



AIHO

Association of
Independent Healthcare
Organisations

AIHO Guide

to Independent Acute Hospitals
for CQC Inspectors

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Introduction

This document is intended to highlight the differences and similarities between independent acute hospitals and NHS Trusts. It covers key concepts particular to independent hospitals, within the framework of the CQC's 5 Key Questions and associated Key Lines of Enquiry (KLOEs).

The document is a guide and is not designed to be read as definitive. Independent hospitals are diverse and have adopted different approaches to meet CQC requirements. The document uses the term 'independent hospitals' to mean 'independent acute hospitals' throughout.

Overview of independent hospitals

Before the National Health Service began in 1948, many hospitals across the UK were what we would now term independent. Since 1948, independent hospitals have existed alongside NHS hospitals, providing choice for people. In 2013, the independent hospitals sector was estimated to contribute £5 billion to the UK economy.

More than 1.5 million patients receive surgical treatment in independent hospitals every year.

On average, independent hospitals have 60-70 beds, compared with the 'traditional' NHS hospital with typically more than 350 beds. Most independent hospitals are elective only and so are not set up for urgent or unplanned care. However, London hospitals are often larger and more complex.

A key feature of independent hospitals is their diversity. Hospitals range from those established by charitable foundations or religious orders, through the not-for-profit sector or specialist providers, to large corporate hospital groups (the largest of which has 59 hospitals and treatment centres).

Overall patient mix across the sector is that 50% are insured patients, 28% are NHS-funded, and 22% self-funded.

Each hospital will treat a mix of funded patients, which fall into four main groups: insured, NHS-funded, self-paying or embassy sponsored. The majority of insured patients are supported through work-related benefit schemes such as corporate medical insurance, while others are self-funded insurance. It is a minority of hospitals (mainly London based) that treat a proportion of embassy sponsored and internationally insured patients. More information on working with the NHS is included in the section on *Responsiveness*.

Regulatory framework

The regulatory framework for independent hospitals dates back to 1984 and has seen various changes since then.

1984

The Registered Homes Act

2000

The Care Standards Act (CSA)

2002

The CSA Private and Voluntary Health Care (England) Regulations 2001 come into force.

2010

The Care Quality Commission (Registration) Regulations 2009, and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 bring the NHS and independent sector under similar arrangements for 'regulated activities'. Essential Standards are introduced.

April 2015

Guidance for providers on meeting the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which have the Fundamental Standards at their core, replace the Essential Standards.

The April 2015 amendment to the regulations provided for consistency between the NHS and independent sector with respect to Fit and Proper Persons, Directors (Regulation 5). The 2015 amendment also created a variation between the NHS and the independent sector, with respect to the regulation on Statutory Duty of Candour. This is explained in more detail under *Lessons learned and improvements* on page 5.

Monitoring and Inspection

The 'information' requirements across the independent sector are being standardised following the establishment of the independent information organisation, the Private Healthcare Information Network (PHIN), mandated by the Competition and Markets Authority. All hospitals in the UK that offer privately funded healthcare (including NHS private patients units) are now required to submit data to PHIN. The publication of information that is directly comparable to the NHS will be available from April 2017.

CQC is already working closely with PHIN to align information and data releases.

The data and information required to complete the Provider Information Return (PIR), and that available on inspection, may not be in the format usually seen in the NHS.

Safe: Protecting people from avoidable harm and abuse

Track record on safety

The independent sector has sought access to the National Reporting and Learning System (NRLS) but to date has been unsuccessful. The sector does report externally over time, as required by regulation, contract or quality systems, to CQC, Coroner, Public Health England, NHS commissioners, private medical insurers and PHIN. The national framework being established by PHIN will provide a comparison on safety performance with similar services.

Each hospital documents information internally to record, review and take action to continually improve safety over time. However, hospitals take different approaches to recording and analysing incidents, concerns and near-misses, depending on the size and maturity of the organisation. These range from spreadsheets or in-house databases, to large well known systems such as Datix or Ulysses. Safety goals or continual improvement cycles may be set at a national level, for example for large corporate organisations or at a hospital or ward level.

Local safety audits include areas such as surgical safety (World Health Organisation) checklist, patient falls, venous thrombosis embolism (VTE) and infection prevention and control (IPC) standards.

Lessons learned and improvements

Many hospitals will use the NPSA Being Open Framework to support conversations with patients when something goes wrong, including giving an apology and informing them of actions taken.

The Statutory Duty of Candour threshold in the independent sector varies from the NHS with respect to the description of a 'notifiable safety incident' (NSI).

The independent sector NSI description is aligned with Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, against which the sector has reported since 2010 (NHS exempt as reported through NRLS). However, the intention is that they should cover the same incidents.

Reviews and investigations are carried out involving the relevant people, when things go wrong. The process may vary, but the outcome is the same in that investigations are undertaken, actions taken, and lessons learned are disseminated. The extent to which lessons are shared will depend on the likelihood of recurrence beyond the affected team or service. Independent hospitals share lessons learned at conferences and the larger corporate groups are involved in Medication Safety Officer (MSO) and Medical Device Safety Officer (MDSO) events. Patient safety incident reporting and investigation is recognised as an essential learning tool throughout the sector, as is patient safety training and leadership.

Reliable systems, processes and practices

Independent hospitals' safe systems of work will be similar to the NHS, including with reference to safeguarding. The continual improvement of safe systems

may also include external certification by UKAS accredited bodies, for example Occupational Health and Safety Management System (OHSAS18001), Information Security Management System (ISO27001) and CHKS. Those engaged in the independent sector undergo statutory training but the mandatory training requirements may vary from hospital to hospital depending on individual risk assessments and organisational values, for example on health promotion.

The independent sector adopts the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. Many independent hospitals attain very high cleanliness scores in the Patient-Led Assessments of the Care Environments (PLACE) audits. PLACE and reporting of healthcare-associated infection (HCAI) to Public Health England are examples where independent hospitals are externally benchmarked. The design, maintenance and use of facilities and premises are focused on meeting safety standards. Aesthetic considerations are taken into account based on the feedback of stakeholders, which include patients and private medical insurers.

The safe systems for equipment and medical device management in independent hospitals are similar to the NHS, although there is less use of designated equipment stores/ libraries due to smaller scale. A third party (with the relevant quality certification) may be responsible for medical equipment maintenance, in which case performance will be monitored through contract and service level agreement. Clinical waste management is predominantly managed

through dedicated third party providers, who often provide training and support as part of the contract.

Safe systems for medicines have pharmacy oversight. The pharmacy service provision may be defined in service elements, for example infrastructure services (such as supply chain and advisory services) and medicines optimisation services (such as patient facing clinical services and professional leadership). The Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy Services provide the framework for service provision (not UKAS accredited at this time).

The pharmacy service may be provided in-house (and may or may not be registered with the General Pharmaceutical Council), through a third party provider, or a hybrid of provision of different service elements. The organisational assurance for medicines optimisation remains with the hospital, including through medication safety meetings, or other committees, relevant to the size of the organisation. For the majority of independent hospitals a Home Office Licence is required for the possession and supply of Controlled Drugs.

Systems for clinical record integration are moving forward at different rates, as is seen across the NHS. Independent hospitals will keep clinical records on site, but may also archive off-site in secure stores.

The integration of consultant records has been occurring over time and will be made easier as IT systems develop, as has been seen with imaging systems.

Where hospitals do not have a fully integrated record, an assessment of risks and any mitigating actions will be documented. Consultants are required to maintain contemporaneous records in accordance with GMC Good Medical Practice.

Risks assessed and anticipated

Emergency scenarios are undertaken for events such as arrest. Independent hospitals will have business continuity plans to manage adverse weather impacts such as snowing or flood. Requests to join major incident scenarios will depend on the local NHS planning, for example where the local NHS has agreed to use the independent sector to transfer elective patients from NHS Trusts to make room for emergency admissions.

Independent hospitals use risk management processes to support safe care, including the use of elective care pathways with pre-admission processes that identify risks prior to admission. Risk-assessments are applied throughout the patient pathway and staffing levels and skill mix are adjusted to meet the needs of the patients. Tools, similar to those used in the NHS, such as NEWS (National Early Warning Score), are used to monitor patients and identify deterioration.

Larger independent hospitals may provide critical care facilities enabling them to treat high acuity patients. Where this is not provided, emergency transfer protocols are in place with their local NHS Trust or another independent hospital, including urgent and emergency transfer of patients.

Independent hospitals will have a system to determine nurse-to-patient ratio and a flexible approach is adopted accounting for patient dependency. Given the smaller size of independent hospitals, nurses tend to work across wards and specialities (information on the medical model is provided in the section on *Effective Staffing*). Independent hospitals offer practice placements to nursing students and allied healthcare professional students, and the majority have career development programmes for healthcare assistants (HCAs). Many hospitals include the recruitment, training and retention of HCAs as part of their long-term workforce strategy. HCAs may work flexibly across departments in smaller hospitals and undertake a wide range of activities under the supervision of trained professionals.

In addition to medical and nursing staff, independent hospitals also employ a range of other health professionals, including operating department practitioners, physiotherapists, biomedical scientists, radiographers and pharmacy professionals. Depending on the range of services offered, other health professionals may be engaged, for example dieticians, chiropodists and osteopaths.

Effective – Achieving good outcomes and promoting good quality of life

Monitoring and comparing evidence-based outcomes

Independent hospitals work closely with consultants to review guidance, standards and best practice, including that from NICE and professional bodies, and include in pathways and guidelines. The process for monitoring compliance will vary, depending on the size or IT maturity of the organisation, from paper-based audits to electronic quality systems.

Independent hospitals participate in national data collection programmes where possible, including audits such as National Joint Registry, National PROMs Programme, National Comparative Audit of Blood Transfusion and NCEPOD research, where applicable.

Work is underway with PHIN to ensure that patients can easily compare NHS and independent sector outcomes and quality data to inform decision-making. This includes the alignment of reporting standards and performance indicators to improve transparency for commissioners and patients.

Staff skills, knowledge experience and team working

Independent hospitals employ more than 60,000 clinical staff, who are subject to the same professional regulation and employment checks as NHS staff. Staff development and appraisal process, including nurse revalidation, are the same as the NHS. The process for medical revalidation is similar, but the process for engaging consultants and other medical staff is different to the NHS and covered in more detail below.

Independent hospitals provide a consultant led and delivered service. The majority of consultants are not employees of an independent hospital, but are usually employed by the NHS and are granted admitting rights in the form of practising privileges, following scrutiny by a Medical Advisory Committee (MAC). The Health and Social Care Act 2008 (Regulated Activities) 2014 includes *“the grant of practising privileges by a service provider to a medical practitioner, giving permission to practice as a medical practitioner in a hospital managed by the service provider”* within the meaning of employment.

Practising privileges, underpinned by GMC Good Medical Practice, are set out by the hospital (or group-wide structure) and outline the criteria and conditions under which licensed registered medical practitioners are authorised by the Registered Manager to undertake the care and treatment of patients in that hospital.

Practising privileges will outline the level of admitting rights (for example outpatients or inpatients), the requirements of attendance (for example daily visits and out of hours response) and the scope of practice.

Scope of practice may be defined explicitly (for example where no NHS practice) or by exception against NHS practice. In either case the consultant is required to work in accordance with GMC Good Medical Practice and recognise and work within the limit of competence. Independent hospitals require consultants to provide explicit evidence of competency and experience for practice outside NHS experience or

involving children and young people. The MAC supports the Registered Manager in decision-making (see *Governance section*). Consultants and providers are required to be transparent and make declarations of any financial interests.

The medical Responsible Officer (RO) has a statutory responsibility to ensure that there are robust systems and processes within the organisation for:

- ▶ undertaking appropriate employment checks for medical appointments (this includes systems for the granting of practising privileges);
- ▶ obtaining appropriate references and;
- ▶ resolving any issues that may arise when recording the results of the checking process that demonstrates that all doctors working within the organisation are fit to practise.

Consultants with an NHS contract are assigned to the NHS 'designated body' and respective RO.

The RO is also responsible for ensuring that effective systems to support revalidation are in place, including supporting whole practice appraisal across the NHS and the independent sector for consultants with practising privileges.

The details of the granting of practising privileges, the scope of practice, whole practice appraisals, revalidation status, and any other matters (for example letters of investigation or complaint), are held on file by the hospital. The large corporate groups with an RO act as the 'designated body' for

consultants with practising privileges, but who do not have an NHS contract. For a full overview of the RO role, please see the GMC website www.gmc-uk.org.

In addition to consultants, independent hospitals also engage the services of Resident Medical Officers (RMOs) to provide 24-hour onsite cover as part of the multidisciplinary team. This includes the day-to-day admission, prescribing, review and discharge duties of the RMO, as well as the management of all emergencies under the direction of a named consultant. The RMO is available to provide immediate life support to any patient, visitor or staff member as required.

In order to fulfil this duty, the RMO will be resident at the hospital for the period of cover, remaining on site throughout. In most cases, a doctor will be actively on duty for 6-8 hours during the day and will be on call for the remainder of the time and overnight. The number of RMOs on-site will vary according to the activity levels, complexity and mix of speciality that the hospital provides.

The RMO and the relevant senior nursing staff will escalate any concerns to the named consultant for advice, within normal working hours or out of hours. Where the situation requires the consultant to see the patient before the next scheduled daily visit, the consultant will attend the patient. The permitted journey time is usually 30 minutes and defined within practicing

privileges, as is the requirement to provide cover if unable to attend. The consultant will attend the patient, or will arrange for a consultant colleague to attend where relevant. The escalation procedures will depend on the nature of the concern and are based on the judgement of the attending consultant. On-call teams for theatres and/or imaging will be mobilised and the consultant will engage with colleagues in the local NHS Trust, if required.

Many RMOs are employed by an RMO service provider, which is responsible for their recruitment, vetting and training. This organisation assigns appropriately qualified RMOs to work in hospitals with which they have service agreements, ensuring that each RMO they employ fulfils the specification provided and is fit to practise in the UK, both in terms of their clinical skills and their ability to communicate effectively.

An RMO service provider will usually employ a medical director, who will also act as the Responsible Officer for the purposes of the regulations (or other provisions are made with another RO as permitted with guidance). In addition to screening and assessing the RMOs, the RO will have overall responsibility for supervising the appraisal procedure for the purposes of revalidation.

Information and consent

The majority of independent hospitals provide elective care supported by pre-admission assessment that allows all the relevant information to be gathered ahead of treatment. The consultants lead on the consenting process and will undertake the first assessments regarding mental capacity and ensure this is communicated to teams prior to admission. Senior staff would be informed where deprivation of liberty authorisation is required. Consent processes are supported by patient information, often sourced from dedicated patient information companies.

Caring – Treating people with compassion, kindness, dignity and respect

Dignity, Respect and Compassion

National NHS initiatives, such as the 6C's, tend to be incorporated into the hospital's own value-based objectives, which may include involving non-clinical staff in wider customer care development programmes.

User engagement and feedback

The elective nature of the services means that the needs of the patient can be assessed in a timely manner, including the need to access information in other languages or forms of communication, and the provision of interpreters where required. Independent hospitals utilise a range of approaches to assess if they are meeting and exceeding the expectations of those who use the service. Satisfaction surveys can incorporate the Friends and Family test as well as other questions that provide feedback on the services specific to the hospital. Face to face feedback may be in the form of user groups or may be part of a 'deep dive' customer survey. National market surveys are also utilised to understand how the users of the services are changing.

Emotional support

Independent hospitals support patients through their care and treatment and are increasingly supporting people who use the service to be focused on their overall wellbeing. This may be in readiness for surgery or as part of a wider process of empowering people to take control of their health and wellbeing. Independent hospitals may have partnerships or contracts with third party services who provide additional or specialist support where required.

Responsive – meeting people's needs

Planning services to meet people's needs

Independent hospitals engage a number of stakeholders in how services are planned and delivered, including patients, consultants, private medical insurers and the NHS.

In 2000 the NHS Plan introduced the concordat between the independent sector and the NHS. Over the last 15 years, this has become formalised through standard contracts to support the delivery of the NHS' patient choice agenda, with more than 240 independent hospitals providing additional capacity through NHS E-Referral (previously known as Choose and Book). Those hospitals now account for more than 520,000 referrals per year, although the proportion of spend is very small in terms of the NHS budget (6%). In 2014 the requirements for an NHS provider licence from Monitor came into force for the independent sector.

Facilities and premises

Independent acute hospitals are evenly spread across the UK but the larger hospitals are found in the major cities – London, Manchester, Birmingham and Leeds. The independent sector has always been responsive to service user feedback, including meeting the requests for comfort as well as quality, privacy and dignity. The aesthetic finishes and approaches can be aligned with quality accreditations.

Operating theatres are core to the majority of independent hospitals, with their associated recovery units. Some hospitals invest significantly in the latest technology and examples include Cyberknife®,

Nanoknife®, and TrueBeam®. Outpatients, day case and inpatient beds are all available, as are extensive diagnostic and treatment facilities.

Physiotherapy is usually provided for both the diagnosis and treatment of injuries, including joint pain and muscle injuries, and the rehabilitation of post-operative patients. Some hospitals will provide other treatments and services such as acupuncture and hydrotherapy, or even extended pathways of care in a gym environment.

Independent hospitals may have their own laboratories or obtain services from a third party. Pathology services in the UK are subject to Clinical Pathology Accreditation (CPA). As part of the transition of all CPA accredited laboratories to UKAS, services are now being assessed to ISO 15189. Where a third party accredited laboratory is used, a service level agreement will provide information on the performance criteria.

Diagnostic imaging services may be provided in-house or out-sourced, or potentially a hybrid, such as a mobile service of a particular modality, for example MRI or CT. Where a third party imaging service is used a service level agreement will provide information on the performance criteria. The UKAS Imaging Services Accreditation Scheme (ISAS) has been developed more recently than CPA and there are only a limited number of services (NHS or independent sector) currently accredited. The safety and governance arrangements under the requirements of IR(ME)R are the same in the independent sector as in the NHS.

Taking account of different people's needs and timely access

Independent hospitals respect diversity and support a range of services including gender reassignment and associated cosmetic surgery. Individual patient needs, including religious beliefs, are supported through planned pre-assessment. Patients come from diverse locations and choose an independent hospital for a variety of reasons. For example, elderly patients may choose to have a procedure at a hospital closer to where their family lives, rather than near their own home. Independent hospitals therefore do not always fit neatly into the CQC's 'care in a location' agenda.

Most independent hospitals have admissions criteria that cover only adult care – the sector does not provide a substantial level of children's services and there is only one independent maternity hospital.

Independent hospitals offer a wide range of facilities and treatments. These include a variety of surgical procedures, such as orthopaedics, neuro-surgery, cardio-vascular surgery and cosmetic surgery. They also offer a range of medical admissions including oncology, sports injuries and women's health. A few independent hospitals are centres of excellence for specialist treatments, e.g. neuro-rehabilitation or specialist cancer treatments. Some hospitals also run clinical trials for new cancer drugs.

The key reasons for patients choosing independent healthcare are choice of hospital, consultant-led care and responsive access for appointments, diagnostic tests and treatment.

Patients also look to independent hospitals for:

- ▶ treatments not available on the NHS e.g. restricted NHS procedures or cosmetic surgery;
- ▶ extended treatment programmes not offered by the NHS e.g. extended physiotherapy treatment plans;
- ▶ choice of date for a procedure (this may include longer timelines to fit around work);
- ▶ second opinion following diagnosis or treatment already received by another provider;
- ▶ health screening and assessment;
- ▶ providing services to corporate clients.

Independent hospitals focus on providing an excellent service to patients including monitoring responsiveness to bookings and cancellations. A significant proportion of patients are referred to independent hospitals through the NHS E-Referral Service, the electronic booking service for people living in England, giving NHS funded patients the choice of an independent provider. Most UK nationals, either insured or self-paying, need a GP or physiotherapy referral to access the independent sector. GP referrals are not required for international patients.

Using feedback to improve quality of care

By law the Parliamentary and Health Service Ombudsman cannot look into complaints about privately-funded healthcare services. The sector has established the Independent Sector Complaints Adjudication Service (ISCAS), with an independent escalation process operated by the Centre for Effective Dispute Resolution (CEDR). ISCAS is a voluntary membership scheme and the majority of all independent healthcare providers across the UK are signed up to it. Its Complaints Code of Practice (the Code) sets out the standards that members agree to meet when handling complaints about their services. The Code is a three-stage process, which focuses on local resolution wherever possible:

- ▶ **Stage 1** – local resolution; usually dealt with by the Registered Manager;
- ▶ **Stage 2** – complaint review; usually dealt with by the chief executive of the hospital group or by a non-executive director/member of the board in the case of a single hospital;
- ▶ **Stage 3** – ISCAS independent adjudication; conducted by an ISCAS independent adjudicator.

The lessons learned from complaints are used to improve quality at each stage of the process and providers are open and transparent in reporting (such as in quality accounts). ISCAS publishes an annual report that provides information on complaints, as well as learning points and feedback from independent adjudicators.

Well led – leadership, governance and culture

Vision and strategy

An independent hospital's vision and strategy may differ in style from the NHS.

Corporate board structures may vary according to the type of organisation, for example charity or private.

There may in fact be more than one board, for example a board of trustees or investor board. Each organisation will have a governing document, for example Charitable Objects/Memorandum or Royal Charter filed with the Charities Commission or Certificate of Incorporation and Articles of Association filed with Companies House. These high level governing documents set out how the organisation is constituted, the membership and the delegated authority for establishing directors. Progress against strategy is monitored and reviewed by the relevant boards, and independent hospitals are required to make annual returns to the Charity Commission or Companies House.

Governance framework and responsibilities

The roles and responsibilities of the key individuals are defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and independent hospitals have Fit and Proper Persons Directors (Regulation 5), a Nominated Individual (Regulation 6), and a Registered Manager (Regulation 7).

The majority of independent hospitals are part of large groups. Five groups

(BMI Healthcare, Spire Healthcare, HCA International, Nuffield Health and Ramsay Health Care) share 61% of the market.

There are also a number of smaller groups consisting of fewer hospitals and a number of single hospitals. Hospital groups tend to have both a Group Medical Director and Group Director of Nursing/Chief Nurse, who provide the clinical leadership at an organisational level. Groups of hospitals will have organisation-wide policies that will apply to each individual hospital, with only some localisation required.

The Registered Manager is the person appointed by the provider to manage the regulated activity on their behalf, where the provider is not in day-to-day charge of the regulated activities. A Registered Manager shares the legal responsibility for meeting the requirements of the relevant regulations and enactments with the provider. The line accountability is defined in each hospital, with a Director of Clinical Services / Nursing Director taking a key clinical leadership role.

The local Medical Advisory Committee (MAC) provides advice and maintains a framework between the hospital management team and consultants and supports the Registered Manager and clinical lead. The MAC acts as an Expert Advisory Group, rather than a committee with delegated authority from the management board. The Registered Manager (in conjunction with the Medical Director in larger groups) generally appoints a Chair of the MAC.

The Chair of the MAC has a key relationship with the Registered Manager and Clinical Lead. The MAC Chair provides expert knowledge and support on decision-making involving consultants and governance matters, including any potential suspension of practising privileges and referral to the relevant RO.

The Registered Manager is accountable for the decisions made in accordance with the requirement of 'fit and proper persons employed'.

Each hospital's MAC is constituted by the hospital and represents the consultants who practise at the hospital; including members from different specialties. The MAC supports the hospital in monitoring safe, effective and responsive care by reviewing, and providing feedback on, the clinical and quality governance reporting managed by the hospital Clinical Lead (including, but not limited to, reporting on incidents, never events, candour, complaints, outcomes and satisfaction).

The MAC considers applications and advises the Registered Manager regarding eligibility for practising privileges and for their continuation following review. The final decision rests with the Registered Manager.

Leadership, culture and engagement

Independent hospitals employ a range of leadership development opportunities for staff to support good quality care. Staff

feedback surveys will be specific to each organisation and aligned with its strategy and values, but may also have a number of questions that equate to the NHS survey. Patient engagement models may vary from the NHS, and may include 'consumer' surveys or market research that looks at a broad range of health and wellbeing needs.

Continuous improvement and sustainability

Independent hospitals manage the strategic vision through business processes that support the sustainability of the organisation as a commitment to their relevant stakeholders.

Independent hospitals produce reports, including annual quality reports, detailing performance in terms of clinical excellence, effectiveness, safety and patient satisfaction. Audit programmes are in place to demonstrate continuous commitment. Hospital acquired infections are closely monitored. In accordance with Department of Health guidelines, those hospitals treating NHS-commissioned patients are required to produce annual quality accounts, including outcomes for the core set of quality indicators. Quality, improvement and innovation goals are also agreed with NHS Commissioners as part of the payment framework.

More broadly, independent hospitals need to meet the requirements of the Health and Safety Executive, Public Health England, Monitor, the Medicines and Healthcare products Regulation Agency (MHRA), and other relevant regulators (for example Human Fertilisation and Embryology Authority) in the same way that the NHS does.



For more information

The following organisations are a useful resource for information about independent healthcare.

Association of Independent Healthcare Organisations (AIHO) – the trade association for independent acute hospitals across the UK.

www.aiho.org.uk

NHS Partners Network (NHSPN) - a trade association representing independent sector providers of NHS clinical services in England.

www.nhsconfed.org/networks

Private Healthcare Information Network (PHIN) – an independent, not-for-profit organisation that collects and publishes data from hospitals and produces safety and quality indicators such as mortality rates, readmission rates and patient feedback. All hospitals in the UK that offer privately funded healthcare, including NHS hospitals, are required to send PHIN data.

www.phin.org.uk

Independent Sector Complaints Adjudication Service (ISCAS) - provides independent adjudication on complaints about ISCAS members. ISCAS is a voluntary scheme for the vast majority of independent healthcare providers.

www.iscas.org.uk

Contact **info@aiho.org.uk**
for more information about this guide.