Regulating private and voluntary health care

BUPA's response to the NHS Executive Consultation document

September 1999

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EXECUTIVE SUMMARY

Introduction

BUPA supports the Government's proposal to create a new statutory regulatory body to regulate the independent healthcare sector.

BUPA particularly welcomes the Government's commitment to further consultation on the issues of regulatory standards and fees and would also wish to be consulted on the detail of proposed sanctions and offences.

The Government's role in regulation

BUPA's view is that the purposes of regulation of the independent healthcare sector should be to ensure that all services provided are: safe, effective and appropriate.

In BUPA's view increased monitoring of services, facilities and organisations through information transfer could both reduce the need, and improve the targeting of, inspections by enabling more focused comparative analysis of performance.

BUPA's view is that, in the first instance, the minimum frequency should be set at one visit per year per provider facility and ideally one review every three years for practitioners, initially in areas of greatest concern, unless that profession has comparable revalidation procedures encompassing independent practice.

BUPA thinks that the proposed regulator will be uniquely well positioned to collect, collate and make available demonstrably objective comparative information and evidence on the nature, scale, safety, effectiveness and appropriateness of independent health services.

BUPA thinks that the specific formal duties of the proposed regulator need to be set out in far more detail.

BUPA welcomes and strongly supports the Government's commitment to apply the Better Regulation Taskforce principles to these matters, but observes little systematic application of the principles in the consultation document.

The scope of regulation

When the Government legislates to establish the proposed new statutory regulator BUPA thinks that it should incorporate powers of secondary legislation to allow it to amend the scope of regulation in the future; especially but not exclusively under advice from the regulatory body. The legislation should be sufficiently flexible to allow changes as to:

- What types of services are regulated
- What premises, equipment, technologies and techniques are regulated

- Who is regulated

BUPA would strongly recommend the immediate extension of the coverage of this regulatory framework to all independent medical and dental practice wherever conducted.

BUPA proposes that the regulatory framework should be capable of extension, by secondary legislation, to any other independent healthcare practitioner, facility or organisation; if in due course the regulator, or any other party, can make a cogent and, hopefully, evidence based case to do so.

It would, however, be unacceptable to BUPA that private practice in the NHS is exempt from the oversight, monitoring, fees and sanctions of the proposed new statutory regulatory body. Such exemption would be inconsistent, anti competitive, inequitable and lack transparency. It would also create confusion among those who work in both sectors concurrently.

BUPA thinks that it is entirely practicable for NHS organisations responsible for monitoring and inspecting NHS Trusts (essentially NHS Executive Regional Offices and the Commission for Health Improvement) to report their findings regarding private practice in the NHS to the proposed new statutory body.

BUPA’s view, in any event, is that inpatient and day care private practice in the NHS should generally be conducted in dedicated pay bed units, except when patients need to be close to specialist facilities and equipment.
Regulatory Standards

BUPA envisages three core regulatory standards:

- A duty of quality, identical to that imposed on NHS bodies, that would encompass duties regarding clinical governance and complaints
- A duty to provide an annual report to the regulator
- A "fit persons" duty

All three core standards should be operationalised through secondary legislation and/or statutory codes of practice. This would build in appropriate flexibility. BUPA particularly welcomes the Government’s commitment to further consultation on the content of such legislation and/or codes.

BUPA supports the consultation document’s proposals on vulnerable groups including children.

BUPA’s view is that the new regulatory body should have discretion to employ whomever they think can undertake inspection most appropriately, effectively and efficiently in any given circumstance; so long as such inspectors are demonstrably objective and impartial.

In addition it is BUPA’s view that it may sometimes be particularly appropriate to draw inspectors from the Commission of Health Improvement so that there is appropriate

cross fertilisation of good practice between the respective evaluative arms of the two healthcare sectors.

BUPA accepts that the proposed new Registered Care Tribunal might provide an efficient vehicle for appeal, so long as the members and officers of the Tribunal have sufficient and appropriate knowledge of the independent healthcare industry to be credible in such a role.

BUPA also thinks that the right of appeal to the proposed Tribunal might also usefully apply to other sanctions and offences under this legislation.
BUPA welcomes and supports Ministers' view that it is unacceptable for any patients to be put at risk because of constraints in the exchange of necessary information between the two healthcare sectors. This problem is exemplified by, but not unique to, the problem of obtaining adequate information about clinicians suspended in the NHS.

BUPA would welcome:

- the extension of alert letters to other healthcare professions, especially other clinical professions
- the classification of alert letters into various categories which would give a clear indication of the nature of the risk or cause of suspension.

BUPA is committed to the timely exchange of information across both healthcare sectors and agrees that the professional registration bodies (such as the General Medical Council) may have an additional valuable role to play in this respect.

BUPA recommends that it would be helpful if all healthcare professionals were obliged to notify all their other existing (and prospective) employers, if they have been suspended or dismissed by any organisation; and if all registered, chartered or associated professionals were obliged to notify their professional body of any such suspension or dismissal.

BUPA has a clearly laid down complaints procedure and is committed to, and working towards, the introduction of such external review of both clinical and non clinical complaints, on a voluntary basis, from 1 January 2000.

BUPA supports the annual publication of a report by each independent provider establishment summarising and categorising all complaints received.

BUPA would be content if the proposed regulator is formally responsible for complaints but thinks that it would be effective and efficient to build on the established expertise of the Health Services Commissioner in the detailed consideration of complaints. The findings of such detailed investigations could be passed back to the proposed regulator for endorsement, enforcement and publication.
Sanctions

BUPA supports the need for criminal offences in principle but would wish to be consulted on the detail of proposed sanctions and offences.

BUPA supports the view that the new regulator should be given power to proscribe particular forms of treatment, to require an establishment to close particular facilities or to suspend admissions (partially or totally). BUPA thinks that all sanctions should be subject to a right of appeal.

BUPA welcomes the Government's commitment to the principles of the Concordat on Good Enforcement.

New regulatory structure and impact assessment

BUPA supports the Government's intention to establish a "new dedicated national regulatory body"; "custom built", "independent" and "with a clear focus on healthcare".

BUPA would oppose regulation by the Commissions for Care Standards as it believes the Commissions would lack a "clear focus on healthcare".

BUPA thinks that failure to appraise the existing regulatory roles, structure and performance of organisations such as the Human Fertilisation and Embryology Authority and the Mental Health Act Commission represents a flaw in completeness and objectively of the DoH's evaluative and consultation processes.

BUPA would be prepared to meet its share of the reasonable costs of a dedicated national regulatory body if they were transparent and proportional and if the organisation were structured and organised to be accountable, targeted and consistent as defined in the principles of good regulation.

BUPA thinks it most important that the new regulatory body maintains a close dialogue with the Commission for Health Improvement, the National Institute for Clinical Excellence, the Commissions for Care Services and other statutory regulatory bodies such as the General Medical Council and the UKCC.

BUPA thinks that the scope of the healthcare regulator should in principle be drawn as broadly as possible.

BUPA thinks that more detailed work is required to define the boundaries between health and social care services for the mentally ill and people with learning disabilities.

BUPA thinks that dual registration should be avoided in almost all circumstances; but that the monitoring and inspection of health services should be tailored to the specific context of the services provided.

Next steps

BUPA hopes that the Government will be able to announce its intentions in these matters shortly after Parliament returns from recess and will be able to undertake the necessary legislation during the Parliamentary Session 1999/2000.

Conclusions

BUPA wishes the new arrangements to be sufficiently flexible to be capable of addressing future, as well as present, regulatory requirements.

BUPA hopes that the new arrangements will be sufficiently effective and efficient to command widespread support and respect.

BUPA looks forward to working with the Government in finalising and implementing the agreed recommendations.

1. INTRODUCTION

1.1 BUPA welcomes the opportunity to comment on the government's proposals for improving the regulation of independent healthcare providers. BUPA broadly agrees with the strategic thrust of the proposals, although there are some elements where BUPA thinks that the scope can be expanded still further or where more detail is needed.

Background

1.2 Implementation of the Government's proposals for improving the regulation of residential and nursing homes would make present arrangements for the regulation of independent healthcare providers unsustainable. BUPA and other leaders in the sector have long held the view that present regulatory arrangements have significant gaps and are unevenly applied. In consequence BUPA has promoted the development of voluntary quality assurance arrangements within the independent healthcare sector under the auspices of the Academy of Royal Medical Colleges Private Practice Forum which are used to set the standards of BUPA's own services and those we contract. BUPA provided both written and oral evidence to the House of Commons Health Committee Inquiry into these matters.

BUPA's Current Position

1.3 Having considered carefully the Inquiry's report and the Government's consultation document BUPA now supports the Government's proposal to create a new statutory regulatory body to regulate the independent healthcare sector.

1.4 BUPA particularly welcomes the Government's commitment to further consultation on the issues of regulatory standards and fees and would also wish to be consulted on the detail of proposed sanctions and offences.

1.5 BUPA's detailed comments on the consultation document are set out below and for ease of reference follow, wherever possible, the ordering of issues established in the consultation document.

1.6 BUPA's comments on the House of Commons Health Committee Inquiry Summary of Recommendations are set out in full in Annex A.

BUPA's Commitment To Quality

1.7 BUPA is totally committed to constant quality improvement and has made significant investment in regulation and standard setting. In addition to complying with current statutory regulation BUPA has implemented several forms of self-regulation and standard setting within its hospitals and screening centres. This includes ISO 9002

accreditation, organisational audit, care pathways and recording and measuring clinical variances.

1.8 BUPA is also committed to ensuring healthcare is based on clear guidelines and standards. BUPA Hospitals has ‘care pathways’ in place for their top 50 procedures in each of its hospitals and is working towards implementing them across its operation. A care pathway describes each stage of patient care and treatment from pre-admission to discharge and in some cases beyond. Every discipline is covered including the care and treatment received and how they would be expected to respond/recover. Any variances are recorded and reviewed.

1.9 BUPA also measures the outcomes of patient treatment. All surgical patients are offered the opportunity to participate. We believe that should this be mirrored in the NHS, the combined data would be of significant value to both clinicians and providers.

2. THE GOVERNMENT'S ROLE IN REGULATION

2.1 BUPA's overall view is that this regulatory framework should underpin all other statutory duties placed on people, premises and organisations providing independently funded healthcare services.

2.2 BUPA agrees with the Government that the purpose of regulation of the independent healthcare sector should be to ensure that all services provided are: safe, effective and appropriate.

2.3 BUPA's view is that innovation regarding treatments within the sector should be encouraged and pursued. However, any development should be closely monitored to ensure that it is safe, effective and appropriate.

The Nature Of Regulation

2.4 BUPA recommends strongly that the minimum frequency of inspections should be subject to change by secondary legislation. The new regulator should be charged with periodic review of the frequency of inspections.

2.5 BUPA's view is that, in the first instance, the minimum frequency should be set at one visit per year per provider facility and ideally one review every three years for practitioners, initially in areas of greatest concern, unless that profession has comparable revalidation procedures encompassing independent practice.

2.6 BUPA actively supports the continuance of unannounced inspections.

2.7 BUPA's view is that the scope for monitoring services, facilities and organisations through information transfer is largely ignored in the consultation document and could both reduce the need for, and improve the targeting of, inspections by enabling more focused comparative analysis of performance.

Duties Of The Regulator

2.8 BUPA thinks that the specific formal duties of the proposed regulator need to be set out in far more detail than present, in order to demonstrate that the whole function will be accountable and transparent. Such an approach would be a testament to the Government's avowed commitment to openness.

2.9 In addition BUPA thinks that the proposed regulator should have an explicit duty, when requested, to provide timely and (prima facie) binding advice to independent healthcare providers.

2.10 BUPA supports Ministers' view that independent providers should make comprehensive information about the services they provide easily available to the public. In addition, the company suggests that the regulator is in a uniquely objective

position to collect, collate and make available comparative information. This should include evidence of the nature scale, safety, effectiveness and appropriateness of any such services. It is important that evidence is presented in a manner that will enable the public, as well as professionals, to compare and contrast the nature and standards of such services within both the independent sector and comparable services provided by the NHS.

2.11 The vast majority of consultants practising in the independent sector also work for the NHS. BUPA thinks that comparative data will be of most value if it takes into account practice in both sectors.
Appraisal Criteria

2.12 BUPA's view is that regulation should be impartial and specific to the needs of the independent healthcare sector. Appraisal criteria should be informed by the best evidence available from all sources, including data and information from the NHS and DoH.

2.13 BUPA welcomes and strongly supports the Government's commitment for regulation to be transparent, accountable, targeted, consistent and proportional. However, there is little evidence of a systemic application of the principles in the consultation document to the scope, standards or structures proposed. Furthermore BUPA observes that most of the structural options identified in the option appraisal document are deemed "unviable" against a poorly defined and largely unexplained need for "independence".

3. SCOPE OF REGULATION

Immediate issues

3.1 When the Government legislates to establish the proposed new statutory regulator BUPA thinks that it should incorporate powers of secondary legislation to allow it to amend the scope of regulation in the future; especially but not exclusively under advice from the regulatory body. The legislation should be sufficiently flexible to allow changes as to:

- What types of services are regulated
- What premises, equipment, technologies and techniques are regulated
- Who is regulated

3.2 BUPA supports the immediate extension of coverage to hospitals established by Royal Charter or special Act of Parliament.

3.3 On the grounds of consistency, equity and overall transparency BUPA strongly recommends the immediate extension of the coverage of the regulatory framework to all independent medical and dental practice wherever it is conducted in England. In particular BUPA notes and endorses the view expressed in the consultation document that:

"the development of new medical technologies outside traditional hospital settings means that, over time, a wider range of healthcare facilities may fall outside the current registration regime". (3.3)

Wider issues

3.4 BUPA regrets that the consultation document does not provide more detail on the case for and against the extension of coverage both to the practice and premises of other registered independent practitioners, not only osteopaths and chiropractors but also disciplines such as nursing, midwifery and physiotherapy. BUPA thinks that, in principle, these professions should be included within the scope of this regulatory framework. In making this recommendation, BUPA recognises that good regulation must be universally and uniformly applied and emphatically supports the principle that regulation should be proportional to the perceived risk. BUPA is also aware that it is particularly difficult to define boundaries in the domain of "primary prevention" where "disease prevention" rapidly shades into the "promotion of well being and healthy lifestyles".

3.5 In addition BUPA is aware that the evidence base to assess the safety, effectiveness and appropriateness of "complementary" and other "unorthodox" healthcare practices is presently incomplete.

3.6 Therefore BUPA proposes that the regulatory framework should be capable of extension, by secondary legislation, to any other independent healthcare practitioner, facility or organisation; if in due course the regulator, or any other party, can make a cogent, and, hopefully, evidence based, case to do so.

Private practice in NHS providers

3.7 BUPA recognises that it might well be more effective and efficient to inspect private practice in the NHS, including that carried out in NHS pay bed units, within the context of an NHS Trust's overall framework of governance and audit, including periodic inspection by the Commission for Health Improvement.

3.8 It would, however, be wholly inconsistent for private practice in the NHS to be exempt from the oversight, monitoring, fees and sanctions of the proposed new statutory regulatory body. Such exemption would not only be inconsistent, but also anti competitive and inequitable. Furthermore, it would lack transparency and create confusion as many doctors work in both sectors concurrently.

3.9 BUPA thinks that it is entirely practicable for NHS organisations responsible for monitoring and inspecting NHS Trusts (essentially NHS Executive Regional Offices and the Commission for Health Improvement) to report their findings regarding private practice in the NHS to the proposed new statutory body.

3.10 Such monitoring and inspection of private practice in the NHS should be conducted according to the criteria and standards established by the new regulator. The new regulatory body should have the power to intervene, inspect, and impose sanctions on private practice in the NHS if it deemed appropriate.

3.11 BUPA Membership's experience as a purchaser of private practice in the NHS is that the standards of a significant number of private practice facilities in the NHS would not stand scrutiny against current regulatory requirements let alone a more robust and consistent regime. BUPA would urge the Government to reconsider this aspect of proposed policy very carefully.

3.12 BUPA's believes that inpatient and day care private practice in the NHS should generally be conducted in dedicated pay bed units, except when patients need to be close to specialist facilities and equipment.

Private practice in armed forces hospitals

3.13 Private practice carried out in armed forces hospitals and Military District Hospital Units should also fall within the scope of regulation.

NHS Services in Independent Hospitals

3.14 Conversely to the arrangements proposed above, BUPA recommends that it would also be more effective and efficient if the proposed new statutory regulatory body reports its findings to NHS Executive Regional Offices and the Commission for Health Improvement when independent providers supply services to the NHS.

3.15 Such monitoring and inspection of NHS services should be conducted according to the criteria and standards established for the NHS by the DoH (NHS Executive) and the Commission for Health Improvement (CHI). Both DoH and CHI would retain their authority to intervene directly if they deemed it appropriate.

4. REGULATORY STANDARDS

Core and Non Core Standards

4.1 In keeping with the recommendations of the Better Regulation Task Force BUPA thinks that primary legislation establishing national minimum standards should be goal based. Where the nature of the risk and the required protection necessitate more prescriptive standards these should be in secondary legislation.

BUPA envisages three core regulatory standards:

- A duty of quality, identical to that imposed on NHS bodies, that would encompass duties regarding clinical governance and complaints
- A duty to provide an annual report to the regulator
- A "fit persons" duty

4.2 All three core standards should be operationalised through secondary legislation and/or statutory codes of practice. This would build in appropriate flexibility. BUPA particularly welcomes the Government’s commitment to further consultation on the content of such legislation and/or codes.

Vulnerable groups including children

4.3 BUPA supports the consultation document’s proposals on vulnerable groups including children.

Inspection

4.4 BUPA’s view on the subject of inspection is that the new regulatory body should have discretion to employ whomever they think can undertake the task most appropriately, effectively and efficiently in any given circumstance; so long as such inspectors are demonstrably objective and impartial.

4.5 In addition it is BUPA’s view that it may sometimes be particularly appropriate to draw inspectors from the Commission of Health Improvement so that there is appropriate cross fertilisation of good practice between the respective evaluative arms of the two healthcare sectors.

Appeal

4.6 BUPA accepts that the proposed new Registered Care Tribunal might provide an efficient vehicle for appeal, so long as the members and officers of the Tribunal have sufficient and appropriate knowledge of the independent healthcare industry to be credible in such a role.

4.7 BUPA also thinks that the right of appeal to the proposed Tribunal might also usefully apply to other sanctions and offences under this legislation.
Protection of Professional Title

4.8 BUPA agrees with the review's recommendation that only state registered practitioners can use such titles such as chiropodists.

Exchange of Information

4.9 BUPA welcomes and supports Ministers' views that it is unacceptable for any patients to be put at risk because of constraints in the exchange of necessary information between the two healthcare sectors. This problem is characterised by, but is not unique to, the real difficulty in obtaining adequate information about clinicians suspended in the NHS.

4.10 BUPA would welcome:
the extension of alert letters to other healthcare professions, especially other clinical professions
the classification of alert letters into various categories which would give a clear indication of the nature of the risk or cause of suspension.

4.11 BUPA has been grateful for help from officials in the Operational Policy Unit in recent months, during which time there have been noticeable improvements in the flow of such information. Difficulties however remain in obtaining timely information directly from some NHS organisations.

4.12 BUPA is committed to the timely exchange of such information across both healthcare sectors and agrees that the professional registration bodies (such as the General Medical Council) may have an additional valuable role to play in this respect.

4.13 BUPA recommends that it would represent a great improvement if all healthcare professionals were obliged to notify all their other existing (and prospective) employers, if they have been suspended or dismissed by any organisation; and if all registered, chartered or associated professionals were obliged to notify their professional body of any such suspension or dismissal. In this context employers are deemed to include organisations and facilities in which healthcare professionals have admitting or consulting privileges or are otherwise associated (e.g. healthcare insurers).

Information for Patients

4.14 This element has been covered in section 2.0 of this response.
Patient Complaints

4.15 BUPA agrees that a clearly laid down complaints procedure as envisaged by the Government is essential, and the company is working towards the introduction of external reviews for both clinical and non clinical complaints, on a voluntary basis, from

1 January 2000. BUPA also supports the annual publication of a report by each independent provider establishment summarising and categorising all complaints received.

4.16 BUPA would be content if the proposed regulator is formally responsible for complaints but think that it would be effective and efficient to build on the established expertise of the Health Services Commissioner in the detailed consideration of complaints. The findings of such detailed investigations could be passed back to the proposed regulator for endorsement, enforcement and publication.

5. SANCTIONS

5.1 BUPA supports the need to create a range of criminal offences in principle but would wish to be consulted on the manner and detail of proposed sanctions and offences.

5.2 BUPA supports the view that the new regulator should be given power to proscribe particular forms of treatment, to require an establishment to close particular facilities or to suspend admissions (partially or totally). Furthermore, BUPA thinks that all sanctions should be subject to a right of appeal.

5.3 BUPA welcomes the Government's commitment to the principles of the Concordat on Good Enforcement.

6. NEW REGULATORY STRUCTURE & IMPACT ASSESSMENT

6.1 BUPA supports the Government's intention to establish a "new dedicated national regulatory body"; "custom built", "independent" and "with a clear focus on healthcare". However, BUPA would oppose regulation by the Commissions for Care Standards as it believes the Commissions would lack both a "clear focus on healthcare" and a national framework of accountability.

6.2 Therefore whilst supportive of the Government's stated intention, BUPA thinks that the failure to appraise the existing regulatory roles, structure and performance of the Human Fertilisation and Embryology Authority, the Mental Health Act Commission, the UK Xenotransplantation Interim Regulatory Authority and the regulatory role of DoH inspectors under the Abortion Act 1983 represents a significant flaw in the completeness of the DoH's evaluative and consultation processes for all the regulators omitted from consideration presently work effectively across both the public and independent healthcare sectors.

6.3 BUPA thinks it most important that the new regulatory body maintains a close dialogue with the Commission for Health Improvement, the National Institute for Clinical Excellence, the Commissions for Care Standards and the other statutory regulatory bodies mentioned above.

6.4 BUPA considers that the scope of the healthcare regulator should in principle be drawn as broadly as possible and include mental health services. BUPA thinks however that where there is a significant residential and social care component in the services provided, inspection arrangements should include expert appraisal of these elements.

6.5 BUPA thinks that dual registration should be avoided in almost all circumstances; but that the monitoring and inspection of health services should be tailored to the specific context of the services provided.

6.6 Finally, BUPA would be prepared to meet its share of the reasonable costs of a dedicated national regulatory body if they were transparent and proportional and if the organisation were structured and organised to be accountable, targeted and consistent as defined in the principles of good regulation. As previously stated, BUPA welcomes the Government's commitment to additional and more detailed consultation on a new fee regime.

7. NEXT STEPS

7.1 BUPA hopes that the further consultation promised on regulatory standards will follow shortly after the Government announces its considered decisions on the scope and structure of regulation together with the timetable for further action. Further consultation on fees and on the detail of proposed sanctions and offences, could follow thereafter.

7.2 BUPA thinks that it would be very difficult for the Government to progress its plans for the reorganisation of the regulation of social care unless new arrangements for the regulation of independent healthcare provision were taken forward concurrently.

7.3 BUPA hopes that the Government will be able to announce its intentions in these matters shortly after Parliament returns from recess and will be able to undertake the necessary legislation during the Parliamentary Session 1999/2000.

8. CONCLUSIONS

8.1 BUPA welcomes the Government's recognition of the need to reconsider arrangements for the regulation of independent healthcare; and endorses its intention to create a new statutory body "with a clear focus on healthcare" to undertake the task.

8.2 BUPA thinks that the purpose of such regulation should be to ensure the safety, appropriateness and effectiveness of the provision of all independently funded healthcare services.

8.3 BUPA wishes the new arrangements to be sufficiently flexible to be capable of addressing future, as well as present, regulatory requirements.

8.4 BUPA hopes that the new arrangements will be sufficiently effective and efficient to command widespread support and respect.

8.5 BUPA looks forward to working with the Government in finalising and implementing the recommendations.

ANNEX A

SUMMARY RECOMMENDATIONS OF HEALTH SELECT COMMITTEE INQUIRY AND BUPA's RESPONSES

The Health Select Committee:

1. Welcomes the fact that the Government now acknowledges the need to review the regulation of the independent sector since we regard current regulation to be inadequate for the task of protecting the public (paragraph 30).

BUPA agrees.

2. We recommend that those providing cosmetic surgery should be obliged as a minimum to print a conspicuous health warning on all their advertisements to the effect that all surgery carries an element of risk (paragraph 52).

BUPA agrees.

3. In the face of the apparent impotence of the ASA we recommend that the Secretary of State for Health consults the Secretary of State for Trade and Industry with a view to ensuring that there is adequate legislation to deal with misleading advertisements for cosmetic surgery and with other unfounded or misleading claims made for other medical or surgical treatment (paragraph 55).

BUPA agrees.

4. We recommend that the Government requires providers of cosmetic surgery and similar related disciplines to provide information as to the efficacy and effectiveness of treatments offered following guidelines set out by the Department. The regulator of the independent sector should assess the accuracy of this information in determining whether or not to grant a licence. We recommend that it be mandatory that providers of such services should distribute such information. We suggest that these information packs should strongly urge consumers to contact their General Practitioner before undergoing medical and surgical treatment and should suggest questions for consumers to ask when considering treatment (paragraph 59).

BUPA agrees.

5. If the providers of cosmetic surgery and other elective surgery are to continue demanding advance payment we think that there should be a mandatory cooling-off period to allow consumers to change their mind before undertaking surgery. We recommend that those undergoing cosmetic surgery and similar related disciplines in the independent sector should have the benefit of a 14 day cooling-off period during which they can withdraw from treatment without financial penalty. We recommend that it should be illegal for providers to charge for treatment before consumers have had a consultation with the surgeon performing the operation. We also believe that providers

should be obliged to provide clear information on the cost of each procedure in advance of any financial commitment on the part of the consumer (paragraph 60).

BUPA supports this recommendation only in relation to cosmetic surgery.

6. We recommend that providers should be obliged to give contact details of voluntary groups undertaking counselling or contact addresses to those seeking treatment to allow them to gain more information in this area (paragraph 61).

BUPA supports the need for well informed consent.

7. We recommend that the GMC in conjunction with the Royal Colleges establishes recognized specialist training in cosmetic surgery which will then assist in the process of revalidation (paragraph 62).

BUPA agrees.

8. We recommend that health authorities, in discharging their responsibilities for planning and ensuring the provision of comprehensive mental health services, should review ways in which the independent sector - both voluntary and private - can contribute to the planning mechanisms. We believe that the outcome should be the provision of optimum services determined by the NHS and provided in a manner which ensures a high quality of care for patients and maximum value for public money (paragraph 72).

BUPA welcomes the recommendation that the independent health sector might contribute to the planning of NHS mental health services especially where it is a significant provider of such services.

9. A reliance on word of mouth notification and retrospective reminders seem to us inadequate measures to ensure the MHAC comprehensively covers the patients it should. We believe that the grant of registration of a mental nursing home to receive detained patients should be notified, as a matter of course, to the Commission. We recommend that this should be a regulatory requirement (paragraph 74).

BUPA agrees.

10. We recommend that an independent regulator should have the powers to remove the authority of a mental nursing home to receive patients detained under a section of the Mental Health Act if the person registered is failing to comply with the requirements of the Mental Health Act. In these circumstances, the continued accommodation of a detained patient in such a home would be unlawful and necessitate their removal to an appropriately registered premises. We believe that the presence of a power to remove the authority to receive detained patients would be sufficient, in most circumstances, to ensure compliance with the requirements of good practice so that patients such as those described at paragraph 64 above would have the right to appeal (paragraph 75).

BUPA agrees.

11. We welcome the review of the Mental Health Act currently in progress and recommend that the role, powers and resources of the Mental Health Act Commission should be reviewed with a view to their extension to cover all designated mental health services (paragraph 76).
BUPA agrees.

12. We recommend that the Mental Health Act Commission should make its reports available to an agency serving both the Regional Commissions for Care Standards and the regulatory body we propose for acute independent services and that it should have representation on the national level of these regulatory bodies (paragraph 77).

BUPA agrees.

13. We recommend that the independent health regulator ensures that inspection teams have appropriately trained and experienced personnel to assess thoroughly the needs of children being treated in the independent sector and to ensure that such needs are met by staff holding the relevant qualifications for treating children even if their treatment forms only a small proportion of a hospital's activity (paragraph 82).

BUPA agrees.

14. We recommend that the Government reviews the current arrangements for transmission of information between private and NHS GPs. We believe that the GMC should assess whether there are treatments and procedures which clinicians should be precluded from administering without access to a full patient medical history. We also believe that patients need to be warned that, if they consent to medical treatment by clinicians who do not have access to their medical records, they may run a considerable risk. This warning should be given verbally and in written form, with a form of words approved by the Department. Patients should be made aware of the strict confidentiality procedures that apply in the NHS, and that breaches of confidentiality will normally result in dismissal (paragraph 89).

BUPA strongly supports the development of full electronic patient records and think that, with the patients consent, these should be available to all clinicians involved in the care, treatment and management of the patient.

15. We believe that a national moderator will be required to assess whether emerging techniques and technologies pose any risk to patient safety. We recommend that, in addition to those invasive techniques currently subject to regulation, other procedures defined by the moderator should also be regulated. It is important that the list should be kept up to date; in our view the Department's failure to maintain and update the 1984 Act in this regard is unacceptable. We recommend that the list should be capable of alteration by secondary rather than primary legislation, and that the Moderator reviews the list at least annually (paragraph 90).

BUPA supports this proposal in principle but would wish to see it developed in more detail. BUPA envisage that the moderator would be a senior clinician and an executive member of the proposed new statutory regulatory body.

16. We recommend the creation of an independent regulator for healthcare outside the NHS, responsible to Government, to identify appropriate standards and relevant activity and to provide for its regulation across the country. The wider range of health care services that we recommend to be brought within this remit will require regulation to be operated on a regional basis sharing a common resources centre with each Regional Commission of Care Standards. This common resource centre, we suggest, could be the location of the intellectual property of both the Care Commissions and the Independent Health Regulator. It could negotiate temporary transfers of staff from one regulator to another, giving an extremely flexible inspection regime. It could also co-ordinate training programmes for inspection staff taking account of best practice in both acute and non-acute care. It could provide a common services agency dealing with legal services and general administrative matters. It could operate both regionally and at national board level to ensure consistency of standards (paragraph 95).

BUPA supports all elements of recommendation 16 subject to the scope of any healthcare regulation justifying common resources centres within each region and subject to the caveat that the inspectors could also be drawn by the independent regulatory body from other public and private organisations as well.

17. We expect all independent acute medical facilities to be brought into inspection so that, for example, there should no longer be exemption for Royal Charter hospitals and those established by Special Act of Parliament (paragraph 96).

BUPA agrees.

18. We recommend that CHI and NICE should inform a common resources centre for an Independent Healthcare Regulator and the Regional Commissions for Care Standards. The Regulator would be expected to draw on the findings of CHI in so far as they are applicable to the individual components under inspection. Independent providers should be obliged on request to submit clinical audit and similar data to CHI and NICE (paragraph 97).

BUPA agrees that CHI and NICE should inform a common resources centre for an Independent Healthcare Regulator and possibly for the Regional Commissions for Care Standards. BUPA agrees that the Regulator might be expected to draw on the findings of CHI in so far as they are applicable to the individual services under inspection. BUPA thinks that Independent providers should be obliged on request to submit clinical audit and similar data to the Independent Healthcare Regulator who would be accountable for what use was made of that data.

19. We recommend that the Mental Health Act Commission be represented on the national board of the common resource centre for the Independent Healthcare Regulator and Regional Commissions for Care Standards (paragraph 98)

BUPA thinks that the Mental Health Act Commission should be represented on the national board of the Independent Healthcare Regulator.

20. We consider that all private health care facilities operated within the management of the NHS should be required to function within the clinical procedures and management of the Trust in which they are located.

BUPA agrees and is content for private healthcare facilities in NHS Trusts to be inspected by CHI.

Such an arrangement should require full participation in the Trust schemes of clinical governance and controls assurance. Only consultants with a current service contract or honorary contract with that Trust should be able to admit and treat private patients.

This arrangement should include a requirement that any complaint in which the private medical care provided by the consultant outside their NHS contract is an issue which should be dealt with under the full complaints procedure of the NHS including access to the Health Services Ombudsman. This provision should be applicable to any private health care delivered within the terms of the NHS Acts and thus be applicable to the private use of the occasional pay bed as well as the consulting and in-patient private patient units of NHS Trusts (paragraph 103).

BUPA disagrees. Private practice in the NHS should be subject to the oversight, monitoring, fees and sanctions of the proposed new statutory regulatory body. Any exemption would be inconsistent, anti competitive, inequitable and lack transparency. Complaints about private practice in the NHS should be the formal responsibility of the proposed independent regulator.

21. Where a private patient unit is operated by a company on behalf of the Trust, we consider that it should fall to be regulated on the same basis as a hospital in the independent sector (paragraph 104).

BUPA agrees, but see 20 above.

22. We recommend that the Secretary of State creates a licensing regime for the independent acute sector offering a wide range of powers and sanctions which places the burden of proof of compliance on the provider, not the regulator. We would like the Independent Regulator to issue a detailed code of practice with a view to ensuring that consistent national standards of inspection apply to the independent healthcare sector (paragraph 108).

BUPA agrees, but please note BUPA's comments on the proposed Regulator. The burden of proof should generally lie with the provider regarding compliance but with the regulator if sanctions are to be invoked.

23. We recommend that the GMC maintains a central database indicating where clinicians are currently employed, and where they have practising or admitting rights. We recommend that when suspensions occur as result of activity placing patients in any risk that suspension should automatically be notified to the GMC for inclusion on its database. The GMC should then be obliged to notify all current "employers" (see above) of the fact of suspension. All organisations employing clinicians should be required to first check their status with the GMC and will be notified of any suspensions currently

applicable. We further recommend that the central councils for each of the other medical professions and professions allied to medicine take steps to ensure that they have robust procedures in place to prevent those under suspicion of endangering patient safety from coming into contact with patients (paragraph 113).

BUPA agrees.

24. We welcome the Secretary of State's uncompromising statement that, in his view, if doctors have been suspended for "anything that could have any possible bearing on the safety or health of patients" they should not be free to work in the independent sector. This is also our view. We also welcome the proposal from Baroness Hayman that consideration should be given to extending the system of alert letters from doctors to other health professionals (paragraph 115).

BUPA agrees.

25. It seems to us that the impact of groundless suspensions in the NHS could be greatly mitigated if the NHS disciplinary procedures were expedited. This is an issue we hope to address in our forthcoming inquiry into adverse clinical incidents and outcomes in medical care (paragraph 116).

BUPA agrees.

26. We recommend that doctors working in specialist, general practice or other unsupervised positions in the independent sector should be required to undertake training of a standard equal to that required for equivalent NHS positions. We also recommend that the GMC addresses this in its proposals for revalidation (paragraph 121).

BUPA agrees.

27. We welcome the Government's commitment to review the Professions Supplementary to Medicine Act with a view to increasing patient safety. We believe that there should be a duty of care imposed on all those directly involved in the provision of health care in the independent sector to ensure that patients are properly informed not only of the qualifications and titles of those seeing them but also of any financial relationship between these individuals and the parent company. Those seeking medical or psychiatric care may be vulnerable and easily impressed by the apparent qualifications of those treating them. It seems to us totally unacceptable that they are not offered greater protection (paragraph 122).

BUPA agrees.

28. We recommend that the Department of Health liaises with the GMC to ensure that the Specialist Register accurately reflects both the qualifications and current experience of clinicians, by specialty and sub-specialty. We further recommend that this information should be made readily available to members of the public and their GPs. We believe that the most recent listing on the register for the surgeon performing an operation should be available to a patient in a readily comprehensible form (paragraph 124).

BUPA agrees.

29. Such is the importance which the independent hospitals themselves attach to Medical Advisory Committees in overseeing clinical standards in their hospitals, we recommend that the principles for the role of Medical Advisory Committees set out in the paper shared by the British Medical Association and the Private Practice Forum of the Academy of Medical Royal Colleges should be given statutory status (paragraph 126).

BUPA particularly welcomes this recommendation.

30. We recommend that the costs of regulating independent health care should be met in full by the sector. We accept that provision might need to be made to exempt certain not for profit organisations, for example some hospices, from all or part of the costs of inspection (paragraph 128).

BUPA thinks that there should be no exemptions, as this will impose increased pressure on the regulator to ensure that all regulation is proportional.

31. We recommend that the Government introduces measures to allow the NHS to recover the costs of remedial treatment in circumstances where practitioners in the independent sector have been negligent; where a sum has been awarded for remedial treatment, and that treatment subsequently takes place in the NHS, then the NHS should be entitled to recover that sum (paragraph 130).

BUPA would wish for further consultation on the detail of any such proposal before forming a view on it. A scheme of this nature would need a mechanism for arbitration or appeal and external audit.

32. We recommend that independent hospitals carrying out surgical procedures which do not have their own intensive care facilities should be required to enter into a formal contract for their provision with a local NHS trust and that the independent providers should be required to compensate the NHS for intensive care provided as a direct consequence of elective treatment undertaken in the independent sector (paragraph 132).

BUPA thinks that all independent hospitals should make formal arrangements for the transfer of patients requiring private intensive care during an elective procedure if these services are not provided in the independent hospital. Such arrangements do not necessarily need to be made with an NHS trust. Provisions for fair price arbitration may need to be developed in some localities.

33. We think it essential that each provider, as part of their mandatory complaints procedure, offers all complainants an early opportunity for an independent review of their case with a view to achieving an adequate explanation of events (paragraph 140).

BUPA agrees that all complainants should have the opportunity for independent review of their case if it is unresolved within a specified period of time (2 months).

34. We recommend that all independent health care providers should be obliged to provide clear and accessible information to their customers on the complaints procedures open to them including external complaint routes such as (at present) via health authorities, or (if our recommendations are accepted) the independent regulator. We believe that the provision of an adequate complaints procedure should be a registration requirement and that the independent inspector should have access to all documentation and records relating to complaints and that these should be taken into account in any decision as to whether to maintain registration (paragraph 141).

BUPA agrees.

35. We recommend that the remit of Community Health Councils should be extended to include the activity of the independent sector. We believe that any costs accruing from this should be met by the sector itself and come out of the licensing fee (paragraph 142).

BUPA agrees.

36. We recommend that, as a statutory condition, the provider organisation should be legally responsible for the investigation of all adverse clinical incidents, including those relating to clinical practice, that take place on its premises and that full medical records should be available at all times to a clinician nominated by the provider as well as to the patient or patient representative. Each provider should be obliged to name and advertise a complaints manager to whom all complaints should be made (paragraph 143).

BUPA agrees.

37. We have considered the argument in favour of extending the role of the Commissioner to cover patients funded privately, but believe it would be preferable for the sector to have a separate Commissioner, with the Health Service Commissioner retaining responsibility for those patients funded by the NHS in the independent sector. We believe it would be more appropriate for such a Commissioner for the independent sector to have powers beyond naming and shaming. We recommend that the findings of such a Commissioner should be transmitted directly to the Independent Regulator who could impose any necessary sanctions. The Commissioner should be accountable to Parliament. We recommend that the costs of a Commissioner for the independent sector should be met in full by the sector (paragraph 146).

BUPA thinks that it would be effective and efficient to build upon the established expertise of the Health Services Commissioner in the detailed consideration of complaints. BUPA would however prefer the proposed new statutory regulator to be formally responsible for these matters, and for the findings of detailed investigations by the staff of the Health Services Commissioner to be passed back to the proposed regulator for endorsement and enforcement, and for the regulator routinely to publish details of the complaints and their outcome. This would provide the clearest and simplest focus for responsibility and accountability whilst still drawing in the expertise of the Health Services Commissioner.

38. We recommend that, in relation to independent mental health services, there should be access to a recognised, nation wide complaints system incorporating an independent review and Ombudsman mechanisms (paragraph 148).

BUPA agrees.

39. Many of the recommendations we have made in this report will require primary legislation which will take time. It is our view that existing regulations could and should be more consistently and effectively implemented until such legislation is enacted (paragraph 149).

BUPA agrees.

ANNEX B

BUPA HOSPITALS ASSESSMENT OF THE COST OF ITS EXISTING QUALITY ASSURANCE AND IMPROVEMENT INITIATIVES 1999

Quality initiatives for 1999	Person responsible	How often carried out	Cost	Project costs for 1999
ISO9002 pilots x 9 (improved customer focus)	Julian Coulden, Amanda Marcovitch 3.5 whole time equivalent	1999	£70k	£70k
Year 2000 x 36	Julian Coulden, Kate Todman			
Leading One Life	Jeremy Topple	1999	£1000 x 100	£100,000
Dendrite computer system pilots x 4	Chris Dark	1999	£150k	£150k
Clinical Governance pilots x 4	Janet Brereton & Neal Barker	1999	£100k x 4	£400k
TOTAL				**£720,000**

Quality proposals	Person responsible	How often carried out	Cost	Project costs for 1999/2000
Disability Discrimination Act (capital & revenue of compliance)	Julian Coulden, Monica Owen			Process not yet begun. Will incur a cost.
New 'Single Complaints Process' Leaflets, signage training	Clinical Team		£1kx36	Approximately £36k
TOTAL				**£36,000**

Ongoing Quality maintenance	Person responsible	How often carried out	Cost	Cost in 1999
ISO9002 Registration & surveillance visits x 36	SGS Yarsley	3 yearly	£34100 + VAT	£40067.5
IIP accreditation x 36	Local Techs.	• Annually	£800 / day incl. VAT x 36	£28800
Home Office License fees for Controlled Drugs x 36	Home Office	• Annually	£600-700 x 36	£23400
Health & Safety Audit x 36	FMA Consultants	• Biennially	£2350 + VAT	£45061.25
Annual Registration of Nursing Homes x 36 under Registered Homes Act	Local Health Authority	• Annually	Minimum 2 visits	Fees £90,000 Associated costs £90,000

SF36 Questionnaire	Chris Dark	• Annually	£75k	£75k
BEM Patient Satisfaction Survey x 36	Liz Dale	• Annually	£45345.60 incl. VAT	£45345.60
TOTAL				**£437,675**

Ongoing Quality maintenance	Person responsible	How often carried out	Cost	Cost in 1999
Ad hoc in / out patient questionnaires for new Hospital services				Absorbed internally
Head Office Clinical Team – annual budget		• Annually	£800k -£1m	£1m
Care Pathways x 36 (part-time Care Management Nurses)	Janet Brereton	• Annually	£12500 x 36	£450k
Clinical Pathology Accreditation	Karl Meyer	• Annual fee • 4 yearly inspection	9 @ £550, 10@ £650 £1100 x 19	£11450 + £20900 = £32350
TOTAL				**£1,482,350**
GRAND TOTAL				**£2,676,025**

ANNEX C

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