Clinical governance arrangements between NHS and independent acute hospitals in England: findings from a national survey of senior leaders

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Summary of key findings

This report presents the detailed findings of a national survey of senior leaders in NHS and independent acute hospitals in England about how clinical governance, quality safety arrangements work between them. A growing volume of NHS funded care is now delivered in independent hospitals, and pathways of care increasingly cross both sectors. Most of the medical consultants who work in independent hospitals have their main employment in an NHS hospital, which has the legal responsibility for oversight of their whole scope practice, including work in the independent sector. There have been a number of reports and inquiries which have highlighted the need for strong, shared arrangements for clinical governance. The key findings from the survey are summarised below – there is much more detail in the main findings section itself. The survey methods, response rate and analysis are described in Annex A.

Arrangements for shared clinical governance between NHS and independent hospitals

- Most independent hospital respondents report that the consultants working at their hospital come from multiple NHS hospitals/trusts, while NHS hospital respondents tend to say that their consultants who undertake private practice mostly work at just one or two local independent hospitals. But NHS hospital respondents were more likely to say they didn't know which of their consultant worked in private practice, or what independent hospitals their consultants also worked at.

- Both NHS and independent hospital respondents reported that they had some contacts with the hospitals in the "other" sector, but only around 1 in 5 said they had a formal agreement or policy on shared arrangements for clinical governance. They both reported having some meetings – often relatively ad hoc or infrequent. Independent hospital respondents reported more meetings and were more likely to say they were formal/minuted than NHS respondents. Overall, independent hospital respondents rated the arrangements for shared clinical governance more positively than those from the NHS.

- One NHS respondent said: *"The two main private hospitals nearby, we have reasonable relationships. I made an effort as CMO to reach out to all local private hospitals, with varying degrees of success. It is all very ad hoc. I have had this conversation with the GMC ELA and RO meetings, that the flow of information and collaborative working needs to improve."* Similarly, one independent hospital respondent said: *"Inconsistent - some are excellent and others less so. Regular meetings and shared learning happen between some hospitals and their local NHS trust. In some localities this is even broader with good relationships across all providers in the ICB region. Some hospitals really struggle to get good collaboration with the local NHS trust."*

Sharing information about consultants' scope of practice

- The arrangements for sharing information about consultants' scope of practice between sectors were quite variable. NHS respondents mostly reported this was done as part of annual appraisals, where a consultant would report on their private practice and in some cases provide a "letter of good standing" from the independent hospital(s) where they worked. Independent hospital respondents largely said that consultants provided information on their NHS scope of practice when they were applying for practising privileges at the independent hospital, and this was sometimes supported by a letter or report from their NHS hospital, or by information from national registries (like the National Joint Registry).

- The arrangements for sharing information about scope of practice, and respondents' confidence in the information they had, varied with more concern generally from NHS respondents. Respondents called for higher quality data, improved communication and information sharing and more robust, formalised and standardised processes. A number of suggestions for improvements were made including: mutual access to appraisal records; a centralised data repository; scope of practice statements with defined level of detail signed by all employers and the consultant; and improved systems and processes for the sharing of information in sufficient detail about consultant practice.

- One NHS respondent said: *"Improvement should involve a bidirectional interface - full NHS scope of practice can come from the Director of Service (DoS) for consultants and last 5 years of practical experience. This could be replicated by private providers. It is not just the scope of practice, rather the complications that are managed and clear understanding of outliers is useful… [Better data sharing] could lead to high quality assurance for patient care within both sectors and comply with the Paterson outcomes."*

Dealing with concerns about consultants' practice

- Over three quarters of respondents from NHS and nearly all respondents from the independent sector reported that their organisations had a policy on handling consultant concerns. Under two thirds of NHS respondents compared with nearly all independent sector respondents reported that the policy included a process for sharing information about consultant concerns with the other sector hospital(s).

- Both NHS and independent hospital respondents said that concerns were shared through Responsible Officers, medical directors or hospital directors – usually by email, phone or using the MPIT (medical practice information transfer) form. They reported that consultants do not necessarily inform other hospitals when there is a concern, problem, restriction on practice or other action involving them at a particular hospital.

- Respondents felt that because the process for sharing concerns was not mandatory and unregulated it was under resourced and this made it harder to verify information. Strong relationships between the sectors resulted in effective communication but a lot of communication was informal and undocumented. Both sectors stated that when there was not an established relationship it was not always clear who to contact. Independent sector respondents stated that it was often difficult to get information from the NHS or engage the NHS.

- Asked about the sharing of significant concerns, interim restrictions on practice, substantive restrictions on practice, suspension/exclusion, and referrals to the GMC, both NHS and independent respondents indicated that these would often but not always be shared with hospitals in the other sector. But they also reported that they thought hospitals in the other sector were much less likely to share such significant concerns etc with them. When there were cases involving the GMC about a consultant's practice at another hospital, respondents were not confident that the GMC would always know that the consultant worked at their hospital and would inform them about the case.

- These issues are well illustrated by what one of our independent hospital respondents said: *"It is quite dependent on the individuals involved and the relationships they have… We therefore ask our Registered Managers to ensure they have a good relationship with the RO/medical staffing team in their local trust to try and ensure intelligence is shared. Many doctors do share information with us, but some do not. We also have a good relationship with our GMC liaison officer, who will keep us updated on aspects related to their investigations."*

Transferring patients and information between NHS and independent hospitals

- Patients are sometimes transferred – usually from an independent hospital to an NHS hospital, often because they need care that the independent hospital is not equipped to provide. While two thirds of independent hospital respondents reported that they had a patient transfer policy on sharing clinical information and records in these circumstances, only a quarter of NHS respondents said there was a policy in place. NHS respondents said they did not always get such information transferred.

- One NHS respondent said: *"Transfers are reliant on paper notes as the private sector still uses paper whilst the local NHS hospital is paperless. Most of the time the transfers either go direct to ITU or A&E after relevant phone calls have been completed."* An independent hospital respondent observed: *"We often rely on the consultants to liaise between us and the NHS as obtaining information from the NHS can be challenging and we are often told they can't update us because of patient confidentiality. Sometimes we just get told that the patient is 'comfortable'.*

Conclusions

Overall, respondents identified a number of challenges related to clinical governance at the interface between the NHS and the independent sector. Some respondents said that the relationships with the other sector were good and that arrangements were reasonably robust, however they often relied on goodwill and individual/personal relationships rather than being systematic. There was often a good relationship with one provider but less good relationships with others, and in those cases there was a greater reliance on the honesty and probity of individual consultants. Respondents in both sectors suggested that the "other sector" was not always willing to share information and seek to create good working relationships. Some NHS respondents were concerned about assurances from the independent sector about the quality of patient care especially at the post-operative stage.

Some NHS respondents felt that the NHS provided appraisal and revalidation services for consultants who do significant volumes of work privately and that this was something the private sector benefitted from. Some NHS respondents said that the independent sector had a lower threshold for restricting doctors practice as they do not need to deal with concerns through the Maintaining High Professional Standards in the NHS (MHPS) route. A number of independent sector respondents said that there could be better sharing of information between the sectors and that the compatibility of IT systems sometimes hindered visibility and information transfer. Some said they would welcome an update of national guidance on shared clinical governance arrangements, while others suggested that new shared arrangements for patient safety learning could lead to improvements in joint working and information flow in the future. Some respondents said that our research project provided much needed focus to these issues and that change would be welcomed and that the survey questions had prompted reflection and discussion on their clinical governance arrangements with the other sector with a view to improvements.

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Main findings

Responses and characteristics

A total of 593 senior leaders at NHS trusts and 176 leads at independent sector hospitals were surveyed and 320 usable responses were received (response rate 42%). This included 235 responses from individuals working in NHS trusts (response rate 40%) and 85 responses from individuals in independent hospitals (response rate 48%).

The survey was sent to senior leaders with clinical governance responsibilities in both sectors (see Table 1). The majority of the responses from the independent hospitals came from Hospital Directors (39%), Directors of Clinical Services (9%) and other roles (15%) e.g. Chief Operating Officer, Clinical Director. The majority of the responses from NHS trusts came from Chief Medical Officers (16%), Medical Directors (13%) and other roles (32%) e.g. Associate Director of Patient Safety, Associate Director of Quality.

Table 1. Respondent job roles in the NHS and independent sector

	Independent hospitals	NHS trusts
Chief Executive	6	3
Chief Medical Officer	4	38
Chief Nurse	3	21
Clinical Governance Lead	6	25
Director of Clinical Services	10	4
Director of Nursing	4	15
Hospital Director	33	9
Matron	1	0
Medical Director	3	31
Responsible Officer	2	14
Other	13	75
Total	**85**	**235**

Where consultants work

We asked senior leaders from NHS trusts how many independent hospitals their consultants also work at (see Table 2, Figure 1). More than a third of respondents from NHS trusts did not know how many independent hospitals their consultants work at. Just under a third of respondents reported that their consultants work at one independent

hospital and just under a quarter said they work at two independent hospitals. We asked senior leaders from independent hospitals how many NHS trusts their consultants come from (see Table 2, Figure 2). Nearly half of respondents said their consultants come from three or more trusts.

Table 2. Where consultants from the NHS and independent sector also work or come from in the other sector

Which of the following best describes the consultants that work at your organisation who also work in the other sector?	**Our consultants mainly work at one hospital/come from one trust**	**Our consultants mainly work at two hospitals/come from two trusts**	**Our consultants mainly work at three or more hospitals/come from three or more trusts**	**I don't know**	**Total**
NHS	69 (29.4)	53 (22.6)	32 (13.6)	81 (34.5)	235
Independent sector	27 (31.8)	16 (18.8)	39 (45.9)	3 (3.5)	85

Figure 1: Number of independent hospitals where NHS consultants work

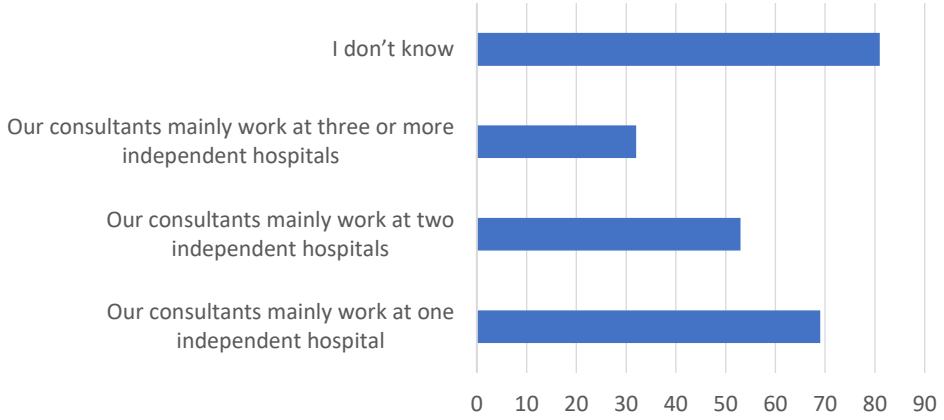
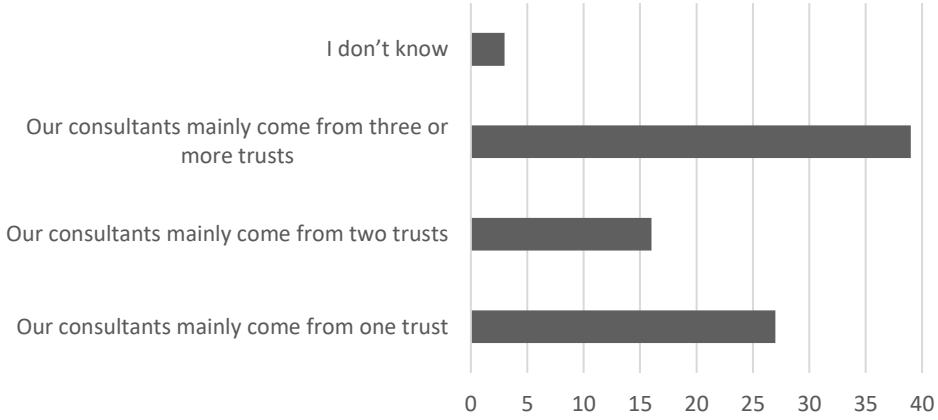


Figure 2: Number of NHS trusts where consultants from the independent hospital come from



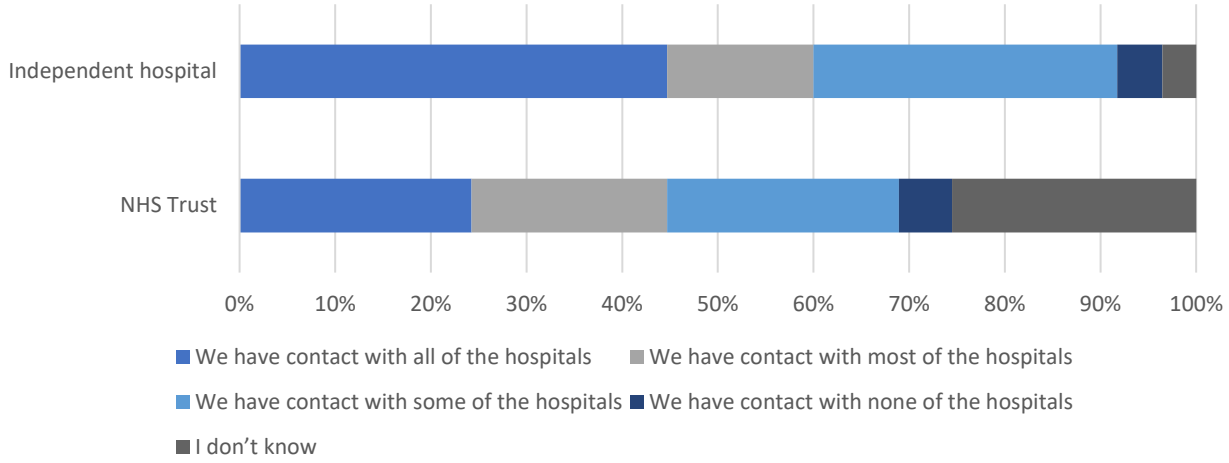
Contact with hospitals from the other sector

We asked senior leaders from NHS trusts and independent hospitals how much contact they have with the hospitals from the other sector where their consultants also work (see Table 3, Figure 3). A quarter of NHS respondents and nearly half of independent hospital respondents reported that they have contact with all the hospitals from the other sector. Very few respondents from either sector had contact with none of the hospitals.

Table 3. Contact between the NHS trusts and the independent hospitals

How many of the hospitals from the other sector do you have contact with?	**We have contact with all of the hospitals**	**We have contact with most of the hospitals**	**We have contact with some of the hospitals**	**We have contact with none of the hospitals**	**I don't know**	**Total**
NHS	57 (24.3)	48 (20.4)	57 (24.3)	13 (5.5)	60 (25.5)	235
Independent sector	38 (44.7)	13 (15.3)	27 (31.8)	4 (4.7)	3 (3.5)	85

Figure 3: Contact between the independent/NHS hospitals



Clinical governance relationships and arrangements between the sectors

We asked respondents if they have a formal agreement or policy in place with the other sector hospital on how you collaborate on clinical governance processes (Table 4). Over half of respondents from NHS and under three quarters of respondents from the independent sector reported that their organisations did not have a formal agreement in place with the other sector hospital.

Table 4. If there is a formal agreement or policy in place with the other sector hospital on how you collaborate on clinical governance processes

Do you have a formal agreement or policy in place with the independent hospital on how you collaborate on clinical governance processes?	**Yes**	**No**	**I don't know**	**Total**
NHS	33 (15.9)	114 (54.8)	61 (29.3)	208
Independent sector	18 (22.2)	58 (71.6)	5 (6.2)	81

We asked respondents if they meet with the other sector hospital about clinical governance (Table 5). Under a quarter of respondents from NHS and over a third of respondents from the independent sector reported that they met with the other sector hospital about clinical governance.

Table 5. Meeting with the other sector hospital on how you collaborate on clinical governance processes

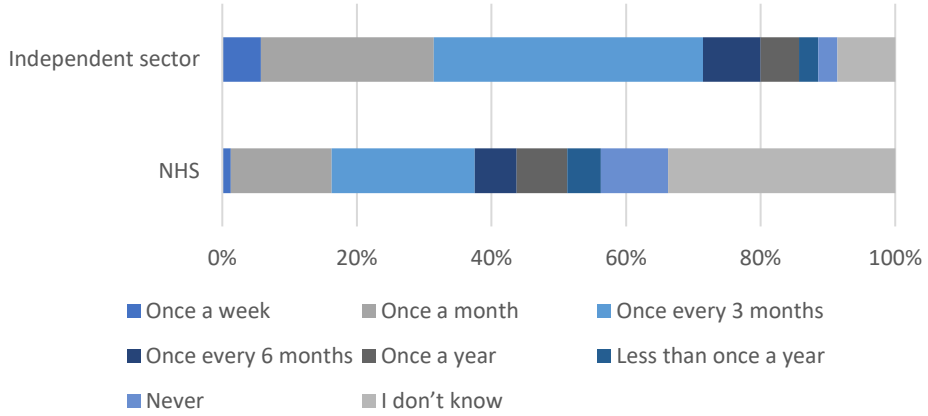
Do you meet with the other sector hospital about clinical governance?	**Yes**	**No**	**I don't know**	**Total**
NHS	48 (23.1)	124 (59.6)	36 (17.3)	208
Independent sector	30 (37.5)	46 (57.5)	4 (5.0)	80

We asked senior leaders in NHS trusts and independent hospitals how often they met staff with responsibility for clinical governance from the other sector hospital who they work with the most (Table 6, Figure 4). Answers were similar across the sectors with one fifth of NHS respondents and two fifths of independent sector respondents reporting meeting on average once every 3 months.

Table 6. How often they meet with staff responsible for clinical governance from the other sector hospital

On average, how often do you meet with staff responsible for clinical governance from the other sector hospital?	Once a week	Once a month	Once every 3 months	Once every 6 months	Once a year	Less than once a year	Never	I don't know	Total
NHS	1 (1.3)	12 (15.0)	17 (21.3)	5 (6.3)	6 (7.5)	4 (5.0)	8 (10.0)	27 (33.8)	80
Independent sector	2 (5.7)	9 (25.7)	14 (40.0)	3 (8.6)	2 (5.7)	1 (2.9)	1 (2.9)	3 (8.6)	35

Figure 4. How frequently the sectors meet about clinical governance



We asked senior leaders in NHS trusts and independent hospitals if meetings about clinical governance were formal (Table 7). Most respondents from the independent sector reported that the meetings were formal, whereas there was a fairly even spread across answer options from the NHS respondents, with over a quarter stating the meetings were formal, informal and both formal and informal, with the rest reporting that they did not know.

Table 7. Types of meetings between the sectors about clinical governance

Are these meetings formal (e.g., minuted, contractually required) or informal (e.g., ad hoc)?	Formal	Informal	Both formal and informal	I don't know	Total
NHS	50 (27.9)	48 (26.8)	48 (26.8)	33 (18.4)	179
Independent sector	73 (96.1)	2 (2.6)	1 (1.3)	0 (0)	76

We asked what happens at clinical governance meetings with the other sector hospital. Senior leaders reported that meetings were held mainly in order to discuss or in response to concerns or adverse events. Respondents reported that meetings did not usually include a formal report, that they were mainly informal and based on the sharing of verbal feedback but would sometimes include sharing information, reports or follow-up actions when required. Meetings were more frequent and more likely when there was NHS contracted work taking place at the independent hospital. Some stated that there was a more formal arrangement in place with the ICB who would organise meetings and receive regular reports.

> *"Meetings will be around governance concerns regarding staff employed within our organisations or if there were clinical/care concerns within the independent hospital." (Chief Medical Officer, NHS)*

> *"[Meetings] Happen when there is formal contracted NHS work happening in private hospital. Do not happen otherwise." (Deputy Chief Medical Officer, NHS)*

> *"Only meet when there is a reason to meet, reports and evidence would be shared if appropriate. We have a more formal arrangement with the ICB - Monthly clinical governance reports are sent to ICB." (Hospital Director, Independent Sector)*

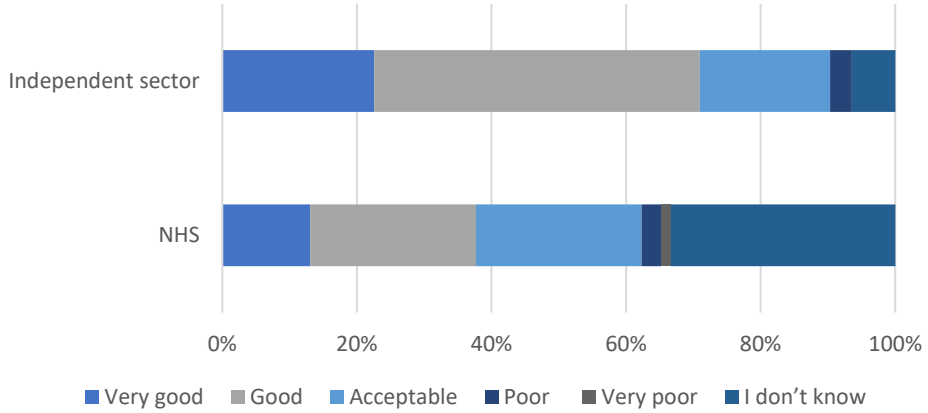
We asked senior leaders what they thought the arrangements were like for clinical governance between their hospitals and the other sector hospital who they work with the most (Table 8, Figure 5). Nearly three quarters of independent sector respondents described the arrangements as very good or good compared to over a third of NHS respondents.

Table 8. Ratings of the clinical governance arrangements between the sectors

How would you describe the clinical governance arrangements you have with the other sector hospital?	Very good	Good	Acceptable	Poor	Very poor	I don't know	Total
NHS	9 (13.0)	17 (24.6)	17 (24.6)	2 (2.9)	1 (1.5)	23 (33.3)	69

Independent sector	7 (22.6)	15 (48.4)	6 (19.4)	1 (3.2)	0 (0)	2 (6.5)	31

Figure 5. Ratings of the clinical governance arrangements between the sectors



We asked what the relationships were like with the other sector hospitals their organisation had contact with. The quality of relationships described were varied, with some described as excellent, good or reasonable and others described as poor, minimal or in need of improvement. Some described relationships as inconsistent, good with one or two of the nearest hospitals they work with the most and little or no relationship with others. Many described interaction between the sectors as sporadic and reactive, with contact made when there was an issue or in response to a concern.

Some relationships relied on personal connections in order for positive interaction to continue. When these connections did not exist, for example due to continuously changing staff, relationships were described as poor. Respondents often referred to RO to RO conversations as the main form of communication between the sectors. Others were dependent on the probity of consultants to provide information about their work in the other sector.

Where there was a contractual agreement between the sectors for providing care, clinical governance was mainly managed within the NHS with investigations carried out jointly. Some had seen improvements in relationships since the Patient Safety Incident Response Framework (PSIRF). COVID was a catalyst for the forming of relationships

between the sectors, but some suggested that this has not been maintained. Some described how relationships were maintained through the oversight of ICB's under the National Quality Board's recommendations.

> *"The 2 main private hospitals nearby, we have reasonable relationships. I made an effort as CMO to reach out to all local private hospitals, with varying degrees of success. It is all very ad hoc. I have had this conversation with the GMC ELA and RO meetings, that the flow of information and collaborative working needs to improve". (Chief Medical Officer, NHS)*

> *"sporadic, on an "as need" basis. Nothing regular, no reg meetings. Good interactions though, when required" (Chief Medical Officer, NHS)*

> *"Good in terms of handling governance issues reactively. More challenging in the wider proactive insight and learning." (Clinical Governance Lead, NHS)*

> *"If there is an issue with one of our doctors I will contact the Responsible Officer for an RO to RO conversation. As part of their appraisal I expect our doctors to include details of their private work in their description of the work that they do and to include a report from that organisation. I also expect to see any private work in their job plan and recorded on their Declarations of interest form." (Chief Medical Officer, NHS)*

> *"For the NHS work we contract to do, the clinical governance is largely provided by the NHS trust other than if a serious incident were to occur in our premises, in which case it would be investigated jointly. For NHS trusts with whom we do not contract, the only contact would be Responsible Officer to Responsible Officer for a concern with an individual practitioner." (Chief Executive, Independent Sector)*

> *"Inconsistent - some are excellent and others less so. Regular meetings and shared learning happens between some hospitals and their local NHS trust. In some localities this is even broader with good relationships across all providers in the ICB region. Some hospitals really struggle to get good collaboration with the local NHS trust." (Chief Clinical Officer, Independent Sector)*

> *"Previously limited, but new PSIRF relationships bring together regional safety leads." (Director of Nursing, Independent Sector)*

> *"Poor engagement from the local trust. Continuously changing staff. No ownership of issues" (Hospital Director, Independent Sector)*

We asked respondents how the clinical governance arrangements with the other sector hospital had developed over time. Some reported more formalised and scheduled arrangements following the Paterson Inquiry report. Others felt that relationships had developed as a result of progress with the PSIRF. One respondent said that their relationships with the independent hospital had developed, allowing them to meet more regularly and not just in response to concerns or incidents. Existing operational relationships allowed for better clinical governance relationships and there was the view that relationships formed or developed during the pandemic to help manage elective procedures had matured and strengthened, allowing for better partnership working and improvements in the processes for patient transfers. Some felt that relationships formed during the pandemic had not been maintained, others went further to say that relationships between the sectors had not developed and that this stemmed from a lack of motivation on the part of the NHS trusts.

"Clinical governance processes have matured as our relationship with them has strengthened. During the pandemic we contracted elective procedures to be managed at SPIRE. This has continued during this elective recovery phase. Through partnership working they have now joined working groups to explore improvements in interfacility transfer of patients." (Associate Director Quality & Safety, NHS)

"We meet regularly now not just when we have a problem." (Medical Director, NHS)

"A formal meeting was set up in the wake of the Paterson incidents. This is called the partnership assurance group (PAG) and meets once every two months" (Assistant Medical Director, NHS)

"Less these days as we have less to do with treating NHS patients." (Group Head of Governance and Compliance, Independent Sector)

"Not at all. There's a lack of appetite on behalf of the NHS trust." (Hospital Director, Independent Sector)

We asked respondents how relationships between the sectors could be improved. Some felt that there was a need for more formal reporting systems, scheduled meetings and improvements in communication and the sharing of information with a wider network of staff responsible for clinical governance. An increase in regional learning forums and the involvement and engagement of the wider health system was suggested as a way to improve and encourage shared learning. Respondents were sometimes pessimistic about improvement and there was a feeling that some organisations had been slow to engage in shared clinical governance.

"Although information is shared a more formal report to include for example, the sharing of Datixs and formal governance reports." (Assistant Medical Director, NHS)

"Better sharing of metrics such as infection rates, returns to theatre, transfusions etc" (Deputy Medical Director, NHS)

"We have frequent ad hoc contact between our regular documented meetings, but we could increase the frequency of those regular meetings. We could also include a wider range of colleagues - at the moment, we still have a consultant 'professional matters' focus so do not include NHS clinical governance team directly in these calls." (Chief Medical Officer, NHS)

"Actually, in my opinion the issues rest with the NHS hospital who have been slow to engage with the private hospital" (Clinical Lead, NHS)

"Regional learning forums exist in some areas of the country that we are a part of, these are generally positive and would be a good thing to encourage other ICBs to do." (Chief Medical Officer, Independent Sector)

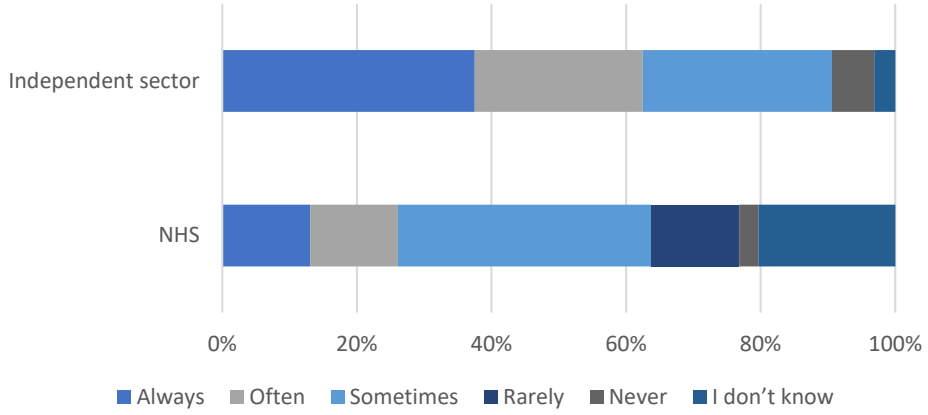
Sharing learning from patient safety incidents

We asked senior leaders in NHS trusts and independent hospitals how often their organisation would share learning from patient safety incidents with the hospitals from the other sector that they work with the most (Table 9, Figure 6). Senior leaders from independent hospitals reported that they shared learning more frequently compared with leaders from the NHS, with nearly two thirds from the independent sector reporting they shared learning always or often compared with over a quarter from the NHS.

Table 9. How often learning from patient safety incidents is shared with the other sector

Do you share learning from patient safety incidents with the other sector?	**Always**	**Often**	**Sometimes**	**Rarely**	**Never**	**I don't know**	**Total**
NHS	9 (13.0)	9 (13.0)	26 (37.7)	9 (13.0)	2 (2.9)	14 (20.3)	69
Independent sector	12 (37.5)	8 (25.0)	9 (28.1)	0 (0)	2 (6.3)	1 (3.1)	32

Figure 6. Sharing learning from patient safety incidents with the other sector



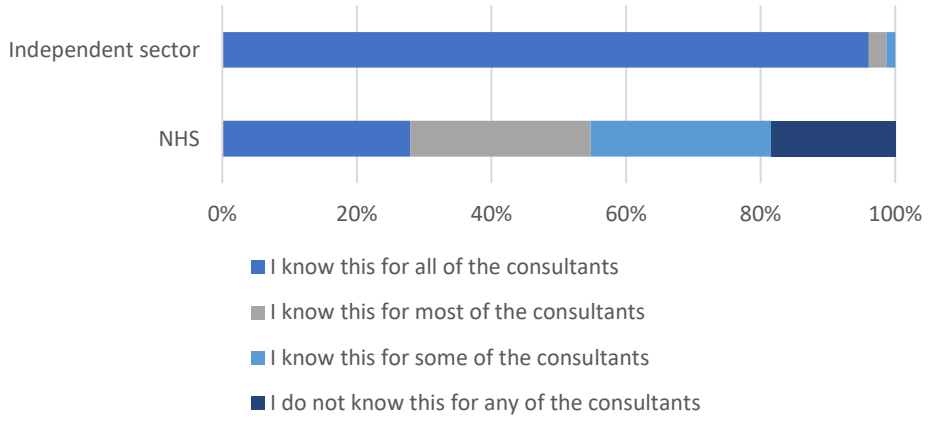
Knowledge of where consultants work

We asked senior leaders in NHS trusts and independent hospitals if they knew which of their consultants were also working at the other sector hospital that they work with the most (Table 10, Figure 7). Nearly all respondents from independent hospitals reported that they know for all of their consultants if they were also working at the NHS trust, whereas only over a quarter of respondents from NHS trusts knew for all of their consultants if they were also working in the independent hospital and just under a fifth did not know this for any of their consultants.

Table 10. Knowledge of which consultants are also working in the NHS trust/independent hospital

Do you know which of your consultants are also working at the other sector hospital?	**I know this for all of the consultants**	**I know this for most of the consultants**	**I know this for some of the consultants**	**I do not know this for any of the consultants**	**Total**
NHS	50 (27.9)	48 (26.8)	48 (26.8)	33 (18.4)	179
Independent sector	73 (96.1)	2 (2.6)	1 (1.3)	0 (0)	76

Figure 7. Knowledge of which consultants work in the NHS Trust/independent hospital



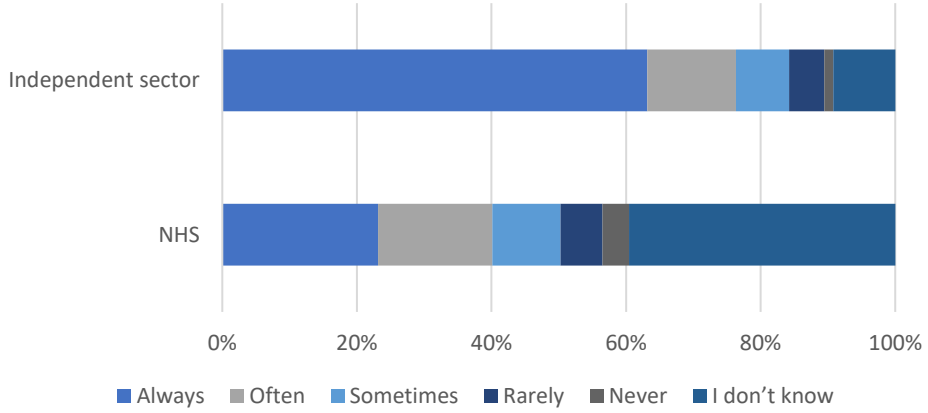
Scope of practice

We asked senior leaders in NHS trusts and independent hospitals how often their organisation gets supporting information about the scope of practice of consultants who also work at the hospital from the other sector that they work with the most (Table 11, Figure 8). Under two thirds of senior leaders from independent hospitals reported that they always get supporting information about scope of practice for consultants who also work at the other sector hospital compared with less than a quarter of those reported by leaders from the NHS with two fifths of NHS leaders reporting that they did not know.

Table 11. How often the organisations get supporting information for scope of practice

Does your organisation get supporting information about the scope of practice for consultants who also work at the other sector hospital?	**Always**	**Often**	**Sometimes**	**Rarely**	**Never**	**I don't know**	**Total**
NHS	41 (23.2)	30 (17.0)	18 (10.2)	11 (6.2)	7 (4.0)	70 (39.6)	177
Independent sector	48 (63.2)	10 (13.2)	6 (7.9)	4 (5.3)	1 (1.3)	7 (9.2)	76

Figure 8. Frequency organisations get supporting information for scope of practice



We asked what the process was for getting supporting information about scope of practice and how scope of practice information is verified. Mostly, information about scope of practice was obtained via annual appraisal or review of appraisal and revalidation records and was often dependent on the doctor's probity to declare all activity. In order for independent hospitals to grant practising privileges they would have their scope of practice reviewed which may include reviewing appraisal and revalidation records, completing a scope of practice form and getting this signed off by their NHS Clinical Director. For others, information about scope of practice was integrated into their biannual review process.

NHS hospitals stated that scope of practice information was sometimes verified with letters of good standing or letters of no concerns provided from employers and through RO correspondence before revalidation. Independent hospitals reported that scope of practice information was verified via log books, the Medical Advisory Committee, cross referenced with other data sources (where available) such as the National Joint Registry (NJR) and confirmation through sign off or correspondence with the NHS trust. Reliance on doctor probity was a concern and some stated that they have no way of knowing if doctors are declaring all of their activity and others stated that letters of verification do not provide enough detail to check if doctors are doing the same procedures in the NHS. It was reported that scope of practice information is not routinely verified and although appraisal covers whole scope of practice it does not formally check whether different procedures are being done in the NHS and private practice. Independent hospitals stated that a barrier to verification of scope of practice information was the motivation of the NHS trust to engage.

> *"All doctors must declare PP and include governance info in their appraisal, but we have no way of knowing they are declaring all activity." (Chief Medical Officer, NHS)*
>
> *"At point of revalidation, we get a statement of no concerns from each IS organisation listed in scope of practice at appraisal. It does not tell us in detail if they do the same procedures as in the NHS." (Responsible Officer, NHS)*
>
> *"I would write to the RO equivalent at the independent hospital if this is not clear in an appraisal process. Often a log is provided by a consultant though this does rely on probity." (Consultant Surgeon, NHS)*
>
> *"It is good practice to receive a report from the RO at the independent hospital although I am not sure this happens too often." (Chief Medical Officer, NHS)*
>
> *"A scope practice form is required to be completed prior to being agreed to have practicing privileges at the Hospital and this needs to be signed off by their NHS Clinical Director and this is reviewed by the Hospital prior to moving forward with agreement of their PP's." (Chief Nurse, Independent Sector)*
>
> *"We ask the consultant to document their scope of practice on application for Practising Privileges and an RO reference. However, the consultant's scope of practice is self-certified." (Hospital Director, Independent Sector)*
>
> *"For some specialties the consultant is requested to get their scope of practice countersigned by their NHS Clinical Director. But compliance is variable - some NHS Clinical Directors are reluctant to engage." (Chief Executive, Independent Sector)*

"MAC committee members. If information is available from other data sources (NJR etc.) then this would be reviewed, but it is not always possible to do this for new applications. Review of SoP would always be done using evidence from clinical outcomes registries/databases." (Chief Clinical Officer, Independent Sector)

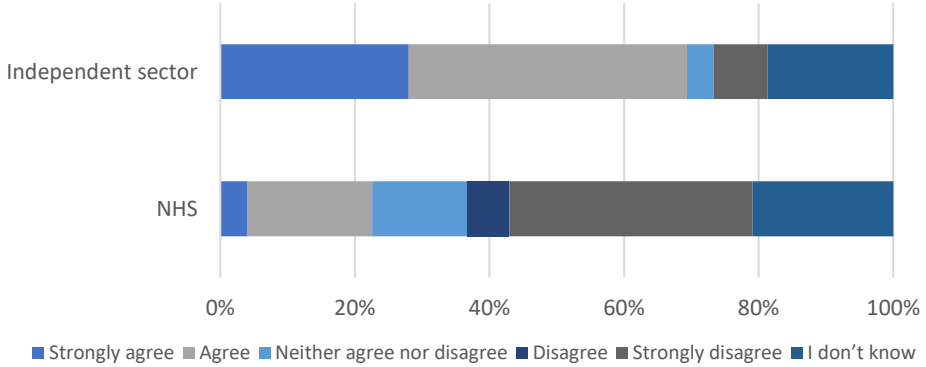
"To be honest we get it from the consultant as part of PPs and you are trusting the consultant that they are telling the truth. We probably don't recheck scope of practice as much as we should." (Hospital Director, Independent Sector)

Respondents were asked about the robustness of their processes for verifying scope of practice (Table 12, Figure 9). Nearly two thirds of respondents from independent hospitals either strongly agreed or agreed that their processes for verifying scope of practice are robust compared with less than a fifth of respondents from the NHS. Over a third of NHS leaders and a small number of independent sector leaders disagreed or strongly disagreed that their processes are robust.

Table 12. Robustness of processes for verifying scope of practice

Our processes for verifying supporting information for scope of practice are robust	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**	**I don't know**	**Total**
NHS	7 (4.0)	33 (18.6)	25 (14.1)	11 (6.2)	64 (36.2)	37 (20.9)	177
Independent sector	21 (28.0)	31 (41.3)	3 (4.0)	0 (0)	6 (8.0)	14 (18.7)	75

Figure 9. Robustness of processes for verifying scope of practice

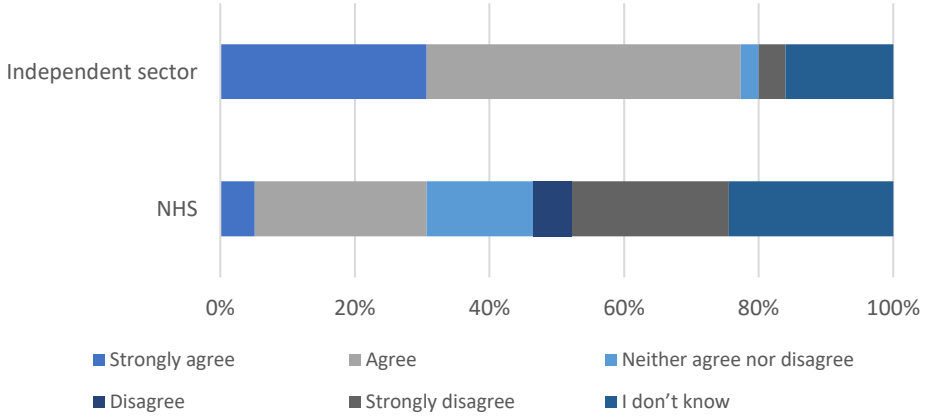


Respondents were asked how confident they were that they know about the scope of practice of their consultants who also worked at the other sector hospital (Table 13, Figure 10). Three quarters of leaders from independent hospitals strongly agreed or agreed that they were confident they knew about the scope of practice of consultants who also work at the other sector hospital compared with under a third of leaders from the NHS and over a quarter of NHS leaders disagreed or strongly disagreed that they were confident.

Table 13. Level of confidence about the scope of practice of consultants who also work in the other sector

I am confident that our organisation knows about the scope of practice of consultants who also work at the other sector hospital	**Strongly agree**	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**	**I don't know**	**Total**
NHS	9 (5.1)	45 (25.6)	28 (15.9)	10 (5.7)	41 (23.3)	43 (24.4)	176
Independent sector	23 (30.7)	35 (46.7)	2 (2.7)	0 (0)	3 (4.0)	12 (16.0)	75

Figure 10. Level of confidence about the scope of practice of consultants working across sectors



We asked senior leaders in the NHS how often revalidation decisions were delayed by not having supporting information about consultants' practice in (Table 14, Figure 11) and we asked senior leaders in independent hospitals how often do consultants share information about their appraisals done by the NHS hospital (Table 14, Figure 12). Over a third of NHS leaders reported that revalidation decisions were rarely or never delayed by not having supporting information about consultants practice in independent hospitals. Over three quarters of independent sector leaders reported that consultants always shared information about their appraisals done by the NHS hospital.

Table 14. How often revalidation decisions are delayed by not having supporting information about consultants' practice

	Always	**Often**	**Sometimes**	**Rarely**	**Never**	**I don't know**	**Total**
NHS - Are revalidation decisions delayed by not having supporting information about consultants' practice in independent hospitals?	5 (2.8)	1 (0.6)	26 (14.7)	50 (28.3)	15 (8.5)	80 (45.2)	177

Independent sector - How often do consultants share information about their appraisals done by the NHS hospital?	58 (78.4)	8 (10.8)	1 (1.4)	0 (0)	3 (4.1)	4 (5.4)	74

Figure 11. Frequency of delay in revalidation decisions due to lack of supporting information about consultants' practice in independent hospitals

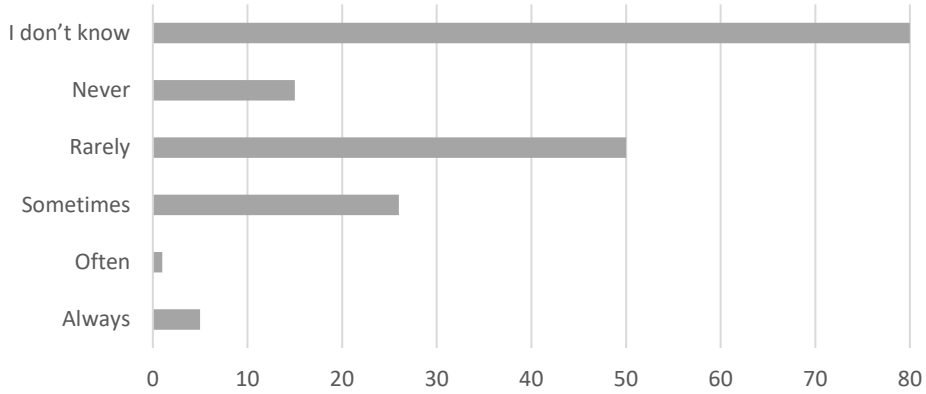
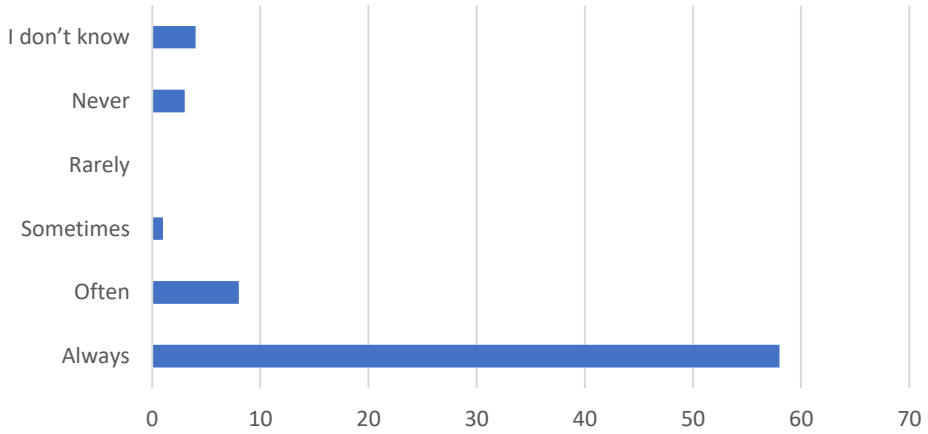


Figure 12. Frequency consultants share information about their appraisals done by the NHS hospital



Respondents were asked how arrangements for verifying scope of practice information could be improved. Respondents called for higher quality data, improved communication and information sharing and more robust, formalised and standardised processes. A number of suggested improvements were made including: mutual access to appraisal records; a centralised data repository; scope of practice statements with defined level of detail signed by all employers and the consultant; and improved systems and processes for the sharing of information in sufficient detail about consultant practice. There were some respondents who felt that the independent sector could be more proactive in providing information about a consultant's private work. Some explained how a more formalised process may help but it would need to be dynamic to cope with ever changing arrangements and the different parameters related to contracted work. Others felt that the current arrangements that they had in place worked well and that there was a good understanding of consultant practice.

"All private hospitals should share with each NHS trusts the consultants they have registered, amount of work undertaken and especially if there are fixed sessions, to triangulate with NHS job plans. I asked for this from one hospital but got no reply" (Chief Medical Officer, NHS)

"It would be ideal to have sufficient detail documented for all NHS consultants that could be shared with IS, and vice versa. Collecting, verifying, documenting and sharing this information would require systems and process we currently do not have." (Chief Medical Officer, NHS)

"Improvement should involve a bidirectional interface - full NHS scope of practice can come from the Director of Service (DoS) for consultants and last 5 years of practical experience. This could be replicated by private providers. It is not just the scope of practice, rather the complications that are managed and clear understanding of outliers is useful. Our trust (trust name) uses a risk adjusted system (system name) to assess the observed and expected complications for each consultant every month. Data of this high quality (particularly if reciprocated) could lead to high quality assurance for patient care within both sectors and comply with the Paterson outcomes." (Assistant Medical Director, NHS)

"Automated letters of good standing sent in by the private provide would be really helpful. Also helpful would be for us to have a "go to" to private providers so that we can get up to date info about a doctors' practice/ performance." (Hospital Director, NHS)

"Formalising the relationships with providers may help but it is challenging as things change frequently and the contractor model for some procedures goes beyond individual organisations." (Clinical Lead for Planned Care, NHS)

"I think the current arrangements of self-reporting with direct contact from Independent hospital if they have concerns is pragmatic." (Chief Medical Officer, NHS)

"A centralised data repository which includes case numbers across a consultant's NHS and private practice, which was the intention with PHIN (but it has not delivered yet)." (Chief Executive, Independent Sector)

"Both we and the NHS have records of what the SoP is at each. At the moment it is ad hoc i.e. we will ask for confirmation that Dr X does these procedures. It would not be impossible to simply compare everyone on a say annual basis." (Hospital Director, Independent Sector)

Handling consultant concerns

We asked respondents if they had a policy on handing consultant concerns (Table 15), and if they did, whether or not that policy including a process for sharing information with the other sector hospital (Table 16). Over three quarters of respondents from NHS and nearly all respondents from the independent sector reported that their organisations had a policy on handling consultant concerns. Under two thirds of NHS respondents compared with nearly all independent sector respondents reported that the policy included a process for sharing information about consultant concerns with the other sector hospital.

Table 15. If the organisation has a policy on handling consultant concerns

Does your organisation have a policy on handling consultant concerns?	**Yes**	**No**	**I don't know**	**Total**
NHS	137 (78.7)	6 (3.5)	31 (17.8)	174
Independent sector	70 (93.3)	5 (6.7)	0 (0)	75

Table 16. If the policy includes a process for sharing information with the other sector hospital

Does the policy include a process for sharing information about concerns with the independent/NHS hospital?	**Yes**	**No**	**I don't know**	**Total**
NHS	87 (63.5)	24 (17.5)	26 (19.0)	137
Independent sector	65 (92.9)	3 (4.3)	2 (2.9)	70

We asked respondents for details about their process for sharing information about concerns with the other sector hospital. On the whole, information about concerns was shared between ROs or sometimes Medical Directors/Hospital Directors. Sometimes this was combined with soft intelligence shared via monthly meetings or informal conversations. Some respondents noted that while it was the doctor's responsibility to inform the organisations where they work if they are under restrictions or investigation, that this was supported by good relationships between the ROs from each sector. Some organisations had specific policies, processes or frameworks in place to manage the sharing of information around concerns, for example a managing concerns policy and escalation process in line with Maintaining High Professional Standard (MHPS), whereas others suggested that they were dependant on doctor probity to inform other sector organisations.

> *"When investigations start or in more serious situations where exclusion is required our NHS Ro will contact the independent sector organisations to inform them accordingly." (Consultant Surgeon, NHS)*

> *"Anyone subject to MHPS investigation and having restrictions on practice in NHS we would automatically inform other places of work." (Responsible Officer, NHS)*

> *"Only in so much as we advise the doctor that they must inform any other employers." (Hospital Director, NHS)*

"I share any formal consultant concern letter with the RO in the NHS directly. Also, we share soft intel also via a monthly meeting." (Hospital Director, Independent Sector)

We asked respondents how frequently information was shared with the other sector hospital regarding significant concerns (Table 17, Figure 13), interim restrictions (Table 17, Figure 14), substantial restrictions (Table 17, Figure 15), suspensions/exclusions (Table 17, Figure 16) or referrals to the GMC (Table 17, Figure 17) about one of their consultants who also works in the other sector hospital. On the whole around half of NHS trust respondents and most independent sector respondents reported that they always share this information with the other sector hospitals. However, when there was a referral to the GMC, less than half of NHS trusts respondents reported that this was shared always and just under a quarter reported it was shared often or sometimes.

Table 17. Frequency of sharing information from the respondent's organisation to the other sector hospital regarding consultant restrictions, exclusion and referral

		Always	Often	Sometimes	Rarely	Never	I don't know	Total
If there is a **significant concern** about one of your consultants, do you share information with the other sector hospital?	NHS	83 (47.7)	22 (12.6)	19 (10.9)	0 (0)	1 (0.6)	49 (28.2)	174
	Independent sector	67 (89.3)	3 (4.0)	2 (2.7)	0 (0)	0 (0)	3 (4.0)	75
If **interim restrictions** (temporary restrictions pending the outcome of an investigation) are placed on the practice of one of your consultants, do you share information with the other sector hospital?	NHS	96 (59.3)	12 (7.4)	8 (4.9)	1 (0.6)	1 (0.6)	44 (27.2)	162
	Independent Sector	64 (85.3)	2 (2.7)	3 (4.0)	0 (0)	0 (0)	6 (8.0)	75
If **substantial restrictions** (restrictions based on conclusions from an investigation) are placed on the practice of one of your consultants, do you share information with the other sector hospital?	NHS	98 (60.9)	12 (7.5)	4 (2.5)	0 (0)	1 (0.6)	46 (28.6)	161
	Independent Sector	65 (85.5)	4 (5.3)	2 (2.6)	0 (0)	0 (0)	5 (6.6)	76
If a consultant in your organisation is **suspended/excluded** for any reason, do you share information with the other sector hospital?	NHS	102 (63.4)	9 (5.6)	5 (3.1)	0 (0)	0 (0)	45 (28.0)	161
	Independent Sector	69 (90.8)	3 (4.0)	1 (1.3)	0 (0)	0 (0)	3 (4.0)	76
If a consultant in your organisation is **referred to the General Medical Council (GMC)**, do you share information with the other sector hospital?	NHS	72 (44.7)	19 (11.8)	20 (12.4)	2 (1.2)	1 (0.6)	47 (29.2)	161
	Independent Sector	64 (84.2)	3 (4.0)	1 (1.3)	2 (2.6)	0 (0)	6 (8.0)	76

Figure 13. Frequency of sharing information about significant concerns

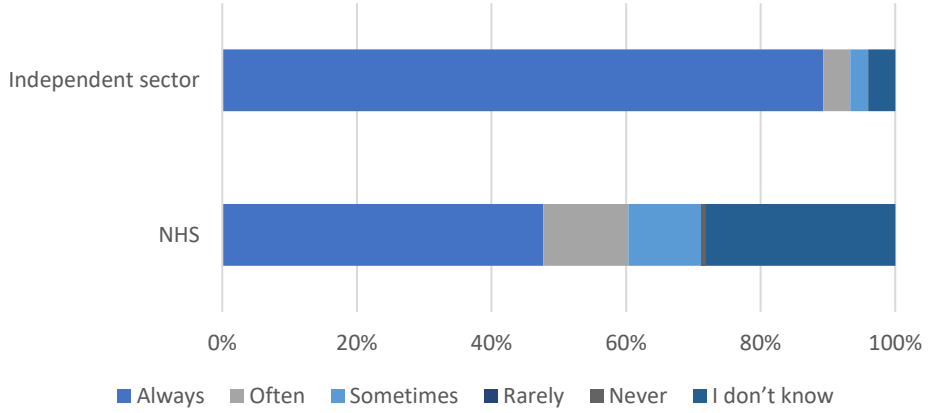


Figure 14. Frequency of sharing information about interim restrictions

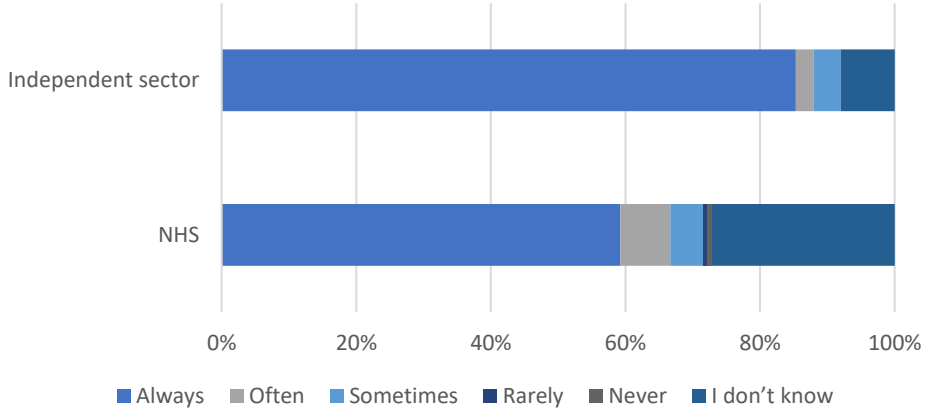


Figure 15. Frequency of sharing information about substantial restrictions

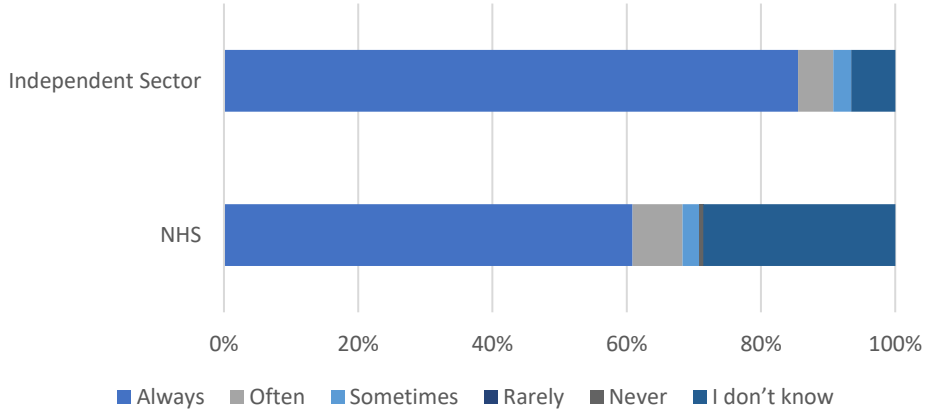


Figure 16. Frequency of sharing information about suspension/exclusion

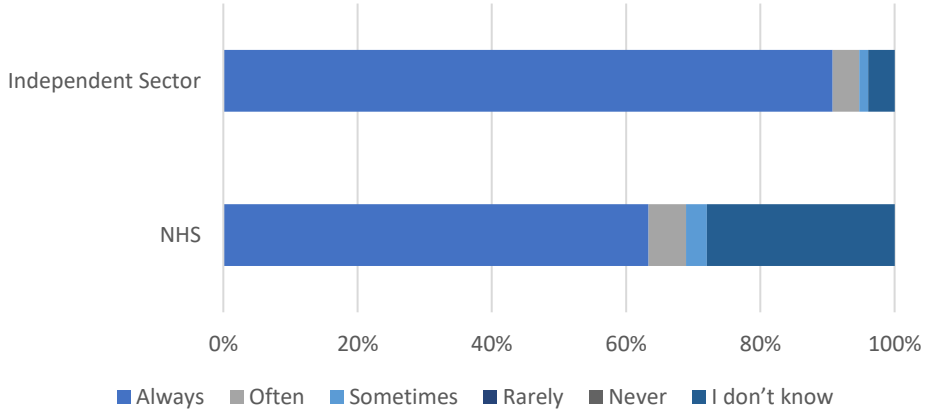
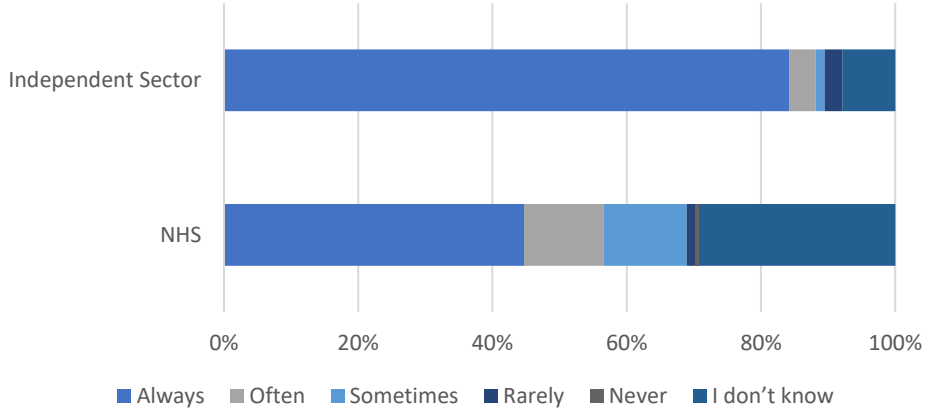


Figure 17. Frequency of sharing information about referrals to GMC



We asked respondents how frequently the other sector hospital shared information with them regarding significant concerns (Table 18, Figure 18), interim restrictions (Table 18, Figure 19), substantial restrictions (Table 18, Figure 20), suspensions/exclusions (Table 18, Figure 21) or referrals to the GMC (Table 18, Figure 22). The majority of NHS respondents did not know how frequently this information was shared by the independent sector. The pattern of results for both sectors suggests that the more serious the action taken regarding the concern, the more likely the information will be shared by the other sector hospital. For example, over a quarter of the independent sector respondents reported that interim restrictions were always shared and two fifths reported that suspensions or exclusions were always shared. The numbers were lower when there was a referral to the GMC, with less than a fifth of NHS trusts respondents and over a third of independent sector respondents reporting that this was always shared.

Table 18. Frequency of sharing information from the other sector hospital to the respondent's organisation regarding consultant concerns, restrictions, exclusion and referral

		Always	Often	Sometimes	Rarely	Never	I don't know	Total
	NHS	25 (15.3)	29 (17.8)	21 (12.9)	5 (3.1)	5 (3.1)	78 (47.9)	163

If there is a **significant concern** about one of your consultants at the other sector hospital, do they share this information with you?	Independent sector	11 (14.5)	26 (34.2)	13 (17.1)	10 (13.2)	1 (1.3)	15 (19.7)	76
If the other sector hospital places **interim restrictions** on the practice of one of your consultants, do they share this information with you?	NHS	40 (24.7)	15 (9.3)	11 (6.8)	2 (1.2)	3 (1.9)	91 (56.2)	162
	Independent Sector	21 (27.6)	15 (19.7)	17 (22.4)	2 (2.6)	2 (2.6)	19 (22.4)	76
If the other sector hospital places **substantial restrictions** on the practice of one of your consultants, do they share this information with you?	NHS	41 (25.3)	16 (9.9)	10 (6.2)	1 (0.6)	3 (1.9)	91 (56.2)	162
	Independent Sector	24 (31.6)	16 (21.1)	16 (21.1)	2 (2.6)	2 (2.6)	16 (21.1)	76
If a consultant at the other sector hospital is **suspended/excluded** for any reason, do they share this information with you?	NHS	48 (29.8)	12 (7.5)	8 (5.0)	1 (0.6)	3 (1.9)	89 (55.3)	161
	Independent Sector	30 (39.5)	17 (22.4)	10 (13.2)	1 (1.3)	1 (1.3)	17 (22.4)	76
If the other sector hospital **refers one of your consultants to the GMC**, do they share this information with you?	NHS	28 (17.5)	17 (10.6)	9 (5.6)	1 (0.6)	2 (1.3)	103 (64.4)	160
	Independent Sector	28 (36.8)	15 (19.7)	9 (11.8)	2 (2.6)	2 (2.6)	20 (26.3)	76

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Figure 18. Frequency of other sector hospital sharing information about significant concerns

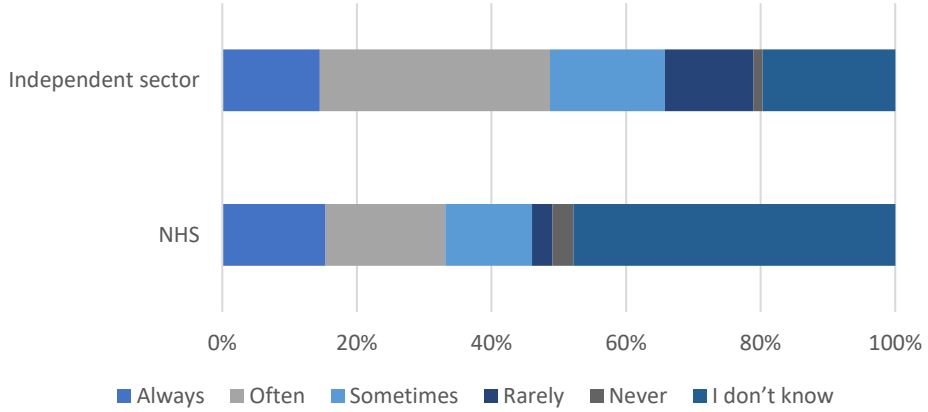


Figure 19. Frequency of other sector hospital sharing information about interim restrictions

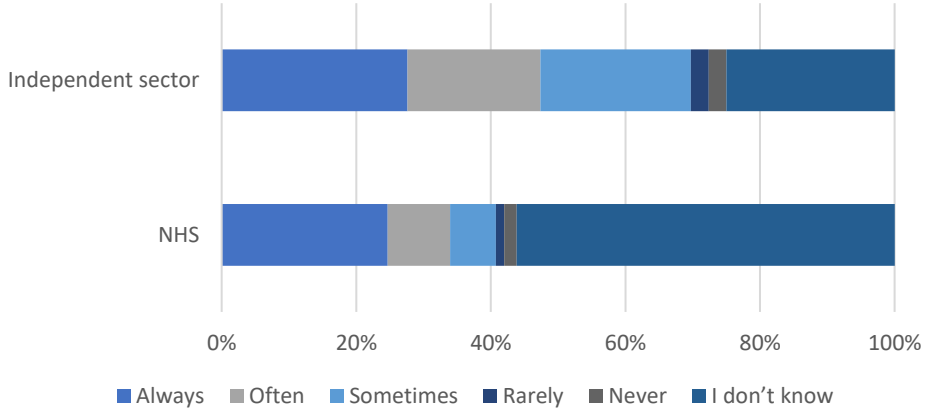


Figure 20. Frequency of other sector hospital sharing information about substantial restrictions

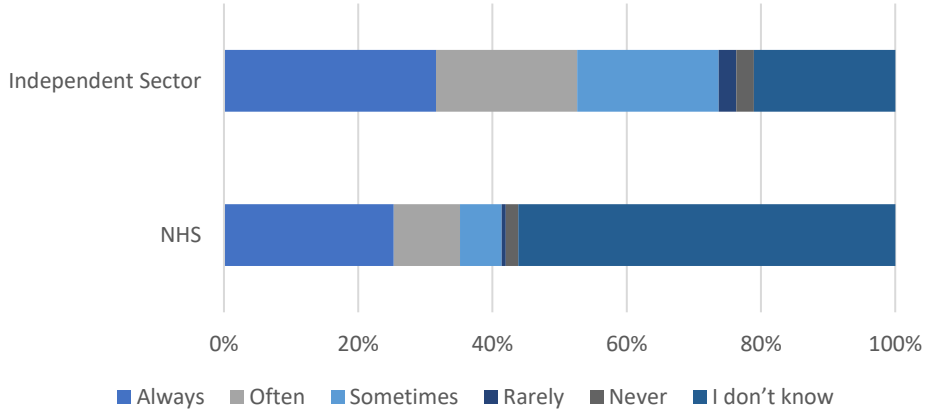


Figure 21. Frequency of other sector hospital sharing information about suspension/exclusion

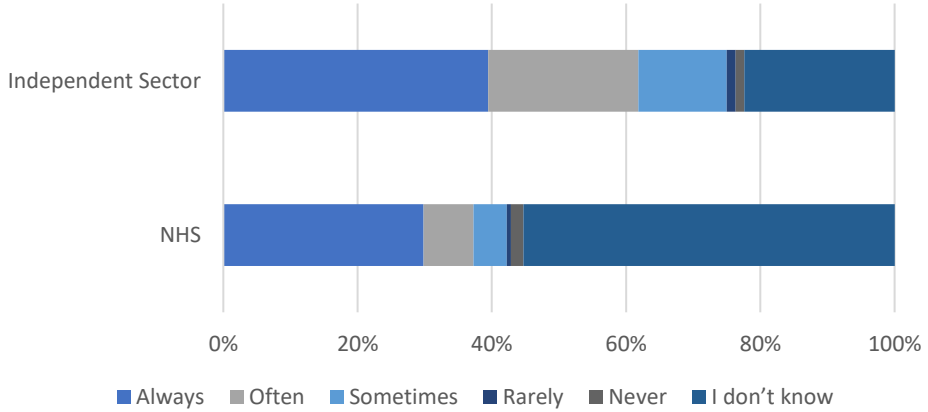
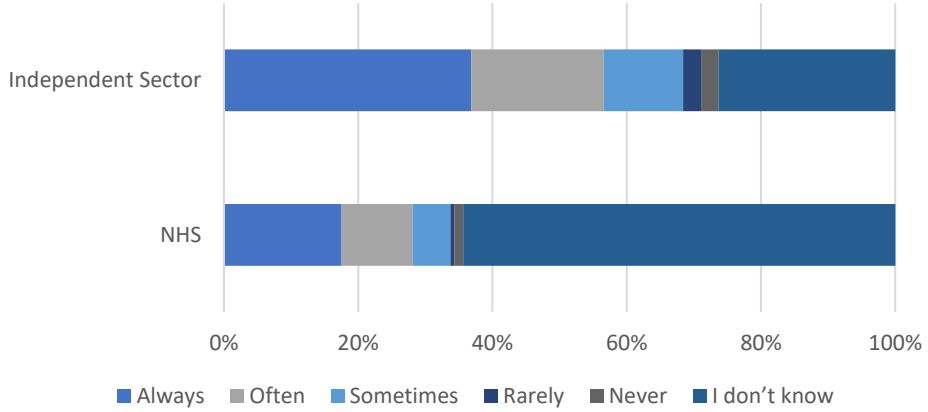


Figure 22. Frequency of other sector hospital sharing information about referral to the GMC



We asked respondents how frequently the GMC shares information about referrals made by the other sector hospital (Table 19, Figure 23) or restrictions or suspensions that they place on the practice of consultants who work at the other sector hospital (Table 19, Figure 24). Just under half of NHS trust respondents and over half of independent sector respondents reported that the GMC, either always or often, informed their hospital directly if a GMC referral was made by the other hospital. Half of NHS trust respondents and over half of independent sector respondents reported that the GMC, either always or often, informed their hospital directly if the GMC restricts the practice or suspends the license of a consultant from the other sector hospital.

Table 19. GMC sharing information about referrals, restrictions and suspensions

		Always	Often	Sometimes	Rarely	Never	I don't know	Total
If a GMC referral is made by the other sector hospital, does the GMC inform your hospital directly?	NHS	55 (34.2)	17 (10.6)	10 (6.2)	2 (1.2)	0 (0)	77 (47.8)	161
	Independent Sector	35 (46.1)	10 (13.2)	5 (6.6)	0 (0)	1 (1.3)	25 (32.9)	76

If the GMC restricts the practice or suspends the licence of a consultant from the other sector hospital, does the GMC inform you directly?	NHS	69 (43.1)	10 (6.3)	13 (8.1)	0 (0)	1 (0.6)	67 (41.9)	160
	Independent Sector	39 (51.3)	6 (7.9)	5 (6.6)	0 (0)	1 (1.3)	25 (32.9)	76

Figure 23. Frequency of GMC providing information about a referral made by the other sector hospital

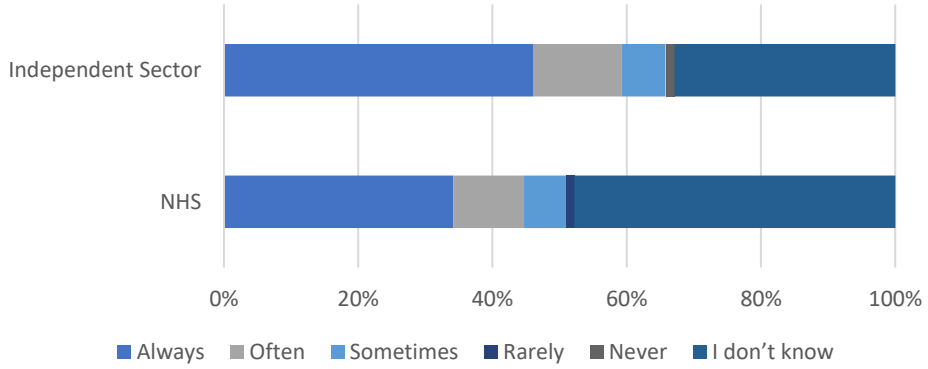
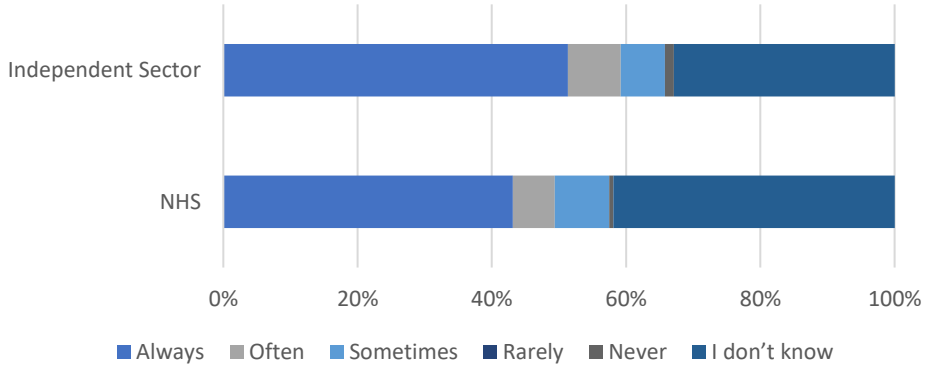


Figure 24. Frequency of GMC providing information about a restriction or suspension they have imposed



We asked respondents who they share information with about concerns, restrictions, exclusion and referral at the other sector hospital (Table 20). Across both sectors information about concerns, restrictions, exclusion and referral is shared mostly with Responsible Officers, Medical Directors and Chief Medical Officers. Some respondents stated that they shared information with other senior staff members or departments such as the Chief Executive Officer, Chief People Officer, Contracts Manager, Director of HR or the MAAR office.

Table 20. Who information about concerns, restrictions, exclusion and referral at the other sector hospital

Who do you share information with at the other sector hospital?	**NHS**	**Independent sector**

Chief Executive	29 (12.3)	7 (8.2)
Chief Medical Officer	65 (27.7)	34 (40.0)
Chief Nurse	10 (4.3)	3 (3.5)
Clinical Governance Lead	18 (7.7)	9 (10.6)
Director of Clinical Services	15 (6.4)	5 (5.9)
Director of Nursing	4 (1.7)	0 (0)
Hospital Director	27 (11.5)	2 (2.4)
Matron	1 (0.4)	0 (0)
Medical Director	34 (14.5)	25 (29.4)
Responsible Officer	52 (22.1)	43 (50.6)
Other	18 (7.7)	6 (7.1)

We asked respondents what was the main method they use to share information about concerns, restrictions, exclusion and referral with the other sector hospital (Table 21). Across both sectors more than a third of respondents reported that the main method for sharing information about concerns, restrictions, exclusion and referral was email followed by MPIT forms which was used by a fifth of respondents from both sectors. Other methods of communication mentioned by respondents included meetings (face to face and online), letters or conversations and some stated it varied depending on the nature and urgency of the situation.

Table 21. How information about concerns, restrictions, exclusion and referral is shared with the other sector hospital

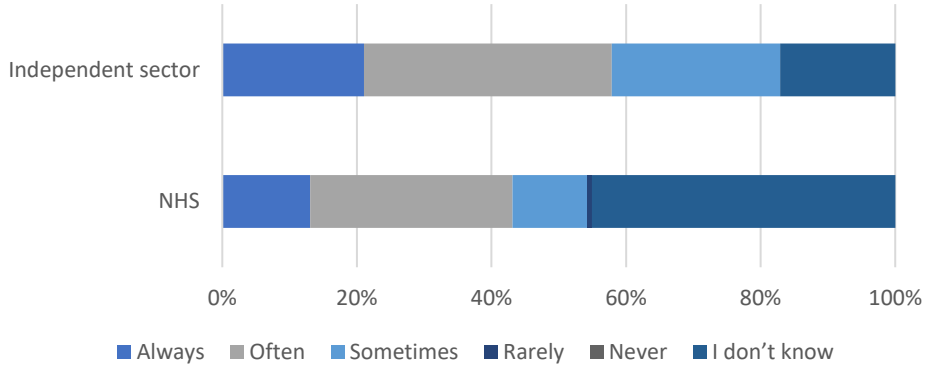
What is the main method you use to share information with the other sector hospital?	**NHS trusts**	**Independent sector**
Medical Practice Information Transfer (MPIT)	32 (21.1)	15 (19.7)
Telephone	17 (11.2)	11 (14.5)
Email	53 (34.9)	31 (40.8)
Other	17 (11.2)	10 (13.2)
I don't know	33 (21.7)	9 (11.8)
Total	**152**	**76**

We asked respondents if consultants fulfil their professional obligation to inform other organisations about significant concerns, restrictions, exclusions/suspensions, including informing the other sector hospital they work in (see Table 22, Figure 25). Under half of NHS respondents did not know but on the whole under a third of NHS and over a third of independent sector respondents felt that this often happened. Less than a quarter of independent sector respondents and more than a tenth of NHS respondents reported that this always happened.

Table 22. Fulfilment of consultant professional obligation to inform other organisations about significant concerns, restrictions, exclusions/suspensions

Do consultants fulfil their professional obligation to inform other organisations about significant concerns, restrictions, exclusions/suspensions (including the other sector hospital)?	**Always**	**Often**	**Sometimes**	**Rarely**	**Never**	**I don't know**	**Total**
NHS	20 (13.1)	46 (30.1)	17 (11.1)	1 (0.7)	0 (0)	69 (45.1)	153
Independent sector	16 (21.1)	28 (36.8)	19 (25.0)	0 (0)	0 (0)	13 (17.1)	76

Figure 25. Frequency consultants inform other organisations about significant concerns, restrictions, exclusions/suspensions



We asked respondents about the strengths and barriers with sharing information about concerns, restrictions and referrals between their organisation and the other sector hospital. Dependence on doctor probity for the sharing of information was a potential concern. Respondents stated that they only know what they are being told and informed and there are no guarantees that they have all the information. One concern was that if doctors were not communicating relevant information about concerns,

this might not get picked up if they are working in larger independent hospitals where it may be easier to keep a low profile. Respondents felt that because the process for sharing concerns was non-mandatory and unregulated it was under resourced and this made it harder to verify information. Strong relationships between the sectors resulted in effective communication but it was seen as a barrier when communication was dependent on these relationships. This also meant that a lot of communication was informal and undocumented. Both sectors stated that when there was not an established relationship it was not always clear who to contact. Independent sector respondents stated that it was often difficult to get information from the NHS or engage the NHS. Some felt it was not a mutual exchange of information, that they would provide details to the NHS trust but this would not always be reciprocated. Reasons for this included the challenges faced by the NHS, the size of NHS organisations and unclear lines of communication, knowledge of where private work is happening, and communication with the private sector not being prioritised. Sometimes requests for information would take time or be delayed or the information was just not passed on, resulting in delays in addressing or reviewing the problems.

> *"I have a good relationship with the management at independent hospitals. One of the weaknesses is "unknown unknowns" - in other words I presume that I am being told of restrictions/concerns but I have no guarantees. Clearly consultants working in the private sector are generating income for those hospitals, so potential conflict of interest. Equally some consultants work at private institutions far away and I may not know about those. Another barrier in private hospitals is their relatively modest governance departments, without the same NHS infrastructure to, for example, conduct their own investigations. I feel their reliance on me is much greater than the other way around." (Chief Medical Officer, NHS)*

> *"…we may not know what we do not know and I would be concerned that the systems in place could be worked around." (Medical Director for Quality and Safety, NHS)*

> *"The process relies on the doctor providing the information. Clearly failing to do so would raise a probity concern." (Responsible Officer, NHS)*

> *"I think the systems are reliant on personal honesty and transparency. If a consultant had practicing rights in [a large private hospital chain] for instance we may not know that. Locally the private hospitals are small and so it would be harder for folks to go under the radar." (Clinical Lead, NHS)*

> *"I think it's obvious that it is poor, unstructured and unregulated" (Chief Medical Officer, NHS)*

> *"Relies on local relationships - both a strength but potentially a weakness as formal process requirements not documented" (Deputy Medical Director, NHS)*

> *"Strengths - good relationships, weakness - process relies on good relationships" (Chief Nurse, NHS)*

> *"There have been occasions where consultant issues have arisen in NHS but the RO has not informed us and the Consultant has not done so. This has caused delays in us being able to conduct our own review of practice." (Hospital Director, Independent Sector)*

> *"I have encountered situations where we are not informed by an NHS trust, either because it is overlooked OR because the consultant has neglected to mention their practice here." (Chief Executive, Independent Sector)*

"It is quite dependent on the individuals involved and the relationships they have. Our organisation has more than 30 hospitals, leading to conversations with RO's in potentially many more trusts. It is difficult to build an effective relationship across this number. We therefore ask our Registered Managers to ensure they have a good relationship with the RO/medical staffing team in their local trust to try and ensure intelligence is shared. Many doctors do share information with us, but some do not. We also have a good relationship with our GMC liaison officer, who will keep us updated on aspects related to their investigations." (Chief Clinical Officer, Independent Sector)

"I do not always feel that the NHS considers and/or involves the independent sector when it addresses these issues." (Director of Nursing, Independent Sector)

"It is not a two-way street - we inform but we are not often informed. This may be because it may be unknown where a consultant has their private practice as not held centrally anywhere (or validated)." (VP of Quality, Independent Sector)

Capacity and capability

We asked senior leaders in the NHS how they would describe their knowledge about the capacity and capability of the independent sector to treat deteriorating patients that require an escalation in care (Table 23, Figure 26) and we asked senior leaders in independent hospitals how they would describe the NHS hospitals knowledge about the capacity and capability of your hospital to treat deteriorating patients that require an escalation in care (Table 23, Figure 27). Independent sector hospitals were more positive about the NHS knowledge of their capacity and capability than the NHS were of their own, with two thirds of respondents from the independent sector reporting that NHS knowledge was very good or good compared to less than a third of NHS respondents reporting their own knowledge was very good or good.

Table 23. Knowledge about the capacity and capability of the independent sector to treat deteriorating patients that require an escalation in care

	Very good	Good	Acceptable	Poor	Very poor	I don't know	Total
NHS - My knowledge about the capacity and capability of the independent hospital to treat deteriorating patients that require an escalation in care is...	15 (10.4)	29 (20.1)	41 (28.5)	9 (6.3)	12 (8.3)	38 (26.4)	144
Independent sector - The NHS hospitals knowledge about the capacity and capability of the independent hospital to treat deteriorating patients that require an escalation in care is…	12 (26.1)	18 (39.1)	9 (19.6)	6 (13.0)	0 (0)	1 (2.2)	46

Figure 26. NHS senior leaders ratings of their knowledge about the capacity and capability of the independent hospital

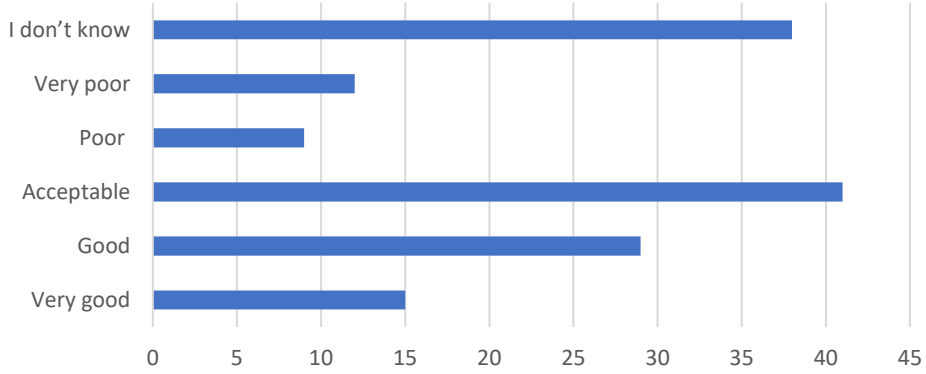
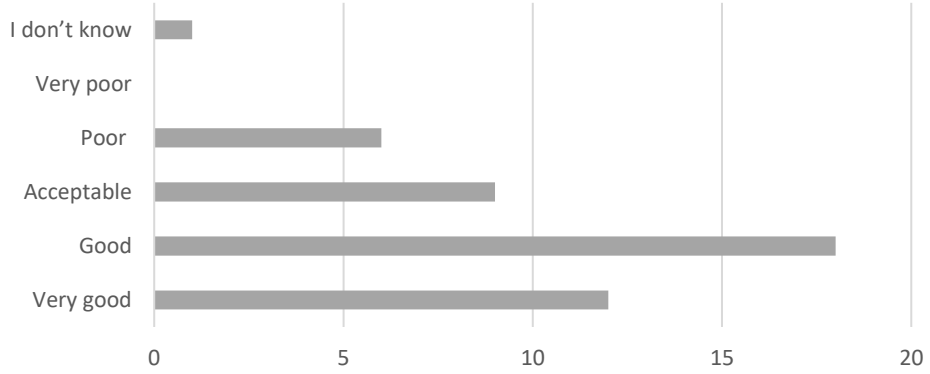


Figure 27. Independent sector leaders ratings of the NHS hospitals knowledge about the capacity and capability of the independent hospital



We asked respondents from the NHS what they knew about the capacity and capability of the independent sector hospital and we asked the independent sector hospital what they felt the NHS hospital knew about their capacity and capability (Table 24). What the NHS said they knew and what the independent sector felt the NHS knew were fairly similar, this included the number of inpatient beds, operating theatres, the presence of critical care facilities and availability of out of hours medical cover. Over a quarter of NHS respondents reported that they knew about none of these aspects of the independent hospital and a tenth of independent sector respondents reported that the NHS hospital knew about none of these aspects of their hospital. However, it should be taken into account that as we did not include an 'I don't know' for this question, people who were unsure of the answer could also have answered 'none of these'.

Table 24. What the NHS hospital knows about the capacity and capability of the independent hospital and what the independent hospital thinks the NHS hospital knows about the capacity and capability of their hospital

	NHS - Which of the following do you know about the independent hospital?	**Independent sector - Which of the following do you think the NHS hospital knows about the capacity and capability of your hospital?**
How many inpatient beds they/you have	54 (23.0)	19 (22.4)
How many operating theatres they/you have	53 (22.6)	20 (23.5)

Whether they/you have their own critical care facilities	76 (32.3)	32 (37.7)
What out of hours medical cover they/you have	53 (22.6)	25 (29.4)
None of these	64 (27.2)	9 (10.6)

Patient transfers

We asked senior leaders from NHS and independent sector hospitals if they had an agreement with the other sector hospital on how you share or transfer patient clinical information and records (Table 25). Independent hospital respondents were more confident that there was a policy or agreement in place with the other sector hospital on how to share patient information with over two thirds stating there was a policy in place compared to just under a quarter of NHS respondents.

Table 25. If the organisation has a policy on sharing or transferring patient clinical information and records

Is there any form of written policy or agreement in place with the independent/NHS hospital on how you share or transfer patient clinical information and records?	**Yes**	**No**	**I don't know**	**Total**
NHS	32 (23.4)	38 (27.7)	67 (48.9)	137
Independent sector	52 (70.3)	16 (21.6)	6 (8.1)	74

We asked senior leaders in the NHS, when there is an urgent transfer of a patient from the independent hospital to your organisation, if they received timely and adequate information from the independent hospital (Table 26, Figure 28) and if they provide information to the independent hospital about subsequent treatment and outcomes (Table 27, Figure 30). We asked senior leaders in independent hospitals, when there is an urgent transfer out of the independent hospital to the NHS hospital, if they sent timely and adequate information about the patient to the NHS hospital (Table 27, Figure 29) and whether they are able to find out about their subsequent treatment and outcomes (Table 26, Figure 31). Nearly all respondents from independent hospitals reported that they always send timely and adequate information when there is a transfer. NHS leaders were less certain they received this information from the independent hospital with nearly half stating this was received always or often but over a third answered that they did not know. Just under half of NHS leaders did not know if they provided information to the independent hospital about subsequent treatment and outcomes but under three quarters of independent sector leaders reported that they were able to find out about subsequent treatment and outcomes.

Table 26. Sending and receiving timely information on the patient when there is an urgent transfer

	Always	Often	Sometimes	Rarely	Never	I don't know	Total
NHS - When there is an urgent transfer of a patient from the independent hospital to your organisation, do you receive timely and adequate information on the patient from the independent hospital?	20 (14.7)	47 (34.6)	15 (11.0)	3 (2.2)	1 (0.7)	50 (36.8)	136
Independent sector - When there is an urgent transfer of a patient from your organisation to the NHS hospital, do you send timely and adequate information about the patient to the NHS hospital?	70 (94.6)	3 (4.1)	0 (0)	0 (0)	0 (0)	1 (1.4)	74

Figure 28. Frequency NHS receive information on a patient when there is an urgent transfer

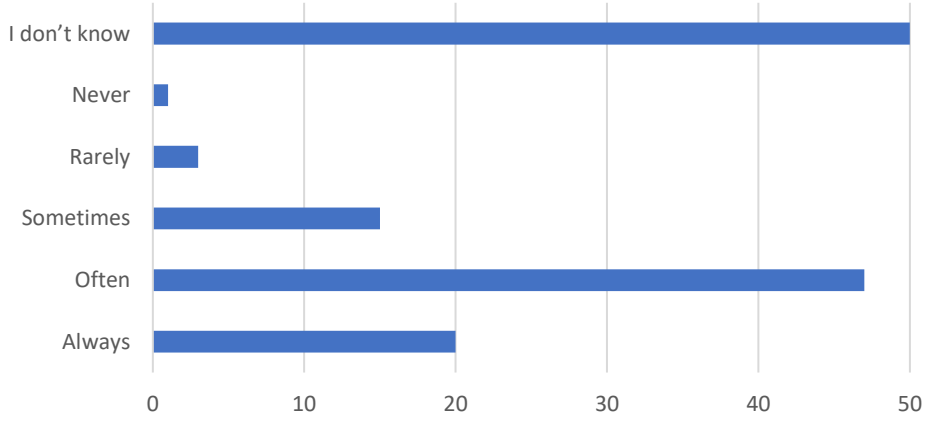


Figure 29. Frequency independent sector send information on a patient when there is an urgent transfer

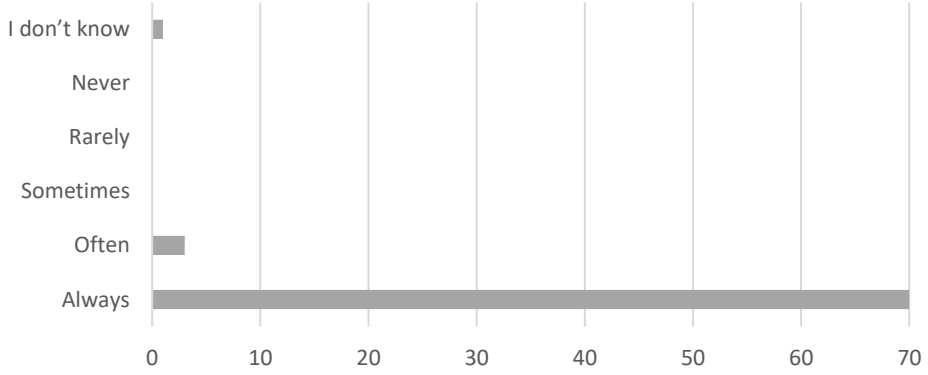


Table 27. Providing and receiving information about subsequent treatment and outcomes following an urgent transfer

	Always	Often	Sometimes	Rarely	Never	I don't know	Total
NHS - When there is an urgent transfer of a patient from the independent hospital to your organisation, do you provide information to the independent hospital about subsequent treatment and outcomes?	15 (11.0)	36 (26.5)	19 (14.0)	3 (2.2)	1 (0.7)	62 (45.6)	136
Independent sector - When there is an urgent transfer of a patient from your organisation to the NHS hospital, are you able to find out about their subsequent treatment and outcomes?	30 (41.1)	22 (30.1)	16 (21.9)	5 (6.9)	0 (0)	0 (0)	73

Figure 30. Frequency NHS provide information to the independent hospital about subsequent treatment and outcomes following urgent transfer

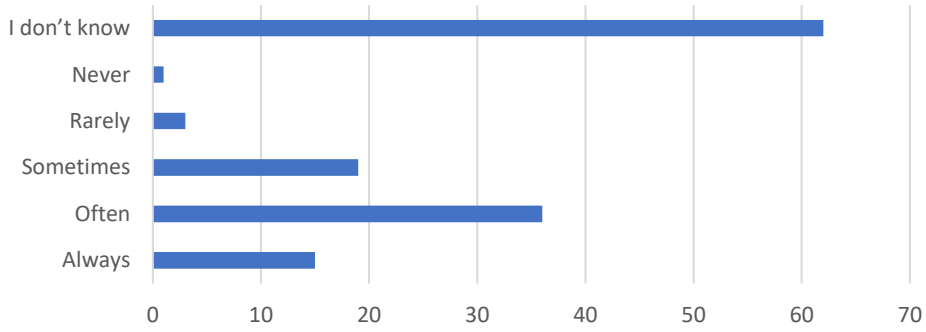
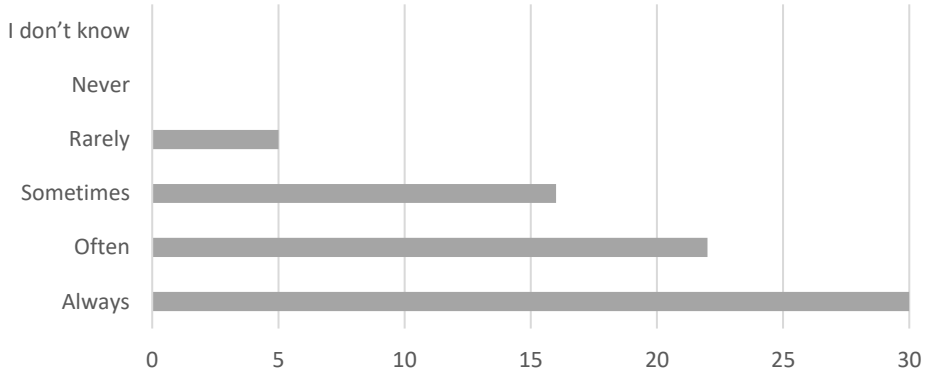


Figure 31. Frequency independent sector receive treatment and outcome information from NHS hospital following urgent transfer



We asked, when a patient is treated on an NHS-funded elective care pathway in the independent hospital, how patient information is transferred from the NHS hospital. Many NHS respondents were uncertain how this happened but mostly respondents stated that notes were transferred in paper format, some specifying that this would be via letter. Sometimes information was transferred electronically via secure email or a shared electronic record system.

We asked what screening and risk management processes they have in place for the safe transfer of patients from the independent hospital to the NHS hospital. Many respondents were unsure of the answer to this question. A large proportion responded that this process was consultant led and involved discussion between consultants from the different sector hospitals. Others referred to policies, agreements or guidelines that were in place for the safe transfer of patients such as risk management policies, transfer guidelines and admission or access policies. Some respondents said this was managed via pre-operative clinics or the ambulance service and the accepting department such as the emergency department or the intensive treatment unit (ITU). Some NHS respondents said that there were no systems in place to cover this and others said there were gaps or areas of concern such as poor communication. A number of NHS respondents mentioned that this was either being reviewed at the moment or was in need of improvement.

> *"All admissions have routine screening for CPE/MRSA and infection control. This is an area of concern as some patients having operations privately would not meet the safe criteria for out of main site operations within our trust. We appear to have little control over this." (Assistant Medical Director, NHS)*

> *"I think there is a lot that could be improved in this area. Neither side communicates well around these issues and I wonder whether the shared learning is optimised." (Clinical Lead, NHS)*

> *"Service level agreement between trust and hospital for emergency transfers using consultant to consultant referral process. Policy to monitor patients who may require transfer to trust and decisions to transfer are consultant led. There is also a patient transfer risk assessment which is completed to ensure the receiving site have all relevant information." (Clinical Governance Lead, Independent Sector)*

> *"There is consultant to consultant telephone referral. Beds are booked and the pt is mostly transferred to a bed and therefore correct specialty. on occasion the trust will ask that the pt goes to A&E. we have access via ACCOTS (Adult Critical Care Transfer Services) to transfer to NHS Critical care units." (Group Director of Governance, Independent Sector)*

We asked how the arrangements for sharing patient information and managing transfers between different sector organisations could be improved. Some respondents stated that the systems they had in place worked well and did not necessarily need to change. Whereas other respondents felt that the ad hoc nature of the arrangements could be improved by the use of standard reporting or an established national policy. Other felt that a dependency on paper notes could be improved with an electronic system for sharing patient records. Some felt that communication could be improved through the use of communication pathways where all appropriate teams and staff are informed of a transfer and relevant procedures are put in place, other said communication could be improved by having named contacts and consultants at the other sector organisations which could be part of a regionally or nationally agreed minimum basic data set. Independent sector respondents reported that it was sometimes difficult to

receive information about the patient from the NHS trust due to patient confidentiality. Independent sector respondents also reported that when patients had to go through A&E this could result de-prioritisation of patients and delays with transfer.

"Information is shared within GDPR rules and Caldicott principles. We do not currently have an electronic patient record so we are reliant on manual processes to scan in records and send them. EPR would improve this. We have a plan to implement an EPR in 2025/26." (Associate Director Quality & Safety, NHS)

"Transfers are reliant on paper notes as the Private sector still uses paper whilst the local NHS hospital is paperless. Most of the time the transfers either go direct to ITU or A&E after relevant phone calls have been completed." (Clinical Lead, NHS)

"A nationally agreed (or regionally agreed) minimum basic data set including the contact details of each of the treating consultants (and their GMC numbers), would allow more timely contact if there is concern and feedback to the individuals." (Assistant Medical Director, NHS)

"We have just recently developed a pathway to follow when the RMO for the independent hospital calls to transfer a patient; this is to make certain the pt gets to the correct place and also so that all relevant staff know the patient is coming to the trust and where they are going. This was created by trust consultants looking after their pt at the independent hospital contacting colleagues and making direct arrangements without telling the pt flow and clinical site management team. So really its communication." (Associate Director of Nursing & Patient Safety, NHS)

"There are no formal arrangements in place, however, teams work with local teams to handover verbally and in exchanging documents. It would be helpful to have IT solutions that interlinked." (Director of Nursing, Independent Sector)

"Secure electronic transfer (information is held in our EPR) for data - this is positive, but only possible since we've had EPR. Some recent concerns raised about delays in ambulance transfer - have resulted in a review of local arrangements for all sites, as well as further guidance to all hospitals about how to ensure timely and effective (safe) transfer." (Chief Clinical Officer, Independent Sector)

"We often rely on the consultants to liaise between us and the NHS as obtaining information from the NHS can be challenging and we are often told they can't update us because of patient confidentiality. Sometimes we just get told that the patient is 'comfortable'." (Hospital Director, Independent Sector)

"A reliable ambulance service that will respond to a transfer request in a timely fashion. Our local ambulance trust very often assumes that because a deteriorating patient is on hospital premises the call is low priority, (i.e. patient in a safe haven environment) when often this is not the case as the deterioration may not be something we can manage as we don't have HDU facilities." (Hospital Director, Independent Sector)

"Patients still need to go via A&E, even though it is a consultant-to-consultant transfer and all notes go with the patient. If we could transfer directly to MAU or SAU rather than through A&E that would be an improvement." (Hospital Director, Independent Sector)

Impact of COVID19 pandemic

We asked senior leaders from NHS and independent sector hospitals if the COVID19 pandemic impacted on the arrangements for clinical governance with the other sector hospital (Table 28) and whether these changes were still in place (Table 29). A third of independent hospital respondents and over a quarter of NHS respondents felt that clinical governance arrangements with the other sector hospital changed as a result of COVID. A larger proportion of independent sector respondents felt that these changes were still in place compared with NHS respondents.

Table 28. Impact of the COVID19 pandemic on clinical governance with the other sector hospital

During the COVID19 pandemic when independent hospitals were providing more NHS funded elective care, did the arrangements for clinical governance between your organisation and the other sector hospital change?	**Yes**	**No**	**I don't know**	**Total**
NHS	38 (27.1)	42 (30.0)	60 (42.9)	140
Independent sector	25 (33.8)	28 (37.8)	21 (28.4)	74

Table 29. Whether changes as a result of COVID19 are still in place

Are these changes still in place?	**Yes**	**No**	**I don't know**	**Total**
NHS	5 (13.2)	22 (57.9)	11 (29.0)	38
Independent sector	10 (40.0)	15 (60.0)	0 (0)	25

We asked what changes there were to the arrangements for clinical governance between the sectors and what impact these changes had. Respondents shared that a number of agreements were put in place and pathways were defined to enable effective working between the sectors and that the independent sector took on more NHS

funded care. Service level agreements, standard operating procedures and key performance indicators were put in place to frame and strengthen the clinical governance arrangements between the sectors. Some respondents reported that the working arrangements improved between the sectors with better communication including improvements in information sharing, issues and risks, better cooperation and increased oversight and robustness.

> *"The methods of information sharing were made more robust during the Covid periods due to the need to increase NHS throughput at that time." (Medical Director, NHS)*

> *"More formal governance processes were set up with quarterly meetings held." (Associate Director Quality & Safety, NHS)*

Anything else

We asked senior leaders if there was anything else they wanted to tell us about the clinical governance arrangements with the other sector. Respondents reiterated a number of challenges related to clinical governance at the interface between the sectors. Some respondents said that the relationships with the other sector was good and that arrangements were robust, however they often relied on goodwill and individual relationships. There was often a good relationship with one provider but for others there was a reliance on doctor probity. Both sector respondents suggested that the other sector were not always willing to share information and seek to create good working relationships. Some NHS respondents were concerned about assurances from the independent sector about the quality of patient care especially at the post-operative stage. One NHS respondent said that both sectors were responsible for a lack of communication and sufficient sharing of information and feedback. There was resentment expressed from one NHS respondent who said that the NHS provided appraisal and revalidation services for consultants who do significant volumes of work privately and that this was something the private sector benefitted from. Some NHS respondents said that the independent sector had a lower threshold for restricting doctors practice as they do not need to deal with concerns through the Maintaining High Professional Standards in the NHS (MHPS) route. A number of independent sector respondents said that there could be better sharing of information between the sectors and that the compatibility of IT systems sometimes hindered visibility and information transfer. Some said they would welcome an update of national guidance, whereas others were hopeful that the introduction of PSIRF and the Learn from Patient Safety Events (LFPSE) service would lead to improvements in joint working and information flow in the future. Some respondents stated that our research project provided much needed focus to these issues and that change would be welcomed and that the survey questions had prompted reflection and discussion on their clinical governance arrangements with the other sector with a view to improve.

> *"Overall, arrangements are informal, ad hoc and sporadic - but usually work as a result of relationships and goodwill." (Director of Nursing, NHS)*

> *"Independent hospitals rely on NHS services for acute care and management of complications but do not, in my opinion, interact or seek to create good working relationships on governance setups." (Medical Director, NHS)*

"I think you have chosen a good subject to look at! I left the IS and i have dealt with a lot of issues with doctors in difficulty in the IS when i was an NHS CMO, the IS are just not interested and hand it all over to the RO/CMO." (Deputy CEO, NHS)

"The independent sector is generally keen to minimise reputational risk, understandably, so has a lower threshold for restriction of a doctors practice, and may remove admitting privileges more readily than an NHS provider." (Deputy Responsible Officer, NHS)

"With the introduce of PSIRF and LFPSE there should be an enhancement of joint working and flow of information, to include collaboration regarding adverse events and investigations. However, this will rely on all organisations to use the PSIRF methodology and use of LFPSE. This also needs clarity on information governance arrangements and use of systems. There is also the challenge of variability of compatible IT systems hindering visibility and information transfer". (Clinical Governance Lead, Independent Sector)

"I feel we provide a lot of information directly to the trust but feel we get less back from them." (Hospital Director, Independent Sector)

"I do think there is always room for improvement with relationships in the NHS but often they are not keen to engage!" (Hospital Director, Independent Sector)

References

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Annex A – Survey design, methods, response rate and analysis

Survey design

The study received research ethics approval from the National Research Ethics Service in England. Agreement to take part was implicit through completion. Stakeholders involved in the survey development included: NHS Medical Directors, a Chief Nurse, Clinical Governance leads in the independent sector, members of the Project Advisory Group and our Patient and Public Involvement Group. Stakeholder feedback was reviewed by the project team and the survey was adapted accordingly. An online bespoke questionnaire consisting of 56 questions was produced using Qualtrics software. Information was gathered about clinical governance processes between NHS hospitals and independent hospitals including: whole scope of practice appraisal and revalidation, dealing with significant concerns, understanding capacity and capability, sharing patient information for elective care and transfers and the impact of the Covid 19 pandemic (a copy of the survey is available on request from the authors).

Survey distribution

A contact list was developed using contact information from the General Medical Council (GMC), the Care Quality Commission (CQC), a contact of one of the research team and a commercial UK healthcare contact data provider. Correspondence with contacts to inform them of the research and to encourage engagement allowed us to refine the contact list, amending incorrect email details and removing people who indicated they were not responsible for clinical governance at their organisation, had changed roles or had left the organisation. The survey link and reminders were distributed via email to these validated contacts – 769 people (593 senior leaders from NHS trusts and 176 senior leaders from independent hospitals in England). Senior leaders included: Chief Executives; Chief Medical Officers; Chief Nurses; Clinical Governance Leads; Directors of Clinical Services; Directors of Nursing; Hospital Directors; Matrons; Medical Directors and Responsible Officers. The electronic link to the survey was active for four months between December 2023 and April 2024.

Survey analysis

The survey was analysed using frequency tables to describe numeric and Likert scale data. Thematic analysis was used to analyse the written responses to 14 questions about perspectives on clinical governance relationships between the sectors, how they have developed and how they could be improved; details of clinical governance meetings; the process for obtaining information about scope of practice, how this is verified and how it could be improved; the strengths and barriers with sharing information about concerns, restrictions and referrals; how patient information is shared between the sectors; screening and risk management processes for patient transfer; and the impact of the pandemic on clinical governance arrangements.(Braun and Clarke, 2012) Patterns of shared meaning were identified utilising an inductive approach where coding and theme development is based on the information found in the responses. Respondent's free-text comments were brief and were used to supplement the findings from associated quantitative questions.(Byrne, 2022) Familiarisation with the free-text data was achieved through iterative reading and for each question possible codes were noted, taking account of repeated words or meaning. All written comments were reviewed holistically and overarching themes were mapped, encompassing the key messages across the data.