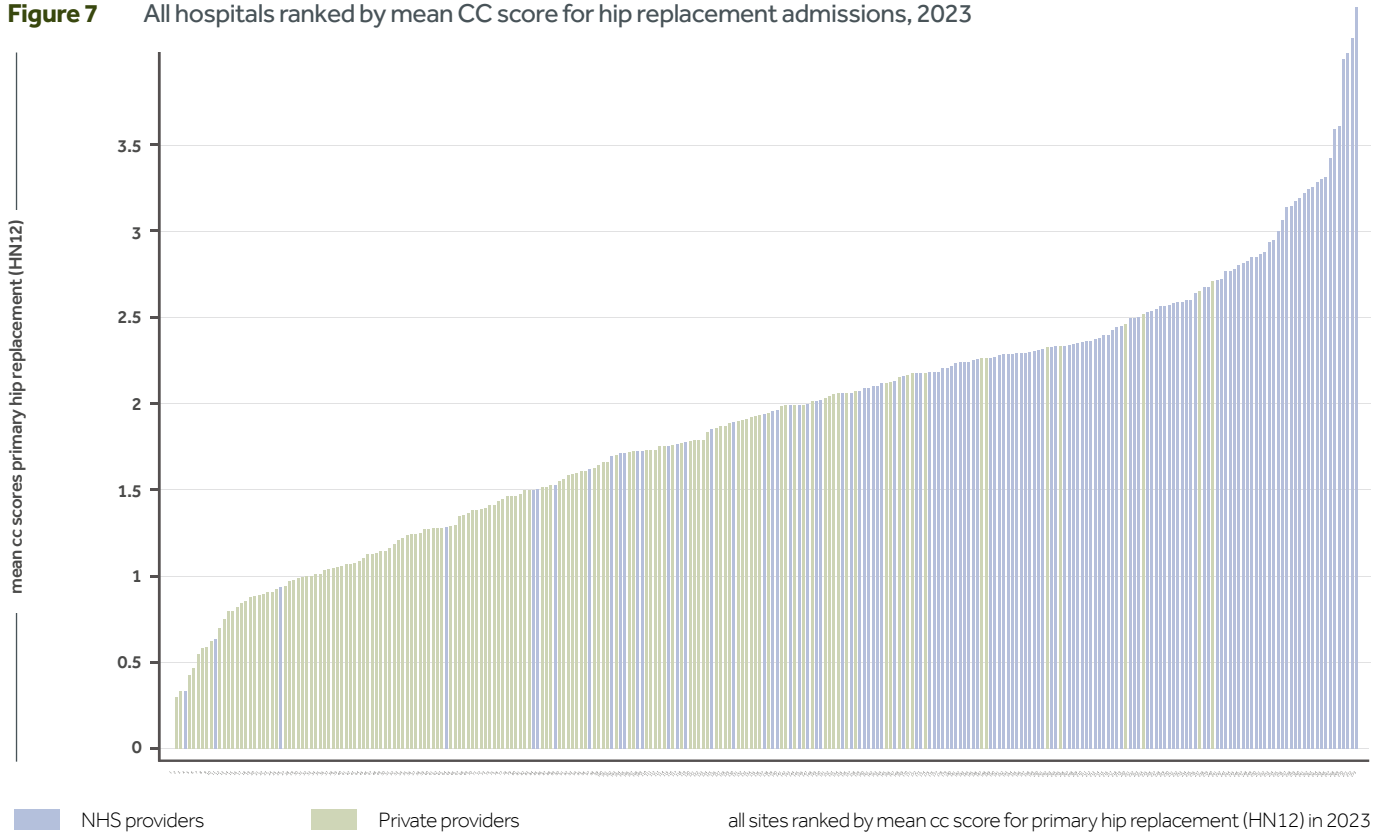
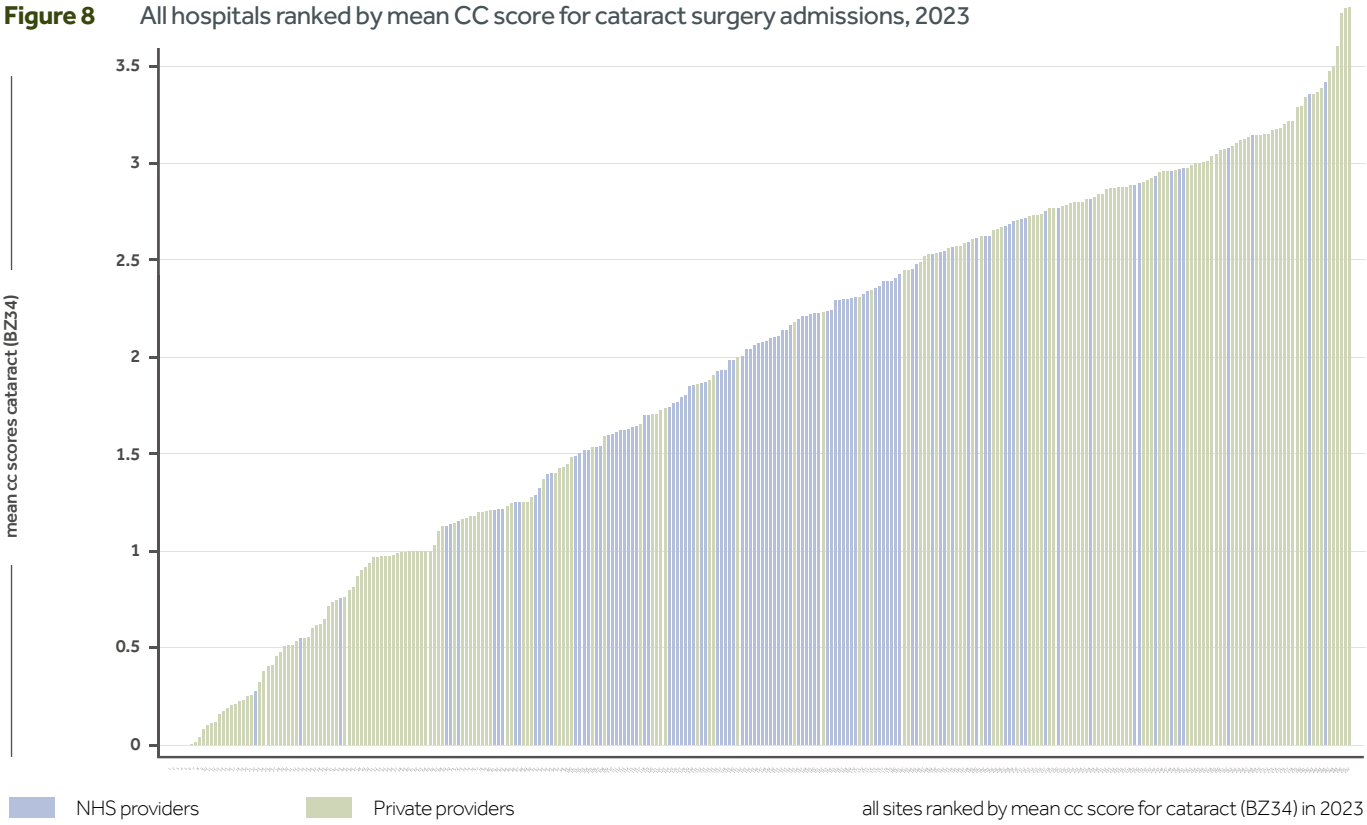


Figure 8 All hospitals ranked by mean CC score for cataract surgery admissions, 2023



This really does not make sense. We know that private providers of cataract surgery operate a number of exclusions which mean they don't treat some complex patients – such as those that need a general anaesthetic, or those who are seriously obese, or those with movement problems which mean they cannot get on and off the operating chair by themselves, or those with various co-morbidities (like prior or ongoing cancer treatment).

A detailed examination of coding practices suggests that private cataract surgery providers are using the ICD codes which they know will generate a higher CC score in order to maximise their revenue, and this was confirmed by some of our interviewees:

> *... at least one of the independent sector providers is under investigation at the moment, because 98 per cent of them required the top code. So, I think it's very interesting when we look at that quality and governance across different providers."*
>
> *(Interview A, NHS)*

> *I think this is them being imaginative within the existing rules... they are maximising the value they get from the codes that are available. .... And it comes back to that, kind of, regulation thing. NHS policy is written with a good person in mind, not someone who's trying to make a profit."*
>
> *(InterviewB, NHS)*

This may mean that NHS commissioners are paying too much for some cataract surgery (and we note that this year NHS England proposed in-year changes to the tariff which reflect this concern) . It also has serious implications for the accuracy and comparability of data if coding practices vary systematically between or across NHS and private hospitals or are influenced by financial incentives, and it highlights the need for enhanced guidance on clinical coding practice and routine mechanisms for data quality reviews.

It may also suggest that the NHS Payment Scheme needs review and reform, to ensure that where it offers differential tariff payments for given procedures, it is carefully targeted on specific underlying differences in complexity which can be measured accurately through available coding data.

15 https://www.england.nhs.uk/publication/2526-nhsps-amendment-consultation/

5

Quality and safety: how NHS and private hospitals are doing

This section presents some of the findings from our research, seeking to compare activity, quality and safety between and within NHS and private hospitals. We have already noted that our ability to do this quantitatively has been hampered by the data access problems outlined above. In particular, many of our analyses which required patient level data which could be linked for the same patient across multiple admissions could only be done using HES, which meant we could not include the admissions that were privately funded and privately provided (quadrant D) contained in PHIN's dataset but which we could not access.

Patients' views about quality and safety in NHS and private hospitals

Three main themes emerged from our interviews with patients: the way they chose a hospital or a consultant and the (lack of) information about quality or safety in that decision, which was mostly led by concerns about access and waiting times and sometimes by informal information from friends or others; the transfer of information between the NHS and private hospitals and some problems with records; and arrangements for aftercare, especially if there were any complications.



Many patients cited long waiting times and difficulty accessing NHS care as the primary reason for choosing treatment in a private hospital, whether it was NHS-funded or self-funded. NHS-funded patients often reported accepting referrals to private hospitals with quite limited information about the hospital or consultant, viewing it as a preferable alternative to enduring longer wait times and a potential deterioration in their condition while waiting to be treated in the NHS. Some self-funded patients cited barriers to accessing NHS care, such as difficulties getting appointments or experiencing long delays between appointments, as a key reason to pay privately for their treatment.

> *I had medical insurance. So, there wasn't really a strong thought process. I needed orthopaedic surgery. I asked a chap who I know very well and he looks after the pensions for footballers and sportsmen. And I said, where would they go, you know? And he said, oh, that's easy, they go and see Mr such-a-body. So, I went to see Mr such-a-body."*
>
> *(Patient interview 9, self-funded)*

> *I think they trust the NHS, and I think they know that most of the doctors that work in the private sector, come from the NHS, so I think that's where they get their trust level from. Beyond that, I don't know how they get their assurance around the safety and the quality that they get when they do have their care, because at the moment people are so obsessed with waiting times and getting seen quicker and getting a diagnosis and getting a decision, I think that over-rides any level of quality of care that you might receive within a different organisation."*
>
> *(Chief Nurse, NHS)*

In part the involvement of private hospitals in providing NHS-funded care was intended to increase patient choice. But we found that NHS-funded patients often recalled making decisions about where to be treated during the same appointment in which they were informed of their options. As a result, their choices were largely limited to the information they already had, typically the hospital's location and its proximity. Given the pressures of long waiting times and difficulties in accessing NHS appointments promptly, patients were generally not encouraged to take additional time to seek further information.

> *I don't think I was provided with any [information]. In fact, to be fair, looking back, it was quite bizarre because he just said to me in the appointment, right you can go to [private hospital] or [private hospital], which would you prefer. I didn't know whether one was better than the other or anything, I just knew one was in [UK city] and one was in [UK town] and it was easier to get to [UK town]."*
>
> *(Patient interview 22, NHS-funded)*

Some self-funded patients – but very much a minority – said they had sought out information from a range of sources to help them make the decision about whether to go to a private hospital and how to choose a hospital and a consultant:

> *I started with just doing research on... the private hospital's website. There was probably about six or seven different gynaecologists that practised there. So I went through and read each person's description and what their clinical interests were, to see which person would align best with the treatment that I needed. Then once I'd narrowed it down to a few I also spoke to family and friends... who had been treated by the same gynaecologists at the NHS, to get their opinion on their treatment and experience with that consultant."*
>
> *(Patient interview 7, self-funded)*

None of our interviewees mentioned using the PHIN website and its resources aimed at helping patients to make their choices.

The second consistent theme concerned communication between the NHS and private hospitals and the transfer or sharing of medical records (including test results, imaging and notes) – where most patients reported difficulties and some said they had to take responsibility for ensuring information about their care was transferred:

> *The main problem as far as the private hospital's concerned was of course the inability to transfer records and data. I've always found that the only way that I can control my patient record anyway is to manage it myself... I go on to all the sites, I collect all the test results, I cut and paste them, I put them together and I send them to the [consultant] or the [other consultant] so that they share... So, I mean, there is obviously a major problem in transferring information. Every time I go into a private hospital, we start from scratch. Any records they've got are the records which they've got in that particular private hospital."*
>
> *(Patient interview 4, self-funded)*

> *There was no communication back from that [private hospital] at all to the NHS. The only common link was me as the patient and the surgeon. There was nothing else. So, as I say, there was no information about the prescription, nothing carried across to my record. When I went back to the NHS for that first follow-up, the records... weren't there of what I'd had done. So, it was only me telling the nurse that I'd had half my lung removed. That's not safe care... So no, the communication was really weak and poor."*
>
> *(Patient interview 23, NHS-funded*

The third theme in our patient interviews was what happened after having an operation in a private hospital, particularly if there was a need for follow-up or if there were complications. Patients reported it was unclear whether they should go back to the private hospital, or turn to their GP or the local accident and emergency department. Doctors reported that patients were often unaware that if a complication arose, the facilities of the private hospital might not be suitable to manage their care and they might need to be transferred into an NHS hospital.

> *Obviously, I left the hospital fine, I had, you know, stitches but then there was a problem. And it's interesting because looking on the hospital website, there's no real mention about aftercare or...obviously, it tells you how to make a complaint but there's no real mention of if things go wrong, you know, what do you do in this situation? .... I think the problem I had was, I just didn't feel it was being taken seriously. And as I say, contacting the secretary when I started feeling unwell and getting a response, go to A&E, just didn't wash with me. You see what I mean, you expect the surgeon to really take responsibility."*
>
> *(Patient interview 5, NHS funded)*

> *So when things go wrong in the private sector and patients get transferred into the NHS for treatment, in my experience, there's a very high volume of at least complaint and not infrequently litigation, some of it justified, some of it perhaps not justified, because anyone can have a bad day in the operating theatre... particularly patients, in my experience, who are fee paying private patients, fail to understand that just because they're going somewhere shiny, with nice carpets, and having prawn sandwiches, you know, that doesn't mean that their operation won't go wrong and they won't have to be transferred somewhere else to have it sorted out."*
>
> *(Consultant Surgeon, NHS)*

It seemed that when patient pathways crossed between NHS and private hospitals (for example with preoperative outpatient appointments in the NHS but the admission itself to a private hospital) there could be a lack of clarity about who or which hospital was responsible for the patient's care – in way that was not seen in the whole pathway was in one sector or the other:

> *The [private hospital] were saying well... now you've got this infection at this stage, it's not our responsibility, get back in touch with your GP. Then the GP was like well hang on, why have you had it done privately, what's that, it's not my responsibility. So it was almost like it's the end, I think, it's got to be more succinct and that aftercare is really, really key. Because when I've had surgery or any treatment through my private medical insurance or anything like that, it's that aftercare it's seamless. You kind of feel really comfortable and confident that somebody's taking the best care of you as possible. Whereas I think with that clunkiness of that NHS, private, the NHS, it was almost like nobody was taking accountability or responsibility for it. "*
>
> *(Patient interview 24, NHS-funded)*

Overall, we found that despite the increased use of the private sector to provide patient choice and to deliver patient care in England, there is a disjuncture between policy expectations on the one hand and what happens in practice, particularly in relation to how patients make decisions regarding their care, and how care is coordinated and administrative and informational transitions are managed.



Measuring and comparing quality and safety: examples from cataract surgery

As has already been noted in the last section, we undertook some in-depth research in cataract surgery, because it is an area where private hospital provision has expanded dramatically in the last decade, to explore and compare the quality and safety of surgery in NHS and private hospitals. Again, we could only work with the data we had from HES, which covers all NHS funded care but does not include data on privately funded, privately provided care. We looked at five measures – waiting times for surgery; mean deprivation scores for patients; rates of intraoperative posterior capsule rupture which is a known complication; rates of post-operative visits to an NHS A&E department within 7 days of surgery; and rates of post-operative YAG laser capsulotomy within 2 years of surgery. The results are in the five graphs below, and in summary they show:

Private hospital median waiting times for NHS funded cataract surgery have been consistently lower than NHS hospital waiting times for many years, but the difference has widened since the pandemic as NHS waiting times have been largely static (at a median of over 100 days) and private hospital waiting times have fallen (to a median of around 30 days).

Overall rates of intraoperative PCR (posterior capsule rupture) have been low – but NHS rates have been consistently higher than those in private hospitals. This may reflect the fact that NHS hospitals tend to see more complex cases, or that NHS operations are carried out by consultants and resident doctors in training while private hospital operations are almost all done by consultant medical staff. The rates appear to have converged in recent years.

Mean Index of Multiple Deprivation (IMD) scores for patients admitted to NHS and private hospitals have converged over time and there is little difference between the two sectors which suggests that private hospital provision has not had an adverse effect on health inequalities.

Postoperative visits to A&E within 7 days are rare, and not very different for surgery undertaken in NHS and private hospitals. Caution in interpreting these data is needed as some post-operative care may be provided within private hospitals and some NHS patients may not go to A&E but instead be directed to call the ophthalmology clinic.

Rates of YAG laser capsulotomy within 2 years of cataract surgery, to deal with posterior capsule opacification, are higher in private hospitals than in the NHS and have increased in recent years. We were told by some interviewees that this related to the choice of intraocular lens, and that cheaper hydrophilic lens led to higher rates of YAG laser capsulotomy than more expensive hydrophobic lenses[16].

On the last measure, one interviewee told us:

> *One thing I did hear that was very, very worrying and I can't remember which ISP it was, they said to the patient, yes, we'll get you in for your cataract's surgery but within twelve months you'll have to have a laser capsulotomy. How do you predict that? Since the advancement of intraocular lens implants and the change of the lens edge designs in the last five to ten years, the instance of PCO has dropped dramatically. What that says to me is that ISP is using cheap, nasty implants, they know that the patients are going to need a replacement laser capsulotomy very soon. To actually be telling them at the time of surgery, you will need this doing within a year, that's terrible."*
>
> *(Interview I, NHS and Independent sector)*

16 Malcolm, J., Donachie, P.H.J., Hernández, R. et al. The Royal College of Ophthalmologists' National Ophthalmology Database study of cataract surgery: report 20, the hidden cost of intraocular lens choices for National Health Service funded cataract surgery in England. Eye 39, 3142–3147 (2025). https://doi.org/10.1038/s41433-025-04033-4

Figure 9 Median waiting time (in days) for cataract surgery admissions - 2013-14 to 2023-24

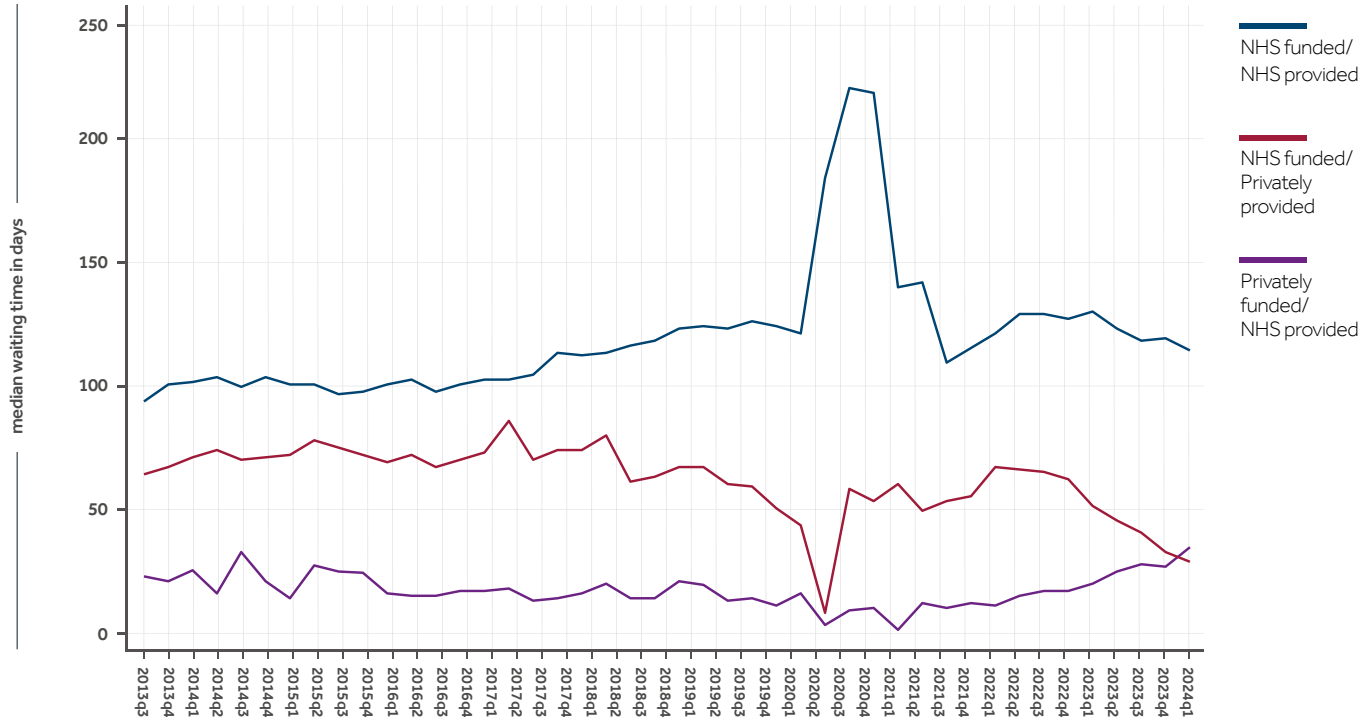


Figure 10 Mean deprivation score (IMD) for cataract surgery admissions, 2013-14 to 2023-24

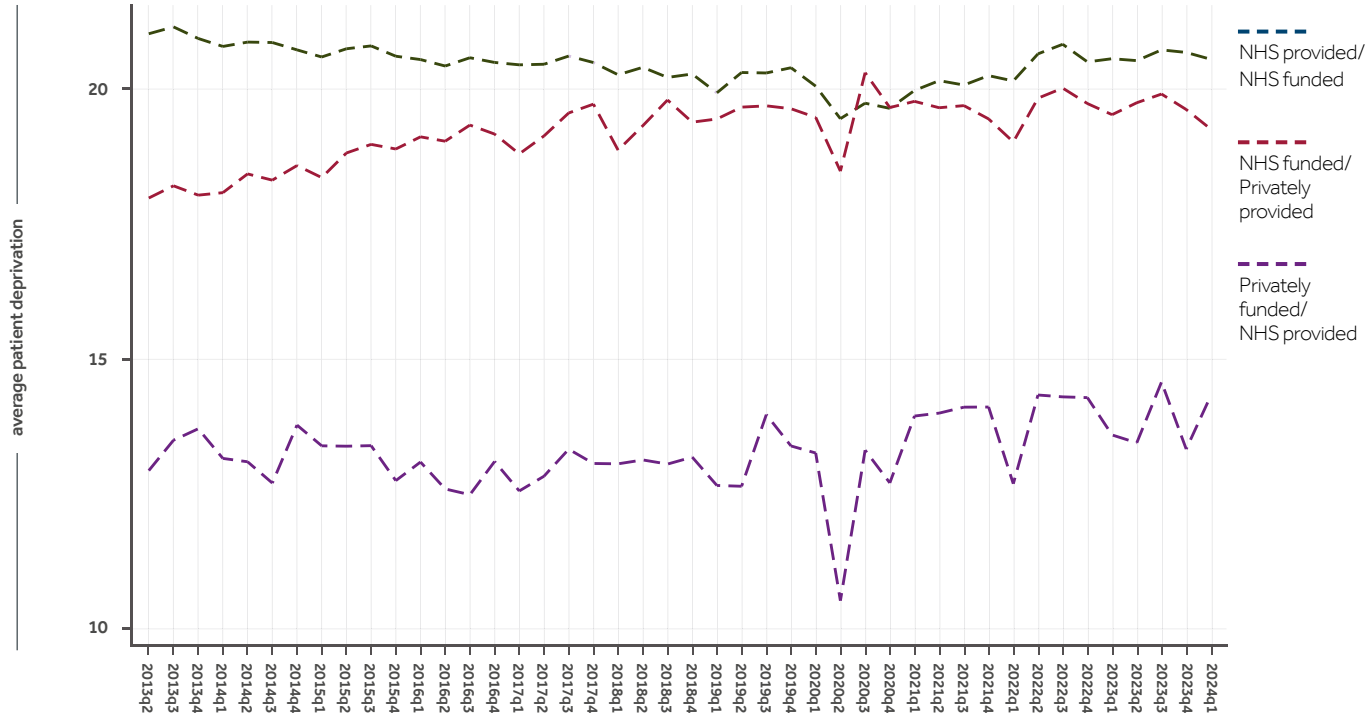


Figure 11 Proportion of cataract surgery admissions with an intraoperative posterior capsule rupture - 2013-14 to 2023-24

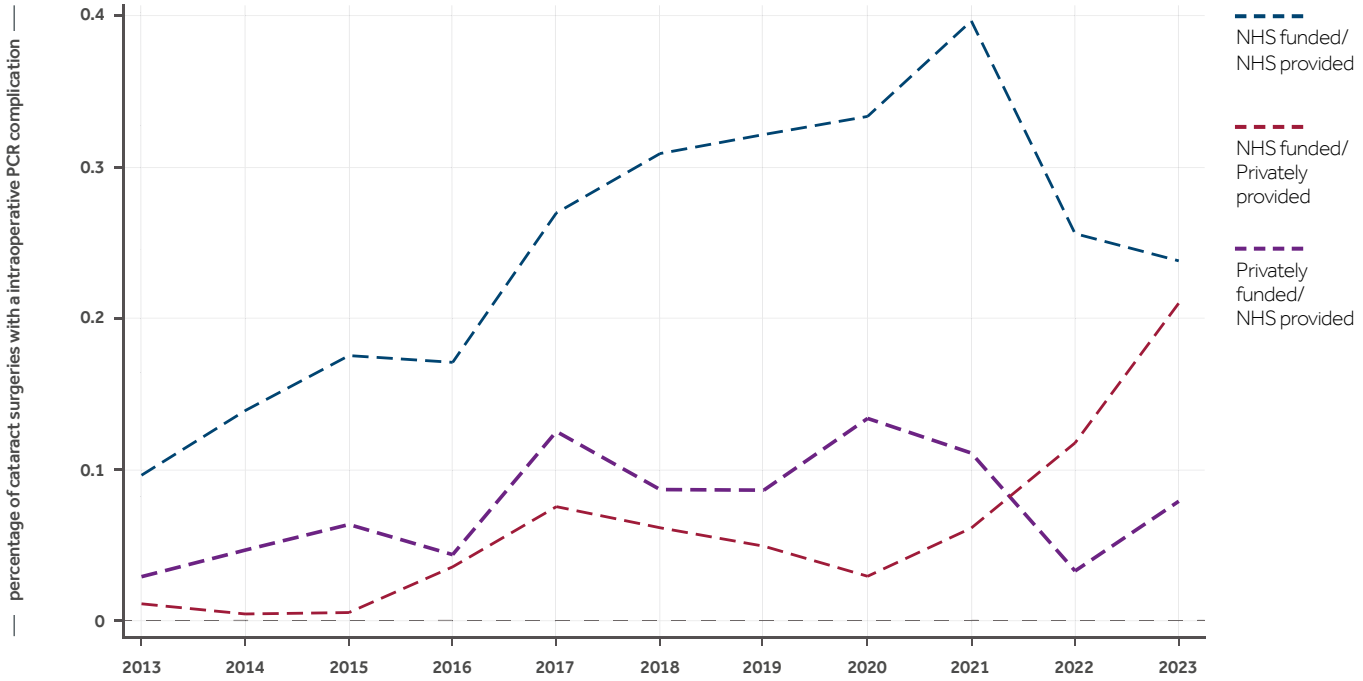


Figure 12 Proportion of cataract surgery admissions that were followed by an NHS A&E department visit within 7 days - 2013-14 to 2023-24

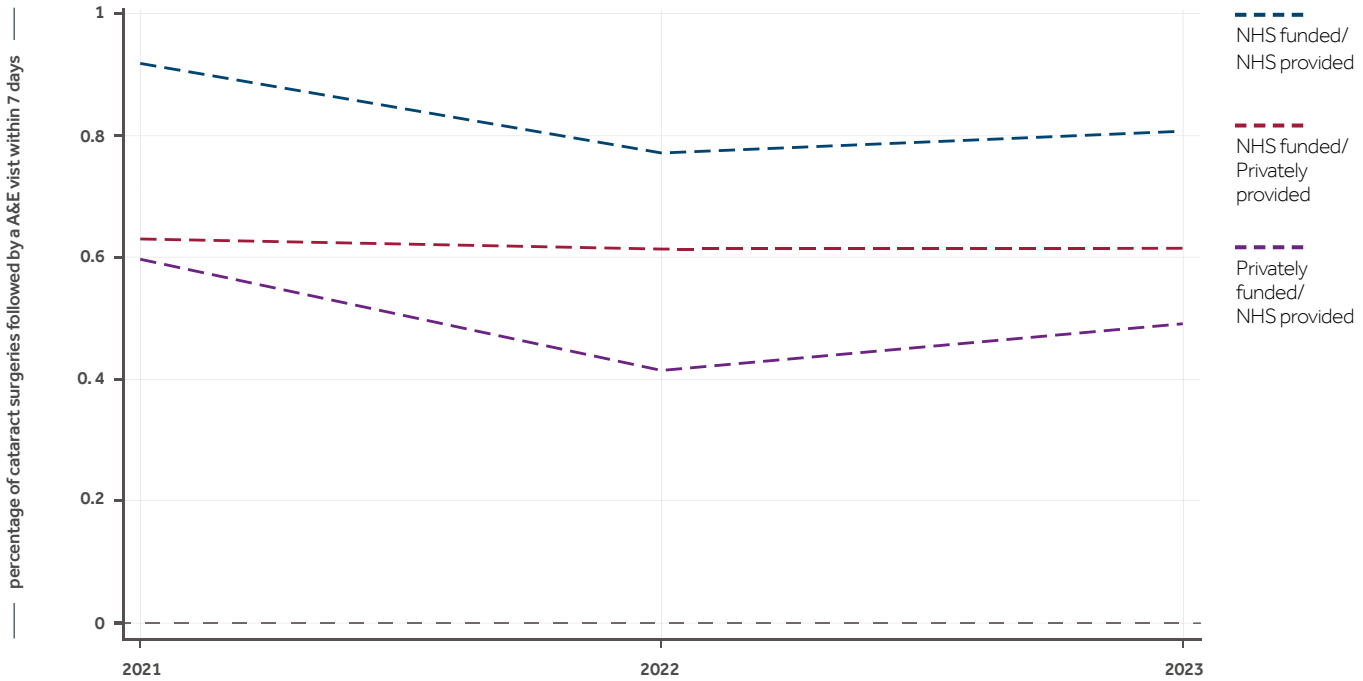
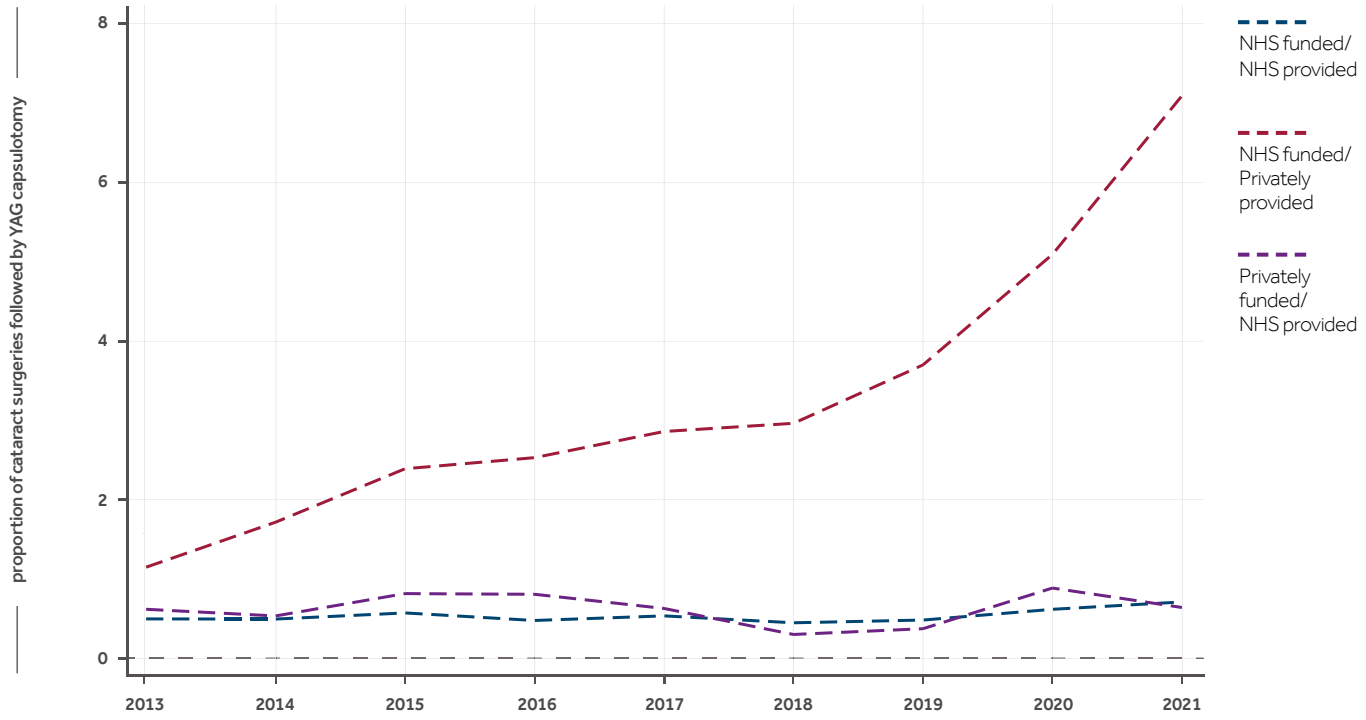


Figure 13 Proportion of cataract surgery admissions that were followed by a YAG laser capsulotomy within 2 years - 2013-14 to 2023-24





Quality and safety for NHS-only and dual practice consultants

We can look at differences in the quality and safety of doctors working in NHS and private hospitals in two ways. One is to compare doctors who work only in the NHS to those who work in dual practice (both in the NHS and in a private hospital) just for the patients they treat in the NHS. We can use HES data to make these comparisons, but we should remember that doctors who choose to work privately as well as in the NHS may be different in some important ways from those who work just in the NHS, so we should be cautious in interpreting any differences.

The second way we can approach this is to look at doctors who work in dual practice (in both an NHS hospital and a private hospital) and make comparisons between the NHS-funded patients they see in the NHS and the NHS-funded patients they see in a private hospital.

We can only do this using HES data for NHS funded patients – we do not have the PHIN data on the privately funded patients they see in private hospitals. In this case we should remember that patients treated in the NHS may be different in some important ways from those treated in a private hospital, and again be cautious about how we interpret any differences.

We took the first approach, using HES data for consultants in seven surgical specialties which make up most private hospital activity (orthopaedics, general surgery, ophthalmology, ENT, urology, obstetrics and gynaecology, and plastic surgery) for the period July 2023 to June 2025, and the results are summarised in **figure 14** below.

Figure 14 Comparing quality/outcome measures for elective and non-elective admissions to NHS hospitals by doctors who work in the NHS only versus doctors who work in dual practice – July 2023 – June 2025

Patient Characteristics	NHS only consultants (n = 8,581) (Mean (SD))	Dual practice consultants (n = 7,200) (Mean (SD))	Difference (DP–Non-DP)	P-value
Gender (% female)	58.0% (0.49)	53.0% (0.50)	−5.0 pp	<0.001
Age (years)	55.91 (20.07)	58.99 (19.85)	+3.08	<0.001
Charlson Comorbidity Index	0.87 (1.40)	0.86 (1.37)	-0.01	<0.001
IMD Quintile	2.83 (1.39)	2.99 (1.38)	+0.16	<0.001
A&E visit within 30 days (%)	12.64% (33.24)	11.58% (32.00)	-1.06 pp	<0.001
Emergency readmission within 30 days (%)	8.73% (28.23)	7.56% (26.43)	-1.18 pp	<0.001
Mortality within 30 days (%)	0.67% (8.13)	0.64% (7.97)	-0.03 pp	<0.001
Length of stay (days)	1.12 (4.67)	1.22 (4.60)	+0.10 days	<0.001

The unadjusted outcomes in the table above suggest slightly more favourable outcomes for patients treated by dual practice consultants, but these differences largely disappear after controlling for patient, consultant and hospital characteristics. These findings indicate that working across both NHS and private hospitals does not either negatively or positively affect the quality of care delivered. It has sometimes been suggested that when consultants work in private hospitals as well as in the NHS, their private and NHS work could conflict, and their work in the NHS could be adversely affected. Our analysis found no evidence that consultant dual practice in England is associated with adverse patient outcomes in NHS hospitals.

Turning to the second comparison – between patients treated in NHS and private hospitals by consultants who work in dual practice – we used HES data for consultants in six surgical specialties (orthopaedics, general surgery, ophthalmology, ENT, urology and plastic surgery) for the period July 2023 – June 2025 and results are shown in **figure 15**.

On the face of it, there appear to be better outcomes in private hospitals in these unadjusted figures. When adjusting for patient characteristics using linear regression and matching models these differences persistent, but when using differential distance as an instrumental variable to account for unobserved differences in case-mix these differences largely disappear apart from reduced length of stay in patients treated in private hospitals.

In other words, the instrumental variable analysis suggests that differences reflect differences in the patient population served in NHS and private hospitals (particularly the complexity of cases and levels of comorbidity) rather than in the actual care provided. It is also worth noting that care in NHS hospitals is led by consultants but provided by a wider medical team, while care in private hospitals is largely provided by consultants.

Figure 15: Comparing quality/outcome measures for elective admissions to NHS hospitals and private hospitals for dual practice doctors – July 2023 – June 2025

Characteristic	NHS Hospital	Private Hospital	P-value
Sample			
Total spells (N)	2,293,917 (77.3%)	674,560 (22.7%)	—
Patient characteristics			
Female, %	49.6% (49.6–49.7)	53.0% (52.9–53.1)	<0.001
Age, mean years	60.8 (60.73–60.78)	64.0 (63.98–64.06)	<0.001
Charlson Comorbidity Index	0.96 (0.96–0.96)	0.43 (0.43–0.43)	<0.001
IMD Quintile	3.02 (3.01–3.02)	3.19 (3.19–3.19)	<0.001
Unadjusted outcomes			
ED attendance	12.9% (12.9–13.0)	5.0% (4.9–5.0)	<0.001
Emergency readmission	5.5% (5.5–5.5)	0.7% (0.7–0.7)	<0.001
Mortality	1.4% (1.4–1.4)	0.0% (0.0–0.0)	<0.001
Length of stay (days)	2.96 (2.94–2.97)	0.34 (0.34–0.34)	<0.001

Emergency department visits after surgery in NHS and private hospitals

It has in the past been suggested that patients who are treated in private hospitals may later need urgent care in an NHS A&E department, and we set out to examine this for a number of common operations. The unadjusted comparisons are set out in **figure 16** below, and it can be seen that rates of A&E visits within 7 days of discharge are consistently lower for private hospitals than for NHS hospitals.

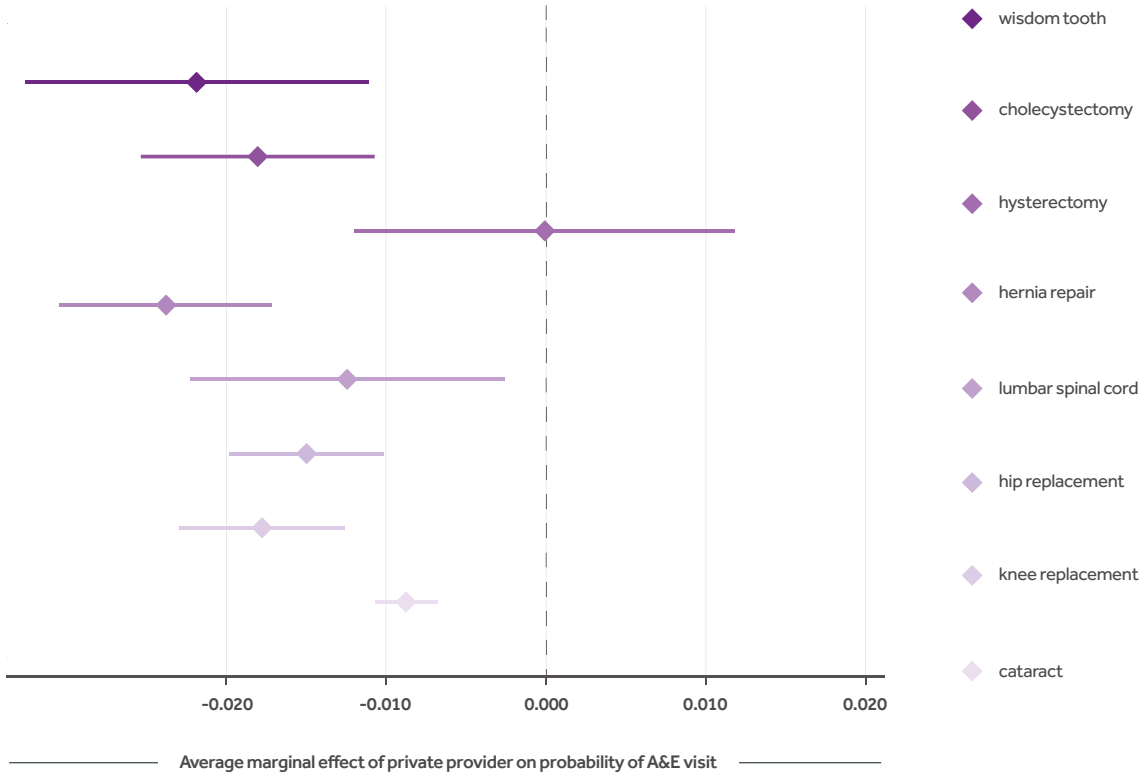
Figure 16 A&E attendances within 7 days following an elective discharge in NHS hospitals and private hospitals, by operation group – 2021-2023

Operation group (OPCS-4 codes in parentheses)	NHS A&E visits within 7 days	NHS elective FCEs	NHS A&E rate	Private hospitals A&E visits within 7 days	Private hospitals elective FCEs	Private hospitals A&E rate
Surgical removal of impacted wisdom tooth (F091, F093)	3,361	94,272	0.036	195	10,956	0.018
Cholecystectomy (J183)	8,662	135,057	0.064	902	19,417	0.046
Abdominal Hysterectomy (Q074)	3,357	68,151	0.049	175	3,245	0.054
Hernias (Inguinal/Umbilical/ Ventral) (T212, T242, T243)	1,932	43,487	0.044	364	16,483	0.022
Decompression of Lumbar Spinal Cord (V255)	890	16,800	0.053	201	5,795	0.035
Hip Joint replacement (W371, W381, W391, W931, W941, W431, W441, W451, W461, W471, W481, W521, W581, W378, W388, W398, W461, W471, W481, W951)	7,202	139,318	0.052	2,742	80,372	0.034
Knee Joint replacement (W401, W411, W421, O181, W431, W441, W451, W521, W531, W581)	8,454	151,946	0.056	3,516	101,547	0.035
Cataracts (C751)	13,122	753,453	0.017	6,780	918,513	0.007

When we undertake a multivariate analysis, designed to take account of patient characteristics (age, gender, deprivation, Charlson comorbidity index and for some unmeasured confounding) the results persist though the absolute differences are quite small, as the chart in **figure 17** below shows. We ran these analyses again to look at A&E attendance within 30 days and got substantially the same results.

Overall, we found that A&E attendance within seven or 30 days of elective discharge was consistently lower following admissions to private hospitals than for admissions to NHS hospitals. This pattern was observed across most procedure groups and remained robust across different approaches to multivariate analysis. Our results do not support the concerns sometimes raised about whether the increase in private hospital use for NHS funded elective care could increase downstream demand for urgent and emergency care. If anything, they suggest that NHS-funded elective care delivered by private hospitals is associated with slightly lower short-term A&E use than equivalent care delivered in NHS hospitals.

Figure 17: Coefficient plot for effect of private hospital treatment across all operation groups on 7-day A&E rates (CEM-weighted logit model) - 2020/21 - 2023/24



Note: Results are expressed as odd ratios (OR) and corresponding confidence intervals (CI). When the corresponding CIs cross the dashed vertical line, coefficients are not statistically significant. The logit model uses weights calculated from coarsened matching.

Medical workforce: activity for NHS only and dual practice consultants

One of the concerns often raised by some stakeholders is that consultants who work in both the NHS and in private hospitals will reduce their NHS commitment because of their private hospital workload, which will generally be better paid. They suggest that as a result increasing private hospital activity comes at the cost of reduced NHS activity – as it is all one medical workforce.

We set out to examine this through an analysis of consultant workload, drawing on data from HES, PHIN, the GMC register, and the NHS Electronic Staff Record. We did this for consultants in six surgical specialties - orthopaedics, general surgery, ophthalmology, ENT, urology, and plastic surgery for the period from July 2023 – June 2025. In our sample there was a total of 7,677 consultants (5,097 dual practice; 2,580 NHS-only). The unadjusted results are shown in **figure 18** below.

Figure 18 Comparison of consultant workload for NHS-only and dual practice consultants in six surgical specialties – July 2023-June 2025

Characteristic	NHS-only	Dual practice
NHS hospital FCEs/ year (mean)	429	395
NHS-funded tariff value/year (mean)	£1,040,814	£1,197,228
NHS-funded FCEs/ year (mean)	429	453
Private hospital FCEs/year (mean)	—	61
Contracted sessions/ week (mean PAs)	9.44	9.33
Years since qualification (mean)	10.0	12.8
% Female	30.9%	10.1%
% UK primary qualification	67.7%	64.7%

On the unadjusted data in the table, it can be seen that dual practice consultants undertake more NHS-funded activity than NHS-only consultants, as well as their privately funded work. The two groups have very similar mean contracted hours (PAs or programmed activities are 4 hour contracted sessions). Dual practice consultants are more likely to be male than NHS only consultants. Multivariate analyses which take account, of consultant characteristics including gender, level of experience, UK primary qualification, and contracted sessions, confirm that there is a small positive relationship between NHS and private workload – for every 10% more private activity a consultant performs, there is between a 0.5 and 1% increase in NHS activity. These analyses were repeated with and without consultant fixed effects to account for differences between and within consultants over two separate analysis years (July 23-June 24, July 24 to June 25) In other words there is no evidence that private activity comes at the expense of NHS workload.

However, this analysis is constrained by the limited availability of privately funded care data from PHIN, which is only available between June 2023 and June 2025. This is because June 2023 marked PHIN's shift to presumed publication for consultant-level activity data, rather than publishing only activity data that consultants had verified; as a result, PHIN consultant-level activity data prior to June 2023 was available for less than half of all consultants.

Future research should revisit this analysis once further PHIN data becomes available over a longer time period, allowing trends in dual practice and private activity to be examined beyond the current two-year window including examining changes in NHS activity that occur when consultants enter and leave the private sector as dual practice consultants.

6

Commissioning for quality: how care is purchased from private hospitals in ophthalmology

We explored how the NHS commissions or contracts for elective inpatient care mainly through our in-depth work in ophthalmology, and particularly cataract surgery. We chose this area to examine because, as has already been noted, it has seen a dramatic increase in the number of private hospitals, the number of NHS-funded cataract operations being undertaken, and the share of cataract surgery being undertaken by private hospitals.

To put some figures on those changes, the annual total number of NHS-funded cataract surgery admissions in England increased from 416,691 cases in 2018/19 to 649,886 in 2023/24 (a 56 per cent rise). This overall rise was accompanied by a major shift in service provision: while the NHS performed over three quarters of these surgeries in 2018/19, by 2023/24 private hospitals and clinics were responsible for 56.8 per cent of NHS-funded cataract surgeries, up from 22.4 per cent just five years earlier.

The number of private hospital sites undertaking cataract surgery increased from 116 in 2018/19 to 183 in 2023/24. There was a growing concentration of cataract activity within a few specialised private groups, for example one group increased from 1 site in 2015 to 52 by 2023 and another went from 5 sites in 2017 to 25 in 2023. We refer throughout this section to these sites as hospitals, for the sake of simplicity, but should note that these newer provider groups generally operate stand-alone clinics with no associated beds or other facilities.



How the market for cataract surgery has developed

In our interviews, respondents noted that these new, specialised private ophthalmology groups had entered the market alongside traditional private hospitals which undertake a wide range of elective surgery in different specialties, and they had expanded very rapidly. They pointed to pressures from growing waiting lists and times for cataract surgery (especially during and after the COVID pandemic). But they also noted that high volume, low complexity cataract surgery was potentially very remunerative for the new providers, especially when they operated from new, purpose-designed facilities, and that patient choice regulations and changing referral pathways from optometrists had made it easier to enter this market.

It was suggested that the transformation of the market for cataract surgery had not been a matter of national policy or planned intent, and that NHS England and commissioning bodies had been essentially passive actors at best in the changes that occurred, as one interviewee observed:

> *...I think there's, kind of, a danger of thinking that there is intelligent design within NHS England in relation to the operation of markets. There is no conscious thought about the operation of markets within NHS England. There is no team that has any responsibility for that. ...We're only really coming to the realisation that there are a series of markets that are failing and we have no means to address them... Ophthalmology is a growing one..."*
>
> *(Interview B, NHS)*

In contrast, respondents from the private sector highlighted that they had recognised the commercial potential of cataract surgery and adapted their business models accordingly. They explained that the pause in elective surgeries during the COVID-19 pandemic in 2020 provided a valuable opportunity to reflect and plan for the future. One interviewee commented:

> *... we moved to be what we are now, which is about 80 per cent NHS work and about 20 per cent private self-pay, so a real big shift in what we did. We did that by reducing dramatically the number of service lines that we offered on the private side and by re-doubling our efforts to become a high-volume NHS cataract provider. Unbeknown to us, we were about to walk into a COVID pandemic, which did a number of things. It probably meant that providers like us became more in demand ... it gave us an opportunity to really stop the business, reset, restructure and go again."*
>
> *(Interview G, Independent)*



How Integrated Commissioning Boards have responded to the changing market

There was broad agreement among respondents that ICBs faced significant challenges in commissioning and contracting cataract services, especially in the context of tight financial and time pressures. As the following commissioner explains, difficulties in commissioning were attributed to limited capacity, expertise, and experience.

> *I think commissioners, in theory, have a lot of powers, they just don't necessarily realise it. And we've made no investment in commissioners since pre-2008... Basically, there's no training, there's no development ... and we have such wide variation in standards because people learn from whoever they sit next to. So, I think a really simple thing to do would be to upskill commissioners everywhere. I just don't think that would be a particularly complicated thing to do and I think that would be incredibly valuable with massive spillover effect in other areas."*
>
> *(Interview B, NHS)*

Respondents described a power imbalance between ICBs and large private groups. These challenges were particularly evident during contractual disputes, where the legal resources available to major groups were perceived to place ICBs at a disadvantage. More broadly, the policy environment for commissioning and contracting meant that ICBs had quite limited powers to influence or control service provision.

ICBs faced limitations in restricting private providers, particularly regarding what was termed "non-contracted activity." Under NHS standard contract terms, a provider with a contract in one ICB in England could operate elsewhere without a local contract with that ICB.

This meant a provider could deliver services, accept referrals and invoice for services in areas where the local ICB had neither commissioned the service nor set quality standards, while the commissioning ICB was not in a position to evaluate or inspect the provider's site for quality and safety. As one respondent explained:

> *I think the choice agenda's sensible but I think it's gone a bit too far. I think we need to rein it in a bit because we just can't have any provider coming along. They do work for us in non-contractual activity and we want them to have a contract, at least we've got control. But if we've got concerns about the provider, we can't stop them delivering, we still have to allow them to deliver but they don't have to do what we ask them to do. So, it's a very difficult balance."*
>
> *(Interview E, NHS)*

Respondents linked this to instances of overprovision, as reflected in the following quote:

> *I can't believe that they have been allowed to allow seven providers in a relatively small area. I feel as though the area that I work in is flooded with cataract providers, absolutely flooded, there are a lot... I have got a friend who's an optometrist who's in one of the commissioning boards... I had a chat with her and I said, why have you allowed these two new premises to open when there's only a ... two week wait for cataract surgery, it's nothing, and she said they had to."*
>
> *(Interview J, Independent sector)*

Whether private providers had a contract with an ICB or not, the processes for documenting activity, checking clinical coding, raising and paying invoices were also called into question by respondents, who felt that the monitoring of activity and expenditure was often quite limited. One respondent illustrated this concern:

> *And one of the ICBs has spent an enormous amount of time pulling apart all these invoices and tracking them and found that actually there's high levels of duplication between them. They break patient pathways across multiple invoices, so it's really hard to track them. There's been all sorts of slightly odd payments and things like this. And so, I think, yeah, there's very odd behaviour going on in this market in relation to this."*
>
> *(Interview B, NHS)*

A respondent from a private hospital group made the point that such behaviours were not universal and emphasised the efforts they made to maintain positive relationships with ICBs and to adhere to established contracts and agreements, but noted that ICBs were not necessarily monitoring or auditing their performance:

> *We only do ophthalmology; we're not owned by an optometry practice like I think a couple of the providers... But no, we certainly make sure...our relationship with ICBs is we're contracted at all of our ICBs... but also, we follow the rules. So that's...you know, and we lose referrals because optometrists get frustrated if we reject patients. But that is the rule for that local ICB. Whether you like it or not, that is the local commissioning guidance and we follow it. So, it is there, it's just whether or not it's being audited, that's a separate issue."*
>
> *(Interview D, Independent sector)*

It was also suggested by a number of respondents that some private providers' clinical coding practices sought to maximise their income, and that ICBs were not well placed to check or challenge them. There is more information about this in **section 4**.

While some respondents reported positive working relationships between ICBs, NHS England and both NHS and private hospitals, for example on eyecare transformation and the redesign of referral pathways, it was clear that commissioners needed improved contract specifications, monitoring, and control, as described by a

> *So, I guess some of the lessons learned working with the independent sector over...well, especially over the last couple of last years is we need to sharpen up our specification to make sure they deliver what we want, not what they want to deliver. We've spent a lot of time working on the cataract pathway."*
>
> *(Interview E, NHS)*

Waiting times, patient choice and access, and referral pathways

Many respondents thought that the greatest benefit to patients from the expansion of cataract surgery provision over recent years had been improved access and reduced waiting times for surgery, both for those treated in the NHS and in the independent sector. As one respondent described:

> *So, I think for patients, it's provided extra capacity, often at a short time, and by and large, the service is good. So, I think for patients that's great and it's got the waiting list right down. If you look at the waiting time for cataract surgery compared to, I don't know, hip surgery or some similar high-volume procedure in ENT, because it's been done out of the hospital in the community, the waiting list has plummeted. And that's fantastic for patients."*
>
> *(Interview C NHS)*

Respondents noted that the referral pathways for patients with cataracts had changed fundamentally in three respects. Firstly, in the past, community optometrists would send a referral letter to the patients' GP, who in turn would then refer the patient, usually to their local NHS hospital ophthalmology department. Now, referrals were made direct from the optometrists to an ophthalmology provider, without the involvement of the patient's GP. Secondly, NHS England guidance on patient choice is clear that patients should be provided with a choice of providers at the point of referral (typically around 5 providers), and ICBs have put in place systems to provide information on options and waiting times to inform patient choice.

Thirdly, as has already been discussed earlier, there has been a dramatic expansion in the numbers of private ophthalmology providers, and particularly in new specialist ophthalmology providers alongside existing multispecialty private hospitals and, of course, NHS hospitals.

Respondents were often sceptical about how well these arrangements for facilitating patient choice worked in practice, often observing that patients simply asked for a recommendation from the community optometrist. They reported that some private providers provided patient transport to and from their clinics, which could be an incentive for some patients to choose them. They also noted that these changes had put considerable influence in the hands of those optometrists, who may have been influenced by the private providers:

> *… when the optometrist was delivering that choice conversation to a patient about where they want to go, that choice conversation had really been influenced by the commercial marketing from the private sector"*
>
> *(Interview K, NHS)*

More concerningly, several respondents suggested that some private providers may offer financial incentives to optometrists for referrals, particularly through contracts for post-cataract follow-up care. As one respondent explained:

> *… optometrists weren't giving choice but they are paid by [private provider name], [private provider name] to refer to them. So, what's happened is that they're paid, they get the money and they refer there, even if the patient doesn't want to go there. And the patient's saying, well, I don't want to go here, what am I doing here, I want to go to the NHS?"*
>
> *(Interview E, NHS)*

However, one private provider respondent clarified that optometrists are paid modestly for delivering aftercare, ensuring continuity, and entering patient data, but stressed that this is not a core business model or incentive-driven arrangement.

Some respondents observed that private hospitals were much more adept than NHS providers at fostering relationships with optometrists:

> *The other thing that the independent sector do… is they spend a lot more time and effort, or they recognise where their source of referral is and they build a relationship. And with all respect to the NHS trusts, they have treated optometrists with contempt for a very long time. And they still continue to do it. Whereas the independent sector will…they run CPD events, they take the time to show them round their clinics, they take the time to… they have customer relationship managers who go into every practice. So, there is a really good, kind of, relationship building."*
>
> *(Interview B, NHS)*

These interactions were viewed by some as positive. Private providers argued that CPD events and related marketing strategies served as legitimate opportunities to build relationships, share information, and respond to queries about their services, ultimately aiming to be considered as a referral option:

> *We also have a team of… I suppose, you might call them a sales team. So, we call them account development managers and they will go and visit optometrists in the community to explain what our offering is and answer any questions that the referrers might have. And they might be well where are your sites and what are your referral to clinic times, what are your referral to treatment times, what are the outcomes that you achieve. So, that when patients do come in, we've at least empowered the optometrist by supporting them with the answers to questions that might come up. Because if we don't do that, we can't expect them to consider us when they're deciding where best to send the patients."*
>
> *(Interview H, Independent)*

However, concerns were raised that efforts by private providers to build and maintain relationships with referring professionals occasionally extended into offering free continuing professional development (CPD) and other incentives, raising questions about the appropriateness of such practices:

> *So, that in the early days was a really big pull, and they would run their own accreditation service – so come along to an education evening and we'll accredit you to do our post-cat follow-ups, we'll give you access to this website where you can see all the information. Oh, and while you're here, we'll give you a nice meal or we'll get some pizzas in and some cakes in and we'll do a bit of education on top and we'll give you some CPD points for doing that too. But I think in recent years the commissioners have really got on top of this, because it just got a little bit murky, so there's really now a good standardised pathway for pre-cataract and post-cataract."*
>
> *(Interview K, NHS)*

A few respondents raised concerns about what happened when there was an organisational relationship (such as shared or linked ownership) between a community optometrist provider and a private ophthalmology provider, and whether this would lead to referrals being directed to the linked provider.

> *So, my concern and what absolutely seems to be happening in [area name], but this is obviously anecdotal, is that [optometrist name] refer purely into [provider name], bypassing other hospitals that are much closer for a patient to go to."*
>
> *(Interview J, Independent sector)*

We find that the rapid growth of NHS funded, private sector cataract surgery in England since 2019 was largely unplanned by NHS England and ICBs. This expansion appears to have been driven by the entry of new specialised private providers responding to high demand, NHS tariffs structures, low entry barriers, and direct referrals from community optometrists, often supported by private equity investment[17]. ICBs struggled to manage this growth due to national policies like the AQP rules and patient choice guidance, combined with limited commissioning capacity. Private providers have used these rules to operate widely, sometimes delivering care without a local contract in place with the ICB, which ICBs must still reimburse. Patient choice requirements have increased referrals to private providers, sometimes incentivised through optometrists' involvement in follow-up care. Efforts to manage the referral pathway have had mixed success and face conflicts with choice policies.

Contractual oversight by ICBs has been weak, allowing some providers to use clinical coding to secure higher tariff payments. Private providers can achieve higher productivity through specialised facilities and financial incentives, contributing to increased surgery volumes and reduced waiting times, while NHS providers' productivity has lagged despite significant investment through NHS England's eyecare transformation programme and the GIRFT (Getting it Right First Time) initiative aimed at improving productivity in ophthalmology[18]. However, concerns remain about quality and outcomes in the independent sector, including higher rates of post-cataract complications like YAG laser capsulotomy.

17 https://www.chpi.org.uk/the-outsourcing-of-nhs-eye-care-to-the-private-sector

18 https://njl-admin.nihr.ac.uk/document/download/2046327

Learning from cataract surgery to improve NHS commissioning

There is much to be learned from this unplanned experiment in the large-scale delivery of NHS funded elective care by private provider groups for the NHS in England, though we should exercise caution in extrapolating from experiences in ophthalmology to other service areas.

First, it demonstrates the importance of effective service commissioning, monitoring and control, and somewhat paradoxically the difficulties that can arise from government policies designed to promote patient choice, markets and competition if they weaken the ability of commissioners to use their purchasing power. Contract specifications need to be explicit about things like referral criteria and thresholds, facilities, procedures and lenses used, data reporting, and outcomes. Much of that may have been taken largely on trust in past contracts with NHS providers.

Second, it shows that the NHS tariff system, which is based on calculations of costs from NHS provider cost returns, is a poor tool for contracting with private hospitals who do not participate in those returns and may have a very different cost structure. NHS England has adjusted the cataract surgery tariff, to reduce some incentives to code for complexity, and has moved away from basing tariffs on the NHS cost returns. Even so, a generous activity-based tariff creates very powerful incentives for all providers to undertake more activity where there is unused capacity available and while that can be positive in helping to tackle waiting times and access problems, it also raises potential risks of overprovision and variable quality, highlighting the need for careful design of referral processes and pathways and robust contractual management to ensure appropriate volumes and standards of care.

NHS England has begun to use "indicative activity plans" for providers in some service areas, which cap activity but are a rather crude way to manage capacity and demand, The NHS could learn from experiences in other countries which have moved away from fee for service tariffs to reimbursement models based around care pathways, care outcomes, or blended models incorporating capitation and encouraging risk sharing between the purchaser and the provider.

Third, it illustrates the need to think less transactionally about a single type of condition or procedure and more broadly about service commissioning at a specialty or multispecialty level. The developments in cataract surgery, which this paper has outlined, have led to large increases in activity and funding, but that is at a cost to other ophthalmology services and indeed perhaps to other acute care services.

In conclusion, increased private sector provision of NHS-funded cataract surgery in England over recent years has provided much greater access to cataract surgery and lower waiting times for patients which clearly has positive consequences for their health and wider life, but at some considerable financial cost to the NHS. Experience in ophthalmology highlights the importance, when moving from a monopolistic, publicly provided healthcare system to one in which there is a greater diversity of private and public provision, of paying careful attention to the design and implementation of commissioning arrangements, contracting, and service monitoring to maximise the potential benefits of greater choice and competition while avoiding or mitigating some potential disbenefits.



7

Conclusions and recommendations

As we observed in our introduction, there has often been more heat than light in the debate about the role of the private sector in the healthcare system in England, and one purpose of our research was to seek to contribute some evidence and data to that debate.

Our key findings are:

The systems for assuring the quality and safety of healthcare in England – what we broadly term clinical governance – have largely been developed around the structures and ways of working of the NHS – a publicly funded and delivered healthcare system. But changes in the way we organise and deliver elective inpatient care through both NHS and private hospitals in recent years with a more diverse provider sector, patient pathways which may cross organisational boundaries, and a shared clinical workforce, mean these systems need review and reform.

The current arrangements for clinical governance were designed to work within organisations like NHS trusts and private hospitals, but not between them. However, as patient care pathways cross organisational boundaries and doctors work in both NHS and private hospitals, there is an increasing need for better inter-organisational or system level clinical governance arrangements. In particular, the role and function of Responsible Officers and the operation of appraisal and revalidation need reform to make a reality of whole scope of practice performance review and to create a duty on Responsible Officers and clinical governance leads to share information and to work in more formalised networks.

The arrangements for gathering data and sharing information about quality and safety between organisations are not fit for purpose. They rely too much on consultants themselves choosing to share or provide information about their performance or any concerns. Data sharing has been hampered by an over-cautious approach to information governance and GDPR concerns and a limited statutory basis to provide senior doctors and others with clinical governance responsibilities with the assurance that they can share data – and, indeed, that to do so is an obligation when there are patient safety concerns.

The national arrangements for the systematic collection of routine data from hospitals about elective inpatient care in both NHS and private hospitals and to make that data available, in a timely and usable form, to those responsible for clinical governance in NHS and private hospitals, to regulators, to professional associations, to researchers, and to patients and the public, have scarcely changed since the Paterson inquiry report in 2020. They are clearly not fit for purpose, and there is no technical or legal reason why the first recommendation of the Paterson inquiry report could not be implemented immediately.

The ADAPt programme demonstrated the technical feasibility of linkage of HES and PHIN datasets, but no further action has been taken to resolve outstanding concerns about the legal authority required and to make such an integrated dataset of public and private funded and provided elective care a routine data collection. We recommend this data collection is initiated and made available through the DARS system in a similar manner to the HES dataset.

There are some longstanding concerns about the performance of private hospitals and the effect of private hospitals on the NHS which are not supported by our findings. The quality of care in NHS and private hospitals is pretty similar on the whole, and differences are largely explained by differences in the populations they serve, with private hospitals dealing with less complex treatments and patients with fewer comorbidities We found no evidence that, when doctors work in dual practice, across both NHS and private hospitals, there is any adverse effect on either their NHS workload or NHS quality of care. Although, our analysis is limited by only having access to full consultant-level PHIN data over two years.

Liaison between NHS and private hospitals where there is shared care or a patient pathway which crosses between them needs to be improved, so that patients are informed about arrangements for ongoing care and patient records are transferred or accessible across the pathway. All providers of NHS-funded services should participate in proposed future arrangements for a shared care record.

The arrangements for commissioning by ICBs were almost wholly designed around commissioning from NHS trusts, and do not take account of the increasingly diverse provider market. ICBs are under-resourced and lack skills to commission, contract and monitor effectively. Requirements to provide patient choice and "any qualified provider" rules can be a barrier to effective contracting and monitoring.

The NHS Payment System and the HRG based tariff used for reimbursing both NHS and private hospitals for activity was designed decades ago when almost all NHS-funded care was delivered by NHS trusts and was founded on NHS cost returns which rely heavily on cost apportionment within large, complex, multispecialty NHS trusts. Private hospitals do not take part in those cost returns and have very different infrastructure costs. This can mean that the NHS tariff exceeds the likely costs for specialist private providers, and may create opportunities for windfall profits. Reforms could make more use of blended reimbursement models, agreed activity level caps, and differential tariffs for providers..

Based on these findings, our main recommendations to government are:

The existing Responsible Officer regulations need to be revised and updated to strengthen Responsible Officers' statutory powers and duties, and to make it mandatory that they and others responsible for clinical governance share information about concerns about doctors with other organisations where they work.

The existing guidance to organisations on appraisals and revalidation from the General Medical Council and NHS England does not have statutory force and while it makes it clear that consultants and hospitals should share data about scope of practice and performance for appraisals and should ensure that appraisal and revalidation processes and outcomes are shared with every organisation where a doctor works, there is no mechanism to check or enforce this. This could be incorporated into future CQC inspections.

Government should move at pace to implement the first recommendation of the Paterson Inquiry report, using its existing legal powers to create a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data, which will be accessible for all those involved in clinical governance, and to patients and the public. That repository should include retrospective data from HES and PHIN.

PHIN has achieved a great deal within the constraints of the CMA order, and has fulfilled its mandate. But in the future, DHSC should use its powers under the Health Act 2022 to collect data from all NHS and private hospitals, and to extend that data collection beyond admitted patient care. PHIN could continue to act as the data processor, or DHSC could collect this data directly as it does for NHS hospitals and for NHS-funded care provided in private hospitals already.

The arrangements for commissioning acute healthcare from private hospitals should be reviewed, to consider whether Integrated Care Boards have the capacity and capability to commission effectively, and to put in place more robust arrangements which ensure effective contract monitoring and enforcement.

The NHS Payment Scheme should be reviewed to consider whether it is fit for purpose for contracting with private hospitals and to explore other ways of setting the reimbursement schemes for providers.



Finally, we note that there is considerable overlap between some of our recommendations and those of the Paterson Inquiry which reported in 2020. We outlined in figure 4 at the start of this report some key recommendations from the inquiry which related particularly to the way that NHS and private hospitals work together. We conclude in **figure 19** with our assessment of progress to date.

Figure 19 Progress towards implementing some of the key recommendations of the Paterson inquiry report in 2020.

	Recommendation	Our summary of progress to date
1	We recommend there should be a single repository of the whole practice of consultants across England, setting out their practising privileges and other critical consultant performance data – for example, how many times a consultant has performed a particular procedure and how recently. This should be accessible and understandable to the public. It should be mandated for use by managers and healthcare professionals in both the NHS and the independent sector.	This has not happened. ADAPt pilot showed there were no technical barriers. Government has the necessary legal powers. Data exists in HES, PHIN, HQIP etc.
3	We recommend that the differences between how the care of patients in the independent sector is organised and the care of patients in the NHS is organised is explained clearly to patients who choose to be treated privately, or whose treatment is provided in the independent sector but funded by the NHS. This should include clarification of how consultants are engaged at the private hospital, including the use of practising privileges and indemnity, and the arrangements for emergency provision and intensive care.	This has not happened. There is still no system for informing patients who are treated privately about the differences between private and NHS hospitals in terms of the scope of practice of doctors, indemnity arrangements, or facilities for dealing with complications or the need for emergency or intensive care.
10	We recommend that the government should, as a matter of urgency, reform the current regulation of indemnity products for healthcare professionals in light of the serious shortcomings identified by the inquiry and introduce a nationwide safety net to ensure patients are not disadvantaged.	This has not happened. DHSC considered introducing regulation of medical defence organisations but has opted instead for a voluntary code of conduct. There is no national safety net and indemnity cover is, if anything, more fragmented with new forms of private providers.

	Recommendation	Our summary of progress to date
12	We recommend that if, when a hospital investigates a healthcare professional's behaviour, including the use of an HR process, any perceived risk to patient safety should result in the suspension of that healthcare professional. If the healthcare professional also works at another provider, any concerns about them should be communicated to that provider.	This has not happened. Government did not accept this recommendation about suspension but did accept that concerns should be communicated. There have been no changes to the Responsible Officer regulations or GMC guidance to make the communication of concerns mandatory.
13	In the NHS, consultants are employees and the NHS hospital is responsible for their management, and accepts liability when things go wrong. The situation is very different in the independent sector where most consultants are self-employed. Their engagement through practising privileges is an arrangement recognised by CQC. However, this recognition does not appear to have resolved questions of hospitals' or providers' legal liability for the actions of consultants. We recommend that the government addresses, as a matter of urgency, this gap in responsibility and liability.	This has not happened. Doctors working in the independent sector remain liable for their clinical practice, and private hospitals do not accept liability for them as they are treated as self-employed independent contractors. The legal position is complex – some would argue that hospitals have a non-delegable duty of care to patients, and cases have been brought in other settings to argue that employer's liability should apply to contractors who act under the direction and control of an organisation. The legal position remains unclear.
15	We recommend that, if the government accepts any of the recommendations concerned, it should make arrangements to ensure that these are to be applicable across the whole of the independent sector's workload (meaning private, insured and NHS-funded) if independent sector providers are to be able to qualify for NHS-contracted work.	This has not happened. The provisions for dealing with complaints, managing concerns about doctors' practice, undertaking appraisal and revalidation, providing indemnity cover for clinical negligence etc all continue to vary according to whether care is NHS or privately funded and provided in NHS or private hospitals.

Appendix - Project Advisory Group and Patient and Public Involvement Forum

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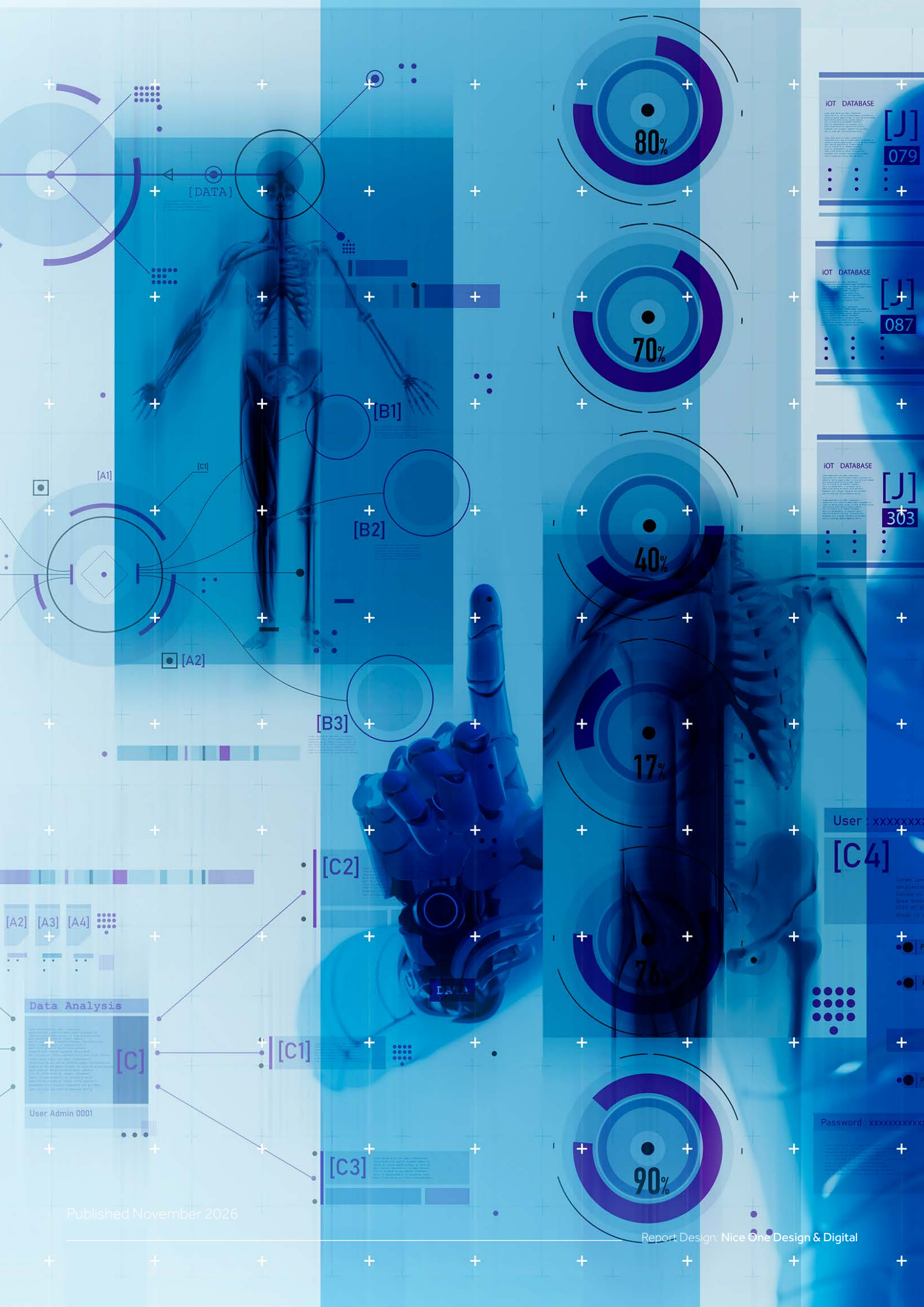
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