MIDDLESBROUGH COUNCIL

AGENDA ITEM 10

OVERVIEW AND SCRUTINY BOARD

16 October 2012

HEALTH SCRUTINY PANEL FINAL REPORT – THE DEVELOPMENT OF PRIVATE PATIENT UNITS

PURPOSE OF THE REPORT

1. To present the outcome of the Health Scrutiny Panel's consideration of the topic of Private Patient Units.

CONSIDERATION

2. One of the most significant elements of the debate around the Health reforms outlined in *Equity and Excellence: Liberating the NHS*, later enshrined in the Health & Social Care Act 2012, was the extent to which the NHS would get involved with the provision of private healthcare.

3. The Health Scrutiny Panel, therefore, identified a strong interest in considering how that aspect of the national reforms would impact upon local services. As such, senior representatives of the South Tees Hospitals NHS Foundation Trust were invited to attend a meeting on 1 August 2012, to provide information and address questions from the Panel.

4. The questions that the Panel was particularly interested in exploring were as follows:

4.1 What does the Health & Social Care Act allow the Trust to do, that it couldn't do previously, with regard to private patient income?

4.2 What proportion of its activity at JCUH is currently non-nhs/privately financed?

4.3 Does the trust have any intelligence on the size of the private healthcare economy/market across Tees?

4.4 If so, what proportion of the local private healthcare economy does JCUH currently capture?

4.5 What would the trust like to grow its private activity to, if at all?

4.6 What are the clinical areas the Trust would expect to see most private activity?

4.7 What, in the Trust's view, would be the most significant impact on NHS services and access to them should there be an increase in private activity?

4.8 Does JCUH have bed capacity to cope with additional private patients?

4.9 What sort of financial contribution would the Trust expect Private activity to make to the Trust's accounts?

5. The South Tees Hospitals NHS Foundation Trust (STHFT) presented a paper to the Panel.

6. The Panel was interested to learn about the size of the private healthcare market in the UK. The Panel heard that In 2009, £5bn was spent on private healthcare in the UK, of which £2.8bn had been paid to private healthcare providers (£1.7bn to consultants and other clinicians and £0.5bn to NHS private patient units). Regionally, the North East has the lowest level of private medical insurance in the UK at 9.7%, compared to a UK average of 16% and the highest level in the South East of 22.3%.

7. The Panel was keen to enquire about the nature of the local private healthcare market. It was reported that data in respect of local markets for private healthcare was difficult to obtain, as such information was not collected or published nationally like NHS services. Nonetheless, it was pointed out to the Panel that within twenty five miles of James Cook University Hospital (JCUH), there are seven facilities offering private health services, in addition to other NHS hospitals offering private services. This figure does not include private mental health providers. The Panel was advised that STHFT only captured a small proportion of the local market, since the Trust had not historically focussed on private patients, nor had it provided any dedicated or differentiated facilities for that particular market. The Panel heard that These include the Nuffield Hospital in Stockton on Tees, the BMI Woodlands hospital in Darlington and the Tees Valley Treatment Centre provided by Ramsay Healthcare at the One Life Centre in Middlesbrough. The Panel noted that given the lack of information on the private healthcare market in the area, the Foundation Trust does not know what proportion of the market it currently captures. The Panel heard that the Trust’s initial deductions, however, would indicate that it only captures a small proportion of the local market, as it has not focused on private patients and does not provide any dedicated or differentiated facilities for them. The Panel was interested to learn that in contrast, BMI Woodlands in Darlington, has 38 beds and 3 theatres focused on providing services for private patients (although under the NHS “choice” agenda it does also provide some NHS funded treatment)

8. The Panel heard that the amount of the Trust's private patient income was currently reported as 0.36% (£1.63m of total income of £450.44m for 2010/2011) and 0.29% (£1.48m of £509.76m for 2011/2012). It was clarified to the Panel that in terms of patient numbers this equated to 5,368 outpatient appointments in 2010/2011, 5,671 in 2011/2012 and 375 inpatients spells in 2010/2011and 355 in 2011/2012.

9. The Panel heard that private activity tended to be performed around the margins of NHS activity, for instance by adding a private patient to the end of an existing operating theatre list and utilising a 'spare' bed on a ward. The Panel was advised that from the STHFT's perspective, conducting private work 'around the edges' of the Trust's NHS work was not ideal, as it ran the risk of having to cancel work and, therefore, jeopardise income should it not be possible to complete the private work.

10. It was reported that whilst there was some private patient activity in many of the Trust's specialities, most of the current patient activity was in cardiothoracic services, radiology and women and children's services. It was pointed out to the Panel that although general surgery and orthopaedics were major areas of private activity nationally, they were not major services currently provided by the Trust. The Panel also heard It was pointed out that whilst private cosmetic surgery was one of the other major areas of private activity nationally, it was not currently provided by the Trust at all.

11. It was confirmed to the panel that that the Health and Social Care Act 2012 effectively removed the cap on private activity for Foundation Trusts, stating that:

The principal purpose of a foundation trust is not fulfilled unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England, is greater than its total income from the provision of goods and services for any other purposes

12. The Panel heard that this would mean that no more than 49% of a foundation trust's income could come from outside the NHS in England. It was confirmed that if a Trust wanted to increase the proportion of its total income earned from outside the NHS in England by more than 5% in a year, it must include this in its forward plan, which must be approved by the Trust's governors. In terms of STHFT it would mean increasing the patient activity to more than 5% of the total income or more than £25m.

13. It was reported that given the current minimal level of activity in relation to private patient income, the Trust was actively investigating the potential to increase such income and the resources that would be required. The Panel heard that it was considered that the STHFT had the potential to offer the more complex services which private hospitals

were not able to provide, due to the extensive clinical support services situated at JCUH. In addition, it was reported that it could build on the quality of current NHS services and strengthen the expertise of medical staff and the co-location of all specialities and diagnostics on one site. The panel was advised that STHFT feels that there is scope to expand all specialties, in particular current general surgery and orthopaedic services and develop private cosmetic surgery services. The Panel was advised that even if the level of activity in respect of private patient income significantly increased it would still be a small proportion in comparison with NHS services.

14. Following questions from the Panel, an assurance was given that as an organisation the Trust was strongly committed to providing NHS healthcare services. Private patient activity was viewed as something providing a business opportunity to offer high quality services for private patients and to generate a significant and much needed income stream to be utilised by the Trust, for the benefit of NHS services. The Panel noted with interest that although such a possibility was still being investigated, research had shown that profit margins of 20% or more had been achieved elsewhere.

15. The Panel was advised that any resources used to deliver private activity, whether beds, operating theatre time or staff time would be in addition to resources required to deliver NHS activity and would be funded out of the private income. The Panel heard that given the current level of NHS activity, it was noted that there were current difficulties in finding space for additional beds or finding unused theatre time, which could be allocated to private patients at JCUH.

16. It was reported, however, that the Trust had an ambitious transformation programme with the aim of increasing efficiency, removing waste, improving patient pathways and managing demand which should free some capacity, either to reduce costs or to reuse for other services, including private patient services. Still, the Panel heard that the preferred route would be to establish a separate section of the site for private patients, which would ensure that both NHS and private work could function independently.

17. It was reaffirmed to the Panel that private patient business would not be pursued unless a significant financial gain would be obtained and then invested for the benefit of NHS services, and it would not impact on the delivery of such services.

18. In commenting on the possible development of private patient units, the Panel emphasised the importance of ensuring that it should not be at the detriment of the delivery and development of NHS services. Reference was made to statements made within the briefing report, regarding challenges facing the Trust in terms of finding space for additional beds or finding unused theatre time for private patients, given the current level of NHS activity. In response, STHFT

representatives confirmed that major developmental work was currently being undertaken, in order to achieve efficiencies in delivering services. This includes improvements to NHS patient pathways, which could result in freeing up space within existing buildings and the availability of resources, to invest in developing private patient units.

19. The Panel was keen to discuss possible concerns in terms of possible detrimental implications on NHS services, or establishing Private Patient Units. It was indicated that there was potentially less risk if there were dedicated facilities for private patients but it was reiterated that this would not be undertaken unless there was sufficient income generated to be re-invested into NHS services. Should private patient facilities be developed it was considered that the Trust would be in a better position to compete in the market with other providers and had the potential to offer more complex services.

20. The Panel expressed a concern that members of staff, funded by the public purse, were spending time looking at how to expand private practice and not concentrating on NHS work. In response, it was confirmed that a relatively small number of people had been assigned by the Trust to undertake work around the development of private patient units. Further, it was currently being considered whether the Trust should move to appoint a temporary project manager. Whilst such work was being initially funded by the Trust, the aim was to generate a larger return in order to provide facilities for private patients and ultimately re-invest into improving NHS services.

21. Following questions in relation to such areas as the forward plan, direction of travel and the extent to which private patient units would be developed, the Panel was advised that the concept was still being researched and it was too early in the overall process, to have firm proposals on such matters. The forward plan provided details on financial sustainability and how services would be developed for the benefit of patients. It was suggested to the Panel that the Trust would be in a better position in around six months' time to provide more detailed information for the Panel.

22. In commenting on overall reporting arrangements with the Trust's Governors and publication of the forward plan, the Panel was assured that the Governors would be kept informed on a regular basis in terms of developing private patient units. This would be regardless of the statutory requirement for them to be informed if it was intended to increase the proportion of the Trust's total income earned from outside the NHS in England by more than 5%. It was confirmed that further details on this matter could be provided.

23. The Panel reiterated the importance of having appropriate procedures in place to ensure that the possible development of private patient units did not have a detrimental affect on local NHS hospital services.

24. The Panel agreed that whilst recognising that the Trust's current work on the possible development of private patient units was in its initial stages, it was considered useful if a briefing report could be prepared on the Panel's observations at this stage of the process. Specifically, the Panel was keen to seek assurances in terms of ensuring appropriate governance and reporting arrangements, in addition to the statutory requirements.

25. The Panel was also keen that the STHFT be able to clearly demonstrate, in the future, how income generated from the private patient units would be utilised for the good of NHS services.

26. In conclusion, the Panel agreed that it would receive a further update on the progress of the project, in early January 2012.

Conclusions

27. The Panel considers that it is almost inevitable that given the challenging financial climate facing the NHS and the prevailing Government policy that actively encourages it, NHS organisations such as South Tees Hospitals NHS Foundation Trust, will seek to supplement their income by exploring private sources of income. The critical matter is how that process, provision of services and income stream is managed.

28. The Panel heard that the Trust would seek to establish a separate private patients unit, where all treatment would be undertaken and the patients would be accommodated. On balance, the Panel thinks that this is an understandable decision, as this will at least lessen the likelihood of private work impacting on the provision of NHS work.

29. The Panel is clear that although there may be separate private and NHS units, all housed on the same JCUH site, it should be mandatory that any contracted partner in the provision of private healthcare services, should be bound to operate according to NHS clinical governance standards. The Panel thinks this should be a non-negotiable aspect of any contract. It would not be acceptable for a Foundation Trust to argue that clinical governance and clinical standards are a matter for the contracted partner. This is important for reputation management, as well as patient safety and clinical quality.

30. The Panel feels that the governance arrangements established to monitor (and ultimately approve) the percentage of Trust turnover attributable to private income are too weak and too easy to evade. Governance arrangements stipulate that if the Trust wants to increase its private patient activity by 5% of turnover, in any one year, it must seek authorisation through the Foundation Trust governors process. The Panel is concerned that, hypothetically, a Trust could increase its activity by 4.9% of turnover each year and it would not need to satisfy any formal process of validation/approval. The Panel considers this

unacceptable and would suggest that any increase in private patient activity should be presented to the governors for authorisation. If the NHS aspect of the Trust would benefit from that additional income, it is difficult to envisage a scenario when governors would object.

31. The Panel notes that the South Tees FT has stated that the Tees area does not have as sizeable a private healthcare market as other areas. This may be the case, although the Panel would be interested to see whether the creation of private facilities at JCUH would stimulate demand and encourage a bigger market to develop. If so, the points raised above become more important. This may well be the case if the NHS financial reality begins to impact on the quality of service provision.

32. Having made the points above, the panel would point out that if a private healthcare market does exist on Teesside, it is surely a positive that the local NHS facilities may benefit financially from that. It may even help to recruit and retain key staff. Still, the Panel is clear that the Foundation Trust should be able to clearly articulate, on an annual basis, how much private income it has received and specifically what areas of NHS service provision have benefited as a result.

Recommendations

33. The Trust's governance arrangements should be tightened to ensure that any percentage increase in the Trust's turnover, attributable to private health care work, should be presented to and verified by, the Trust's Governors. Local Overview & Scrutiny Committees should also be informed.

34. That, in such an event that a private healthcare provider contracts to deliver services on the Foundation Trust's property, the Trust ensures that the clinical governance standards in force are of the same rigour as NHS clinical standards. This should be a non-negotiable element of the contract signed. In addition, the quality of the physical environment of NHS wards should be protected, to ensure that private facilities are not made to look better, due to the lack of attention paid to NHS ward facilities.

35. That the appropriate local Health Scrutiny function receives a retrospective annual report of private activity each year, the money it generated and how that money has developed NHS services. The Foundation Trust should also publish a forward work programme of areas of clinical practice that it is considering providing or contracting to provide, a private healthcare equivalent.

36. As a matter of organisational policy, the Trust should make clear that in such an event as the Trust's private work not providing adequate financial contribution to the operation of the Trust, it should cease in the provision of that private service. The Trust should never find itself in

the position that the provision, or contracting for the provision, of private healthcare work leaves the Trust ‘out of pocket’.

Councillor Eddie Dryden
Chair, Health Scrutiny Panel

BACKGROUND PAPERS

37. Please see the Health Scrutiny Panel Agenda and Supporting Papers from 1 August 2012.

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