Bentinck House
3-8 Bolsover Street
London, W1W 6AB
Email: office@fipo.org
Tel. 0207 339 3292
www.fipo.org

FIPO
federation of independent practitioner organisations

The Bishop of Norwich's Paterson Inquiry: FIPO Response

FIPO, *The Federation of Independent Practitioner Organisations, gave evidence to the Rt. Rev Graham James' inquiry into the actions of breast surgeon Ian Paterson. It highlighted concerns which led to many of the Report's recommendations. A* ***FIPO*** *Board member served on the Inquiry's Clinical Panel.*

BACKGROUND TO THE REPORT

Midlands breast surgeon Ian Paterson performed inappropriate surgery on many thousands of patients. Concerns about his practice were first raised in 2003, and he was suspended from his NHS Trust and Private Hospitals in 2011. In April 2017, he was convicted of wounding with intent, and unlawful wounding. His sentence of 15 years imprisonment was felt to be too lenient and was increased by the Court of Appeal to 20 years in August 2017.

In December 2017 the Secretary of State for Health set up an independent, non-statutory inquiry into Paterson's malpractice, chaired by the then Bishop of Norwich, the Rt. Rev. Graham James. The Inquiry heard from 211 patients and individual patients' relatives and published its report on 4 February 2020.

Its recommendations relate to Patient information, consent, complaint management, and ongoing care; access to specialist multi-disciplinary teams; clinical indemnity, and the regulation and investigation of Professional practice and behaviour; and Corporate accountability.

Patient information about doctors

The Report recommends that information about individual consultants should be available. A Consultant Information Sharing System is being developed jointly by the Independent Hospitals Provider Network (IHPN) and the NHS, and **FIPO** have been asked to advise on this initiative. Information should be published about the number and types of procedures performed by doctors in their whole practice across the NHS and the private sector. **FIPO** endorses this not just for patient information, but also to reduce the number of places to which doctors would need to submit data.

The Private Healthcare Information Network, PHIN, has been mandated by the CMA to record the numbers of procedures performed. **FIPO** however maintains that numbers alone are not a measure of the quality of care or indeed the likelihood that an individual patient will have a successful personal outcome. It is important that the individual consultant's privacy is respected and that there is independent medical oversight.

Communication with patients

The 2013 Kennedy and current 2020 Inquiries both raised concerns that some of Paterson's letters to GPs did not correlate with the discussions, which he had had with individual patients, and this might have prevented his malpractice from being discovered earlier.

Bentinck House
3-8 Bolsover Street
London, W1W 6AB
Email: office@fipo.org
Tel. 0207 339 3292
www.fipo.org

The Bishop of Norwich recommends that doctors in the NHS and private sectors should address the clinic letters about their diagnosis and treatment options to the individual NHS and private patients with copies to their GPs; these letters should be written in simple English. Whilst it is clearly in the best interests of patients to have clarity about their conditions, some difficulties may arise from the stipulation that "simple English" should be used. Clinical letters are important documents and there are some doctors with highly specialised practices, where many patients are secondary or tertiary referrals needing complex opinions and extensive clinic letters. There may be misunderstandings if non-medical generalities are used, or difficulties from inexact terminology if medico-legal concerns arise. Nevertheless, **FIPO** would support the general use of simple English with the use of technical terms, where required for clinical accuracy.

Consent

Some of Paterson's patients said that they felt pressured to have surgery, due to the alleged urgency of their condition, but did not receive adequate explanations about therapeutic options or treatment risks. Some of this "clinical urgency" was entirely fictitious.

As a result, the Inquiry has recommended that a "cooling off period" should become standard practice as part of informed consent, to allow reflection on treatment choices. In practice, depending on the patient's condition there will normally be a period of waiting between consultation and treatment.

This may lead to patients routinely having to return for a separate "consent clinic appointment" prior to admission to hospital. This has become standard practice for some specialties, such as spinal surgery and cosmetic surgery. However, introducing this across the NHS and private sectors would require a substantially greater number of outpatient appointments, which would need to be funded either by the taxpayer, the private insurers or the patients themselves. The administration and costs of this might be difficult to implement.

Procedure coding and information sharing about individual clinicians

In order to disseminate information about an individual consultant's caseload, all procedures performed need to be accurately coded. However, procedure coding differs significantly between the NHS and private sectors. The NHS uses OPCS-4 and ICD-11, and often include multiple codes for accurate description of clinical episodes. Private insurance companies use Clinical Coding & Schedule Development (CCSD), which often bundles together various aspects of a clinical episode to generate a single code for billing.

As many private hospitals providers perform NHS work as well, they have to duplicate their coding to meet the NHS and PHIN requirements as well as those of the PMIs, using different systems. **FIPO** agrees with the recommendation of the Inquiry that there should be a transparent collection of procedures across the NHS and private sectors. In order to do this accurately, the NHS coding system of OPCS and ICD-11 should become the universal currency of clinical coding and this would better allow for accurate data capture of complex procedures requiring multiple interventions. **FIPO** has been asked to advise CCSD on these issues.

Multidisciplinary Team (MDT) Meetings

The Bishop of Norwich and his professional clinical advisers agreed that all patients (not just cancer patients) requiring multi-disciplinary discussion should be discussed in a properly constituted MDT meeting,

Bentinck House
3-8 Bolsover Street
London, W1W 6AB
Email: office@fipo.org
Tel. 0207 339 3292
www.fipo.org

with the results recorded and disseminated appropriately. The Inquiry recommended that, as a matter of urgency the CQC should ascertain that all hospital providers are complying effectively with up-to-date national guidance on MDT meetings.

At its meeting with the Inquiry, **FIPO** emphasised that, although MDT discussion occurs routinely for appropriate NHS patients, this does not happen in a uniform manner for private patients requiring multidisciplinary care. In some parts of the country, patients covered by private health schemes are discussed within the context of the local NHS MDT meeting, often without funding from their insurer, even though MDT meetings consume significant resource.

The NHS is unable to take on the financial burden and medico-legal responsibility for hosting MDT discussions for private patients without appropriate reimbursement. Although some PMI companies claim that the consultation fees charged by consultants should cover MDT discussions, the actual cost of presenting a patient for MDT discussion is greater than the consultation fee reimbursed by the insurer. Clinicians present at the MDT may not have been previously involved with the patient or received a consultation fee.

Reimbursement for MDT meetings was previously covered by some PMI companies, but this was subsequently withdrawn. For this recommendation to be met, PMI companies will need to reinstate reimbursement for their subscribers' MDT discussions.

Complaints

Every patient has the right to an independent resolution of their complaint, though the Inquiry found that many private patients were unaware of this option. Unlike those treated in the NHS, they cannot complain about their care to the Parliamentary and Health Service Ombudsman (PHSO). Some private hospital providers subscribe to the Independent Sector Complaint Adjudication Service (ISCAS), which offers independent investigation and adjudication of complaints, and it is likely that all private hospital providers will be mandated to subscribe to ISCAS.

FIPO would recommend that every provider in the private sector including the PMIs should be subject to independent oversight. Some insurance companies have introduced their own internal clinical review of an individual consultant's decision to treat; these reviews are performed by consultants employed by the PMI companies, who have never seen or examined the patient concerned. **FIPO** has previously stated in Independent Practitioner Today that it believes that these clinical decisions and referral pathways made by PMIs should be subject to independent medical review without commercial constraint. This should mean prospective audit of both aggregate and individual decisions.

Differences: the NHS and private hospitals

The Inquiry found that the arrangements for emergency care and the employment status of consultants practising independently were often not explained to patients.

Unlike the NHS, most private hospitals are relatively small and do not have comprehensive facilities such as critical care units (CCU) and will only treat relatively fit patients. Many private hospitals have formal agreements with the local NHS hospital for private patient care in a NHS CCU, if required.

Bentinck House
3-8 Bolsover Street
London, W1W 6AB
Email: office@fipo.org
Tel. 0207 339 3292
www.fipo.org

Consultants practising privately are almost all self-employed. The relationship between private patients and their consultants is outlined very clearly in the **FIPO** Patients Charter.

It is expected that in future, the private sector will have to disclose information such as what practising privileges are held, indemnity, and provisions for transfer of sick patients.

The employment model may gain traction in the private sector but there are a number of issues, not least potential compromise of professional autonomy, which should be considered before such an approach becomes the norm.

Indemnity

Paterson's medical defence organisation (MDO) declined to cover his malpractice, as the cover which he had subscribed for was discretionary. The MDO exercised their discretion to refuse to settle any claims as his actions were deemed to be criminal as opposed to negligent.

The Inquiry has recommended an urgent review of medical indemnity, so that there can no longer be discretionary withdrawal of cover, which might disadvantage future patients. **FIPO** concurs with this view.

Investigating poor practice

Concerns within the NHS about Paterson's practice were subsequently referred to the National Clinical Assessment Service (NCAS - now known as Practitioner Performance Advice). The fact of the referral was deemed to be a confidential HR issue and not shared with other hospital providers.

The Inquiry has recommended that, in future, any concerns about an individual doctor should be shared between all hospital providers where the doctor works, most likely by enhanced communication between Responsible Officers. A similar recommendation is in the Medical Practitioners' Advisory Framework (MPAF) document prepared under the chairmanship of Sir Bruce Keogh, with which **FIPO** assisted.

The Report also recommends that any investigation which highlights a perceived risk to patient safety should lead to the suspension of an individual healthcare professional, until the investigation has been completed. This Inquiry recommendation prioritises any perceived risk to patient safety above the reputation of hospital institutions or health care workers. However, the Report does not state what immediate measures should be take, if the perceived safety risk arises from systematic failures in the institution. **FIPO** believes that the issue of 'patient safety' needs clear guidance for its interpretation and application. In addition, a contextual understanding is necessary before any precipitate actions are taken against individuals.

Medical Advisory Committees (MACs)

Private hospitals have so far relied on unpaid MAC Chairs, MAC Governance Leads & MAC members to provide clinical oversight on matters such as practising privileges, clinical governance, patient safety, and complaints management. The MAC is only advisory and has no executive power. The registered hospital manager and matron make the final decisions in line with policy set up by each hospital group. The Report

Bentinck House
3-8 Bolsover Street
London, W1W 6AB
Email: office@fipo.org
Tel. 0207 339 3292
www.fipo.org

has not suggested dismantling the private sector practising privileges model, instead placing significantly greater responsibility on the hospital senior management team and the MAC.

It is likely that significant reform will be required for MACs. **FIPO** published guidelines for MACs in the private sector more than 15 years ago and is now working with IHPN and others to update these guidelines so that these are fit for purpose in the current era.

Corporate accountability

During the Class Action in the High Court, Spire Hospitals attempted to distance itself from Mr. Paterson by stating that he was a self-employed surgeon, who had been granted practising privileges. This stance was criticised by Sir Ian Kennedy's Report as well as by this Independent Inquiry. There was also concern that the hospitals, where Paterson had practised, had not apologised to patients. The Inquiry recommended that apologies should be offered at the earliest opportunity regardless of any potential liability issues, in the same way that the duty of candour should compel doctors to apologise when things go wrong.

The Bishop of Norwich has recommended that the issue of the corporate liability of private hospitals should be urgently addressed. In future, it is highly likely that the individual private hospitals, as well as the hospital groups to which they belong, will be wholly or partially liable for the actions of individual donors working in them.

Patient recall

The recall of affected patients was fragmented and poorly coordinated. In future, the NHS and private sectors will have to develop a coordinated protocol, which will allow for a comprehensive recall off patients in any future incident involving large numbers of patients. The Acute Data Alignment Project, which is currently out for consultation, proposes the merger of public and private sector data. Notwithstanding the interpretation differences between data across the sectors, if successful and used with intelligence, this should assist with any future patient recall. **FIPO** will be responding to the consultation in detail.

Regulation and whistleblowing

One of the Paterson's consultant colleagues presented evidence about Mr. Paterson's malpractice in 2003. This and other subsequent concerns were ignored by the Trust. In 2007, several doctors wrote formally to the Trust, expressing grave concerns. Subsequently four of the whistleblowing doctors were referred to the GMC, in order to determine their fitness to practice.

Although the Inquiry has not recommended any additional regulator measures, the Bishop of Norwich has proposed better collaboration between regulators, who should make patient safety their top priority. Currently, several thousand staff are employed by the CQC, GMC & NMC with an annual budget of £435 million.

Sir Robert Francis' Inquiry into the Mid Staffordshire scandal in 201 led to the establishment the Freedom to Speak up Guardians (FtSU). However, the Bishop of Norwich noted:

Bentinck House
3-8 Bolsover Street
London, W1W 6AB
Email: office@fipo.org
Tel. 0207 339 3292
www.fipo.org

"Protection of whistleblowers was not in place when concerns were raised about Paterson in the NHS in 2003 and 2007. However, we observed a belief among healthcare professionals that those who raise concerns or whistle blow today could still be penalised in some way, despite this protection."

FIPO raised the matter of whistleblowers and their protection to the Inquiry. If there is to be no additional regulation, there will have to be significant improvement. The CQC is statutory regulator and already encourages providers to develop a Whistleblowing Policy for use within their organisations. Further, the CQC may wish to consider establishing a confidential reporting service for whistleblowers, to provide a safety net when the FtSU up process fails to deal with the safety issues raised. It would then be incumbent on the CQC to seriously consider and investigate independently these safety concerns.

Conclusion

FIPO believes that every doctor's primary responsibility is to the patient and has always upheld this GMC requirement. **FIPO's** Patients' Charter very clearly describes how this relationship should work. Paterson's aberrant practice was able to continue because of a failure of clinical governance, which should have been effective and free from conflicting interests. Private medical practice requires independent professional medical oversight of all decisions on patient pathways and should not be constrained by financial concerns.

FIPO believes that it is important that actions taken by Government as a result of this Inquiry's recommendations are applied to all stakeholders in the independent sector including doctors, providers and PMIs.

Bentinck House
3-8 Bolsover Street
London, W1W 6AB
Email: office@fipo.org
Tel. 0207 339 3292
www.fipo.org

APPENDIX

The FIPO Patients Charter