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Albion Chambers REGULATORY NEWSLETTER

Under-regulated?

Private hospitals and lessons from the Paterson Inquiry Report

Ian Paterson carried out unnecessary and botched breast surgeries in both public and private hospitals. He was imprisoned in 2017. However, investigations into his abuse revealed the poorer practices of some independent providers of health care and underlined the need for improved focus on patient safety. February 2020, saw the findings of the Paterson Inquiry published, along with recommendations for improving patient safety in private hospitals[1].

This is not a newly-identified problem. In 2017, the Centre for Health and Public Interest (CHPI) issued a report "No Safety Without Liability"[2]. In independent hospitals, liability does not lie with the hospital but with the individual consultant. The CHPI report concluded that "The Ian Paterson scandal represents a major failing of the private hospital business model and exposes the ineffective way that private hospitals in England are regulated". Whilst acknowledging that civil and criminal liability lay with Paterson himself, the report writers concluded that the way hospitals are run allowed his abuses to occur, and that "This, in itself, requires a public policy response from the Government and at the very least an independent inquiry". The report noted that this was particularly urgent, given the increasing numbers of NHS patients being treated in private hospitals – a trend which continues.

The report's recommendations were as follows:

1. Private hospital companies should directly employ surgeons, anaesthetists and physicians who work at their hospitals, and take on responsibilities for their monitoring and appraisal;

2. There should be facilities on site to deal with patients whose condition deteriorates, to avoid the need for risky transferrals to NHS hospitals for those patients with life-threatening post-operative conditions;

3. Junior doctors should no longer work alone on extreme shift patterns to provide post-operative care;

4. Private hospitals should be required to adhere to the same reporting requirements as the NHS to improve the chance of harm to patients being detected;

5. Legislative amendment should provide that all private hospitals registered with CQC should be fully liable for all the services they provide including the actions of surgeons and healthcare professionals.

In 2018, a report on the sector by CQC[3] found a lack of robust oversight of practising privileges for consultants, as a result of a culture of viewing consultants as 'customers' of the hospitals, who attract business if they have a good reputation. Bosses, therefore, have a disincentive to look at what consultants in fact do, and because if blame is established for a mishap it is the consultant's insurers who pay, there is no incentive for the private hospital to minimise risk.

The Paterson Inquiry report has echoed the CHPI report's findings of concerning holes in the regulation of private healthcare. The report makes far-reaching recommendations, covering many areas, from information available to patients (there should be a database available to all showing how many times a practitioners has performed particular procedures), recall of patients (there should be a national framework or protocol for the management and communication of patient recall), to complaints. There were a number of recommendations of particular interest to those involved in the regulatory sphere.

Firstly, the report noted that the care of patients treated by Paterson was not discussed at properly constituted Multi-Disciplinary Team meetings. This is a requirement of national guidance in relation to breast-cancer care, and is considered by CQC under the 'safe' and 'effective' sections of its inspection. It was recommended by the Inquiry that CQC should, as a matter of urgency, assure itself that all hospital providers are complying effectively with up-to-date national guidance on MDT meetings, and that patients are not at risk due to non-compliance in this area.

Secondly, the report highlighted the problems posed by liability lying with the individual practitioner and the potential for patients to be left unable to claim damages. Medical defence organisations cover such costs but are not subject to financial conduct regulation and they have a discretion as to whether to provide indemnity cover. In the case of Paterson's victims, they were left without cover because the Medical Defence Union used its discretion to withdraw on the basis that Paterson's activity was criminal. The report recommended that the Government should, (again, as a matter of urgency), reform the current regulation of indemnity products, and introduce a nationwide safety net to ensure that all patients have access to damages.

Thirdly, the report made a damning

1. https://assets.publishing.service.gov.uk/Government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf
2. https://chpi.org.uk/papers/reports/no-safety-without-liability-reforming-private-hospitals-england-ian-paterson-scandal/
3. https://www.cqc.org.uk/sites/default/files/state-care-independent-acute-hospitals.pdf

observation in relation to what might be summarised as a bloated but ineffective regulatory system:

"In 2018/19, the Care Quality Commission, the General Medical Council and the Nursing and Midwifery Council, had a total annual budget of over £435m per year, and between them employed over 5,200 people. In addition to this, the Professional Standards Authority for Health and Social Care employed a further 40 people with an annual budget of £4m, raised by fees paid by the regulatory bodies it oversees.

Despite the scale of the regulatory system, it does not come together effectively to keep patients safe. We also heard that it is not accessible or understood by patients. We do not believe that the creation of additional regulatory bodies is the answer to this."

The resulting recommendation is somewhat nebulous – that the Government should ensure that the current system of regulation serves patient safety as the top priority – but the observation that the recommendation was made because of *"the ineffectiveness of the system identified in this Inquiry"* ought to make ears prick up in Whitehall. Once a government system designed to protect life has been publicly labelled as ineffective, there are potential Human Rights Act-based consequences for the Government.

Fourthly, the report recommended that suspension should result if a hospital investigates a professional's behaviour and identifies that a patient has been put at risk, and concerns should be communicated to any other provider that professional works for.

Fifthly, the report recognised again the problems posed by the self-employed status of consultants working in private hospitals, and their engagement through practising privileges, in terms of the hospitals avoiding liability for the consultants' actions. The report recommends that the Government addresses this gap in responsibility and liability as a matter of urgency.

Finally, the report highlighted that the different governance models of the independent sector and the NHS result in differences in the extent to which recommendations accepted by the Government are adopted. Whilst good practice is implemented in the NHS, it is often voluntary in the independent sector, and when adoption does happen the focus is often on innovation and flexibility (business-focused?) rather than patient safety. As a result, the report recommended that if the Government accepted any of the recommendations made, it should ensure that they are adopted across the whole independent sector if it is to qualify for NHS-contracted work.

Comment

Some have already suggested that the Paterson Inquiry represents a missed opportunity to improve patient safety, and failed as an exercise in root cause analysis. In an article published in the British Medical Journal on 19 February 2020[4], David Rowland of CHPI suggest that the learning points fail to focus sufficiently on the financial incentives for consultants to over-treat patients and the business reasons for hospital management to turn a blind eye. Ultimately, the business model has profit at its heart, rather than patient safety – right down to the fact that the consultant renting a room from the hospital, rather than being employed, is beneficial for tax purposes for both parties. There is criticism of the report's failure to recommend that private hospitals should employ those who work there, and Mr Rowland noted that the Spire hospital wrote to one of Paterson's victims saying that it was "under no obligation to provide competent surgeons to perform breast surgery" (it has since apologised). The Inquiry report is also criticised for placing responsibility for safety with the patient, e.g. in recommending the national database of consultant performance data.

Practitioners representing private hospitals should expect a laser-sharp focus from CQC and other regulators on the issues raised in the Inquiry report in coming months. Whether the Government will legislate in the ways recommended by the report remains to be seen, but with so much pressure on the NHS, there is a clear incentive for the Government to ensure that the public continues to view private healthcare and surgery as a safe alternative.

Anna Midgley

4. https://blogs.bmj.com/bmj/2020/02/19/david-rowland-the-paterson-inquiry-is-a-missed-opportunity-to-tackle-systemic-patient-safety-risks-in-private-healthcare/

The exciting world of H&S statistics

If you wish to swiftly conclude a date with a normal person, begin by talking about statistics. It is remarkable how previously unmentioned, but ever-so urgent 'other plans', need attending to. Conversely, when speaking to non-normal people, let's call them other regulatory and health and safety lawyers, talking about statistics captures the romance, interest and the heightened emotions of the 'spaghetti' moment in Lady and the Tramp. Simply electric. So to satiate the readers' dark desires for all things 'stats', this article will focus on this enticing topic based on the most recent published H&S stats.

If you don't like statistics*, or bullet points, this isn't the article for you…

What's the picture related to workplace illnesses?

- 1.4m people in Great Britain suffering from work-related ill-health
- 0.6m people suffering from work-related stress, depression or anxiety
- 0.5m people suffering from work-related musculoskeletal disorders

But what about workplace injuries?

- 0.6m people sustained non-fatal injuries whilst at work
- Of which, 69,208 were reported by their employers
- 147 fatal injuries sustained whilst at work
- 12,000 lung-disease deaths per year resulting from previous workplace exposure.

What does this cost?

- £9.8b cost of new ill-health cases to British economy and state
- £5.2b cost of workplace-injury cases to British economy and state
- 28.2m working days lost.

Are any trends or conclusions discernible?

- Stress and depression account for over half of all lost days
- But account for only 44% of new workplace-injury cases
- Therefore, stress and depression cause workers to be away from work for longer

- Industries with higher than average stress, depression or anxiety include public admin and defence, health and social work, and education
- Since 2001 there has been a gradual increase, though fluctuating trend, in cases of stress, depression and anxiety
- Upper limb, neck and back injuries account for 80% of musculoskeletal injuries
- Industries with higher than average musculoskeletal injuries are, unsurprisingly: construction, agriculture, forestry and fishing, and health and social care
- Health and social care is the only industry to appear in the 'top three' for both physical and mental injury
- Since 2001, there has been a gradual increase, though fluctuating trend, in cases of musculoskeletal injury.

A European perspective

- The UK has the fewest (per head of population) fatal injuries, marginally lower than Germany
- France has the most
- The UK has the second fewest workplace-related injury sick-leave days. Poland has the fewest
- France has the most
- The UK has the fewest workplace-related illness sick-leave days, marginally less than Italy
- Poland has the most.

All in all, I hope you'd agree, a most enjoyable romp through some statistics. Until next year…

Richard Shepherd

* Data available at https://www.hse.gov.uk/statistics/overall/hssh1819.pdf

HSE Prosecutions

Lower risk/higher consequence?

The Health and Safety Executive ('HSE') recently published its annual statistical release: 'Enforcement Statistics in Great Britain 2019'. It showed a continuing trend for fewer prosecutions, with a reduction in the number of cases brought to prosecution for the third year running.

In 2018/19 the HSE and Crown Office and Procurator Fiscal Service ('COPFS') in Scotland prosecuted 394 health and safety cases, down 23% from the previous year. The 394 cases where a verdict was reached was the lowest seen in the last five years.

The statistically-significant reduction cannot be explained by any change in HSE prosecution policy, which has been unchanged in recent years. The HSE is looking into the falling rates and the publication offered three explanations:

- The increased time being spent on dealing with challenges raised with defence solicitors on the Sentencing Guidelines;
- A greater number of 'Newton' hearings;
- A larger than normal number of inspectors in training.

It is of interest that these are described (at page 3 of the publication) as "factors in this decrease", whereas in the source (HSE Annual Report and Accounts 2018/19 at page 31) they are described only as "*potential* factors" (emphasis added) with no further source added.

Nonetheless, the change in the sentencing landscape for health and safety cases over recent years has meant the consequence of conviction for a health and safety offence (upon prosecution by HSE or other agencies) has greatly increased. The conviction rate also remains noteworthy, in 2018/19 this was 92%, up slightly on the 91% recorded for 2017/18. The proportion of cases resulting in a conviction (for at least one offence) has been between 92-95% for the last five years.

The total fines level levied by the courts following HSE or COPFS prosecutions was £54.5 m in 2018/19, noticeably lower than the £72.6 m in 2017/18. However, the average fine per case was £150,000. This was close to the 2017/18 average of £148,000, itself a rise of 17% from the previous year and which meant the average level of fine had increased over 400% during the three-year period from 2014/15 – i.e. the final full year before the Sentencing Guideline for Health and Safety Offences was implemented in February 2016 (when the average fine was £27,000).

The HSE statistics for 2018/19 provided a further comparison with those for 2014/15. The highest fine in 2018/19 was £3 million and 36 cases led to a fine in excess of £500,000. The largest fine in 2014/15 was £525,000, with only five cases with fines of £500,000 of more.

The increase in average fines over the period is noteworthy in itself, but also in striking contrast to the level of fines recently imposed by the Magistrates' Court for health and safety offences; levels which until recently would have been striking in high-profile cases dealt with in the Crown Court and upon appeal.

Prior to 12 March 2015, the fine options available to magistrates were 'capped' depending on the nature of the offence committed. Fine levels were set on a "standard scale" of 1-5 (5 being the most serious with a 'cap' of £5,000). Some offences fell outside of the standard scale. In respect of health and safety offences (falling under the Health and Safety at Work etc. Act 1974 ('HSWA') and the Health and Safety (Offences) Act 2008), fines were capped at £20,000.

On 12 March 2015 (with the coming into force of s.85 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012), magistrates were granted powers to issue unlimited fines for health and safety offences. Recent cases demonstrate little reluctance on the part of the Magistrates to exercise these powers:

- On 9 January 2020, DB Cargo (UK) Ltd was fined £1.2m, with £27,873.03 costs, after being convicted of one offence under s.3(1) of the HSWA at Wolverhampton Magistrates' Court, following a prosecution by the Office of Rail and Road.

The court heard that a 13-year-old boy suffered life-changing injuries after receiving an electric shock from overhead line equipment at Bescot Yard freight terminal in Walsall. DB Cargo had failed to take reasonably practicable measures to prevent trespassers from entering the Yard.

- Tesco Stores Limited was fined £733,333.33 at Luton Magistrates' Court on 24 January 2020 following a prosecution by Dacorum Borough Council. This arose from breaches of Tesco's s.2 and s.3 HSWA duties, after a 91-year-old man suffered multiple fractures to his hip at a Hemel Hempstead store.

These fines reflect a demonstrable

trend towards the Magistrates being ready to flex their new-found sentencing muscle (some might say in contrast with the caution exercised by the higher courts when dealing with 'very large' organisations). Other recent examples include:

- On 24 July 2019, Delphi Diesel Systems Ltd were fined £1,000,000 and ordered to pay costs of £9,374 at Cheltenham Magistrates' Court for a breach of s.2(1) of the HSWA. Two employees of the Company were burnt when the vapour of a flammable chemical being used to clean a distillation tank, ignited and caused an explosion. Both employees suffered significant burn injuries, with the injuries of one being so serious they could not return to work for over two months.
- On 29 March 2019, 2 Sisters Food Group Ltd, was fined £1.4 million with £38,000 in costs at Doncaster Magistrates' Court for breaches of s.2(1) and s. 3(1) of the HSWA after a worker was injured while unblocking a machine on the poultry slaughter line.
- One week earlier, on 22 March 2019, another food company – Karro Foods Ltd – had pleaded guilty to breaching s.2(1) of the HSWA and was fined £1,866,000 and ordered to pay £8,019 in costs by Leeds Magistrates'. This followed two workers suffering serious injuries when they fell over four metres through a rooflight.

So, fewer HSE prosecutions and no indication that this trend will be halted, but there has been a demonstrable step-change in the consequences for breaches of the HSWA, not only in the more high-profile cases, but also in those where their allocation to the Magistrates' Court would (on a superficial level) suggest them to be less serious.

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