11 February 2016

Archwilydd Cyffredinol Cymru
Auditor General for Wales

A Review of the Impact of Private Practice on NHS Provision

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

I have prepared this report for presentation to the National Assembly under the Government of Wales Acts 1998 and 2006.

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Background

1 Private healthcare offers alternatives to government-run publically funded healthcare systems. Private healthcare by definition operates outside the bounds of government control and receives funding only from patients and their insurance policies, although the provision of private healthcare is regulated through a number of bodies including Healthcare Inspectorate Wales.

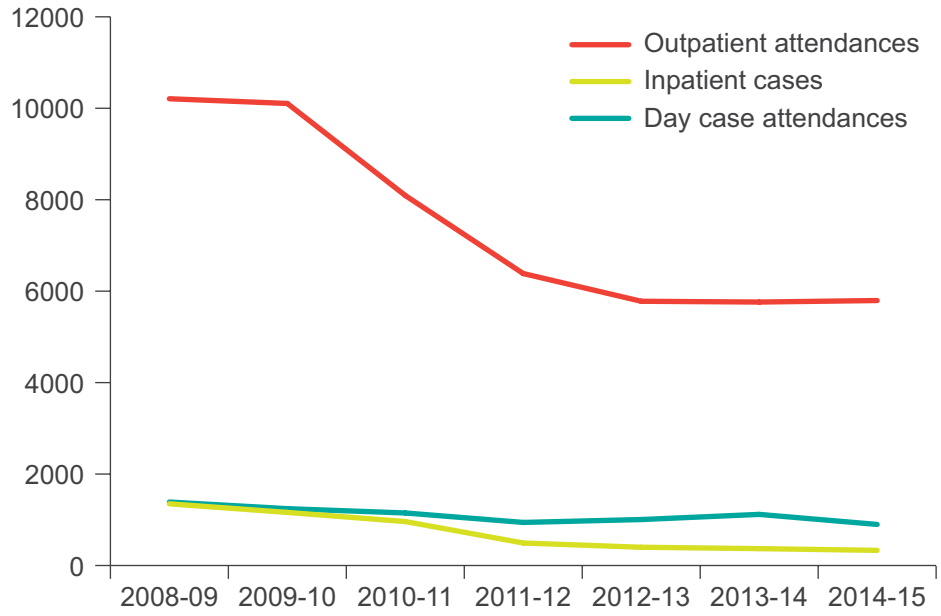
2 There are many reasons that patients choose to receive private healthcare, one of which is the ability to access healthcare much more quickly than the current waiting times for NHS treatment. There are wide ranges of treatments provided through private healthcare, including those currently available through the NHS such as hip replacements and Magnetic Resonance Imaging (MRI) scans. Private healthcare also offers patients access to treatment not available through the NHS, such as cosmetic surgery. Other reasons for choosing private healthcare include the flexibility for patients to choose when and where they receive treatment, to choose which consultant or specialist provides their care and the ability to seek a second opinion on treatment advice received through the NHS.

3 Based on the latest figures from Healthcare Inspectorate Wales[1], there are currently 21 private and independent hospitals and clinics in Wales. Some of these provide specialist treatment such as podiatric treatment or specialist knee treatment. However, a number provide a broad range of services available on the NHS. These are set out in Appendix 1.

4 Private healthcare can also be provided through private treatment rooms, and agreed private consultation and treatment sessions within NHS facilities. No information on private activity undertaken in private and independent settings is available in the public domain. However, data submitted to the NHS Wales Informatics Service (NWIS) and reported through Welsh Government statistics[2] would indicate just over 7,000 instances of private practice outpatient and inpatient activity (excluding diagnostic tests and therapy interventions) occurred in NHS facilities during 2014-15, although this has reduced over the last six years, from 13,000 recorded in 2008-09 (Figure 1). The level of private practice activity undertaken in NHS facilities in 2014-15 accounts for just 0.02 per cent of the total level of outpatient and inpatient activity across the NHS during the same period, which was reported to be in excess of 4 million.

1 Establishments registered as independent clinics or hospitals (acute) on the Independent Healthcare Register, Healthcare Inspectorate Wales, April 2014
2 www.gov.wales/docs/statistics/2015/150114-health-statistics-wales-2014-chapter-16-en.xls

Figure 1 – Private practice activity undertaken in NHS facilities



Source: Wales Audit Office analysis of PEDW data, Welsh Government statistics

5 During 2014-15, there were 5,795 private outpatient appointments reported in NHS facilities, compared to 3.1 million NHS outpatient appointments. The highest numbers of private outpatient appointments were in Abertawe Bro Morgannwg, Aneurin Bevan and Betsi Cadwaladr University Health Boards accounting for 91 per cent of all private outpatient appointments in the NHS (see Appendix 2, Figure 1). The highest volumes of private outpatient appointments in 2014-15 were in Ophthalmology, and Trauma and Orthopaedics, accounting for 51 per cent (see Appendix 2, Figure 2). The number of private outpatients per specialty varies considerably across Wales.

6 There were 1,229 privately funded hospital admissions to NHS hospitals in 2014-15, compared to 915,000 NHS hospital admissions. The highest numbers of privately funded admissions were also to Abertawe Bro Morgannwg, Aneurin Bevan and Betsi Cadwaladr University Health Boards. The majority (898) of private patients were treated as a day case, which reflects an increasing shift from inpatient to day-case activity. The remaining 331 patients required one or more nights in hospital as part of their treatment. Across Wales, the highest volumes of private hospital admissions were in Ophthalmology and Trauma and Orthopaedics, which accounted for 48 per cent. General Surgery, Urology and Cardiology also made up a further 36 per cent of activity, although activity levels by specialty vary across Wales (see Appendix 2, Figure 3).

7 Many consultants who provide private healthcare are also employees of the NHS. The NHS body that employs them should agree the time they spend providing private healthcare, ensuring that their private commitments do not adversely affect the provision of NHS services. Patients can access private healthcare through a GP referral or by contacting a private consultant directly. Many patients will choose to receive the totality of their treatment privately, particularly if they are in receipt of private health insurance, whilst others will choose to revert to NHS treatment following an initial private consultation and/or diagnostic test.

About this report

8 During an inquiry following the Auditor General's report **Consultant Contract in Wales: Progress with Securing the Intended Benefits** (February 2013)[3], the National Assembly's Public Accounts Committee (the Committee) raised questions about 'whether private practice created the potential opportunity for 'queue jumping' NHS waiting lists'. Evidence provided to the Committee by the Welsh Government indicated that there are rules and procedures in place to prevent private patients 'queue jumping'. However, further evidence provided by two health boards suggested that the extent to which these rules were being robustly applied differed across organisations. Commenting on this issue in its report on **Consultant Contract in Wales: Progress with Securing the Intended Benefits** (September 2013)[4], the Committee concluded that there was a lack of clarity on whether 'queue jumping' was happening in practice. It recommended that the Auditor General should examine NHS bodies' processes and procedures for patients moving between private and NHS practice. During its inquiry, members of the Committee also raised concerns about how NHS bodies go about recouping costs from private work undertaken in NHS facilities.

9 In response to the Committee's concerns and specific recommendation in relation to 'queue jumping', the Auditor General has undertaken an examination of national and local approaches to managing the impacts of private practice on NHS provision. This report presents the findings from that work and sets out a number of recommendations for the Welsh Government and health bodies.

3 www.audit.wales/publication/consultant-contract-wales-progress-securing-intended-benefits
4 www.assembly.wales/Laid%20Documents/CR-LD9466%20-%20Report%20of%20the%20Public%20Accounts%20Committee%20on%20'The%20Consultant%20Contract%20in%20Wales%20Progress%20with%20securing-09092013-249813/cr-ld9466-e-English.pdf Report of the Public Accounts Comm ittee on 'The Consultant Contract in Wales: Progress with securing the intended benefits'

Our approach

10 Our approach has involved analysis of private practice data relating to activity undertaken in NHS facilities and information, together with fieldwork visits to a number of health boards. Visits included reviewing pathway information for private patients who had received an initial private consultation and were then placed on the NHS waiting list, noting that due to the lack of available information relating to patients who are seen in a private or independent setting, the sample only included patients who received the initial private consultation in an NHS facility. Visits also included reviewing financial data to track through whether the costs associated with private practice activity undertaken in NHS facilities were recouped. We have reviewed data relating to 2014-15 to provide the most up-to-date position on private practice within the NHS; however, to enable us to understand the total length of time these patients waited and to allow sufficient time for income to be recouped, we have also considered data relating to 2013-14. Further details of our audit approach are provided in Appendix 3.

Main conclusions

11 Private practice represents a very small and reducing level of activity when compared to the totality of NHS activity that takes place in Wales. Nonetheless, this review has shown that health bodies are not effectively managing the impact of private practice on NHS activity. Some are failing to recoup all the costs associated with private practice work that takes place on NHS premises and there is potential for patients to gain an unfair advantage by paying for an initial private consultation or diagnostic test and then reverting to an NHS waiting list, although insufficient data exists at present to allow any definitive conclusions to be drawn on whether this is happening in practice.

12 Various guidance exists on how private patients should be transferred to NHS treatment but there are inconsistencies in its content and the way it is used by staff. Welsh Government guidance suggests that private patients should be placed at the start of the waiting list, while UK-wide guidance, including that issued by the British Medical Association (BMA), indicates that they should be placed on the list at the point in which they would be had they received their consultation through the NHS. The main waiting times guidance used by NHS staff in Wales, however, does not refer at all to the management of private practice and many staff are unaware of the Welsh and UK-wide guidance.

13 There is no requirement for health boards to identify private patients entering NHS pathways, which makes it difficult to differentiate these patients from NHS patients referred by GPs and consequently to undertake any detailed analysis of whether those patients who pay for an initial consultation and then join an NHS waiting list get treated more quickly.

14 Where patients' initial private consultation takes place in an NHS facility, it is possible to undertake some analysis of how quickly they are treated when reverting to the NHS for treatment, and to compare this to standard NHS waiting times. As part of this review such an analysis was undertaken and identified that actual waiting times vary significantly. When compared against both the average wait for NHS patients, and the point by which 95 per cent of all NHS patients have been treated, no clear pattern is observed. Some private patients who transferred to an NHS list were treated more quickly than the NHS average, although a large proportion of these were identified as urgent patients, so a shorter wait would be expected, while others actually waited longer. The data reviewed would suggest that the majority of private patients who transfer to the NHS for their treatment are generally managed in line with NHS patients. However, a much larger set of data would need to be analysed to confirm this emerging conclusion.

15 The ability of a consultant to undertake private practice work can be an important factor in attracting high calibre individuals to NHS consultant posts. Moreover, NHS organisations can generate income from private practice work undertaken in their facilities which can then be invested in NHS services. The basic principle underpinning guidance on private practice is that it should not impact on NHS provision. However, the guidance which exists lacks clarity as to when and how much private practice can take place in the NHS. Arrangements are in place to ensure that consultants are aware of the guidance but there is little consideration of private practice activity as part of the consultants' job planning process, and there are no monitoring mechanisms to ensure that the activity is not taking place during periods where consultants are committed to working for the NHS. Many operational staff are not aware of the guidance and directorate managers typically lack awareness of private practice activity taking place within their own clinical areas. Along with inaccuracies in the data held on patient administration systems, the weaknesses in controls around private practice in the NHS limits the necessary assurance that NHS capacity and resources are not used inappropriately.

16 While there is a general perception that private practice activity takes place during out of hours and weekends, we identified that 98 per cent of private practice in NHS facilities takes place during the week. While some of this is managed before and after NHS sessions, and in dedicated sessions, which is acceptable practice, a number of cases were found to be taking place during periods when consultants are committed to working for the NHS. There is evidence that private practice will sometimes be cancelled to accommodate NHS pressures; however, health boards are not fully recognising the impact on capacity from private patients, particularly in relation to bed capacity.

17 All health boards have policies and procedures in place to recoup the costs of private practice. However, the administrative processes to ensure that the health boards receive the income are cumbersome and reimbursements are often based on incorrect information. Private practice and finance teams are reliant on timely and accurate information being sent by consultants and their staff. To ensure that patients are billed correctly, it is necessary to crosscheck multiple sources of information. The tariffs for private practice across Wales vary and not all cost information is up to date and reflective of the true cost to the service. A review of the finance information relating to a sample of private practice patients identified that whilst most health boards appear to be recouping the costs of private practice, a quarter of activity takes more than three months to be paid and six per cent of activity was not being recouped at all.

Recommendations

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R1	The guidance from the Welsh Government on how to manage private patients onto the NHS waiting list conflicts with other guidance and is not reflected in the routine referral to treatment documentation used by NHS bodies, resulting in a lack of awareness and inconsistencies on where private patients are placed if they join an NHS waiting list. The Welsh Government should therefore adopt the approach set out in UK-wide and professional body guidance, ensuring that the referral to treatment documentation used by NHS bodies is updated to reflect this. Health boards and trusts then need to ensure that this guidance is implemented by all staff involved in the administration of referral to treatment pathways within health boards and trusts.
R2	There is currently no requirement for health boards and trusts to identify private patients reverting to NHS treatment on their patient administration systems, which makes it extremely difficult to establish whether these patients are gaining faster access to NHS treatment. The Welsh Government should update the NHS Wales Data Dictionary and mandate the identification of private patients entering NHS waiting lists to enable regular monitoring to take place. Through the revised guidance set out in recommendation 1, the Welsh Government should also set out an expectation that health boards and trusts will regularly monitor the waiting times for this cohort of patients.
R3	Private practice can play an important role in attracting consultants and generating income for the NHS yet local policies lack clarity on when and how much private practice can take place in the NHS, and monitoring arrangements to ensure that NHS provision is not affected are weak. Where private practice is undertaken in NHS facilities, health boards and trusts should ensure that policies clearly state when and how much private practice, and specifically inpatient activity, can take place to minimise the impact on NHS resources. Private practice activity should be collected and reported in line with the requirements of the Competition and Markets Authority, and this information should routinely form part of the annual job planning process for all relevant consultants to ensure policies are complied with.
R4	The processes for recouping the costs associated with the provision of private practice within NHS facilities are cumbersome and often reliant on out-of-date and incorrect information. Health boards and trusts should ensure that sufficient attention and resources are given to the cost recovery process. The level of resources should be reflective of the scale of private practice undertaken but should be sufficient enough to provide robust assurances to boards that income is being appropriately recovered. A single-invoice system can assist with full cost recovery and has already been adopted in a number of health boards. Those health boards and trusts which are not currently operating this system should give urgent consideration to doing so.

Part 1

Despite high-level guidance that private patients should not be able to access subsequent NHS care quicker than NHS patients, weaknesses in local systems increase the risk of inequitable access to treatment

There is guidance on how private patients should be transferred to NHS treatment but there are inconsistencies in its content and the way it is used by staff

1.1 Various Welsh Health Circulars (WHCs)[5] leading up to the implementation of Referral to Treatment Time (RTT) targets in 2009 set out guidance on how to manage referrals from private practice. Both WHC (2006) 081 and WHC (2007) 075 refer to private patients wishing to transfer to an elective NHS pathway stating that 'where a patient wishes to transfer to an elective NHS pathway for treatment following a private consultation, they must first be seen in an NHS outpatient or pre-assessment clinic. The 26-week pathway will commence upon receipt of the referral. A patient who has been seen in a private capacity will join at the start of the 26-week pathway or at the outpatient stage, whichever is earliest, and the time they will wait will be based on their clinical priority only.'

1.2 If the principle set out in the WHCs is adopted, then patients who seek an initial private consultation who then transfer to an NHS waiting list, would always be placed at the start of the pathway, as this will always be the earliest point in the process. This would potentially mean they would have a longer wait than those who are already on the pathway as a result of an NHS referral.

1.3 The principle set out in the WHCs also conflicts with other guidance in existence which all make reference to 'patients who have had a private consultation for tests and diagnosis can still have treatment on the NHS and that the position on the NHS waiting list should be the same as if the original consultation was on the NHS'. This other guidance includes that issued from the BMA Medical Ethics Department on the interface between NHS and private treatment[6], the NHS Direct Wales (NHSDW) website[7] and the Code of Conduct for Private Practice issued by the Department of Health[8] which is recognised by clinicians and used in Wales.

1.4 Our work has shown that awareness amongst NHS staff of the principles for managing private patients onto the NHS waiting list, either those set out in the WHCs or in the other NHS guidance, is limited. NHS staff who manage waiting lists routinely refer to the rules for managing RTT[9], yet there is no reference in this document as to how private patients wishing to join the NHS waiting list should be managed.

5 WHC(2006) 081 Access 2009 – Delivering a 26 week patient pathway, WHC(2007) 041 – Access 2009 – Referral to treatment time measurement, WHC(2007) 051 – 2009 Access – Delivering a 26 week patient pathway – Integrated delivery and implementation plan and WHC(2007) 075 – 2009 Access Project – Supplementary guidance for implementing 26 week patient pathways

6 BMA Ethics, **The interface between NHS and private treatment: a practical guide for doctors in England, Wales and Northern Ireland**, May 2009

7 www.nhsdirect.wales.nhs.uk/encyclopaedia/w/article/waitingtimes/

8 A Code of Conduct for Private Practice – guidance for medical staff, Department of Health

9 Rules for RTT.

1.5 All health boards have developed local policies or guidelines that set out the principles governing private practice, with clear emphasis on ensuring that private practice does not disadvantage NHS patients in any way or lead to faster treatment for private patients who subsequently revert to NHS status. However, with the exception of the Cardiff and Vale University Health Board policy, none of the policies refer to where private patients should be placed on the NHS waiting list when they transfer. The focus of such documents is much more on the management of private practice activity within the NHS and the recouping of costs, which is discussed later in this report. The guidance for Cardiff and Vale University Health Board, however, does refer to the principle of placing private patients at an appropriate point on the waiting list in line with the Department of Health guidance.

1.6 Not surprisingly, because of the conflicting guidance, there are differences across Wales as to where private patients transferring to the NHS waiting list are placed. Health boards and staff who are more aware of the WHC guidance will place private patients at the start of the 26-week pathway, while others will place them at a point which is deemed appropriate had they received their initial assessment on the NHS. However, making an assessment of where on the NHS pathway to place a private patient is extremely difficult given that NHS Wales currently lacks clarity on the expected waits relating to the different stages that make up the RTT pathway[10]. It is therefore difficult for staff to make a judgement as to where patients would have been on the list had they received NHS treatment, as waits for each NHS patient are highly variable. This results in private patients joining the pathway at a point which may or may not be comparable to NHS patients. Had component waiting times for receiving inpatient treatment been measured, then waits for NHS patients, regardless of whether their initial consultation was NHS or private, would be more comparable. Following the Auditor General's report **NHS Waiting Times for Elective Care in Wales**, the Welsh Government has committed to publishing component waiting times.

10 The RTT pathway consists of four stages: stage 1 (waiting for a new outpatient appointment), stage 2 (waiting for a diagnostic or Allied Healthcare Profession (AHP) test, intervention or result), stage 3 (waiting for a follow-up outpatient appointment or waiting for a decision) and stage 4 (waiting for an admitted diagnostic or therapeutic intervention (ie, treatment)).

On the whole, health boards are unable to identify private patients reverting to NHS care which makes it difficult to ensure that they are not being treated more quickly than NHS patients

1.7 None of the existing Welsh or UK-wide guidance makes reference to how a private patient wishing to transfer to an elective NHS pathway should be referred across to the NHS. This is replicated in local policies with the exception of the policy for Betsi Cadwaladr University Health Board which stipulates that 'private patients who transfer to NHS status must always be referred back to their GP'.

1.8 The minimum data sets currently applied to NHS Wales do not require patients referred via a private or independent setting to be identified as such on the patient administration system. Consequently, private patients transferring to the NHS are recorded as a GP, or in some cases, a consultant referral on the system. This means that staff are unable to identify these patients on the patient administration systems which makes it is very difficult to monitor the waiting times for these patients across Wales.

1.9 Most health boards have a central process for adding patients to waiting lists, and unless it is clear on the referral that the patient has already received a private consultation, booking clerks will add them to the start of the 26-week pathway, which complies with the WHC guidance but conflicts with the other guidance in circulation. All referrals, however, should be classified according to whether they are 'routine' or 'urgent'[11] based on clinical need and it is this that will determine their priority on the waiting list.

1.10 Given the difficulties associated with identifying these patients, health boards are not routinely checking that private patients who transfer to the NHS are not receiving faster treatment. The health board staff we spoke to confirmed that it was difficult to identify private patients who changed status in order to monitor the length of time they waited for treatment. Several health boards said that a lack of capacity limits their ability to monitor patient pathways, whilst some felt that the exercise would require more resources than were justified given the relatively small numbers of patients involved.

11 The 'urgent' category applies to patients with urgent suspected cancers as well as patients who are urgent for other reasons.

1.11 Despite these comments, one of the health boards we visited had implemented mechanisms that assisted in identifying private patients who subsequently join NHS waiting lists. The compliance team at Aneurin Bevan University Health Board runs daily checks on current waiting list data to look for anomalies and was confident that this would identify patients who had experienced unusually short waits. The Health Board has developed a bespoke code to identify private patients who have 'changed status' to become an NHS patient, which is recorded on its patient administration system. However, this daily spot check relies on the experience of compliance staff rather than a more formal audit process.

1.12 None of the health boards we visited have conducted any kind of review of the classification of cases to understand the degree of urgency in order to monitor whether some of these patients have been falsely classified as 'urgent' to expedite their treatment. One person told us it would be useful to conduct peer reviews, which examined 'urgent' and 'routine' classifications; however, it was recognised that this process would require additional resources.

An analysis of the limited data which exists does not allow any definitive conclusions to be drawn on whether private patients who revert to an NHS list get treated more quickly

1.13 Given the challenges associated with identifying patients who have chosen to receive NHS treatment following a private consultation, we have reviewed a sample of the cohort of patients who attended a private consultation in an NHS facility to understand how many of those patients reverted to NHS treatment and how long they waited for NHS treatment.

1.14 Our review focused specifically on a sample of patients attending private consultations in Aneurin Bevan, Abertawe Bro Morgannwg, Betsi Cadwaladr and Hywel Dda University Health Boards during 2013-14. Of the 416 patients reviewed, we found that 81 were recorded as reverting to NHS for further treatment, of which 26 went on to have an elective NHS hospital admission. Seventeen of these patients (65 per cent) were classified as 'urgent' on the waiting list, with all private patients admitted for NHS treatment in Aneurin Bevan University Health Board classified as 'urgent' (Figure 2).

Figure 2 – Number of private patients reverting to NHS treatment during 2013-14 that went on to have an elective hospital admission

Health Board	Number of patients seen as private in NHS facilities	Number of patients who reverted to NHS for further treatment	Number of patients who reverted to NHS and went on to have an elective hospital admission	Number of patients admitted as 'urgent'
Abertawe Bro Morgannwg	116	19	2	1
Aneurin Bevan	120	40	12	12
Betsi Cadwaladr	117	6	6	1
Hywel Dda	63	16	6	3
Total	416	81	26	17

Source: Wales Audit Office analysis of health boards' patient administration systems

1.15 The waiting times for the 26 private patients who went on to receive further treatment on the NHS was compared to the average waits experienced by NHS patients to see if there was any evidence of 'queue jumping' by the private patients when they reverted to the NHS lists. To form as complete a view as possible, the analysis involved a comparison to both the average wait for NHS patients treated in the same specialties and health boards, and also to the point by which 95 per cent of all patients have been treated. The results of this analysis are shown in Figure 3, which superimposes the waits of each of the individual private patients onto the average and 95th percentile NHS waits, and also shows which private patients were classified as urgent at the point when they joined the NHS list.

1.16 Five of the 26 patients actually experienced much longer waits than those experienced by 95 per cent of NHS patients, even though some of these were classified as urgent. This might be due to local interpretation of guidance with some private patients positioned right at the start of the 26-week pathway. It may also reflect some patients choosing to receive a private consultation after already being on an NHS waiting list for some time.

1.17 Figure 3 indicates that the remaining 21 private patients were treated within the average and 95th percentile NHS waiting time. However, this does not necessarily mean that they received quicker treatment than corresponding NHS patients as the average and 95th percentile waits shown in the diagram will be made up of a very wide range in individual NHS patient waits, reflecting issues such as urgency and type of treatment, the need for sub-specialist treatment and choice as to where to receive treatment. A much more detailed examination of the data than was possible within the scope of this audit would therefore need to be undertaken in order to provide a more definitive answer on whether private practice patients can 'jump the queue' by joining an NHS list. This would need a much larger data set than is currently available, supplemented by more detailed case-by-case reviews of both private and NHS patients receiving like-for-like treatment.

1.18 Such an analysis could usefully include an assessment of whether private patients who are classified as urgent when they join an NHS list receive quicker treatment than NHS patients who are similarly categorised. At present such an analysis is not possible as NHS waiting time data does not differentiate between urgent and routine patients. The Auditor General's report on **NHS Waiting Times for Elective Care in Wales** included a recommendation to address this as part of a number of actions to make published NHS waiting time data more meaningful.

Figure 3 – Actual waiting times for private patients transferring to NHS treatment that went on to have an elective hospital admission, compared with the average wait for the same specialty and health board and the 95th percentile

Source: Wales Audit Office analysis of health boards' patient administration systems

Part 2

Health boards are not managing the impact of private practice on NHS resources and activity effectively

Local guidance lacks clarity on when and how much private practice can take place in NHS facilities, and health boards lack controls to ensure that private practice work is not impacting on the provision of NHS services

2.1 It is important to note that private practice plays a crucial role in attracting consultants to work in Wales, and when managed appropriately, private practice in the NHS can generate income for health boards to invest in NHS provision. Both the guidance from the Department of Health and the BMA Medical Ethics department makes reference to how private practice should be managed appropriately, stating that:

- The provision of services for private patients should not disrupt NHS services.
- With the exception of the need to provide emergency care:
  - NHS commitments should take precedence over private work where there is a conflict, or potential conflict, of interests; and
  - practitioners should not provide private patient services that will involve the use of NHS staff or facilities, unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient.

2.2 During our fieldwork, health boards cited the main source of information to manage private practice in the NHS as the Department of Health's Code of Conduct for Private Practice 2003, referred to as 'The Green Book'. Some of their own policies reflect the code of conduct and for some, there is clear guidance based on which clinics or theatre slots can be used for private practice. In many cases, health board policies state that private activity can only take place in agreement with the health board either through a private patient office, or through the relevant directorate. In both Abertawe Bro Morgannwg and Aneurin Bevan University Health Boards, private practice activity is, in part, facilitated through dedicated private facilities, namely the Bridgend Clinic and the Glan Usk Suite.

2.3 However, policies lack information on the volume of activity permitted or how they intend to manage the impact on NHS patients, with health boards telling us that the volume of private activity is so small it does not warrant a definition as it is unlikely to impact on NHS patients. There is also no reference in any policy to how activity should change with the seasons, given that NHS services are likely to experience greater demand during the winter period. Nor is there reference to how private practice undertaken in the NHS fits into the job planning process for consultants and how compliance with job planning principles is measured.

2.4 Several of the health boards we visited have registers for consultants wishing to conduct private work and most include links to the BMA guidance and the Consultant Contract, which provide guidance for consultants on the principles governing private work. We have not tested compliance with these registers but are aware that the registers for both Betsi Cadwaladr and Hywel Dda University Health Boards are not regularly maintained.

2.5 Where a private patient office exists, staff within these offices will book patients into private theatre lists or clinic slots, but this is only the case in Abertawe Bro Morgannwg and Aneurin Bevan University Health Boards. In other health boards and for activity that falls outside the two private practice facilities in Abertawe Bro Morgannwg and Aneurin Bevan University Health Boards, consultants and their medical secretaries will arrange private practice activity. Awareness of local guidance on private practice in the NHS, however, varies. Some health boards ask clinicians to sign an agreement to confirm that they are fully aware of current policies and procedures relating to private practice in the NHS, while others have no mechanism for ensuring clear communication of policies to all relevant staff, including medical secretaries.

2.6 Aneurin Bevan University Health Board provides training to booking centre staff on private practice, which has developed a strong ethos amongst staff that NHS patients should not be disadvantaged because of private practice. This means that booking centre staff act almost as ‘gatekeepers’ alerting the compliance team of potential issues.

2.7 However, we found that typically directorate managers in the sites we visited across Wales had little knowledge of how private practice in the NHS is managed. Indeed many did not know the extent to which private practice activity is undertaken within their own directorates, despite small but not insignificant levels of private practice being reported in some of their directorates. This lack of knowledge therefore makes it difficult for managers to provide assurance that private activity is not occurring during clinicians’ contracted NHS hours and is not having a knock-on impact on NHS resources. This impact could include placing demands on bed capacity if private patients are admitted over the weekend and then need to stay on an NHS ward; or affecting the start of NHS clinics or theatre activity due to overruns with private consultations.

2.8 Several health boards told us that private practice does form part of the job planning discussion with consultants and job plans do include information on private practice. However, the focus of these discussions is on private practice activity undertaken outside of the NHS. Health boards recognised that there are no routine checks of whether private work on NHS facilities is taking place, and if so, when and where. Abertawe Bro Morgannwg University Health Board identified that it would be very difficult to monitor when private activity takes place because consultants regularly change private clinic and theatre times to accommodate changes to their NHS schedule.

2.9 Information relating to private practice activity in the NHS is not readily available to those who need it, and when it is, there are weaknesses with the accuracy of the data. Patients receiving private healthcare within the NHS should be recorded on the patient administration system as private patients. During our fieldwork, we found a number of administrative errors on the patient administration systems resulting in:

- NHS patients incorrectly recorded and reported as private patients; and
- private patients seen in private clinics and noted on the patient administration system as being private, but recorded as NHS patients.

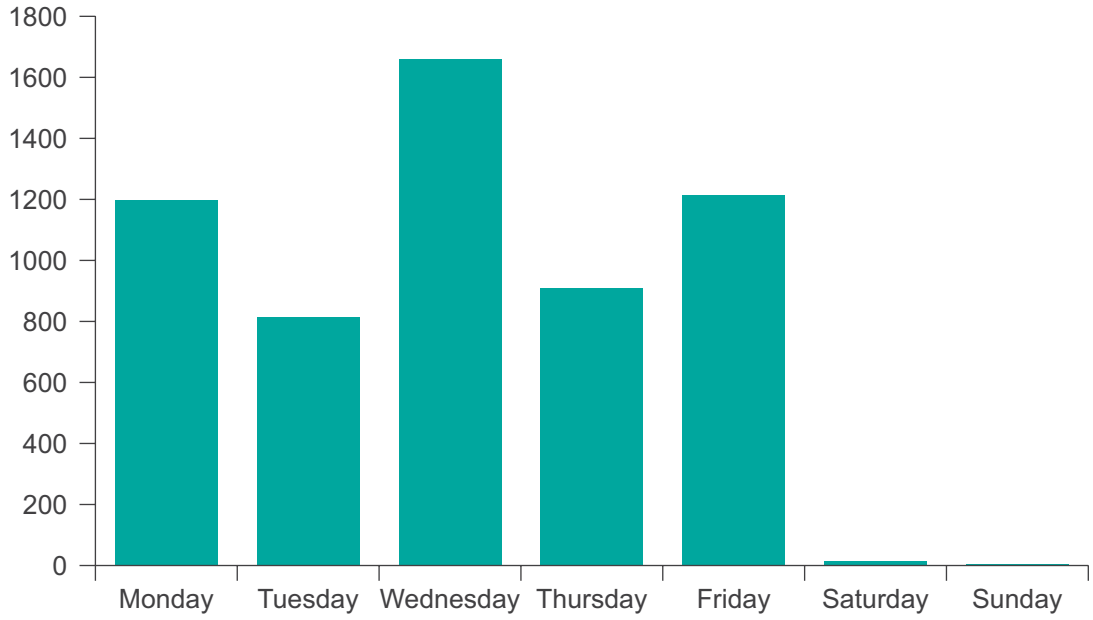
2.10 During our visit to Abertawe Bro Morgannwg University Health Board, staff told us that none of the private outpatients seen at the Bridgend Clinic are recorded on the health board's patient administration system. This represents approximately 10,000 outpatients a year. Similar issues have also been raised in other health boards where it has been difficult to identify the true scale of private practice taking place. Health board systems for identification of private patients are routinely paper-based, relying on consultants identifying patients and therefore it is possible that the data reported to the NHS Informatics Service is not an accurate reflection of private practice in NHS facilities in Wales.

A significant proportion of private practice takes place during the week and while some of this is managed out of hours and in dedicated sessions, it is highly likely to be impacting on NHS resources

2.11 There was a perception by the operational staff to whom we spoke in health boards that private activity within NHS facilities takes place either before or after NHS clinics, or outside the consultants' contracted NHS hours. As part of our review, we have analysed the data relating to all private patients recorded as being treated in the NHS during 2014-15 to get a view of when private practice activity actually takes place and the extent to which it has the potential to impact on NHS capacity and resources.

2.12 During 2014-15, 5,975 private outpatient appointments were held, accounting for 3,996 patients. Our analysis has identified that almost all of these outpatient appointments were held on a weekday (Figure 4).

Figure 4 – Number of private outpatient appointments held in NHS facilities by day of the week in 2014-15

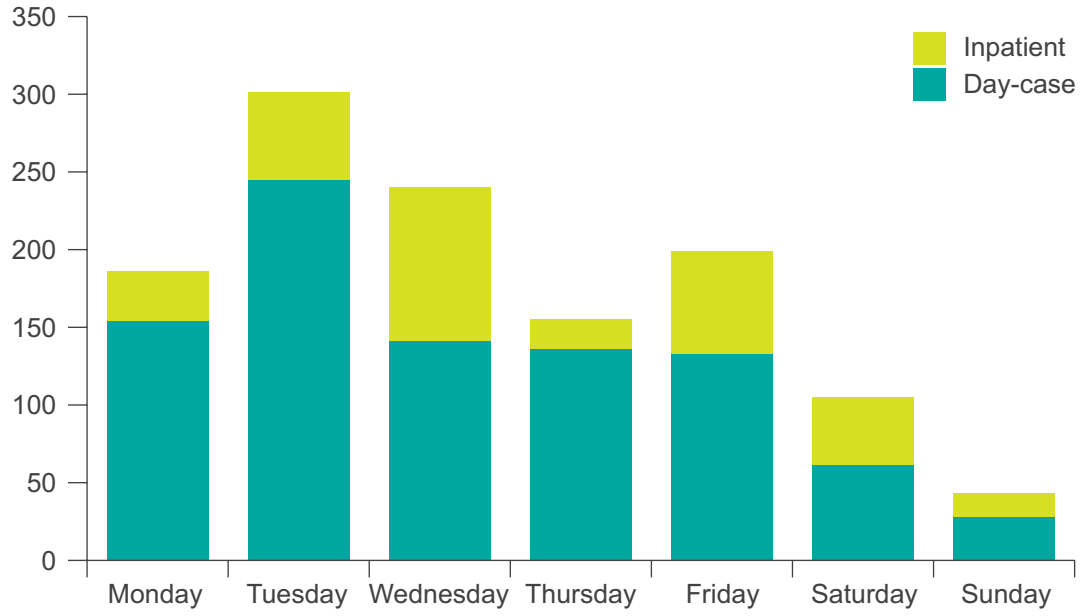


Source: Wales Audit Office analysis of PEDW data

2.13 Data available from NWIS does not include the outpatient appointment time and therefore it is difficult to know at what time of the day these patients are being seen and how this related to scheduled NHS time. Some private patients are seen during the normal working day for genuine reasons. A large proportion of private outpatient appointments held in Cardiff and Vale University Health Board relate to the provision of IVF treatment which is recognised as being a privately funded service. At Aneurin Bevan University Health Board, 211 out of a sample of 220 outpatient consultations were held in the Glan Usk suite, which is the dedicated private facility. However, a review of a sample of 60 private outpatient appointments held in Hywel Dda University Health Board, which has no dedicated private facilities or clinic sessions, identified that 40 per cent were seen before 9am or during lunchtime (between 12pm and 2pm), while the remaining 60 per cent of appointments were held during NHS sessional time. A review of job plans for some consultants confirmed the potential for private patients to be seen during NHS sessions.

2.14 During 2014-15, there were 1,229 private admissions to NHS hospitals, of which 331 required overnight stays. Whilst we were told that many private admissions to NHS hospitals, particularly day-case admissions, took place on a Saturday, our analysis has found that 88 per cent of such admissions actually took place on a weekday (Figure 5).

Figure 5 – Number of private hospital admissions (inpatient and day-case) to NHS facilities by day of the week in 2014-15



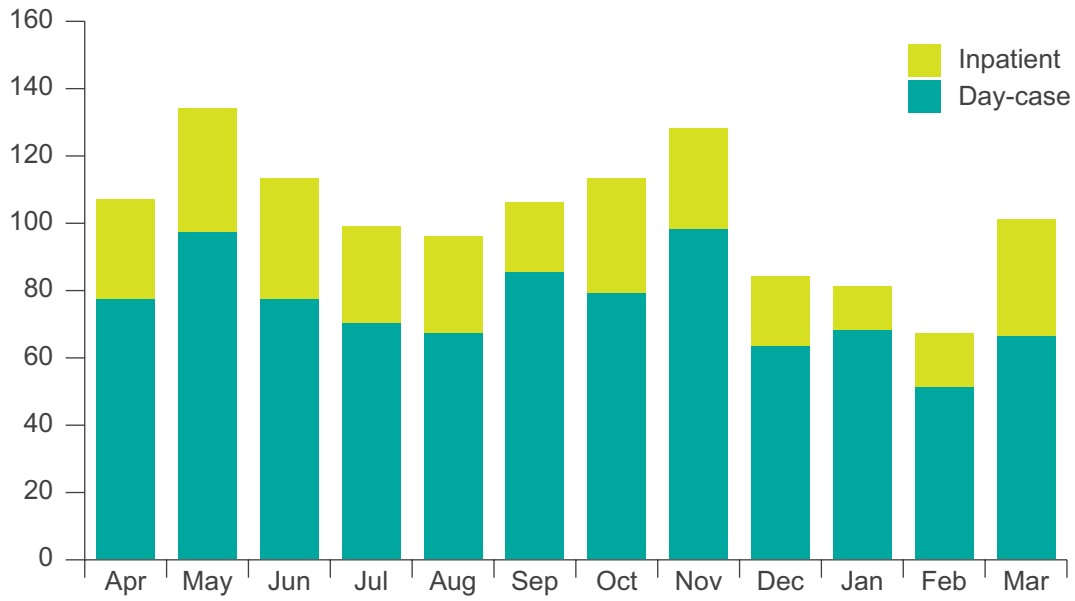
Source: Wales Audit Office analysis of PEDW data

2.15 Again, data available from NWIS does not include the admission time and therefore it is difficult to know whether these patients are being admitted during NHS time. However, given the time needed to recover from a day-case procedure, it is likely that many of these patients will have been admitted during the day. We did find that a number of private ophthalmology patients at Betsi Cadwaladr University Health Board were operated on during NHS theatre times. It was not possible to determine whether these private sessions were booked in to 'backfill' theatre time that could not be used for NHS patients or whether they were using theatre capacity at a time that could have been made available to NHS patients. However, we found that the system for booking private ophthalmology patients at the health board was open to abuse as there was no oversight to make sure that consultants' secretaries did not book private patients into NHS theatre sessions.

2.16 Aneurin Bevan, Abertawe Bro Morgannwg, and Cardiff and Vale University Health Boards reported the highest numbers of private patients who stayed in hospital for at least one night. These patients accounted for 1,305 bed days in total with an average length of stay of 5.1 days (see Appendix 2, Figure 4). In Aneurin Bevan University Health Board, 108 admissions during 2014-15 accounted for 495 bed days. These admissions were in a variety of specialties: cardiology; general surgery; gynaecology; and trauma and orthopaedics. Whilst these patients undoubtedly required specialist care which might not have been available elsewhere, it is reasonable to assume that some of these occupied NHS beds during their stay, given that patients admitted to the Glan Usk suite are transferred to an NHS ward after the first overnight stay.

2.17 Pressure on hospital beds becomes more acute during the winter. Whilst the number of private admissions to NHS hospitals fell during the winter months, some private activity continued (Figure 6).

Figure 6 – Number of private hospital admissions to NHS facilities by month



Source: Wales Audit Office analysis of PEDW data

2.18 At Abertawe Bro Morgannwg, Aneurin Bevan, and Cardiff and Vale University Health Boards, private activity over the winter included a small number of private inpatient admissions. Despite the small numbers, these patients accounted for a considerable number of bed days, with 36 patients accounting for 308 bed days. The data does not tell us whether these admissions were urgent or routine private patients but regardless this is a considerable number of bed days, which were not otherwise available for NHS patients. We found little evidence of planning from health boards to manage the impact of private patients on NHS bed capacity. Abertawe Bro Morgannwg University Health Board completes a risk assessment, including an estimate of length of stay in hospital, prior to admission for private cardiology patients. Similarly, Aneurin Bevan University Health Board completes a risk assessment which is considered at the daily capacity meeting, but we found no evidence of similar risk assessments elsewhere.

2.19 Health boards did tell us that private patients will always be cancelled before NHS patients and we found several examples during our fieldwork of private activity being cancelled to allocate resources to NHS patients during bed pressures or for waiting list initiatives. The Glan Usk Suite at Aneurin Bevan University Health Board has subsequently changed status from a dedicated private facility to include a mix of private and NHS patients, and the Bridgend Clinic at Abertawe Bro Morgannwg University Health Board accommodates NHS patients when required.

2.20 Our work also considered the level of private radiological tests being undertaken within NHS facilities. In some health boards, we were told that privately funded diagnostic tests are carried out outside normal working hours but in other health boards, these tests are conducted where there is spare capacity and with approval of the relevant manager. During 2013-14, there were 2,400 private radiological tests undertaken in the NHS across Wales. Of these, 291 were for MRI. We do not have information relating to when tests were carried out in all health boards, but analysis of the data provided to us by Abertawe Bro Morgannwg, Aneurin Bevan and Cardiff and Vale University Health Boards indicates that 69 per cent of privately funded radiological tests were undertaken during normal working hours. Whilst the data is not definitive, it would be reasonable to conclude that this level of privately funded diagnostic work is going to have some impact on hospitals' ability to meet NHS waiting time targets for diagnostic tests.

Whilst most health boards appear to be recouping the costs of private practice, others are not doing this effectively due to cumbersome administrative processes and unreliable information

2.21 Health board guidance documents generally describe clear processes for recouping the costs of private practice from patients and insurance companies. Most set out clear roles and responsibilities, and have a series of forms for staff and patients to complete at different stages in the process. All health boards require self-funding patients to sign documents to show their intention to pay which includes an estimate of the charges they are likely to incur. This reflects the 'Green Book' guidance, which requires a commitment, or undertaking that patients will pay before providing private services within NHS facilities. In Aneurin Bevan University Health Board, there is also a requirement for self-funding patients to pay a 100 per cent deposit prior to admission. The application of the process for recouping costs is, however, fraught with a number of challenges.

2.22 Aneurin Bevan, Abertawe Bro Morgannwg and Betsi Cadwaladr University Health Boards each have a small dedicated team to oversee the management of private practice, typically comprising two or three members of staff. There are no resources in the other health boards and trusts, some of which have much lower levels of private practice activity. Responsibility for the invoicing process and the recouping of costs, however, generally falls to the finance team in all NHS bodies. Whist there is a requirement for health boards to record private patients on the patient administration system, the private practice offices and finance departments have to rely on timely and accurate information, detailing the patients' treatment plans, from consultants, their secretaries and clinical teams in order to raise an invoice. However, our work identified a number of occasions where this information is not complete, timely or just not being provided:

- staff at Betsi Cadwaladr University Health Board told us that they often did not get the required paperwork;
- late submission of information to the private practice office at Abertawe Bro Morgannwg University Health Board meant that patients were not signing a commitment to pay prior to their outpatient appointment taking place; and
- consultants in some specialties in Abertawe Bro Morgannwg University Health Board were failing to complete paperwork to declare private activity.

2.23 All health boards have a pricing tariff for private practice. Most are the result of negotiation with insurance companies, or based on BUPA tariffs with an annual uplift for inflation. Pricing tariffs for both Betsi Cadwaladr and Hywel Dda University Health Boards, however, were found to be out of date, with different tariffs for each hospital site in Hywel Dda University Health Board reflecting the arrangements that existed in the predecessor NHS trusts prior to NHS re-organisation in 2009. In contrast, the pricing tariffs for Abertawe Bro Morgannwg, Aneurin Bevan, and Cardiff and Vale University Health Boards were up to date and reviewed annually to ensure that the prices are a fair reflection of the costs.

2.24 What is included within the tariff, however, differs across Wales. The final price for a hospital admission can include a charge for the procedure with charges for the theatre use, an overnight stay and consumables such as prosthetics added on top, or a package price including all of these items and an estimate of the number of nights a patient is likely to stay. Abertawe Bro Morgannwg and Aneurin Bevan University Health Boards also account for deterioration of equipment for diagnostic tests to ensure that income from private activity contributes to the sustainability of the service. The tariff for an outpatient consultation also varies from a flat rate per appointment, to the cost of the consultation being included in the professional fees, which then requires the consultant to pay for the use of a room.

2.25 The inclusion of professional fees within the invoice from the health board also varies across Wales. In most health boards, the consultant and anaesthetist will charge professional fees separately and the health boards will invoice just for the costs to the NHS. This results in the patients receiving multiple invoices, which is not always made clear to them upfront and on occasions, will result in disputes between the patient and the health board. In Abertawe Bro Morgannwg University Health Board, professional fees associated with clinical physiology are paid through the health board and show on the clinician's payslip. This provides an incentive to report private activity accurately and timely because clinicians only get paid if they submit a claim. Cardiff and Vale University Health Board is developing a similar system for all of its private practice with a single invoice system including professional fees for consultants, anaesthetists and any NHS facilities they use. Professionals will then receive payment as part of the health board's payroll process following receipt of the income from the insurance company or where relevant, the patient.

2.26 The process for recouping costs requires checks and balances to ensure that paperwork is completed and that the invoice is an accurate reflection of the costs incurred. Some health boards conduct monthly checks using data from the patient administration system to crosscheck the information with that provided by the consultants, such as procedure and length of stay although this is not always reliable given errors within the patient administration system as discussed in paragraph 2.9.

2.27 However, capacity is often an issue with some health boards unable to carry out these checks on a regular basis. This was particularly the case for Hywel Dda University Health Board where the responsibility for private practice activity was falling to one member of staff in the finance department, alongside their other responsibilities. Where the booking of private practice activity is routed through a central office, such as the Swansea-based private patient office in Abertawe Bro Morgannwg University Health Board, reports are produced on the number of admissions booked through the office so they can be crosschecked with the paperwork from consultants.

2.28 There is no formal and common IT solution for managing private practice within NHS Wales. This is resulting in private practice and finance teams using a combination of paper-based and electronic records. These often differ across sites within the same health boards, making the process of managing and monitoring private activity difficult and time-consuming. In some cases, in order to find out which procedure a patient had, whether they were charged accurately and whether they paid for their treatment, it is necessary to cross-reference information from two or three different systems, none of which are integrated in any way.

2.29 However, during our fieldwork, we identified several good examples of standalone databases being used to manage private practice. The Nevill Hall office at Aneurin Bevan University Health Board uses a system, which self-populates with information from the patient administration system. Cardiff and Vale University Health Board uses a spreadsheet to monitor private practice which includes patient contact details, details of the procedure they had, invoice number, price and payment date with a hyperlink to an individual charge sheet which breaks down costs for each patient. Having all of the information in one place makes it easier to deal with queries and enables the finance department to extract monthly data on income from private practice efficiently.

2.30 During 2013-14, the NHS in Wales reported receiving £8.5 million from private patient income. Although a substantive amount, this represents just 0.1 per cent of the total operational budget of the NHS in Wales. Abertawe Bro Morgannwg University Health Board received by far the largest proportion of this private income, at £3.3 million. As part of our work, we tested samples of private patient activity undertaken in NHS facilities during 2013-14 to understand the extent to which all appropriate costs for private practice activity are recouped by the health boards. The activity related to outpatient appointments, inpatient admissions and radiological tests. Our analysis identified that in six per cent of these cases, income from private practice activity was not recouped that should have been (Figure 7). The bulk of these cases where income was not properly recouped were in Hywel Dda University Health Board.

Figure 7 – Level of private practice activity undertaken in NHS facilities where income was not recouped appropriately

Type of activity	Sample size	Number of cases where income was not recouped appropriately	Percentage not recouped appropriately
Outpatient	450	22	5%
Inpatient	172	14	8%
Radiology	206	14	7%
Total	828	50	6%

Source: Wales Audit Office analysis of health board financial systems

2.31 Within the sample, we found a number of occasions where recouping the income was not appropriate because:

- patients were recorded incorrectly as private patients on the patient administration system when in fact they were receiving NHS treatment; and
- patients had cancelled or did not attend their private appointment.

2.32 These cases, however, take time and effort from the finance teams to understand why it is not appropriate to invoice for treatment due to the correct information not being available at the start of the process. On occasions, this has resulted in invoices being issued to patients who then inform the health board that they should not need to pay.

2.33 All health boards, with the exception of Hywel Dda University Health Board, produce monthly reports showing the income from private practice, and in Abertawe Bro Morgannwg, Aneurin Bevan and Cardiff and Vale University Health Boards, targets relating to income from private practice have been set. These reports, however, just show the monetary value and provide no information on the level of activity being undertaken, or whether the income recouped is the correct level of income for the activity. Our analysis also identified that although 51 per cent of invoices for private treatment in the NHS are paid within a month of the invoice date, 26 per cent take more than three months to be paid, with eight per cent taking more than six months and on occasion more than a year. While it is positive that on the whole the income for private practice activity is being recouped, cumbersome administrative processes and unreliable information mean that a financial burden relating to the provision of private practice healthcare is placed on the NHS until the point when those costs are recovered. In recognition of this, a number of health boards, particularly those with a greater level of private practice activity, have requested their internal audit function to undertake reviews in this area over the last 12 to 18 months. These reviews have identified specific actions that local teams need to take to strengthen their arrangements.

Appendices

Appendix 1 - Location of private hospitals and independent clinics in Wales

1 North Wales Medical Centre, Llandudno, Gwynedd

2 Abergele Consulting Rooms, Abergele, Conwy

3 Spire Yale Hospital, Wrexham

4 Werndale Hospital, Bancyfelin, Carmarthenshire

5 Sancta Maria Hospital, Swansea

6 Vale Healthcare, Llantrisant, Vale of Glamorgan

7 Cyncoed Road Clinic, Cardiff

8 Spire Hospital, Cardiff

9 Consulting Rooms, Newport

10 St Joseph's Hospital, Newport

Appendix 2 - Analysis of private practice activity undertaken in NHS facilities

Figure 1 – Level of outpatient and inpatient private practice activity undertaken in NHS facilities during 2013-14 and 2014-15 by health board and trust

	Outpatient attendances		Inpatient cases		Day-case attendances	
Health board/trust	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
Abertawe Bro Morgannwg (ABM)	1,159	1,329	100	74	141	124
Aneurin Bevan (AB)	2,087	2,105	101	108	152	101
Betsi Cadwaladr (BCU)	1,888	1,920	59	53	664	544
Cardiff and Vale (CV)	90	35	54	73	58	56
Cwm Taf (CT)	84	47	11	9	25	26
Hywel Dda (HD)	438	359	16	13	104	45
Powys (P)	4	-	-	-	-	-
Public Health Wales	-	-	-	-	-	-
Velindre	12	-	2	1	2	2

Source: Wales Audit Office analysis of PEDW data

Figure 2 – Private outpatient activity by specialty (2014-15)

Specialty	Appointments	Patients	Health boards with the highest volumes of activity (appointments)
Ophthalmology	2110	1180	BCU (1628), HD (258) and ABM (204)
Trauma and Orthopaedics	852	673	AB (607) and ABM (200)
Cardiology	434	385	AB (311) and ABM (108)
Dermatology	422	259	ABM (279) and AB (134)
General Surgery	421	362	AB (271) and ABM (105)
Gynaecology	301	232	AB (206)
ENT	251	203	All in BCU (187) and ABM (64)
Neurology	187	150	AB (168)
Gastroenterology	149	107	All in AB (141) and ABM (8)
Urology	146	123	AB (99) and ABM (43)
Respiratory Medicine	96	57	All in AB
Rheumatology	87	82	AB (72)
Cardiothoracic Surgery	84	55	All in ABM
Clinical Haematology	60	38	All in ABM
Pain Management	59	53	BCU (51)
Oral Surgery	20	19	All in BCU (20)
Clinical Oncology	27	8	All in ABM (27)
Forensic Psychiatry	77	73	All in ABM
General Medicine	9	9	HD (7)
Paediatrics	1	1	HD (1)
Plastic Surgery	1	1	ABM (1)
Anaesthetics	1	1	CT (1)

Source: Wales Audit Office analysis of PEDW data

Figure 3 – Privately funded admissions to NHS facilities by specialty (2014-15)

Specialty	Hospital admissions			Health boards with highest volumes of activity
	Total	Day case	Inpatient	
Ophthalmology	416	406	10	BCU (326)
Trauma and Orthopaedics	172	67	105	AB (83) and ABM (40)
General Surgery	157	97	60	AB (54) and BCU (50)
Urology	103	63	40	BCU (66)
Cardiology	91	81	10	ABM (34) and AB (25)
Gastroenterology	86	86	-	BCU (63)
ENT	50	36	14	BCU (27) and ABM (22)
Gynaecology	50	25	25	AB (23) and CT (18)
Cardiothoracic Surgery	40	1	39	All in ABM (24) and CV (16)
General Medicine	11	9	2	CV (10)
Pain Management	10	10	-	HD (7)
Clinical Oncology	8	1	7	All in BCU (6) and Velindre (2)
Oral Surgery	7	6	1	All in BCU (7)
Paediatric Surgery	6	2	4	All in CV (6)
Other	22	8	14	CV (8)

Source: Wales Audit Office analysis of PEDW data

Figure 4 – Privately funded inpatient admissions to NHS hospitals across Wales with a length of stay greater than zero (2014-15)

	Inpatient admissions	Bed days	Average length of stay
Abertawe Bro Morgannwg	74	444	6.0
Aneurin Bevan	108	495	4.6
Betsi Cadwaladr	53	143	2.7
Cardiff and Vale	73	366	5.0
Cwm Taf	9	168	18.7
Hywel Dda	13	35	2.7
Powys	-	-	-
Velindre	1	1	1.0
	331	**1,652**	**5.0**

Source: Wales Audit Office analysis of PEDW data

Appendix 3 - Audit approach

The review of private practice took place between August 2014 and May 2015. Details of the audit approach are set out below.

Document review

We reviewed relevant documents for all NHS bodies including:

- documents setting out the NHS body's policy on private practice including guidelines for patients accessing NHS treatment following a private consultation or diagnosis, and guidelines for clinicians conducting private work in NHS facilities;
- information on the billing mechanism for private work in NHS facilities;
- documents profiling demand and activity and how private work (including consultation, diagnosis and treatment) is planned in the light of this profile; and
- theatre lists, clinic lists and job plans that show the balance of private and NHS work and whether private patients are seen at the end of clinics or at other times.

We also reviewed any Welsh Government communication to NHS bodies setting out guidelines on private patients entering the RTT pathway and the management of private practice in NHS facilities.

Centrally collected data

We analysed all private practice outpatient and inpatient activity undertaken in 2013-14 and 2014-15, which was made available to us through the Patient Episodes Database for Wales (PEDW) analysis team. We also analysed all private practice radiological diagnostics undertaken in 2013-14, which was made available to us through the radiology departments across Wales.

Data testing

Focusing specifically on the health boards with the greatest levels of private outpatient and/or private inpatient activity (Abertawe Bro Morgannwg, Aneurin Bevan, Betsi Cadwaladr, Cardiff and Vale, and Hywel Dda), we reviewed a number of samples of private patient data with a specific focus on:

- mapping individual patient pathways and for those who received NHS inpatient treatment, identifying key milestone dates in their pathway in order to compare their total waiting time with that experienced by a typical NHS patient; and
- identifying each component of the private treatment the patients received in NHS facilities and matching the information with financial records from NHS bodies to understand the extent to which associated costs of treating those patients in NHS facilities had been recouped.

Interviews

Focusing on the same five health boards as the data testing exercise (Abertawe Bro Morgannwg, Aneurin Bevan, Betsi Cadwaladr, Cardiff and Vale, and Hywel Dda), we interviewed a range of staff to find out whether they have a clear policy and process for managing the impact of private practice on the NHS and to understand how these policies were implemented. Where they existed, this included interviewing private practice managers along with directorate managers for specialties that recorded high numbers of private practice activity.

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