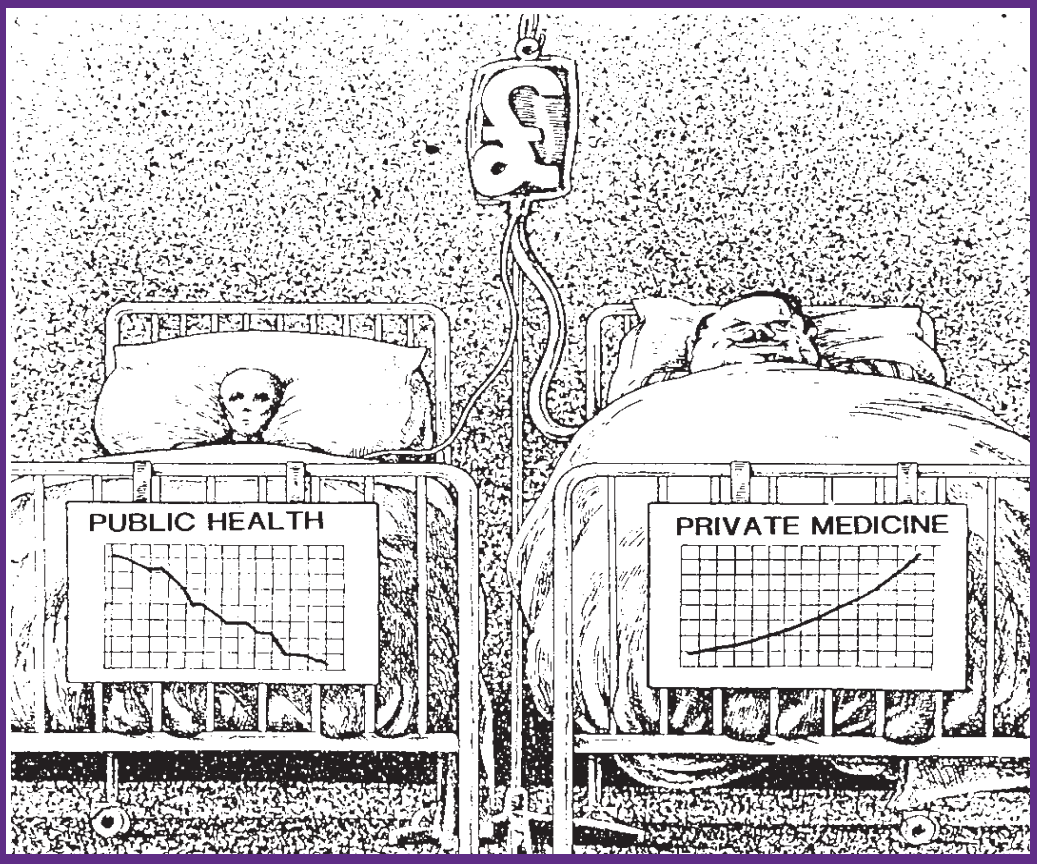
How much are private patients costing the NHS?



An investigation of hospital trusts in UNISON's Eastern Region

By John Lister

UNISON

How much are private patients costing NHS?

It's time for a thorough, public, audit of the value for money of NHS hospital private patient units, as new doubts have emerged over the costs and the balance sheet of services shrouded in secrecy.

For many people the idea of using taxpayer-funded buildings and resources, and the highly skilled teams which can only be found in NHS hospitals, to deliver privileged access to health care for those able to pay the cost of treatment or make use of private medical insurance is inherently wrong.

But even for those who have embraced Nye Bevan's historic compromise that in 1948 stuffed the mouths of hospital consultants with gold, and allowed them to continue to treat private patients in private beds within newly-nationalised NHS hospitals, the stipulation has to be that such services must not be allowed to get in the way of the real business of the NHS – providing a comprehensive service to all on the basis of clinical need, not ability to pay, with treatment paid for collectively through general taxation rather than at point of use.

In other words what private treatment does take place within the NHS needs to more than pay its way, and generate a surplus, to justify its access to the various sophisticated support services of NHS hospitals – no equivalent of which is available in private hospitals.

However our recent research gives grounds for concern that this is not always the case: and that trust boards and the local bodies which are supposed to scrutinise the working of the NHS are allowing themselves to be kept in the dark on the real situation.

In patchy answers to requests made by health union UNISON under the Freedom of Information Act, 14 NHS hospital trusts in the East of England[1] have revealed that they treated almost 10,000 private patients in 2017, for which they invoiced for just under £12m in charges.

However the same responses also revealed that few of the trusts know what the associated costs of delivering this care add up to, or how many staff are employed to look after paying patients.

This lack of information raises the real possibility that one or more of these Trusts are running private treatment that delivers preferential care to a minority of patients who are willing and able to pay (or who are covered by private insurance), at the expense of depleting or diverting resources for the services provided to the vast majority of NHS patients.

This comes at a time when staffing levels in NHS services in England are under serious strain, and the NHS is facing 100,000 vacancies even before the predicted Brexit exodus of qualified

[1] Covering Bedfordshire, Hertfordshire, Essex, Suffolk, Cambridgeshire and Norfolk

staff; in addition NHS hospitals are struggling through peak demand with front line beds often close to 100% occupied.

Bedford Hospital Trust, one of those studied in this report, had 100% of its beds occupied in the normally quieter period April-June 2018. So the NHS is in no position to shoulder unnecessary costs or strain on its already over-stretched resources. Any level of losses or potential losses on delivering private patient services is an especially serious problem.

Previous reports

In 2009 an investigation by journalist Sally Gainsbury for the *Health Service Journal* found that "up to 30 per cent of patients who pay to receive private treatment in NHS hospitals are charged less than their care costs the trust."[2]

It is worth noting that this estimate was based on costs *excluding* "the extra costs of single rooms, VAT and higher levels of nursing and domestic staff for private patients," which the UNISON investigation was also hoping to identify.

The charges levied by the minority of trusts which responded were compared with estimated overhead costs and the NHS standard tariff price paid to trusts for each treatment, and Gainsbury shows that in many cases private patients were not even paying the basic tariff cost of the operation, let alone anything for their stay in hospital.

However none of the detail of these services is published in the very general figures included with trusts' annual reports and accounts, nor are they reported in detail to trust board meetings. Nor are any of the business plans for the dedicated private patient units that have been set up by trusts and foundation trusts over the years in the public domain.

Because these details on how large-scale public sector resources are used are not published, the only way to draw out such data is the Freedom of Information Act.

UNISON's investigation, focused on the acute hospital trusts in just one region of the country, shows that many of the problems identified back in 2009 and by previous critics before that have still not been addressed. Yet the one principle that has been supposedly central to any provision or expansion of private medicine was the one set out in a Department of Health 'Code of Conduct on Private Practice' back in 2004:

> **"The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services."[3]**

In March 2018 a separate, national study by Dr Sarah Walpole for the Centre for Health in the Public Interest (CHPI) found many NHS hospitals have increased their overall income from

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[2] Gainsbury S. (2009) NHS cash subsidises private patient care, *Health Service Journal* 21 May, available (£) https://www.hsj.co.uk/acute-care/nhs-cash-subsidises-private-patient-care/5001681.article

[3] Department of Health (2004) A Code of Conduct for Private Practice Guidance for NHS Medical Staff, available http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4100702.pdf

private patients, but that there was still a "lack of proper accounting" for the income and expenditure involved in services for private patients. Worse still:

> **"Nine of the 41 trusts who provided data were making a loss on these services in "some or all of the years from 2010/11 to 2015/16…. one had lost a staggering £18m over the six-year period."[4]**

The Eastern Region survey

On March 2 2018 UNISON Eastern Regional Head of Health Sasha Pearce wrote to 14 acute trusts, invoking the Freedom of Information Act, and asking them to answer six questions:

- The number of private patients treated during 2017
- How many of these patients required treatment under anaesthetic
- What specialist services were involved in treating private patients
- Whether patients who stayed in hospital after surgery were accommodated on NHS or private wards
- How many medical and non-medical staff were involved in the provision of treatments (including cleaning, catering and other hotel services and administration)
- The whole cost of the treatment and hospital stay
- The amount billed to health insurers or to patients

The replies[5] varied in tone and content: one or two trusts came back promptly, others dragged their heels and delayed beyond the FoI deadlines … and **Norfolk & Norwich Hospitals Foundation Trust** has yet to send over the promised information after offering weak excuses for previous failures to respond. Yet Norfolk & Norwich's Annual Report reveals that it collected almost £1.4m from treatment of private patients in 2017-18, down from £1.6m the year before.

In the event not one of the 14 trusts answered all of the questions. The majority of them insisted they either did not collect or could not easily access any data on some of the key questions raised.

Some trusts have played fast and loose with their obligations under the Act, hiding behind its provisions, by claiming that to collect the request information would be complex, time consuming and expensive.

It's not clear whether the trusts which argued this will have recognised their own mistake: that by stressing how complicated and drawn-out the process would be to assemble the

[4] Walpole, S. (2018) NHS treatment of private patients: the impact on NHS finances and NHS patient care, CHPI, March, available https://chpi.org.uk/wp-content/uploads/2018/03/CHPI-NHS-Private-Patients-Mar18.pdf.

[5] All of the exchanges in relation to this are now accessible in the public domain at https://www.whatdotheyknow.com/user/sasha_pearce/requests

requested information, they were in fact confirming UNISON's suspicions that the data are not being properly collected, monitored, scrutinised and reported.

Some trusts eventually and grudgingly handed over partial information very late. A number of the requests for information that yielded unsatisfactory answers are still technically undergoing a review six months later – although it would be unwise to cherish any real hope that the required information will emerge at the end of this.

It's clear from all of the answers (summarised in table form on page 14 below) that the way in which private patient services are administered makes it very difficult for most trusts in the region to keep track of costs and resources used.

Good practice in estimating costs of private care

In July 2017 NHS Shared Business Services published a brief document setting out the potential business case for hiring in a prefabricated 16-bed Private Patient Unit[6].

This is useful and interesting for this discussion, since it itemises the key costs of running such a unit (bearing in mind that 16 beds is larger than most of the private patient facilities covered in this report, so the actual numbers are not of any use).

Among the relevant headings for revenue costs are:

- **Ward pay** ("inclusive of all Nursing wages from Ward Sister, Senior Staff Nurse and Healthcare Assistants to admin staff such as Ward Clerk and Housekeeper")
- **Ward overheads non-pay** ("essentials for the day to day functioning of the ward, but also include the luxuries that are typical of a Private Patient Standard facility. These include Drugs, Dressings, Medical Gases along with Newspapers, Telecommunications/WiFi, Food and Refreshments")
- **Theatre costs** ("calculated based on both pay and non-pay per Theatre hour (£304.70), then cross reference with the amount of time it takes per procedure").

The numbers included in the NHS SBS document may not be relevant to the specific services and units in the East of England under discussion in our report: but it's reasonable to assume that some element of each of these costs will inevitably be incurred by any provision of private medical treatment, especially where this takes place in a dedicated PPU.

It is therefore quite possible – and necessary – for NHS trusts to make their own working estimates of what these costs are (even if the non-clinical staff spend only a fraction of their time on such patients and areas). Without such estimated costs, the calculation of a fee that will more than cover these costs is impossible – effectively reduced to guesswork.

[6] Executive Summary only available, at http://www.healthcarehire.co.uk/pdfs/MCH-PPU-ExecSummary.pdf

However a serious approach to private patient income as a source of profit for reinvestment in the trust also requires each private patient transaction to deliver an adequate rate of return to justify the application of NHS resources that might otherwise be more productively used attending to the majority of NHS patients.

A 2014 Business case produced for St George's Hospital in London also brought a degree of reality to bear in discussing the need to set a high target for the profit margin for its operations. It spelled out their approach quite clearly, and the aim:

> "to increase returns by focussing on **higher margin private patient activity with minimum margins of 40%** unless agreed at a lower rate for strategic reasons"[7]

As will be seen from the available figures below, there are serious grounds to doubt whether the trusts in East of England are generating any significant return at all, and nothing to suggest that the real profit margin is anything approaching the 40% level.

Costs of delivering private care

Ten out of the 13 trusts responding with data were unable or unwilling to show what the total costs were of delivering private treatment. Several trusts admitted that this information was simply "not collected" or "not available" (which might mean the same thing).

A few trusts gave deliberately evasive answers ("private patients are treated alongside NHS patients and costs are not directly attributable to them;" "the cost to our NHS trust should be zero, as all this is picked up privately"). One trust chose to invoke "commercial confidentiality" to conceal both the costs and the amount billed. This secrecy reinforces concerns that the trust could knowingly or unwittingly be hiding a deficit, using a wall of silence to cover up a complete absence of financial scrutiny.

When specifically asked how many medical and non-medical staff were involved in the provision of private treatment, only three trusts offered any data: the other 11 trusts responded that the information was either not available or too complex and costly a job to uncover. This was true even of trusts which run separate private patient facilities.

Case studies

The specialist **PAPWORTH HOSPITAL**, which is not included in this survey, was identified in the recent CHPI report as the most heavily involved in private medicine in the East of England (turning over £7.5m in 2015/16, equivalent to 5.6% of its total trust income).

[7] Outline Business Case for a Private Patient Unit (PPU) p5, available https://www.stgeorges.nhs.uk/wp-content/uploads/2014/01/4.3-TBR-14-3-Private-Patient-Unit-OBC-v07.pdf

However among the acute Trusts studied in this report, **CAMBRIDGE UNIVERSITY HOSPITALS FOUNDATION TRUST (CUH)** is by far the region's largest player in private medicine in terms of revenue.

An attempt to further expand this with the building of a new £120m 90-bed private hospital right next to Addenbrookes in partnership with Australian private health corporation Ramsay Health Care collapsed in the autumn of 2016. Ramsay were to have put up the capital and run the hospital, while the Trust argued in justification that it would benefit from "an additional flow of income to support NHS work" and from keeping up to 200 consultants who otherwise leave the campus to treat private patients much closer to the trust and their NHS patients[8].

CUH now runs the Cambridge Heart Clinic jointly with Regent's Park Heart Clinics Ltd. But to judge from its response to the FoI request, the Trust appears to be unable to provide almost any of the data requested by UNISON.

The Trust's response argued that the data requested is "not held centrally" by the Trust, and could only be extracted by reviewing "the individual medical records for all private patients over the last 12 month period". The information was limited to a ball park total of 2,024 patients invoiced in 3,478 transactions during 2017, generating invoices totalling over £5.3m (this is a less than 1% of the trust's total income of £662m in 2017/18).

However since there is no corresponding information on the costs incurred by running the Cambridge Heart Clinic, and even less detail forthcoming on other private patient services in the Trust, it is impossible to tell if this income represents a net benefit to the Trust – or the service is running at a deficit. Unless reports are published to the closed sessions of the Trust Board it seems likely the Board's own directors are equally in the dark.

Indeed the figure sent by CUH in reply to the FoI request is at variance with the figures for treatment of private patients in the Annual Report and Accounts, which shows private patient income over a different 12-month period as £6.4m in 2017/18, down from the previous year's figure of £7m. Both figures are higher than the figure given to our request. It's not clear why this discrepancy arises, but given the lack of data from CUH in response to most of the other questions asked, there are reasons to believe that there are weaknesses in the reporting of this area of activity.

It is difficult to believe that the Trust's Private Patient Team could realistically issue bills on the basis of the information they now claim not to have available.

Without any clear statement of what costs and charges the invoices are supposed to cover, it's questionable whether they would easily secure payment from insurance companies that are notoriously eager to find excuses not to pay out, or from individuals who will also be keen to see how the cost has arisen.

[8] https://www.cambridge-news.co.uk/news/cambridge-news/healthcare-firm-pulls-out-120m-12052497

The exceptions: trusts volunteering information

Two notable exceptions which chose to answer questions on the costs of private treatment and on the corresponding amount of invoices to patients or insurance companies were Luton and Dunstable and North West Anglia Foundation Trust. Both were able to put a figure on the costs they had incurred (£1.63m and £1.02m respectively).

LUTON & DUNSTABLE HOSPITAL FOUNDATION TRUST reported billing £1.83m to insurance companies for treating 597 private patients. This gives an average charge of £3,100 per patient – and an apparent average surplus per patient of just £335. This is an exceedingly small return for provision of care, especially for the 478 patients whose bed was in the Trust's Cobham Clinic.

This small unit has 13 en-suite single rooms offering "personal and friendly care in first class facilities". Unlike private hospitals, the unit boasts of "24 hour access to ITU and HDU beds should they be necessary, as well as MRI, CT and Ultrasound scanners and twelve operating theatres."

The cost of staffing, cleaning, maintaining, servicing and catering for this "first class" unit is inevitably higher than the average NHS ward: yet if the figures are correct, the enhanced service is virtually given away to private patients even in this trust where at least some overall tally has been kept of costs.

In **NW ANGLIA FOUNDATION TRUST** (a merged trust covering Peterborough and Stamford hospitals and Hinchingbrooke Hospital in Huntingdon) 1,054 private outpatients and 278 private inpatients generated bills totalling £1.7m, yielding an apparent margin of almost £700,000. Patients are assured that "any profit is reinvested in the hospital".

How much profit there really is, however, is still in doubt, not least because of the Trust's lack of data on how many staff are required to deliver the service, which is lavish by NHS standards.

While NW Anglia was the only trust to give an overall total of staff employed to deliver the private services (16.2), their response makes clear that this does not include cleaning or catering staff numbers since "there are no staff employed specifically for these duties for private patients". However this latter statement conflicts with the marketing claims made by the Trust itself.

While Peterborough City Hospital has no separate private ward, the majority of NW Anglia's private patients were treated at the smaller Hinchingbrooke Hospital, in the dedicated private patient unit, the Mulberry Suite, which according to the figures released appears to have accommodated just 425 inpatients in 2017, although 7 dedicated beds are available, giving a leisurely average of just 60 patients per bed per year, or just over 1 patient per bed per week.

The Trust's own online advertising promoting the merits of the Mulberry Suite implies that it has its own "enhanced menu," which presumably is freshly cooked and produced by its own catering team:

> "Our appetising, wide and varied menu offers delectable cuisine incorporating … the freshest and finest ingredients from local suppliers. Prior arrangement can be made for the patient to invite a guest to dine with them.
>
> "We offer a newly renovated 7-bedded en-suite dedicated private patient ward for elective patients from both the local and international market requiring surgery. "Accommodation only" is an option for patients who wish to have their surgery through the NHS but then pay for one of our rooms. The benefits of this would be a private room with en-suite facilities on Mulberry Private Ward, Sky-television, open visiting, free car-parking, daily newspaper, access to £5 of telephone calls and an enhanced menu.
>
> "The cost for this option is currently £325 per day."

So the question remains: are *all* of the costs and *all* of the staff involved in delivering *all* of the private health care in NW Anglia Trust covered by the figures in the FoI response? Or is this only part of the picture? And how can it possibly be cost-efficient to run these enhanced facilities at such low bed occupancy, when the trust as a whole is running under massive pressure at peak times?

Is anyone at Trust Board level aware of the full picture, and can anyone demonstrate with clear figures that the various private patient services generate a real surplus for the Trust and are not incurring losses that would prejudice the care of NHS patients?

SOUTHEND HOSPITAL FOUNDATION TRUST is the only other trust of the 14 to offer a costing for their provision of private treatment. While refusing to divulge how much they aimed to recoup in charges, they are willing to say that the treatment of 252 private patients cost the trust £211,000 – an average cost of £837 each.

However no data is provided on what specialist treatment these patients received, or how many of them were treated under anaesthetic or stayed overnight or longer in hospital.

The relatively low average figure suggests the majority of these patients received only diagnostic or outpatient treatment, since the tariffs for other NHS private patient units include very few surgical interventions at less than £2,000. In fact Southend won't even tell us what specialties were involved in private treatment. So without more details it is impossible to be sure that these services are not running at a loss.

The rule: trusts which fail to respond on key issues

The larger units that were not able or willing to give a cost of delivering private care but did give a total for invoices issued included **WEST SUFFOLK HOSPITAL** (1,321 private patients, generating bills of just £104,757) and Cambridge University (2,024 patients, discussed above).

The largest private caseload of the 14 trusts in east of England is at **BEDFORD HOSPITAL** which treated 2,050 private patients in 2017, 606 of whom had treatment under anaesthetic and 253 of whom spent time in an NHS ward. The Trust issued bills to insurance companies adding up to £1.54m.

Bedford is one of the most forthcoming in showing the breakdown of private caseload between the various specialist services, but even in this trust the absence of any data on staffing and any estimate of the costs of providing the service to private patients raises the question of whether and how accurate bills can be sent out, and how the trust can be sure the service is running at a profit and not draining further resources from an already deficit-ridden trust. The lack of data on staff and costs is especially puzzling since the Trust runs much of this work through a dedicated PPU, the Bridges Clinic, which has:

> "6 private consulting rooms, located at Bridges House on the Bedford Hospital South Wing site, offering free parking for private patients, comfortable reception and waiting area with complimentary tea and coffee, as well as a welcoming team to guide you through your healthcare journey."

It is surely reasonable to expect that this unit would keep a firm track of the costs, the beds and the staffing it uses, and a clear view of the theatre time required for the treatment it was delivering. However given the limited numbers of patients using these lavish facilities (6 consulting rooms and all the reserved space to deal with fewer than 40 patients a week, and an average of just 12 private operations per week) it's questionable whether the scale of provision is justified by the demand.

Puzzles and inconsistencies

Perhaps the biggest puzzle is **BASILDON & THURROCK HOSPITALS FOUNDATION TRUST'S** private Nash Basildon unit, offering:

> "the additional comfort, flexibility and choice of private care with the 24/7 back-up of The Essex Cardiothoracic Centre, a leading NHS centre … At Nash Basildon, you can access a wide range of specialist treatments for heart and lung conditions, from diagnostic investigations to major heart surgery"

We might assume that such expertise and special treatment don't come cheap: but according to the Trust, the total billed to health insurance companies was just £23,017 in 2017, for 9 inpatients and 178 outpatients.

This is completely at variance with the figures in the latest (2017-18) annual report and accounts, which shows private patient income up to £2.9m from just £479,000 the previous year. It's clear that whoever has responded to the FoI request has either mistakenly or deliberately supplied the wrong information.

Either way, a substantial private patient unit is running in a major NHS trust, and almost £3m worth of activity is taking place with no apparent scrutiny from the Board – and there is no

public accounting to show that it is not "prejudicing the interests of NHS patients" by running at a loss, and draining resources from patient care in the remainder of the Trust.

In similar fashion, **JAMES PAGET HOSPITAL'S** Charnwood Suite for private patients offers its 306 paying customers:

> "a dedicated private unit with eight single en-suite rooms and one consulting room, providing nursing services and accommodation for private and amenity patients. We have a small, professional team of nurses and healthcare assistants who strive to provide the highest standards of care throughout your stay."

A slightly muddled list of special services available to private patients includes:

> "Single, en-suite accommodation with nurse call system; Flat screen LCD TV; Telephone; Private menu; Open visiting with protected meal times; Pre-operative assessment clinic; Pre-operative and post-operative care; Follow up care including suture removal and wound checks and Wifi"

We might hope that the clinical elements of this are also available to NHS patients, but it's clear that a dedicated private unit is offering a touch of luxury to those able to pay: the menu of operations available ranges upwards in price from carpal tunnel release at £1951 to hip and knee replacements and breast enlargement – all at more than £5,700.

Yet the trust's reply to the FoI does not reveal how many staff make up the "small professional team", how much the unit costs to run, or how much is invoiced to the 306 patients who received treatment in the unit. The Trust's most recent annual Financial Statements show private patient income for 2017-18 at just over £1m: is that enough to cover the bills?

Indeed for patients making use of the Charnwood Suite it must be a rather eerie experience, since the average of just 6 patients per week are rattling around in a unit with 8 beds, most of which must be empty most of the time.

The James Paget response perhaps understandably ducks the question of how much has been charged over the year for treatment at this unit. They replied instead that they do not invoice insurance companies because "invoices are raised and billed direct to the patient". No figure is given for the amount billed to patients either.

So does the Charnwood Suite make a profit? Or a loss? Does the trust know whether it makes a profit or not? Does anybody on the trust board even ask the question?

Another riddle is the partial response from the newly-merged **EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST,** which comprises the former Colchester Hospital Foundation Trust and Ipswich Hospital. The response covers only Colchester Hospital, only answers some of the questions, and only gives a figure for bills issued to insurance companies, leaving us to guess how many self-pay patients have not been included.

The response indicates that 586 private patients were seen at **COLCHESTER**, just under half of them treated as inpatients, and just £335,000 billed to insurance companies. This would give an average fee of just £571 each, so it's clear that a lump of further invoicing direct to "self-pay" patients has been left out of the reply.

However we also know from its Annual Report that **IPSWICH HOSPITAL** had its own, slightly larger private patient business, with income of £687,000 in 2016-17, up from the previous year. So it's likely the combined East Suffolk and North Essex Trust will have private patient turnover in excess of £1m per year, but incurring unknown costs and operating on undisclosed margins with an unknown number of staff.

The neighbouring **MID ESSEX HOSPITALS TRUST** appears to have treated 646 private patients in 2017. But in response to the question how much these services cost the Trust to deliver, the answer was either a profession of ignorance or an evasion:

> "Not able to provide a meaningful response to this question without further detail."

It's hard to imagine any other area of activity of the Trust where the question of how much the service costs should be seen as in any way confusing. Perhaps it is embarrassment at the fact the Trust appears to have no idea of how much it is spending on care of private patients that leads to a further non-answer on how much they have been billing insurers and patients:

> "Private Health providers are billed as per agreed tariff "

This answer not only fails to give any figures for comparison with other trusts, but also raises the question of whether private insurers are only being charged the standard NHS tariff price for treatment in Mid Essex – which would effectively leave the Trust subsidising the private sector – or whether there is a separate tariff for private treatment.

EAST AND NORTH HERTFORDSHIRE HOSPITALS TRUST reported treating 372 private patients, 361 of whom had treatment under anaesthetic. The Trust's website makes no reference to any private ward or clinic, but claims:

> "Our Trust offers a wide range of competitively priced private inpatient and outpatient services across all four of our hospital sites."

It seems that although it has no data on numbers of staff involved or the costs of delivering the private treatment, the Trust billed patients for £139,588 and insurance companies £822,873, giving an overall average bill of £2,600 per private patient.

Conclusion

There is genuine cause for concern that the information that is missing or withheld could well reveal that one or more, even possibly all of the private patient units and all of the private treatment provided by NHS trusts in the East of England could be running at a loss, or generating a bare minimum return inadequate to justify the assets it requires.

The absence of clear business cases, balance sheets and ready responses to straightforward questions is a warning sign that must be taken seriously at a time when the limited resources of the NHS are under ever-increasing strain.

Three of the region's trusts (Luton & Dunstable, North West Anglia and James Paget) run Private Patient Units, each of them at extremely low levels of utilisation and occupancy overnight. The least utilised is Luton's 13 bed unit, running at just 36 inpatients per bed per year – less than one patient per bed per week. James Paget is only fractionally better used, with just 38 patients per bed per year: but even in North West Anglia's Mulberry Unit in Hinchingbrooke Hospital the 7 beds are used by just 425 patients per year, just over one patient per bed per week.

It is hard to see the justification for dedicated beds, wards and staff being diverted into providing such little-used services, especially when mainstream NHS services are under such strain and the apparent financial return to the NHS is so low, and possibly non-existent.

For any money to be lost by trusts in delivering private care, for staff to be ineffectively employed or for beds in private wards to be only partially or infrequently used while acute beds are in such short supply at peak times would be in breach of the Department of Health's key guideline that the interests of NHS patients must not be prejudiced by treating private patients.

Unpaid bills

A further question which should be pursued through a separate FoI enquiry is the scale of unpaid bills and bad debts incurred by these and other trusts after invoicing "self-pay" patients for their care. In some cases such failures to pay might be mitigated by requirements to pay up-front and in advance for treatment, but the CHPI report highlights the scale of some of the debts written off by the trusts most involved in private patient activity. In Guy's and St Thomas' Hospital Foundation Trust 300 debts adding up to £407,000 were written off in 2015/16, while Chelsea and Westminster Hospital FT wrote off 647 bad debts totalling £251,000. In each case the numbers of bad debts had sharply risen from the year before.

UNISON would prefer the NHS not to engage at all with treating private patients: but if any such activity is to take place, we need to ensure it demonstrably delivers a tangible and significant material contribution to the NHS, and does not drain NHS resources.

Given the stresses and strains on NHS staff and on the finances and resources of NHS trusts at present, the lengthening queue of patients waiting for treatment and the prospect of longer waiting times for elective care, the case is clear for a full-scale public audit of the scale, costs and income from private patients in every trust that has developed this work. As the CHPI report concluded;

> "To ensure adherence to the values of the NHS, including equity of access and quality of care, and to ensure financial sustainability, NHS hospital trusts should be required

to measure, record and report the costs of, and income from, the treatment of private patients."

Even though the trusts are technically in competition with private hospitals, it's clear the NHS hospitals are offering a unique depth of service, and we must not accept any appeals to "commercial confidentiality" or business secrets in the way these public assets are deployed.

The books must be fully opened – to the trust boards, to scrutiny bodies, regulators, governors of FTs and to the wider public. Where necessary additional admin staff may be required to keep tight control over costs and resources of private treatment and ensure these are more than covered by the resulting bill.

The onus must be on each trust to make the case for treating private patients, and to show value for money for the NHS of the expenditure, staff time, accommodation and resources in terms of the effective use of the beds, adequate productivity of staff and the return on investment.

Where this case is not proven, private patient activity must cease, with staff transferred into mainstream services within the hospital and any bed, office or reception space reallocated to regular NHS activity.

Moreover as long as the operation of a 2-tier service and the provision of clinical care on a commercial basis by NHS trusts continues, there should be at least a recognition of the need for equal and fair charging. It's clear from the tariffs of charges that have been published by a few trusts in East of England that there is considerable variation in prices charged by different NHS PPUs for similar operations and treatment.

The audit should therefore also investigate the amount charged to patients and health insurers – to ensure that the rates are sufficiently above the basic NHS tariff – and enough to ensure the activity generates significant resources to be reinvested in NHS care.

A future government will need to address these issues, with new legislation to reverse the Health and Social Care Act, reintegrate the NHS, alongside a substantial injection of cash and bold policies to win back, train, recruit and retain sufficient staff to enable NHS trusts once again to bring down waiting lists and waiting times and eliminate the pressure on patients to seek private treatment.

Drafted for UNISON by John Lister, September 6 2018

Eastern Region Roundup

Trust	Total private patients	Patients needing GA/LA	Patients stayed on NHS ward	Patients stayed on Private ward	Staff involved	Whole cost of care (£000s)	Amount billed insurer (£000)	Billed to patients (£000)
Bedford	2050	606	253	no data	no data	no data	1,504	0
Basildon	187	10	9	no data	no data	no data	23	no data
East Suffolk	586	250	250	no ward	no data	no data	334	no data
Cambridge	2024	no data	no data	no data	no data	no data	5,331	no data
E&N Herts	372	361	no data	no ward	4 admin	no data	823	140
James Paget	337	326	31	306	no data	no data	no data	no data
Luton & Dunstable	597	no data	119	478	29	1,630	1,830	no data
Mid Essex	646	no data	no data	no ward	no data	no data	no data	no data
Norfolk & Norwich No data supplied: initial response blamed bad weather!								
NW Anglia	1332	350	no data	425	16.2	1,018	925	791
QEH Kings Lynn	20	0	no data	no ward	no data	no data	no data	no data
Southend	252	no data	no data	no ward	no data	211	no data	no data
West Herts	152	no data	152	0	no data	no data	no data	no data
West Suffolk	1321	19	19	no ward	no data	no data	105	no data
Totals	9876	1922	833	1209		2,859	10,875	931