

Health care outside the NHS

Written evidence to the House of Commons Health Committee Inquiry into the adequacy and extent of the regulation, monitoring and inspection of health care outside the NHS.

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Health care outside the NHS

Conclusions and summary



BUPA welcomes this Inquiry as a timely opportunity to develop universal standards which will improve the quality of care for patients.

BUPA believes that the NHS and the independent sector should be regulated and monitored on broadly the same basis. Benefiting and protecting patients should be the focus for any regulatory framework. Patients must be confident that they are receiving care which is:

- Evidence based
- Provided to agreed standards in both the NHS and the independent sector.

This will result in a seamless service which will optimise the use of the combined resources of the NHS and independent sector and will encourage collaboration between the two where appropriate.

1. The advantages of regulating and monitoring the independent health care sector on broadly the same basis as the NHS are:

- The best possible quality of care and protection for patients;
- Health care based on the same set of agreed standards in both the NHS and the independent sector;
- Opportunities to share information between the NHS and the independent sector about best practice, activity and performance for the purpose of clinical audit and outcome (results and benefits for patients) monitoring;
- Direct and meaningful comparisons between the sectors
- Ensuring that practitioners have the capacity and capability to meet their responsibilities;
- Opportunities for collaboration.

In addition, patients could benefit significantly from

The independent health care sector should be regulated and monitored on broadly the same basis as the NHS

the creation of electronic health care records, which combine both NHS and independent health provider records.

Ref: [*The Independent Sector*](#)

2. BUPA's view is that all health care should be evidence based and subject to regulation by external monitoring, scrutiny and evaluation of its risks and benefits. This should include:

- The entire range of medical practice;
- Care and treatment provided by dentists, opticians, dispensing pharmacists, osteopaths, midwives, nurses, physiotherapists and other professions allied to medicine;
- Complementary or alternative practitioners;
- Immunisation, screening and occupational health services.

The onus of justifying exemptions from regulation should lie with each profession or discipline.

The most important test of health care is appropriate outcomes (the results and benefits for patients) of care and treatments. The necessary evidence base to support such regulation does not presently exist. The process of researching and evaluating such practices in order to create the necessary knowledge should therefore be accelerated.

Ref: [*Quality and performance management*](#)

[*Expanding the scope of regulation and monitoring*](#)

[*Regulating premises and people*](#)

Health care should be evidence based and subject to external monitoring

Premises and people should be regulated

3. Two primary subjects of regulation are required: premises and people, particularly but not exclusively the health care practitioners responsible for care and treatment. There should be clarification of the regulatory role in ensuring the quality of care and appropriateness of those persons involved.

Ref: [Regulating premises and people](#)

Clarification of the regulator's role

GMC registration and revalidation

4. It would be helpful if the General Medical Council (GMC) issued guidance that entry onto the GMC specialist register should be the minimum criterion for conducting independent practice in the relevant speciality. Periodic revalidation of fitness to remain on the specialist register is also necessary.

Ref: [Other Issues](#)

External arbitration for complaints

5. There should be an external complaints procedure which embraces the NHS and the independent sector. The Health Ombudsman might take this role.

Ref: [Other Issues](#)

Regional Commissions for Care Standards

6. BUPA is content with the proposed regulatory framework for “non-acute” nursing home and residential care services set out in the Government White Paper “Modernising Social Services” and would welcome the establishment of Regional Commissions for Care Standards. However, we do have considerable reservations about the standards proposed by the Centre for Policy on Ageing. BUPA has offered an alternative set of standards to The Royal Commission on Long Term Care.

Ref: [Other Issues](#)

**BUPA supports
Government policy
objectives**

7. We support the principles and policy objectives of regulation that have been set out by the Government's Better Regulation Task Force.

**BUPA's preferred
structural plan**

Our preferred structural option for the regulation of the independent health care sector would be to extend the terms of reference of the Commission for Health Improvement and delegate some responsibility to NHS Executive regional offices and the Royal Colleges. This option would improve the quality and safety of health care for patients by:

- Introducing common measurable standards across the NHS and the independent sector which would facilitate effective collaboration and a seamless service for patients;
- Maximising information sharing;
- Introducing more effective monitoring;
- Offering the greatest flexibility;
- Consolidating and complementing existing arrangements;
- Providing a practical framework for the implementation of such regulation.

Such regulation should be practical and cost effective to implement. Its focus should be the maintenance and improvement of quality health care and not as a mechanism for apportioning blame.

Ref: [*The Independent Sector*](#)

[*Options for the regulation, monitoring and inspection of health care outside the NHS*](#)

BUPA is happy to provide additional evidence to support any of the issues raised in this document.

Health care outside the NHS

1. The Independent sector

[1.1 The independent sector's contribution to health care.](#)

[1.2 Why statutory regulation?](#)

[1.3 The purpose and benefits of health care regulation](#)

1.1 The independent sector's contribution to health care.

The independent health care sector makes a significant contribution to health care in this country. One million people receive inpatient treatment in independent hospitals each year. The independent sector is responsible for 20% of all planned operations (non-emergency) which would otherwise cost the Government between £500m - £1bn (assuming capacity was available) each year and would significantly increase NHS waiting lists.

It would cost the Government between £500m- £1bn each year treat those patients currently cared for in the independent sector - this would increase significantly increase NHS wating lists

1.2 Why statutory regulation?

Statutory regulation would command greatest public confidence and is likely to be more binding and effective than a voluntary system.

Such regulation should:

- Ensure patients receive the best possible care and treatment;
- Facilitate continual development and improvement of health care standards;
- Command public confidence;
- Satisfy public expectations that agreed standards are being consistently met;
- Be clearly understood;
- Be cost effective and practical to implement;
- Be flexible enough to adapt to changing demands and patterns of health care delivery;
- Not restrict the freedom to trade.

Statutory regulation would command greatest public confidence and is likely to be more binding and effective than a voluntary system.

1.3 The purpose and benefits of health care regulation

We believe the main purpose of statutory regulation is to provide a clear and concise set of rules and guidelines that ensure the safe and effective management and delivery of health care.

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2. BUPA's support for statutory regulation

The provision of health care is becoming increasingly complex. The Government should therefore assure the quality of all health care services if it is to discharge fully its responsibility to protect and promote the health of the nation.

BUPA welcomes the opportunity to fundamentally re-appraise the regulation, monitoring and inspection of non-NHS health care, for the following reasons:

[2.1 Shared benefits and risks](#)

[2.2 Encourage transparency, accountability and consistency](#)

[2.3 Flexible, practical and realistic regulation](#)

[2.4 Broader regulation and equal standards](#)

[2.5 Closer relationships with the NHS](#)

The emergence of new technologies, improved drugs, surgical techniques and therapies lead to greater benefits and risks

Statutory regulation of health care should benefit and protect patients, staff and the public

2.1 Shared benefits and risks

The emergence of new technologies, improved drugs, surgical techniques and therapies lead to greater benefits and risks.

Events during the past year have highlighted the inadequacy of current regulatory arrangements for conventional medicine and surgery in both the public and independent health care sectors.

2.2 Encourage transparency, accountability and consistency

BUPA wholly supports the principles and policy objectives of regulation set out by the Government's Better Regulation Task Force to encourage transparency, accountability, targeting, proportionality and consistency. Statutory regulation of health care should benefit and protect patients, staff and the public and in particular:

- Ensure that all health care-related risks are being managed effectively and that appropriate operational policies and records

are developed and maintained;

- Ensure that effective and appropriate therapies are being employed and that the effects and impact of such therapies are being systematically recorded and evaluated;
- Promote the dissemination of best practice but clearly distinguish between “requirements” (which must be implemented) and “aspirational” suggestions;
- Improve the quality of health care by working to agreed standards as well as shared learning and information
- Protect freedom of choice and equity.

2.3 Flexible, practical and realistic regulation

A regulatory system must be sufficiently flexible to promote innovation and adapt to changing needs. This will only be achieved through practical and realistic proposals that acknowledge the limits of regulation and do not restrict freedom to trade or consumer choice.



2.4 Broader regulation and equal standards

BUPA thinks an opportunity therefore exists to broaden the scope of current regulation and set equal standards across the independent sector and the NHS in order to benefit patients by:

- Ensuring patients receive all health care based on the same set of agreed standards in both the NHS and the independent sector;
- Improving the quality of care for patients, in all health care settings;
- Creating regulatory equality between the independent sector and the NHS;
- Maximising the opportunities to share knowledge and information about patients, best practice and activities;
- Making direct and meaningful comparisons between the sectors;
- Ensuring that practitioners have the capacity and capability to meet their responsibilities.

A common approach is needed

2.5 Closer relationships with the NHS

This Inquiry is a timely opportunity to develop closer working relationships with the NHS.

This Inquiry is a timely opportunity to develop closer working relationships with the NHS. BUPA believes that closer collaboration will result in better and safer care for patients.

Examples of BUPA's joint initiatives with the NHS

Funding of an MRI scanner between BUPA Cambridge Lea Hospital and Addenbrookes NHS Trust

Two BUPA hospitals built on NHS hospital sites in Hastings and Redhill

Funding for the TMR laser trial at BUPA Cambridge Lea and Papworth NHS Trust

Clinical placements for nurses in many of our hospitals

NVQ centres in two BUPA hospitals

Funding and support for the lithotripter service at St Thomas's Hospital in London

Treatment of more than 25,000 NHS patients

Assisting NHS hospitals with the 'flu crisis'

Courses developed by BUPA and Huddesfield University used to train NHS nurses

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3. Quality and performance management



In 1998 the Government announced detailed plans to manage more closely the performance and quality of services provided by and to the NHS. BUPA supported these plans by making commitments (in public and to the Government) to match these standards by implementing parallel systems. Our responses to these plans are described below.

[3.1 Setting clinical standards - guidelines, methods and information](#)

[3.2 Providing quality health care](#)

[3.3 Purchasing quality health care on behalf of patients](#)

[3.4 Quality frameworks for the independent sector](#)

[3.5 BMA Private Practice Committee report](#)

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[3.7 The Independent Hospitals Association \(IHA\)](#)

BUPA has started to set standards to match the NHS



3.1 Setting clinical standards

- guidelines, methods and information

The Department of Health document “A First Class Service” suggests that NICE should produce and disseminate:

- clinical guidelines based on relevant evidence of clinical and cost-effectiveness; and
- associated clinical audit methodologies and information on good practice.

NICE will therefore be instrumental in setting clinical standards. These are currently only intended to cover the NHS. BUPA believes that in order to achieve equal standards across both sectors NICE should also include the independent sector.

BUPA and the BUPA Foundation already provides funding for the work of a number of UK academics who research and promote evidence-based health care including Sir Michael Peckham at University

College, London and Dr Muir Gray and Prof. David Sackett at Oxford University.

Response to A First Class Service - Quality in the new NHS

BUPA strongly supported the Government's consultation document,

A First Class Service

- *Quality in the new NHS*.

Our response to this

document is attached at [Annex](#)

[A](#). A full reply to the issues

raised in

our response is awaited.

3.2 Providing quality health care

“A First Class Service” proposed a coherent and increasingly comprehensive framework for health care standard setting, to assure and evaluate the quality of services. BUPA has responded by preparing a revised Clinical Services Strategy, setting out new local requirements ([see Annex B](#)) and building on a series of quality assurance and improvement initiatives undertaken by BUPA Hospitals over the past five years ([see Annex C](#))

3.3 Purchasing quality health care on behalf of patients

BUPA spends more than £600m per annum on health care, for its private medical insurance (PMI) members. Examples of BUPA’s initiatives are summarised in [Annex D](#).

PMI purchasers of care can also play a legitimate role in setting and improving quality standards. This is achieved through the contracting process - which includes the setting and agreeing of minimum standards with those hospitals who care for PMI members.

Response to Office of Fair Trading (OFT) report on Health Insurance - Reducing complexity for the consumer

In 1998 the OFT published its second report on Health Insurance in the individual market. The OFT was concerned that consumers were confused by the complexity of health insurance products. BUPA has played a central role in developing practical and constructive proposals for the PMI sector as a whole, in

3.4 Quality frameworks for the independent sector

In October the Private Practice Forum of the Academy of Royal Colleges asked BUPA’s Group Medical Director to coordinate the development of a “private medicine clinical quality framework” that should become the benchmark for medical practice in hospitals and clinics across the sector from 1 January 2000. This framework complements BMA proposals and also considers issues of responsibility at the level of each “facility” (hospitals and clinics). The Academy of Royal Colleges aims to submit its framework to the Inquiry on 27 January 1999.

response to the OFT's report.

These proposals have now been accepted by the OFT. BUPA continues to play a leading role overseeing the implementation of these proposals.



3.5 BMA Private Practice Committee report

In 1997 the BMA established a Private Practice Committee (PPC) which has prepared a wide ranging discussion paper about developing systems for Clinical Governance in independent health care.

BUPA supports the PPC proposals, which have been discussed with the BMA and which, we understand, have been submitted as part of the BMA's evidence for the Inquiry.

The BMA PPC recommendations are designed to ensure that:

- There are mechanisms in the independent sector to monitor practitioners and facilities in a similar fashion to the NHS;
- Specialists working outside formal hospital structures should be accountable, perhaps through local independent hospital Medical Advisory Committees (MACs);
- MAC chairmen in independent hospitals should fulfil a similar role to that of medical directors of NHS Trusts in relation to local professional self-regulation;
- A formal procedure exists for patients to pursue complaints about the clinical care they receive which is at least as rigorous as in the NHS;
- There should be agreed arbitration procedures for non-clinical complaints which are open for use by all parties;
- Private medical facilities and laboratories should be subject to inspection as rigorous as those undertaken at NHS There should be national standards and a similar inspection regime for NHS pay bed units;
- Where doctors in independent medical practice have concerns about the performance of colleagues, they should have a professional and moral responsibility to bring the matter formally to the attention of other colleagues.

The BMA has proposed a range of procedures to investigate and resolve all types of performance issues (which MAC chairmen should ensure are in place).

3.6 Health and social regulation

In December the Government announced plans to establish Regional Commissions for Care Services to improve and increase the regulation of social care provision, currently inspected by DHA's and local authorities. BUPA believes that the future regulation of all independent health care should be addressed simultaneously.

3.7 The Independent Hospitals Association (IHA)

The IHA has strongly supported the PPF initiative. It has accelerated existing proposals for an independent sector complaints procedure and co-ordinated preparations by the industry for its contribution to this Inquiry. BUPA Hospitals, a member of the IHA, has participated in the IHA's submission to the Inquiry.

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4. Expanding the scope of regulation and monitoring

[4.1 What is currently regulated?](#)

[4.2 Why the review should extend current regulation](#)

4.1 What is currently regulated?

Current regulation in the independent sector includes facilities used for medical, nursing, inpatient care, maternity homes, psychiatric nursing homes and premises used for surgical procedures. It does not include premises used for outpatient consultations/treatments.

BUPA's facilities are currently regulated in a number of ways, for example:

- District Health Authority inspection and registration of all BUPA's nursing homes and hospitals
- CPA accreditation in all BUPA pathology laboratories
- Home Office inspections of all BUPA pharmacies
- Professional registration of all clinical staff
- Fire inspections
- Independent biannual Health and Safety inspections
- ISO 9002/IIP accreditation in BUPA hospitals
- Organisational audit
- Measurement of health care outcomes for patients
- Recording and measuring clinical variances
- Care pathways for BUPA's top 50 procedures

What is a care pathway?

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, e.g. surgery, physiotherapy, etc.

BUPA Hospitals is working towards care pathways for all its procedures. These are currently in place for BUPA's top 50 procedures.

4.2 Why the review should extend current regulation

All health care should be evidence based

Health care practices and technologies have developed substantially over the past 20 years.

It is BUPA's view that all health care should be evidence based and the risks and benefits subject to regulation by external monitoring, scrutiny and evaluation. This view has wide ranging implications for health care practice and would extend the scope of regulation to include:

- The entire range of independent medical practice;
- Independent care and treatment provided by dentists, opticians, dispensing pharmacists, osteopaths, midwives, nurses, physiotherapists and other professions allied to medicine;
- Complementary or alternative practitioners;
- Immunisation, screening and occupational health services.

The onus for justifying exemptions from any such regulation should lie with each profession or discipline.

The evidence base necessary to support such regulation does not presently exist. The process of researching and evaluating such practices in order to create the necessary knowledge should therefore be accelerated.

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5. Regulating premises and people

[5.1 The focus of regulation](#)

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5.1 The focus of regulation

BUPA believes that the focus of regulation should encompass premises and people (particularly but not exclusively the health care practitioners responsible for care and treatment). Managers of hospitals and clinics should continue to take responsibility for the regulation of practitioners and other employees.

The District Health Authorities are currently responsible for ensuring the quality of care provided in regulated health care premises and the appropriateness of individuals “employed” in them. At a local level this is currently interpreted inconsistently. It would therefore be helpful to clarify the regulatory role.

5.2 The terms of regulation

Whilst “inputs” and “outputs” remain important terms of measure (especially at initial registration and during the development of new services), the most important test of health care is appropriate “outcomes” - the results and benefits for patients.

The most important test of health care is appropriate "outcomes" - the results and benefits for patients

5.3 Benchmark standards

The combined work of the proposed Department of Health Research and Development Programme, the work of NICE, the proposed National Health Services Frameworks and the NHS performance management and quality frameworks, should result in benchmark standards for treatment and care of patients in the NHS and the independent sector. These should take into account differences in case mix in the NHS and the independent sector.

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6. Other issues

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[6.2 Co-ordinating information](#)

[6.3 Complaints procedure](#)

[6.4 The regulation of “non-acute” nursing homes](#)

6.1 Assuring the standards of independent medical practice

It would be helpful if the General Medical Council (GMC) issued guidance that entry onto the GMC specialist register should be the minimum criterion for conducting independent practice in the relevant speciality. Periodic revalidation of fitness to remain on the specialist register is also necessary.

6.2 Co-ordinating information

Pooling information with the NHS and other independent health care organisations about patients, practitioners, activity and outcomes would support clinical audit and the improvement of health care standards. It would also mean that “employers” could better ensure that health care professionals have the capacity and capability to meet their responsibilities.

One complaints procedure for both the NHS and the independent sector

Electronic health care records

Patients could benefit significantly from the creation of electronic health care records, which combine both NHS and independent health records.

It would be helpful to pool information with the NHS and other independent health care organisations about patients, practitioners, activity and outcomes

6.3 Complaints procedure

There should be an external complaints procedure which embraces the NHS and the independent sector.

The IHA in principle supports a revised Ombudsman scheme that embraces both the NHS and the independent sector. Until this can be implemented, the IHA and BUPA recommend an independent procedure under the auspices of the IHA. BUPA has a complaints procedure which has clear guidelines and deadlines for the processing and management of complaints.

6.4 The regulation of “non-acute” nursing homes

BUPA notes that the Inquiry’s terms of reference do not exclude consideration of the regulation of “non-acute” nursing homes. BUPA is the largest provider of nursing home and residential care services in the UK and supports the proposed regulatory framework for “non- acute” nursing home and residential care services set out in the Government White Paper “Modernising Social Services”. BUPA would welcome the establishment of Regional Commissions for Care Standards but has considerable reservations about the standards proposed by the Centre for Policy on Ageing. BUPA has offered an alternative set of standards to The Royal Commission on Long Term Care.

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Health care outside the NHS

7. Options for the regulation, monitoring and inspection of health care outside the NHS



[7.1 Removing the requirement for regulation or maintaining the status quo](#)

[7.2 Other options](#)

[7.3 Extending the terms of reference of the Regional Commissions for Care Services](#)

[7.4 Extending the terms of reference of the Commission for Health Improvement and delegating some responsibility to Regional Offices and the Royal Colleges](#)

[7.5 Creating a new national statutory body, accountable to the Secretary of State for Health, responsible for regulating the independent health care sector, perhaps with delegated powers to industry representative bodies](#)

[7.6 BUPA's preferred option](#)

7.1 Removing the requirement for regulation or maintaining the status quo

BUPA suggests that removing the Government's responsibilities for regulation of independent health care would contradict recent evidence suggesting that greater statutory regulation is required to ensure quality of health care practice. Attempts to maintain regulatory responsibilities at District Health Authority level are likely to breach the Government's own principle of good regulation and are likely to be inefficient, especially if Regional Commissions for Care Services are established.

7.2 Other options

We envisage three main structural options to deliver a revised regulatory framework for the independent health care sector (excluding "non acute" nursing homes)

7.3 Extending the terms of reference of the Regional Commissions for Care Services

This option would integrate health and social care regulation and help to harmonise standards in both disciplines. However, it might dilute expertise and divert resources from the analysis and evaluation of health-related risks. It does not take advantage of the structure and expertise that already exists at a local level.

7.4 Extending the terms of reference of the Commission for Health Improvement and delegating some responsibility to Regional Offices and the Royal Colleges

This option would facilitate maximum cross-fertilisation of knowledge and common standards between the Department of Health, the NHS, and the independent health care sector and would aid standards monitoring. It would also consolidate regulatory roles and expertise at regional office level, in a manner that would complement existing and proposed responsibilities for the performance management of the NHS and the regulation of social care.

7.5 Creating a new national statutory body, accountable to the Secretary of State for Health, responsible for regulating the independent health care sector, perhaps with delegated powers to industry representative bodies

This option is consistent with Government policies for delegating regulatory power to industries under executive supervision. However, it fails to optimise the potential benefits of closer collaboration between the independent sector and the Department of Health and NHS at policy and higher management levels.



7.6 BUPA's preferred option

Any regulation should be in the interests of patients, staff and public, practical to implement, cost effective, flexible and not restrict the freedom to trade

BUPA's preferred structural option for the regulation of the independent health care sector would be to extend the terms of reference of the Commission for Health Improvement and delegate some responsibility to regional offices and the Royal Colleges. This option would:

- Offer the greatest flexibility
- Introduce common standards across the NHS and the independent sector
- Maximise information sharing
- Introduce more effective monitoring
- Consolidate and complement existing arrangements
- Offer the best protection for patients
- Provide a level playing field for the NHS and the independent sector
- Encourage regulatory equality
- Take advantage of the expertise and structure which already exists

Any regulation should be in the interests of patients, staff and public, practical to implement, cost effective, flexible and not restrict the freedom to trade.

We are happy to provide additional evidence to support any of the issues raised in this document.

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Health care outside the NHS

Annex A - BUPA's response to "A First Class Service", Consultation Document on Quality in the new NHS



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BUPA's correspondence with NHS

Mr Simon Reeve

Quality Management Team

NHS Executive Headquarters

Department of Health

Room 605

Richmond House

79 Whitehall

London

SW1A 2NS

18 September 1998

Dear Mr Reeve

“A FIRST CLASS SERVICE”

CONSULTATION DOCUMENT ON QUALITY IN THE NEW NHS

HSC 1998/113

I enclose BUPA's response to this consultation. BUPA strongly supports the proposed quality framework for the NHS set out in “A First Class Service”. BUPA will adhere to the proposed framework when providing services to the NHS.

BUPA is developing a parallel quality framework for the health services it funds and provides independently. BUPA is also playing a leading role in discussions

about the scope for a co-ordinated approach to these matters by the independent health sector.

I would welcome a response to the nine questions raised in our response. I would also welcome the opportunity to discuss these and related matters directly with Ministers.

Yours sincerely

Val Gooding
Chief Executive

Copy:

Mr David Miliband, Head, No 10 Policy Unit

Ms Sarah Casemore, Private Secretary to Baroness Hayman, MS(L), Dept of Health

Mr Martin Staniforth, Director of Corporate Affairs, NHS Executive

Mrs Virginia Jones, Head of Operational Policy Unit, NHS Executive

Mr Ken Groom, Chairman, PMI Committee, Association of British Insurers

Mr Charles Auld, Chairman, Independent Health care Association

BUPA'S RESPONSE TO "A FIRST CLASS SERVICE" CONSULTATION DOCUMENT ON QUALITY IN THE NEW NHS

1.0 Introduction

BUPA strongly supports the quality framework for the NHS, set out in "The New NHS" and amplified in "A First Class Service".

BUPA will adhere to the proposed framework when providing services to the NHS in our hospitals, nursing homes and other settings.

1.1 A parallel quality framework

BUPA is developing a parallel quality framework for the health services it funds and provides independently. BUPA is also playing a leading role in discussions about the scope for a co-ordinated approach to these matters by the independent health sector. BUPA believes that the Department of Health should also seek to protect and promote the interests of citizens who use independent health care services and that more should be done to share knowledge and data between the public and private health sectors.

1.2 BUPA wishes to know:

What scope independent health care providers will have for variation from the NHS quality framework in non NHS business?

What scope BUPA will have for sharing knowledge and data on quality issues with NHS organisations and the Department of Health?

Whether clinical audit will be mandatory for GPs with an NHS contract?

1.3 Setting Standards

(National Institute of Clinical Excellence (NICE) and National Service Frameworks (NSFs))

In principle BUPA would support a wider role for NICE encompassing primary and secondary prevention of disease; but supports the DoH's intention to focus NICE on "clinical services" in the first instance.

BUPA will be guided by the NSFs (particularly in its UK businesses) and guidance from NICE. **BUPA therefore wishes to have the same access as NHS organisations to NSFs and NICE including desk-top dissemination and decision support engines. Will such access be available?**

BUPA will be prepared to contribute to the collection of evidence for, and work to support the implementation of, NICE guidelines and NSF's. **Do Ministers wish to include information from the independent health care sector in the evidence base for UK medicine and nursing?**

Statistics collected by Professor Brian Williams of Nottingham University indicate that the independent sector carried out over 12% of all elective surgery in England and Wales in 1992/93; including, for example, over 20% of elective inguinal hernia repairs, cholecystectomies and total hip repairs. Figures for 1997/98 should be available in December.

As the largest independent integrated health care organisation in the UK, leading the quality agenda in our sector, **BUPA would welcome a place on the NICE Partners Council, for one of our senior clinicians. Do Ministers wish to support the identification and dissemination of best practice across both health care sectors?**

1.4 Delivering Standards

(Clinical governance, lifelong learning and professional self regulation)

BUPA will complete the implementation of a parallel framework of clinical governance; adopting many of the elements of the framework set out for NHS Trusts

A. Lines of responsibility and accountability for the overall quality of clinical care:

- Every health care facility will have a designated senior clinician responsible for ensuring that systems for clinical governance are in place and monitoring their continued effectiveness.
- Managers of BUPA Hospitals will take overall local responsibility for all aspects of quality and risk management. Parallel duties will apply at business and Group levels. BUPA will strengthen existing linkages between clinical and corporate governance at local, business and group levels.

B. Programmes of quality assurance and quality improvement:

- Participation in clinical audit (internal and external) and National Confidential Enquiries and adherence to GMC good medical practice guidelines will be made conditions of receiving and maintaining medical admitting rights to BUPA hospitals from 1 January 1999, and incrementally through 1999 a condition of recognition of medical services provided to BUPA members. Participation in clinical audit is already a condition of membership of BUPA's Consultant Partnership.

C. Policies aimed at managing risks:

- Clinical risk management will be more closely integrated into BUPA's wider risk management framework in all UK businesses.

D. Procedures to identify and remedy poor performance and conduct:

- **Protocols will be developed to promote earlier and closer liaison with NHS organisations when a clinician's performance or conduct gives cause for concern. Will Ministers actively support this development?**

BUPA will review its policies, priorities and programmes for personal and professional development of all staff and other business partners in order to ensure that these are aligned with its clinical and corporate objectives.

BUPA Hospitals are currently developing a national continuing development programme for all their clinical staff, to which three regional advisors in clinical education have recently been appointed. A training needs analysis for nurse education has already been carried out and links are being developed with a university for the provision of tailor-made education. In the longer term it is intended that all BUPA Hospitals staff will have a personal development plan.

BUPA Care Services awaits the Social Care White Paper with interest and would welcome more detailed guidance from the Department on how the framework will be applied to the provision of publicly funded nursing home and residential care services.

1.5 Monitoring Standards

(Commission for Health Improvement (CHI), National framework for assessing performance and survey of patient and user experience)

BUPA notes paragraphs 4.37 & 4.38 of the consultation document; and **would welcome early and close dialogue with officials and Ministers about the options for the regulation of the independent acute sector; and in particular a discussion about the potential scope of CHI. Will such dialogue be initiated?**

BUPA requests early clarification as to whether the NHS quality framework will apply to private practice in the NHS? BUPA would welcome the framework being so applied.

BUPA welcomes the national framework for assessing performance and is developing a parallel framework. BUPA intends to report to its members on these aspects of its performance more fully in future years.

BUPA welcomes the Government's intention to develop and publish risk adjusted performance tables of clinical quality by speciality for each NHS Trust in future years.

BUPA welcomes the proposed National Survey of Patient and User Experience (of the NHS). BUPA already collects similar information. BUPA has also started pilots to collect information about patients' perception of the outcome of their treatment (using SF-36). BUPA suggests that the NHS may wish to use its

National Survey to collect similar information.

Val Gooding
Chief Executive

18 September 1998

Health care outside the NHS

Annex B - BUPA Hospitals, Clinical Services Strategy



[2.0 Quality Strategy](#)

[2.1 Clinical Governance Strategy](#)

[2.2 Implementation](#)

[2.3 Clinical Audit](#)

[2.4 Continuing professional development](#)

[2.5 Clinical Risk Management](#)

[2.6 Information for patients](#)

[2.7 Non clinical risk management](#)

2.0 Quality Strategy

The overall quality strategy will embrace the following:

- Clinical governance
- Clinical effectiveness
- Education and Training
- Clinical Audit
- Clinical risk management
- Customer perception of service
- Non clinical services
- ISO 9002 and IIP

It will be disseminated and communicated throughout the hospital with involvement of staff at all levels in implementation

2.1 Clinical Governance Strategy

There will be a written strategy for clinical governance, developed locally, which will incorporate the following elements:

- Roles and responsibilities of key personnel
- Required skills and knowledge
- Training needs
- Resources to implement clinical governance
- Required outcomes of the implementation

2.2 Implementation

- There will be a named lead clinician responsible for implementation and monitoring
- The MAC Chairman will assume a role similar to that required of Medical Directors in NHS Trusts for the purposes of clinical governance
- There will be a quality report at each MAC meeting and monthly at Hospital Senior Management Team
- A designated individual will be responsible for supervising collection of information (usually the Care Management Nurse)
- Each Hospital will provide an Annual Report with an assurance statement of clinical quality signed by the General Manager
- Formal links with the local NHS Trusts for integration of clinical governance arrangements are encouraged; these arrangements should be locally determined
- Multi-professional teams will take the lead on clinical governance and will report to the lead clinician
- The lead clinician is responsible for the development of and overseeing the implementation of the local quality strategy, in line with corporate strategy

2.3 Clinical Audit

- At hospital level priorities will be identified and documented for clinical audit
- Agreed protocols will be used for clinical audit
- The lead clinician will support and co-ordinate clinical audit programmes across the hospital
- All clinicians will participate in programmes of clinical audit
- Results of audit studies will be disseminated throughout the hospital
- There will be full participation in national confidential enquiries (e.g. NCEPOD)
- There will be full participation in national clinical performance indicators where applicable
- There are networks to share clinical guidelines and care pathways which have been successfully developed and implemented
- There is a named person to provide guidance and support across the hospital in the development of local standards and care pathways
- There is a house style document to ensure consistency of presentation of care pathways
- Available feedback from patients is used to gain a patient perspective

- There are clear arrangements for ensuring that clinical audit addresses evidence of effectiveness and monitors the implementation of clinical effectiveness
- There are links with external agencies to review and inform clinical effectiveness and evidence based practice
- Clinicians have access to up to date information on evidence based clinical practice
- There are systems promoted to clinicians throughout the hospitals for disseminating information for effective practice

2.4 Continuing professional development

- Consultants must meet the CME requirements of their appropriate Royal College
- There must be continuing professional development programmes in line with the BUPA framework for education and in line with appropriate colleges and professional associations
- Training must reflect evidence based practice and provide mechanisms for accessing available evidence
- Clinical audit findings must link to education to assist professionals in changing their practice
- The hospital must be involved in and fully co-operate with existing systems for professional self-regulation

2.5 Clinical Risk Management

The Lead Clinician will:

- Ensure that all clinical services undertake clinical risk assessments
- Ensure that there is training for staff in undertaking clinical risk assessment
- Ensure that the findings from clinical risk assessments are analysed and work practices are reviewed and changed as necessary
- Ensure that all complaints are analysed and appropriate action taken
- Promote a “no blame” culture in the investigation progress
- Ensure full compliance with a single incident reporting system
- Co-ordinate activity to ensure compliance with level 1 CNST standards

2.6 Information for patients

- Information must be available to help patients to make informed choices based on the best available evidence on effective and appropriate interventions
- Patients should be encouraged to discuss the information they are given before making a decision

2.7 Non clinical risk management

Non clinical risk management arrangements primarily concerning health and safety are well embedded in hospitals. These arrangements are reflected in compliance standards, corporate and local policies and procedures and audit activity. Work will proceed to integrate where beneficial procedures and systems to ensure complete synergy between clinical and non clinical risk management.

Health care outside the NHS

Part 1. Organisational Quality Assurance

3.0 ISO9002

In 1995, all existing BUPA hospitals achieved International Standards Organisation accreditation (ISO9002), the internationally recognised successor to BS5750, adopted in more than sixty countries. BUPA was the first Health Care company in the United Kingdom to be so accredited.

ISO9002 is designed to ensure consistency in service delivery, where the focus is upon the customer and achieving customer satisfaction. It is a documented quality system where BUPA's service has been defined against agreed standards. ISO9002 may be awarded by one of several accreditation organisations licensed by the United Kingdom Accreditation Service, (UKAS) an agency of the Department of Trade and Industry. BUPA Hospitals receive accreditation from SGS Yarsley who independently assess and validate a sample of BUPA sites every six months. Accreditation therefore remains dynamic with the onus on the demonstration of continuous quality improvement.

BUPA Hospitals is committed to maintaining ISO9002 and independent accreditation and is presently preparing its new hospitals for accreditation in 1999.

3.1 Hospital Organisational Audits

For the last 3 years, BUPA Hospitals has also undertaken, on a sample basis, an internal hospital organisational audit process, based on peer review. A team of Hospital Manager, Matron and professional peers visit a hospital for one day to assess the way in which the hospital is managed, and how patient services are provided. This is an all encompassing audit, which is considered to have significant benefit, both for the hospital and the peer assessors, who are drawn from other hospitals. This audit is different from other quality audits in that the assessors have complete freedom to cover ground of their choosing (within a reasonably defined framework designed to ensure consistency between audits and to enable comparisons).

3.2 Investors In People

In 1995 all existing BUPA Hospitals gained (and have maintained) Investors in People (IIP) accreditation. Hospitals subsequently acquired by BUPA are due to obtain this accreditation in March 1999. IIP is an audited commitment made by unit management to develop all employees to achieve its business objectives.

3.3 Patient Satisfaction Survey

As part of BUPA Hospitals' commitment to monitoring patient satisfaction in their hospitals, biennial research is conducted by BEM, an external company, to identify which aspects of the service are likely to satisfy the needs of the patient and ascertain whether each hospital has delivered them effectively.

The most recent research was carried out in 1997. A study of all inpatient, daycase and outpatient episodes will be surveyed in Quarters 1 and 2 1999.

3.4 Health & Safety

Corporate policies and procedures are assessed biennially by an independent company of health & safety advisers. A report with recommended actions is sent to each hospital General Manager. These must be followed up within the recommended time scale and at least within 6 months. Mandatory training for staff is identified and audits ensure full compliance with BUPA Hospitals policies. Health & Safety advice is freely available from BUPA Hospitals external advisers, and this is regularly fed into policy development, review and training. Hospitals are subject to inspection by inspectors from the Health and Safety Commission.

3.5 Complaints Policy

BUPA recognises that complaints are learning opportunities which an organisation must ingest to ensure that not only does it address the complaint itself, but puts in place systems or processes to prevent a repetition of the circumstances of the original complaint.

BUPA Hospitals' complaints policy contains a number of key requirements.

- It covers customer complaints made verbally or in writing
- It contains tightly defined acknowledgement and response times.
- Complaints are categorised and summarised by each hospital every quarter and returns sent to Head Office.
- A higher level corporate summary and analysis of complaints is compiled and presented to the Hospitals Management Team (HMT) to consider trends and take appropriate management action.
- Where a complaint clearly has hospital service and consultant clinical components, the Hospital Manager will discuss the investigation in detail with the consultant and endeavour to give the patient as complete a response as possible.
- Patients who are dissatisfied with a response received from the Hospital Manager should write to the Managing Director of BUPA Hospitals.

Part 2. Clinical Quality Assurance

3.6 National arrangements

There is a detailed quality assurance strategy for BUPA Hospitals. There are two new posts of National Clinical Audit Manager and National Clinical Risk Manager in addition to an existing Corporate Quality Manager post to support this.

There is full participation in the National Confidential Enquiry into Peri-Operative Deaths (to which we also give financial support).

BUPA has established a specific quality network for the treatment of symptomatic breast disease. All of our 31 hospitals which applied for recognition are now recognised by BUPA for management of their members. They meet evidence-based criteria set by professional groups in the NHS following the Calman-Hine report.

Our relationship with consultant providers is formalised as policy in the Consultant Handbook. This defines the rules for gaining and retaining admitting privileges, the constitution of the Medical Advisory Committee and quality standards for clinical practice, e.g. obtaining consent and attending inpatients.

3.7 Local arrangements

There are written minimum standards for the granting and retention of admitting rights in our hospitals. Such rights are specific for that hospital, for a particular speciality and, increasingly, for specific procedures.

All hospitals have a Medical Advisory Committee (MAC) with representation of each speciality working in that hospital and governed by a written constitution.

Allegations of poor performance by doctors are investigated by the MAC and appropriate action is taken by the General Manager. If necessary a formally constituted Professional Review Committee may be required.

Participation in clinical audit is now mandatory for retention of admitting privileges for all clinicians working in our hospitals.

Each of our hospitals has a dedicated care management nurse, part of whose role is to co-ordinate clinical audit and clinical risk management.

There is 24 hour on site Resident Medical Officer (RMO) cover. All RMOs have advanced life support training (both adult and paediatric) and appropriate training and experience prior to taking up post.

All current audit data are reported to the MAC on a quarterly basis. We are in the process of setting up multi disciplinary teams to review all audit data on a regular basis.

3.8 Care pathways

Locally-developed, evidence-based multi disciplinary care pathways are now in place in hospitals for our fifty top procedures. Analysis of variance from the pathways takes place in all hospitals.

3.9 Outcomes

Outcomes following surgical interventions are now surveyed in several of our hospitals with a view to full roll out. We are measuring change in self-reported health status using the SF-36 questionnaire which is administered immediately preoperatively and at 12 weeks postoperatively.

In hospitals where cardiac surgery is performed there is collection of the minimum data set of the Cardiothoracic Society and contribution to the National Heart Valve Registry.

4.0 Cardiopulmonary resuscitation (CPR)

All employed clinical staff receive formal training in CPR. Details of each resuscitation attempt are recorded and reviewed locally and centrally.

4.1 Critical Incident reporting

All clinical critical incidents are reported to the centre according to policy. The Critical Incident reporting scheme is currently being widened to include all critical incidents, both clinical and non-clinical.

4.2 Clinical performance indicators

We collect data on five key indicators of clinical performance namely

- unplanned transfer (including admission to ITU)
- unplanned readmission
- unplanned re-operation
- unexpected death
- unexpected surgical death

These are collated quarterly and presented by Matron to the Medical Advisory Committee and are sent to Head Office for scrutiny by the Head of Clinical Services.

4.3 Prospective clinical risk management

All inpatients and selected day stay patients complete pre-operative questionnaires which are reviewed by the Care Management Nurse.

Work is underway to achieve full compliance with level 1 CNST (Clinical Negligence Scheme for Trusts) criteria by the end of 1999.

4.4 Clinical Pathology Accreditation

CPA (Clinical Pathology Accreditation UK Ltd) is a Pathology accreditation body established by the College of Pathology in association with the Institute of Biomedical Scientists and others. CPA is a professionally led organisation and not a statutory body. It is generally accepted as the UK organisation which defines standards for the organisation and performance of clinical pathology. Those laboratories with CPA accreditation are able to reassure users that they have a recognised hallmark of performance lacking in non-accredited laboratories.

Of BUPA Hospitals' 18 in-house laboratories, 17 have CPA accreditation and 1 will be reassessed. The first laboratory achieved accreditation in 1995.

Accredited laboratories are subject to periodic re-inspections at 3-4 year intervals. BUPA retains the services of 3 Consultant Pathology advisors who provide clinical advice whilst also visiting laboratories as a secondary form of quality assurance.

4.5 Year 2000

A physical inventory of all medical equipment with embedded chips has been completed and BUPA is contacting the manufacturers to obtain compliance information. An investigation of BUPA's supplier base is in hand to ensure continuity of supply in the Year 2000. Formal contingency planning has already started and will continue through 1999 to help ensure that BUPA Hospitals, and therefore patients, are protected. BUPA Hospitals Year 2000 programme is being continually reviewed and monitored. There is independent audit by KPMG throughout the programme.

BUPA has co-ordinated discussions between the NHS and IHA members that have shared good practice and ideas about solving Year 2000 problems.

4.6 Radiation Protection

In addition to each hospital retaining the services of a local Radiation Protection Advisor, BUPA Hospitals also retain the services of two independent advisors, both of whom are senior clinicians from the Regional Radiation Protection Service Department of Medical Physics, St Luke's Hospitals Guildford. The advisors are responsible for helping to devise and implement an annual radiation protection plan whose objectives are: the reduction of radiation dose via regular patient dose monitoring, staff training and purchase of new diagnostic imaging equipment.

Health care outside the NHS

5.0 General requirements

BUPA Membership in its relationships with providers assumes quality assurance functions. For example, doctors recognised by BUPA must be on the UK GMC specialist register and hold NHS Consultant posts or equivalent. When BUPA recently decided to offer complementary therapies to its members, recognised providers were limited to those with statutory regulation such as osteopathy . For homeopaths and acupuncturists who have no statutory regulation, providers are also required to be medically qualified, for consumer protection. Hospitals with which BUPA contracts are required to adhere to terms on a wide range of clinical and non-clinical issues, for example medical cover, infection control and competence of clinicians providing care.

5.1 Hospital Quality Assurance

Hospitals within BUPA's Hospital Network are required to adhere to a wide range of explicit quality standards. This may be complemented by the achievement of externally validated quality assurance standards such as King's Fund accreditation.

5.2 Quality Assurance Inspections

By June of this year, BUPA will have completed an exercise whereby all hospitals which are not part of its network will have completed a detailed quality validation covering patient, service and business practice issues. This will include inspection by quality assurance teams from BUPA of all hospitals whose quality of service is questionable. Hospitals which are unable to meet BUPA's quality standards will no longer be contracted with as BUPA providers..

5.3 Year 2000

In order to assure continuity of patient care and service delivery BUPA Membership has been undertaking a comprehensive and detailed internal review of its Year 2000 compliance and that of its many hundreds of external suppliers.

5.4 BUPA Consultant Partnership

The BUPA Consultant Partnership was established in April 1997. Members treated by consultant partners benefit from the reassurance that all their bills will be covered in full. Consultant Partners also commit explicitly to engaging in clinical audit and continuing medical education. So far 5,000 consultants have joined the Partnership.

5.5 Breast Care Network

BUPA Membership have created a network of 150 BUPA Approved Breast Care Units which deliver care according to the recommendations of the British Association of Surgical Oncology and the Clinical Outcomes Group. Hospitals which did not achieve recognition as a BABCU are no longer eligible to treat BUPA members with breast cancer.

5.6 Cardiac Services

BUPA Membership have established performance based contracts for the delivery of cardiac surgery and invasive cardiology at selected hospitals within Greater London. Contracts specify quality criteria ranging from levels of nursing skill and medical cover, to desirable volumes of work as specified by the British Cardiac Society.

In 1998 BUPA Membership funded the establishment of a national register of cardiac outcomes.