Response to Healthcare Commission Review of the quality of care provided by wave 1 independent sector treatment centres to NHS patients

Questionnaire for stakeholders

Background

Following the Health Select Committee's inquiry into Independent Sector Treatment Centres (ISTCs) earlier this year, the Secretary of State announced that she had asked the Healthcare Commission to review the quality of care provided by wave 1 ISTCs to NHS patients.

The terms of reference for the Healthcare Commission's review focus on three areas:

- quality of clinical care and clinical governance
- the experience of patients
- the impact and interaction of regulatory requirements and the terms of the relevant contracts

This questionnaire has been designed to focus on the first of these areas and has used the evidence previously submitted to the Health Select Committee's inquiry to help identify specific issues to explore in more detail.

The information collected will be analysed and will contribute to an interim report at the end of 2006. Evidence from national data sets, ISTC site visits, interviews and the Healthcare Commission's registration and inspection activities will also be considered. A final report will be published at the end of March 2007.

How to complete the questionnaire

Please complete the questionnaire **electronically**, keying in your responses below each question and detailing the nature of your evidence source where indicated. We would welcome as much comment as possible.

If you have already responded to the question as part of the Health Select Committee's inquiry and have no **additional** or **updated information** to include, please make a note of where, in your Health Select Committee's submission, the evidence to answer the question can be found.

If you have no comment to make against a question, please note this.

As with the evidence submitted to the Health Select Committee's inquiry, all questionnaires returned will be made publicly available using our website. If there is any information that you think should be omitted because it compromises patient confidentiality, please mark this clearly within the text.

Please return this questionnaire **electronically** to:

ISTC.Review@healthcarecommission.org.uk

by **5pm on Friday October 13th 2006.**

If you have any queries about this questionnaire, please e-mail Beverley Fitzsimons, also at: **ISTC.Review@healthcarecommission.org.uk**

Questionnaire for stakeholders

Section 1: General information

Name of organisation you represent	AvMA (Action against Medical Accidents)
Name and contact details (should we have any queries and need to contact you)	Fiona Freedland/Liz Thomas
Date completed	13/10/06

Section 2: Quality of clinical care and clinical governance

1. To what extent do the outcomes of care provided by independent sector treatment centres (ISTCs) differ from those of the NHS? What evidence (including knowledge of audits) do you have to support this view?

The fact that this question has to be raised at all is a matter of concern. This data should already be readily available to the Healthcare Commission. That data is not currently being collated in a manner that ensures effective clinical governance and patient safety is down to the fact that the appropriate structures are not in place to monitor outcomes. ISTCs, with their commercial considerations, cannot be wholly relied upon to record outcomes, particularly where the outcome may not be known until after the patient has left the care of the ISTC. A lot of ISTC work is in areas such as orthopaedics, for example hip replacement work, where the long term outcome may not be known for many months and sometimes several years when operations have to be redone or revised – latent failures. The core issue is patient safety and so monitoring must ensure that the care provided is safe and effective. At the moment, much of the evidence is anecdotal – through legal cases, evidence given to the Health Select Committee, high profile cases which have come to light over the past three years where surgeons have been responsible for multiple operation failures etc. However, we are fairly confident that many more failures will come to light in future years and months as problems related to treatment or surgery become apparent.

Nature of evidence:

N/A

2. What is your view of the adequacy of the arrangements within ISTCs to support the reporting and monitoring of critical incidents and to encourage organisational learning? What evidence do you have to support this view?

We do not have access to inside knowledge and, therefore hard evidence on this, but it is evident that we need one comparable system across all healthcare settings whether NHS or independent providers but tailored to the specific nature of the service i.e. core indicators are necessary together with specific indicators relevant to the care setting.

Complaints are an integral and essential part of effective monitoring. The independent sector generally does not have a good record on patient and public involvement (PPI) and from AvMA's experience, nor in relation to complaints handling. Clarity needs to be forthcoming on how complaints handling is to operate in circumstances where complications arise or issues arise following treatment in an ISTC/private treatment centre and how we can ensure that lessons can be shared across both NHS and independent sectors about good as well as poor practice..

Patients need to be informed about the nature of treatment and aftercare in independent treatment centres. How easy will it be for the patient to be readmitted into the NHS following a complication in a private centre rather than expecting the same centre to resolve the issue itself and how effective the current systems are for recording that readmission?

What the patient reports about their experiences needs to be treated as core evidence rather than relying simply on bare statistics on complaints handling. Thus, a robust system for patients to report concerns needs to be ensured. What is currently lacking is the type of watchdog/complaints role that Community Health Councils' previously provided. We need to go back to a model of complaints support for patients that will ensure that there can be closer monitoring and collation of complaints from an independent perspective rather than this resting in the hands of the body responding to the complaint. This is with a view to restoring the early warning system that complaints can provide rather than relying on the individual patient to have the stamina and wherewithal to get their complaint as far as the Healthcare Commission. The Healthcare Commission should also examine some of the headline cases to look at what evidence reached the Healthcare Commission and at what stage to ensure that monitoring systems are made as effective as possible.

Patient questionnaires often fail to capture information on clinical outcomes, seemingly suggesting that patients do not have any valid information to contribute. It is essential that patient questionnaires are developed to capture this type of information and would recommend that patients groups are involved in their design.

Nature of evidence:
N/A

3. What works well and what works less well about the arrangements the ISTCs have in place for ensuring that clinical staff are enabled to perform their roles competently in terms of:

(a) recruitment (including whether staff have the appropriate qualifications and, where relevant, are included on the appropriate specialist register)?

Cases that have hit the headlines would indicate that the systems are not in place. This is critical because one surgeon can cause a lot of damage over a short period of time in this type of intensive setting with a high throughput of operations/treatments/diagnoses. The NHS should be involved in the vetting and recruitment process if the professionals are going to be treating and operating on NHS patients. The evidence can be taken from the cases that have already made the headlines but we also need to look at the whole process of professional regulation and revalidation for doctors working outside the type of managed environment found in the NHS. This was one of the weakest parts of the GMC revalidation proposals.

Nature of evidence:

(b) induction?

Please see comments at 3a) above. We are not aware of the nature and type of induction processes available in an ISTC setting that enables clinical staff to perform their roles competently.

*N*ature of evidence:

(c) ongoing support and mentoring?

We do not have direct knowledge of the effectiveness or the nature and type of support and mentoring(if any) that enables clinical staff to perform their roles competently but evidence given to the Health Select Committee inquiry into ISTCs earlier this year, would indicate that the Royal Colleges have concerns in particular about professionals coming from Europe and overseas and practising within a different healthcare system without adequate retraining. The point is made that even a very small difference in practice and procedure can result in a catastrophic outcome for the patient. However, there may equally be problems with UK trained healthcare professionals in the absence of effective peer review and team support.

The regulations contained within the Care Standards Act 2000 in relation to the licensing of independent healthcare organisations was wholly inadequate with respect to clinical standards, having largely retained the predominance of hotel type regulation found in the previous Registered Homes Act 1984 as opposed to focusing on patient safety and clinical outcomes. This clearly has implications for all care provided within the independent sector and needs to be addressed before the public can have confidence that the independent sector is subject to adequate regulation and monitoring.

Nature of evidence:

(d) appraisal and continuing professional development?

Please see our comments with regard to Q. 3a) above. We have real concerns about the appraisal process relating to clinicans working outside the NHS. The Royal College of Surgeons has articulated its concerns about adequacy of training of overseas surgeons particularly given the fact that surgeons do not need to be on the specialist register even though they must be registered with the GMC. We share concerns that have been expressed by health professionals' regulators about the varying arrangements for education, training, audit and fitness to practice procedures

across European Union states. Under European law doctors have a right to work in any member state.

Nature of evidence:
N/A

4. What works well about the system for referring patients to ISTCs and what works less well?

In our memorandum to the Health Committee Inquiry on Independent sector treatment centres (13th February 2006) AvMA dealt extensively with the issue of NHS indemnity arrangements. We are concerned that the indemnity arrangements that apply to NHS institutions apply to private sector treatment centres where services have been commissioned by the NHS to treat NHS patients. We have been made aware of a number of cases since the inception of ISTCs two years ago where confusion over where liability lies has proved to be a significant problem. Many of AvMA's lawyer members are reporting incidents where complications have arisen, particularly with patients demonstrating co-morbidities. The troubling feature has been that when something has gone wrong, no-one seems to accept responsibility for dealing with the injured party's claim for compensation– each party pointing the finger at another. No patient ought to be caught in the web of the complex commissioning arrangements established between the NHS, clinicians and private sector organizations. In our memorandum we sought to highlight the problems inherent in these arrangements. In streamlining the indemnity arrangements so that CNST applies to all companies contracting with the NHS (in turn, the NHS can seek indemnities from the companies responsible) the NHS will be in a position to audit performance and quality and ensure the safety of patients.

Nature of evidence:

5. What is your view on the quality of decisions made by ISTCs to accept or decline referrals? What evidence do you have to support this view? (When considering your response, please think about both appropriate and inappropriate referrals and include the impact these decisions have on patients.)

This is not a matter within our direct knowledge. However, we believe it is essential that a proper analysis is made of current arrangements for referrals for secondary care, with particular reference to arrangements such as referral management schemes, where the body arranging the referral is several steps removed from the patient and lacks the level of knowledge that the patient's own GP would have of the patient's particular healthcare needs. This is particularly important in relation to referrals to ISTCs, many of which will not be equipped to deal with patients with significant co-morbidities, thereby putting the patient at risk. .

Nature of evidence:

6. What do you think about the quality of arrangements ISTCs have in place to provide out-of-hours cover and to access specialist medical advice when patients

develop complications before discharge? What evidence do you have to support this view?

This is a matter not within our knowledge or experience. However, from our experience of cases coming to AvMA, there is a general issue with respect to day case surgery and the apparent lack of adequate discharge arrangements as well as expertise within community health services to diagnose and respond to complications should they arise. This is compounded by the pressure to send patients home from day case units even though they may be exhibiting symptoms which would normally require ongoing monitoring. For example, we have seen a case involving a day-case laparoscopic procedure where post-operatively the patient complained of significant abdominal pain but as the unit was due to close for the night, was sent home with pain-killers and advised to contact her GP if she remained unwell. The patient called the out-of-ours GP service during the night and was advised without being seen to see her GP the next day if the problem had not resolved. Late the following day she was admitted to an NHS intensive care unit with potentially life-threatening peritonitis. This is the type of case which if presented as a complaint, needs to be recognised as an essential tool in identifying failures in the care pathway and for improving patient safety.

Nature of evidence:

7. How well does the process for transferring patients from ISTC care to NHS care work when patients develop complications that the ISTC is unable to deal with? If there are problems, what are they? (Please consider patients who are transferred directly from an ISTC and patients who present at an NHS site post discharge and follow up.)

We do not have detailed evidence at this stage.

Nature of evidence:

8. How well do you think that communication between ISTC staff and NHS staff is working? What evidence do you have to support this view?

This is not a matter of which we have direct knowledge or experience.

Nature of evidence:

9. What is working well about the relationships between ISTCs and local NHS services (including primary care) and what is working less well?

This is not a matter of which we have direct knowledge or experience.

Nature of evidence:

10. Which aspects of care provided within ISTCs work well?

We cannot comment on this.

Nature of evidence:

11. Are there any aspects of care provided within ISTCs that have caused concern to either NHS staff or patients? If so, what are they and why are they of concern?

Yes. Please see our responses to questions 1 and 4.

Nature of evidence

12. Are there any issues that may have a positive or detrimental impact on the quality of care provided in the future?

We believe that the Healthcare Commission already has access to a wealth of evidence as provided to the Health Select Committee inquiry into ISTCs earlier this year – albeit that much of this evidence demonstrated the lack of knowledge of how ISTCs were performing in terms of patient safety.. We therefore do not wish to rehearse these issues here. Suffice it to say that it is apparent from the evidence collated to date that there exists an intrinsic conflict between commercial considerations such as the viability of these units as profitable concerns and patient safety.

A great deal of concern was registered by the Royal Colleges in particular concerning the effect that the presence of competing ISTCs will have on the quality of care in the NHS. Many surgeons, for example, are concerned that ISTCs undertake more routine procedures that hitherto would have been relied upon as an essential staging post for junior doctors to perform as part of their core training. It will therefore be necessary for ISTCs to invest in providing training posts to ensure that junior doctors are exposed to routine surgical procedures. Clearly this impacts on revenue that will be moved from acute trusts to the ISTC.

Concerns have clearly been identified and subsequently supported by a number of cases that have arisen in relation to doctors and other healthcare professionals who normally practise outside of the United Kingdom undertaking procedures that they may not be adequately trained to do. For example we learned of a case where a knee replacement was undertaken where the prosthesis applied was not familiar to the surgeon, who then proceeded to apply techniques learned from his general practice to this procedure that were wholly inappropriate. It is believed that a number of operations such as this will have been performed by this one surgeon and therefore a number of patients are likely to be recalled. Also, if overseas doctors are on short term contracts then the patient is likely to suffer from a lack of continuity of care.

Nature of evidence:

13. In summary, what is your overall view on the quality of care provided by ISTCs and what do you think of the arrangements they have in place to ensure the quality of care provided?

Given the relatively small number of ISTCs in existence there do seem to have been a disproportionate number of 'headline cases' being reported. Whilst ISTCs might appear to provide a pragmatic and expedient solution to the issue of waiting lists, we need to ensure that both in the short term and perhaps more significantly, the longer term, patient safety is not compromised. This is not only in terms of the individual patient but also the potential impact that ISTCs will have on the quality, availability and safety of care provided by the NHS. The patients that are most likely to be affected are those requiring more complex and expensive treatments where the

financial viability of maintaining high quality NHS provision will be directly impacted by the loss of routine procedures to the independent sector.

Section 3: Additional information

14. Are there any other comments that you would like to make that you think would be useful for the Healthcare Commission's review?

Thank you very much for your help.

Please return this questionnaire electronically to:
ISTC.Review@healthcarecommission.org.uk

by **5pm on Friday 13th October 2006.**