Privatisation and independent sector provision in the NHS
Introduction

This paper revisits the BMA’s 2016 report1 into privatisation and independent sector provision in the NHS in England. Two years ago, our report highlighted that the role of independent sector providers in the NHS was increasing, and set out a range of concerns about the impact this was having on NHS services and staff. We made eight recommendations focused on bringing greater transparency to the use of such providers at a time when the NHS is under unprecedented financial pressure.2

The recent case of legal action brought against several CCGs by Virgin Care should serve as a stark reminder of what can happen when the relationship between the NHS and private sector sours. A settlement reported to be in the region of £330,000 was paid to Virgin Care in December following a procurement process that saw an alliance between a foundation trust and local social enterprises win a contract to provide children’s services across Surrey.3 This comes at a time when budgets are increasingly tight, and the NHS cannot afford to see any money wasted.

In this report, we revisit our original eight recommendations to see what changes, if any, have taken place since their publication. This report also looks at the latest data from the DH (Department of Health) annual accounts for the 2016/17 financial year to provide an update on how much of the NHS budget is currently being spend on ISPs (independent sector providers). The BMA’s concerns about the growing role of ISPs in the NHS – particularly around lack of transparency and accountability – still very much stand in 2018. We remain convinced that the NHS should be the preferred provider of NHS services, and that ultimately the introduction of a competitive procurement framework as set out in the Health and Social Care Act 2012 has been detrimental to the health service. We will continue to lobby for greater transparency, and ultimately for legislative change to move beyond the current discredited competition framework in England.

---

2 As in previous BMA reports, the definition of independent sector providers used here includes commercial and private sector, ISTCs (independent treatment centres) and social enterprises. This is to correspond with Department of Health data on the purchase of healthcare from non-NHS providers.
3 https://www.hsj.co.uk/commissioning/commissioners-settle-with-virgin-following-contract-dispute/7021159.article
The financial picture

The latest financial data from the DH published in July 2017 revealed that:

- Spending on ISPs continues to rise.
- As a proportion of the DH budget, independent sector healthcare provision remains high compared to historic levels.
- Spending on non-NHS provision as a proportion of the budget has increased for the third year in a row.

Between 2013/14 and 2016/17 the amount spent on non-NHS healthcare provision grew by £3.2 billion, from £9.5 to £12.7 billion, an increase of 35%. Over the same period the amount spent on ISPs grew by £2.5 billion, from £6.5 to £9.0 billion, an increase of 39%.

<table>
<thead>
<tr>
<th>Year</th>
<th>Independent sector providers</th>
<th>RDEL (2016/17)</th>
<th>Non-NHS provision</th>
<th>Proportion of RDEL spent on ISPs (%)</th>
<th>Proportion of RDEL spent on non-NHS bodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>6.5</td>
<td>106.5</td>
<td>9.5</td>
<td>6.1</td>
<td>8.9</td>
</tr>
<tr>
<td>2014/15</td>
<td>8.1</td>
<td>110.6</td>
<td>10.4</td>
<td>7.3</td>
<td>9.4</td>
</tr>
<tr>
<td>2015/16</td>
<td>8.8</td>
<td>114.7</td>
<td>12.2</td>
<td>7.7</td>
<td>10.7</td>
</tr>
<tr>
<td>2016/17</td>
<td>9.0</td>
<td>117.0</td>
<td>12.7</td>
<td>7.7</td>
<td>10.9</td>
</tr>
</tbody>
</table>

These figures show that 7.7% of DH running costs (RDEL) was spent on ISPs in 2016/17, up from 6.1% in 2013/14. This is only slightly less than was spent on the whole of general practice over the same period (£9.3 billion). Some changes in definitions mean that the figures above are limited in terms of their comparability, but they are broadly consistent with the long-term trend which has seen small increases in spending on independent sector provision for the past fifteen years.

---

4 This also includes voluntary and local authority bodies

5 RDEL (Revenue Departmental Expenditure Limit) refers to the amount of money spent by the DH on day-to-day costs across the health service
Figure 2: Total spending on non-NHS healthcare provision

The most recent accounts indicate that spending on ISPs has broadly stabilised, increasing by just £0.2 billion between 2015/16 and 2016/17. However, this remains a high proportion of NHS spending compared to historical levels, and the BMA’s position remains that the government should be actively seeking ways to reduce this figure.

One year on – revisiting the BMA’s eight recommendations on ISPs

Recommendation 1:
The BMA’s 2016 report noted that NHS England does not collect data on levels of independent sector provision of NHS services broken down by sector – for example for community services, acute services, and mental health services – and recommended that this type of data should be gathered in future.

An FOI (freedom of information) request made by the BMA in August 2016 indicates that some data collection of this kind does take place at CCG level. However, just one third of CCGs that responded to the request supplied data in this format, suggesting that though the means exist to record spending by sector, most CCGs either do not organise their spending data in this way, or were not prepared to disclose this type of information.

In response to an enquiry from the BMA, NHS England said the following:

“As part of the Annual Accounts submissions, all NHS England entities (including CCGs) are required to submit a breakdown of the total non-NHS spend into its component parts. This information is a manual collection, is not audited and is used to inform ad hoc requests from the DH (Department of Health). The guidance for this breakdown is published on the NHS England intranet but is provided by the Department of Health. This information could be requested from each individual CCG.”
Therefore, it remains impossible to obtain information on independent sector provision by sector without another FOI request submitted to all 207 CCGs. Given this ongoing lack of transparency, and the BMA repeats its call for NHS England to collect and publish this data.

**Recommendation 2:**
The BMA called for thorough impact analyses to be conducted before any independent sector provider is chosen as a preferred bidder, so as to ensure that the decision will not destabilise existing NHS services or cause disruptions to patient pathways.

We found little evidence that such impact assessments are being undertaken on a systematic basis, although some individual examples do exist.

In one example from 2017, PwC (PriceWaterhouseCoopers) conducted an independent impact assessment of the transfer of musculoskeletal services in Lewisham and Greenwich to Circle Health. The accounting firm found that Lewisham & Greenwich trust would stand to lose up to £6.6 million of income if the move went ahead, which in turn would mean that the trust would be at risk of being placed in financial special measures. Consequently, Circle agreed to several proposals by the trust to mitigate the effects of losing the contract, and avoid destabilising existing NHS services (including a specified “minimum activity level” for the trust for the life of the £73 million, five-year contract).6

Though the decision to carry out an impact analysis was a positive one, especially as it highlighted unforeseen implications for Lewisham & Greenwich Trust, it seems unlikely that it would have taken place at all if not for pressure put on the trust by local campaigning organisations (and it is alarming that prior to the report’s publication, there was no contractual obligation on the part of Circle to ensure that it did not jeopardise the viability of local NHS services). Neither the CCG nor NHS England felt that it was within their remit to undertake the analysis, although NHS England did clarify that it considered the impact analysis to be part of due diligence on the part of the CCG.7

It is encouraging that impact analyses are considered part of due diligence, however it is unclear whether this is established practice across the NHS in England, or whether this has been clearly communicated to commissioners. There is a need for clarification on what exactly is meant by ‘due diligence’ in this context, as well as more oversight from NHS England to ensure that CCGs fulfil this obligation. We recommend that NHS England ensures such impact assessments are enshrined as a core element of the procurement process.

**Recommendation 3:**
The BMA proposed that during any procurement process that involves an independent sector bidder, CCGs should carry out a full risk assessment for what might happen if NHS staff do not wish to transfer their existing contractual terms and conditions to an independent sector provider through TUPE (transfer of undertakings under present employment) regulations and how this might impact on the continuity of service provision. TUPE regulations come into force when staff are transferred from one provider to another – they are important because they can ensure that existing contractual terms and conditions are preserved.

There is currently very little evidence around the implications of staff refusing to transfer under TUPE regulations. However, there does seem to be some evidence that assessment of the wider risks of the transfer of staff is not necessarily taking place. For example, in 2017 nurses in Berkshire expressed concerns that moving to an independent provider would damage integrated working arrangements that had taken years to develop, as well as affecting their own professional development and training. Additionally, staff said that they were worried they would lose access to the NHS patient record system.8

8  https://www.nursingtimes.net/news/community/exclusive-nurses-raise-concerns-over-new-private-contract/7020553.article
Similarly, in May 2017 Hull CCG had to seek assurances after an independent firm that was awarded a £6 million contract warned staff that they would not be paid their first month’s wages in full.9 Staff who transferred under TUPE regulations were informed days before pay day that overtime and expenses would not be paid until later because of cash flow problems. The issue was only resolved when the CCG met with representatives of the independent sector contractor.

Though contracts are protected by the relevant regulations, it is unclear if other issues (eg continuity of care, access to patient records, ensuring that employers can pay wages on time and in full) are being considered. If these issues represent a secondary concern during the procurement process, it seems unlikely that the possibility of NHS staff refusing to transfer their employment to a new provider (and the resulting implications) is being fully considered during procurement processes. If TUPE is taking place, a full risk assessment should be carried out in which the concerns of staff are prioritised.

Therefore, the BMA is recommending that NHS England should ensure that CCGs carry out formal risk assessments during the procurement process, not only to examine the implications of staff refusing to transfer, but also to examine all possible outcomes of TUPE (including not limited to potential damage to working relationships, continuity of care, staff access to NHS resources and the capability of private firms to meet the terms of their new employees’ contracts)

**Recommendation 4:**
In recent years the number of NHS patients treated in private hospitals has increased substantially (figures 3,4). In 2015, 5% of NHS funded elective surgical admissions were to independent sector facilities, compared to just 0.35% in 2004/05.10 Given the increasing role of private hospitals in NHS provision it is of great concern that there continues to be no obligation on ISPs to report patient safety incidents and performance data. The BMA restates our recommendation that this become a formal requirement.

---

9 [https://www.bmj.com/content/full/354/bmj.j7252](https://www.bmj.com/content/full/354/bmj.j7252)
On the question of patient safety, the requirements of CQC (Care Quality Commission) regulations for non-NHS providers include a ‘Duty of Candour’, which is broadly in line with the regulations and requirements for NHS providers. Independent providers must notify the CQC in the event of a serious incident (injuries to patients and patient deaths) but there is no obligation to make publicly available any information about the nature or severity of these incidents, and neither does the CQC publish this information. Furthermore, ISPs are not required to provide the CQC with regular updates on other, less serious, safety incidents and according to the think tank CHPI, only 63% of hospitals do so.\(^{11}\)

Some information about ISPs is available via the PHIN (Private Healthcare Information Network), a non-profit organisation which received a government mandate in 2015 to provide information about ISPs and improve data quality and transparency.\(^{12}\) ISPs are required by law to submit data to the PHIN, and though the network is still in its infancy, it could grow to become a valuable source of information about patient safety in independent sector hospitals. However, the BMA’s Medico Legal and Private Practice Committees have expressed several concerns about PHIN including its failure to address the fact that doctors do not necessarily treat all patients that are nominally under their care, and thus when patients are cared for by other consultants, the recording of complications is not always accurate. There is concern that data for re-admission rates could be wrong as a patient may return to hospital within a month for a new condition that was unrelated to their operation. There is also presently no clinician with active clinical private practice on the board of PHIN.

While the PHIN remains a potentially useful tool, these issues need to be addressed, while work also needs to be done to ensure that the private sector is under the same obligation as the public sector to report patient safety incidents; this means that the level of scrutiny and transparency that the PHIN offers is currently inadequate. The PHIN has itself called for the DH to address the issue of comparability of data across the two sectors. The BMA therefore continues to call for more consistency and transparency with regard to safety in private hospitals.

**Recommendation 5:**
Following analysis undertaken by CHPI in 2015 on patient safety in private hospitals,\(^{13}\) the BMA recommended that the CQC should develop a more standardised approach to regulating ISPs in line with NHS providers.

From 2015 onwards, CQC inspection of acute, independent hospitals has been broadly in line with the inspection of NHS providers of acute care. The list of services considered to be ‘core’ (ie inspected at every site) is the same at both NHS and independent sector acute hospitals, and in some instances, inspections are more extensive at independent sector hospitals due to differences in how services are organised and the level of risk (for example the termination of pregnancies is also considered a core service at independent sector hospitals). However, the CHPI report noted that despite more standardised inspection guidelines, CQC inspections of independent hospitals are often inconsistent and that there was a ‘lack of systematic collection and reporting’.\(^{14}\)

Following at least one high-profile incident at a private hospital in the last 18 months, a government inquiry will this year determine whether the CQC’s inspection regime needs to be strengthened. Though the decision to focus more attention on safety and procedure at private hospitals is to be applauded, it is concerning that it required a serious incident to force the CQC to address this issue, when the BMA and others have been drawing attention to it for some time.

---

12 https://www.phin.org.uk/about/about-phin
14 Ibid.
It is currently the responsibility of the CQC, and by extension the DH, to ensure that inspections at independent sector acute hospitals are conducted as rigorously as those at NHS sites, and regular evidence that this is the case from either organisation would be welcomed. The BMA contacted the CQC to ask for clarification on what measures, if any, were being implemented to improve consistency, especially in light of the fact that provision of services often differs significantly between the public and private sector. The CQC clarified that it is developing a methodology for carrying out provider level assessment, which will include assessing the efficacy of governance structures. This is a positive step, especially as serious failures in hospital governance have been identified in some cases of patient safety incidents at private hospitals. The CQC will also be consulting on plans for future approaches to inspecting and rating ISPs in early 2018. While we welcome these steps are, more clarity on patient safety as a focus of the CQC’s inspection of ISPs would be welcomed.

Last year the DH also published a draft bill aiming to clarify the remit of the recently established HSIB (Healthcare Safety Investigation Branch), an independent organisation with legal powers to investigate serious safety incidents or risks to patient safety. The bill specifies that incidents occurring during the provision of NHS care will be within the scope of the HSIB; thus, it could ‘investigate an incident that occurred during the provision of NHS services in a private hospital or privately-owned care home.’ The extent to which this right will be exercised remains to be seen however, and is also contingent on the bill proceeding unimpeded through Parliament. Pending further clarification on the scope and role of the HSIB, the BMA repeats its call for a more standardised approach to regulating ISPs in line with NHS providers.

**Recommendation 6:**
As a consequence of several incidents in which ISPs terminated contracts early, the BMA recommended that safeguards should be introduced to protect NHS patients and services if the terms of contracts are unmet by private companies. As highlighted in the previous report via the example of Hinchingbrooke, which was run by Circle for several years until the company deemed the contract financially unviable and terminated it, the implications for trusts and CCGs can be serious if ISPs decide to walk away from contracts.

One major stumbling block in protecting the NHS against incidents of this nature appears to be a lack of expertise within CCGs in constructing contracts to indemnify local services against the risks of providers failing to fulfil their obligations.

This was acutely clear in the case of Uniting Care in 2015. Though it involved a consortium of NHS trusts, the collapse of the Uniting Care Partnership in Cambridgeshire and Peterborough clearly demonstrated the need for more safeguards and guidance from NHS England for CCGs with regards to commissioning large contracts. Despite ‘extensive reporting and discussion’ throughout the procurement process for the £725 million contract, there was a failure to analyse the impact of Uniting Care’s LLP (limited liability partnership) status. As a result of that status, the VAT liability for the partnership was much higher than expected, but neither the CCG nor Uniting Care had made the necessary provisions to ensure that the VAT was budgeted for. When after just eight months Uniting Care announced it was handing back the contract, £16 million had already been spent, an expense that had to be shared between the two trust partners and the CCG (while at the same time organising the alternative provision of care for patients).

---

Following an inquiry by NHS England into the collapse of the Uniting Care contract, and with the move towards new care models and contracts in mind, NHS England and NHS Improvement published an advisory document in November 2016 that laid out a number of recommendations for both NHS England itself, as well as CCGs.¹⁷ These recommendations offer clarity with regard to how the procurement process should work, and warn against the dangers of delegating responsibility ‘to CCGs to enter into large complex novel contracts without the need to provide any assurance to NHS England.’ Another recommendation proposes ‘establishing an assurance process for novel contracts carried out by appropriately skilled individuals.’

It largely remains to be seen whether these recommendations will be taken into account. However recent evidence suggests more may need to be done to enforce these new guidelines. Recently a company operating one of the first integrated NHS 111 and GP out of hours services was forced to hand back its contract to the NHS just seven months into a three-year deal. CCG board papers from early 2016 rated the risk of the proposed transfer of services as ‘red’ and yet the deal went ahead. A new procurement process will now take place, along with another investigation into the award of contract.¹⁸

The BMA remains concerned about a lack of expertise within NHS commissioning bodies in constructing contracts to indemnify local services against the risks of providers failing to fulfil their obligations. NHS England should conduct and publish an evaluation to ascertain whether the recommendations made in its 2016 report on the collapse of the Uniting Care contract have been successfully implemented, particularly in relation to the development of an assurance process for novel contracts. Assurance processes must contain safeguards to protect patients and services if providers walk away from contracts prematurely.

**Recommendation 7:**

The BMA recommended that the DH should carry out a regular review of admissions from ISPs to the NHS to determine the nature and cost of these incidents. In response to an enquiry from the BMA, the DH confirmed that other than the number of incidents, information on patients admitted to NHS hospitals from independent sector hospitals is not collected. The latest figures for admission episodes for NHS providers where the source of admission was a non-NHS hospital are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Elective</th>
<th>Emergency</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>1,898</td>
<td>4,328</td>
<td>1,802</td>
<td>8,028</td>
</tr>
<tr>
<td>2014/15</td>
<td>2,134</td>
<td>3,341</td>
<td>1,979</td>
<td>7,454</td>
</tr>
<tr>
<td>2015/16</td>
<td>2,610</td>
<td>3,070</td>
<td>1,753</td>
<td>7,433</td>
</tr>
</tbody>
</table>

Adequate information on admissions from independent sector providers to the NHS is not currently collected or reviewed, so the BMA repeats its call for the DH to conduct regular reviews of such admissions.

¹⁸ [https://goo.gl/ZYuucu4](https://goo.gl/ZYuucu4)
**Recommendation 8:**
The BMA recommended that the NHS Standard Contract should be amended to include a clause requiring ISPs to contribute towards the education and training of the NHS workforce – either financially or by making available suitable opportunities. This would be in addition to the existing requirement to support the work of HEE (Health Education England) and LETBs (local education and training boards).

There does appear to have been some progress regarding this recommendation. The 2017/18 NHS Standard contract is more robust in terms of the demands it places on providers. The contract calls for them to provide ‘proper and sufficient induction, continuous professional and personal development, clinical supervision, training and instruction’, and it also specifies that: ‘The Provider must cooperate with the LETB and Health Education England in the manner and to the extent they request in planning the provision of, and in providing, education and training for healthcare workers, and must provide them with whatever information they request for such purposes. The Provider must have regard to the HEE Quality Framework.’

The 2017/18 NHS Standard Contract appears to give HEE the ability to demand that the ISP offers the training and education that HEE tells them to provide, so the onus is on HEE to determine what it wants each ISP to do on a case by case basis. However, the extent to which HEE is exercising this right is unclear, and greater clarity in this area would be welcomed by the BMA.
Conclusion

The BMA remains deeply concerned about the continued predominance of independent sector provision in the NHS, and despite progress in some areas there continues to be a worrying lack of transparency and accountability — particularly important given the increasing amount of taxpayers’ money being spent on ISPs.

Many of the examples highlighted in this report point to a lack of adequate safeguards and sufficient expertise at a commissioning level to manage the risks associated with contracting NHS services to ISPs — something the BMA has consistently raised as a weakness of the current commissioning system. We will continue to monitor developments in this area as the nature of commissioning in the NHS in England changes — particularly in the context of NHS England’s promotion of ACOs (accountable care organisations), which bring together multiple providers into one contract for a defined population. Developments in this area have significant implications for how services are commissioned, and what role ISPs will play in the NHS in future.

Finally, we will continue to lobby for greater transparency and accountability around the role of ISPs in the NHS, in line with the recommendations set out in our 2016 report. The BMA remains committed to monitoring the level of private sector involvement in healthcare provision; if you have any concerns about privatisation of services in your local area or any other issues highlighted in this report, please email info.policy@bma.org.uk.