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TRANSCRIPT OF "FILE ON 4" – "PAYING THE PRICE – PRIVATE HOSPITALS"

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ACTUALITY IN OPERATING THEATRE, BEEPING MACHINES

WOMAN: Are we all in agreement and happy to proceed?

VOICES: Yes, yes.

WOMAN: Thank you.

ACTUALITY OF DRILLING

JACKSON: At this private hospital in Cheshire, Tuesday is a busy day in the operating theatres. For patients, the day of their much-needed surgery has finally arrived. For Spire, the company who runs the hospital, the procedures will generate revenue. One of the clients paying is the NHS.

ACTUALITY OF DRILLING

JACKSON: Susan Clementson's knee replacement surgery is one operation that is being funded by the NHS. She's letting us follow her treatment.

CLEMENTSON: Well, I've had bad knees for a while, so I went to see the doctor last summer and he gave me the, sent me here for the first one, and I had that in December 5th, and then the other one's started to play up as well, so I'm having the other one done as well.

JACKSON: And what's been the problem? What pain have you been in in both knees?

CLEMENTSON: Well, it just, it used to click out, it used to literally click out. It was affecting my back in a lot of ways more than my knee, but it was very painful sometimes, but not all the time. So you put it off for a long time and then suddenly it becomes too much and you have it done.

JACKSON: Susan is one of around half a million patients who the NHS will pay the private sector to operate on this year - part of an effort to reduce NHS waiting lists. This is the second time the NHS has paid for Susan to go private to have a knee replacement.
It's hard to tell two knees apart, isn't it?

CLEMENTSON: It is really, yes. You can hardly see the scar, and that one's because it's all bulging, that's what's wrong with it.

JACKSON: And it's an indelicate question, but how old are you?

CLEMENTSON: [LAUGHS] 76.

JACKSON: So the left knee is six months old and the right knee is a bit older.

CLEMENTSON: Very old [LAUGHS].

JACKSON: As we were chatting, Susan's surgeon, Mr Predhan, called in to see her. Demonstrating on her knee, he showed Susan what he was planning to do.

CLEMENTSON: So you don't cut the bone off there and then?

PREDHAN: We do, but a little bit, not a lot, a little bit.

JACKSON: Do you happen to know how many NHS patients you are doing this morning?

PREDHAN: So I've got two NHS and two private patients on my list today.

JACKSON: So fifty fifty.

PREDHAN: That's correct.

JACKSON: This is a Tuesday morning. Couldn't it be said that you might be better off dealing with the NHS today, trying to shorten their waiting list?

PREDHAN: The difference really is that here we've got beds, there's availability, so it is possible to do it here.

JACKSON: So you're saying there's only a, effectively there's only a certain number of patients you can do within those hours in the NHS, assuming it has the capacity to enable you to do those?

PREDHAN: That's correct. So as soon as we feel that in our NHS hospital we can do more than what we're doing right now, we employ another consultant straightaway. So if we can accommodate more consultants to increase our throughput, we would just do that.

JACKSON: So you wouldn't need this, you wouldn't actually need to be here if the NHS had the capacity to do the work?

PREDHAN: That is correct. I think what the Government is looking at is whether it is easier to create more capacity in the NHS or buy what is already existing capacity here, because I don't think these hospitals will fill up if NHS work goes out of here.

JACKSON: Being seen here by Mr Pradhan, instead of up the road at the NHS hospital he also works at, means Susan gets her knee fixed sooner.

CLEMENTSON: I saw him in July and I'm having it done now. Well, if it was in the NHS hospitals it would have been a lot longer.

JACKSON: Could you have waited that long or was the pain so bad do you think?

CLEMENTSON: Well maybe. But why, if you don't have to? [LAUGH]

JACKSON: And just to be clear, this isn't costing you a penny?

CLEMENTSON: No, it doesn't cost anything, no. It's just like being a private patient.

JACKSON: Is that part of the attraction for you? Not only the wait being less, but the experience here in your own room, looking over the trees of Cheshire there?

CLEMENTSON: It is definitely, yes.

ACTUALITY OF DOOR CLOSING

JACKSON: So we have left Sue to get ready for surgery and we've been waiting in one of the rooms here, and it is rather like being in a hotel room – there's the latest plasma TV on the wall, looking out over these beautiful fields of corn. It is very quiet

JACKSON cont: and it's easy on the face of it to see why patients like Sue might want to have their treatment here compared to a busy ward on an NHS hospital. As well as being treated quicker, Susan is in a hospital that's been judged Outstanding by the regulator, the Care Quality Commission. But earlier this year, the CQC published the results of its first comprehensive inspection programme of private hospitals. In its report, published in April, it warned that when it came to safety, four in ten private hospitals across England needed to improve.

LEYS: I'm Colin Leys. I'm a Co-Chair of the Centre for Health and the Public Interest, which began work in 2013, and we've been looking at the state of healthcare in private hospitals since 2014, and we've published about four reports and a number of short pieces on this question.

JACKSON: One of his reports was based on a review of 177 CQC inspections of private hospitals. The report was published last year, and found there are a number of systemic safety risks specific to the private sector, including one key concern.

LEYS: I think it's not so much the standards of care that are offered - for example, hygiene or infection rates and so on - though they are significant. It's more what happens if something does go wrong in a private hospital. The great majority of private hospitals are small facilities who, curiously enough, employ no doctors directly and this means that that the facility doesn't have a range of departments like an NHS hospital, and in particular, because they don't employ doctors, they can't have intensive care beds, and we know that about one in six patients admitted to any hospital will have some adverse event. It may be tiny, it may be they didn't get their medication when they should have, or they might have something very serious. They might get a postoperative infection, which quickly can become very dangerous or they might have internal bleeding, which could be fatal very quickly. So depending on the risk of that, it makes a big difference what kind of hospital you're in. And if you're in a hospital without medical staff on site and no intensive care beds, clearly that risk is much higher.

JACKSON: But isn't it, to some extent, always the case that the surgeon operating on you won't be able to hang around and give you intense care post-operatively? There will always be a handover and they will always have to be on the end of

JACKSON cont: the phone to some extent rather than by your bedside. I mean, is that that different to what happens in the NHS?

LEYS: Well, yes it is very different, because the consultant has a team and he's training that team, and some people in the team will be ready to become consultants themselves, they'll be very experienced in the field of surgery - I suppose it's surgery that we're talking about. And some of these will always be on site and on duty, so the nurses calling somebody in are not calling a junior resident medical officer whose only appeal is to a consultant somewhere offsite. She will call immediately to some of the team.

JACKSON: But it is true to say, isn't it, that you could be having a similar procedure in your local NHS district hospital or something like that under the same scenario, couldn't you? If things go wrong, you might need to be transferred to the bigger NHS hospital. So isn't it a little unfair to finger the private sector for that calibration of things?

LEYS: If something really serious, life-threatening goes wrong, they will have to be taken to the nearest NHS hospital in an ambulance, and if they're still well enough to be saved and if there's an intensive care bed free, then that's where they will get treated. Therefore, there is always delay and in a number of the cases that we know about through inquests, that delay factor has been critical.

ACTUALITY OF CAR DOOR CLOSING

JACKSON: I'm in Bolton this morning to meet another lady who has had private treatment paid for by the NHS. Her name is Mary Greaves and she's had hip replacement surgery.

GREAVES: Sorry about the ground.

JACKSON: Is it moles?

GREAVES: I think so.

JACKSON: Mary's fully recovered from her operation. She made light work of the obstacles we encountered in the Lancashire countryside.
I can't even tell which one you've had done. Which?

GREAVES: Well, actually I've had both [LAUGHS] and it was really because there were three of us - I have two brothers - and we all had a hereditary condition called hemochromatosis, which in my case caused me to get arthritis at quite an early age really. So it was recommended that I would have hip surgery and everything went fine. I think at most I think it was three days I was in hospital and then I came out, I walked out of hospital with crutches and I had no problems, so from my point of view everything went really, really well. And I didn't, I couldn't see that there would be any reason not to go into a private hospital. I didn't realise that there might be any issues of any kind - until later.

JACKSON: The family's hereditary medical condition meant it was no surprise when, not long after her operation, Mary's older brother, Peter O'Donnell, was told he needed a hip replacement too. She encouraged him to accept the same treatment at the same hospital, the BMI Beaumont hospital in Bolton.

GREAVES: I just told him, you'll be fine. I said, you know, I mean, I was only in for about three days and out, and I just said, you know, it's going to make a big difference to you. And I did persuade him in the end, you know, to go in and I feel, well I feel bad about it now. If you come this way you can see Peter's grave; it's not somewhere where I ever thought I would be or I ever thought would happen. I've got this on it – 'With love, we remember Peter O'Donnell, a very dear son, brother and uncle, who died 21st January 2017 aged 77.' A young 77. And there's a space for me there because I will be eventually buried with my brother.

JACKSON: Because you were close?

GREAVES: Because we were very, very close.

JACKSON: Is it difficult for you to come here?

GREAVES: It is difficult. Yes. I never, ever thought … I know he was older than me and I knew at some point he probably would die before me, but this wasn't his time and this wasn't the reason he should have died.

JACKSON: Peter did decide to have the same operation as Mary. They were especially close – the pair had ended up living together after Mary was widowed as a young woman.

GREAVES: Yeah, very, very close really, because we'd lived together for 24 years. In a way we just did everything together. He liked sport, we used to go to football matches and Accrington Stanley [LAUGHS].

JACKSON: Peter went into hospital on the 14th January last year. He had his right hip replaced and to start with, things appeared to have gone well. Just tell us what happened to Peter then, having the same treatment in the same hospital.

GREAVES: I took him into the hospital and he had the operation on the Saturday and I went to see him on the Sunday. Sunday afternoon he was fine. He was a bit tired and everything, but he was fine, because he rang two of his friends to tell them he was okay and everything. I went to see him on Sunday night and he wasn't all right. He was very confused and he was falling asleep talking to me. But he was saying peculiar things to me. He said, 'There is somebody at our front door.' He wasn't making much sense.

JACKSON: Peter had picked up a chest infection, but he wasn't given antibiotics straightaway and ended up with pneumonia. During the third night after his operation, he got much worse, but it wasn't until 11 o'clock the following morning staff called 999. He was rushed by ambulance to the nearest NHS hospital. It did have an intensive care ward. By now Peter was dangerously ill.

GREAVES: The phone rang and it was somebody saying, 'Your brother's gone into cardiac arrest and they're trying to save him now.' Somebody met me there and said, you know, 'We'll take you in, but they're trying to resuscitate him.' There must have been about eight people around the bed. I'm a bit upset really.

JACKSON: Peter never regained consciousness. A week after his operation in the private hospital, he died of multiple organ failure. At the subsequent inquest, his death was officially put down to the infection he picked up straight after his surgery, sepsis and heart disease. The coroner identified serious failings in the care he'd received. [MUSIC] He decided 'neither protocols nor procedures existed for the transfer of unwell patients to local acute hospitals'. A CQC report had stated that the BMI Beaumont Hospital had policies in place. The CQC has insisted to File on 4 it did see a transfer agreement 16 months before Peter O'Donnell's death. BMI says it's modified its transfer arrangements so better information is made available to hospitals that take in its patients. Whether any arrangements were in place when Peter died still isn't clear to his family.

ACTUALITY WITH KEYS

JACKSON: At home, Mary has collected all the paperwork that revealed what had happened to her brother.

GREAVES: So I've got a great big folder of, you know, different statements and different coroner's reports and different things, so it's endless.

JACKSON: When Peter was rushed to the NHS intensive care ward, key medical notes were faxed across. They showed his observations had been poorly recorded in the private hospital.

GREAVES: There's a gap.

JACKSON: There's a gap in that column there, nothing written.

GREAVES: There's a gap for three, is it ….

JACKSON: Looks like two or three hours.

GREAVES: Yes, there's a gap.

JACKSON: So that would look like no observations taken.

JACKSON cont: But Mary also has a copy of the original document. The one that remained at the private hospital. On this version, there weren't the same gaps in Peter's care.
What's the difference there?

GREAVES: Well they look like the figure's been written over some way or another.

JACKSON: Peter's inquest heard that two nurses had admitted they'd changed the notes in the days after he'd died.

GREAVES: They actually said at the inquest that they'd found the documents were in a room that was used actually by nurses for records and things, and they were on the table, and they looked at them and they decided that they needed, they'd missed some things out and they wanted to show that they had actually given this care, so they updated so-called or amended.

JACKSON: Do you think that's an acceptable explanation?

GREAVES: Not really, no, I don't. In any other job, you know, I think there would have been very serious consequences.

JACKSON: BMI disciplined the nurses and gave them a final written warning. The coroner said the pair should have been referred to the Nursing and Midwifery Council. BMI told File on 4 it sought advice from the NMC and is confident the steps it took were in line with what it suggested. Colin Leys believes what happened to Peter O'Donnell has revealed a systemic failure.

LEYS: So the information in CQC reports didn't match the reality, and we don't even know whether other things in both what the CQC was told when they did their inspections was also perhaps not as good as it should be, so ….

JACKSON: That's pretty shocking, isn't it?

LEYS: It is very shocking and very dangerous that that situation should exist.

JACKSON: So you would say there is a sort of inequity there between the visibility of the NHS compared to private situations?

LEYS: Yeah, I mean, I think it's, it's a dark field. We don't know much about what goes on and that's partly why there is still this prevailing feeling that private is good. Because the data on which we could check that statement isn't available. Private hospitals are not subject to the same requirements as the NHS to report on all, all the outcomes on all the events that occur. They're only required to report deaths and serious incidents. They report them to the Care Quality Commission and, in the case of NHS patients, also to the Commissioning CCG. They're not required to give detailed reports of all the other events that happen to a patient. So the short answer is, we don't know much about the outcomes in private hospitals compared with NHS hospitals.

JACKSON: The then Health Secretary, Jeremy Hunt, was also concerned by what had happened to Peter O'Donnell. In May this year, he highlighted the case in a letter he wrote to private healthcare companies. In particular, he demanded the sector become more transparent about safety failures. The Department of Health was already dealing with the fallout from the Ian Paterson scandal – [MUSIC] an NHS breast surgeon who'd also worked in the private sector. Paterson was jailed for carrying out unnecessary operations. The CQC's landmark report into the private sector had also landed. Overall, a third of private hospitals were judged to require improvement. Five months on from Jeremy Hunt's letter, it's still difficult to find detailed published information about how private hospital patients fare. So we asked the Care Quality Commission to give us the information private hospitals do send it - the number of serious injuries and unexpected deaths for the five years from 2013. For all private patients, not just those sent by the NHS, the figures showed that the number of unexpected deaths had risen by about a third - from just under 180 deaths to just over 240 last year. Serious injuries had risen much more sharply, almost tripling from just under 300 to over 850. Things only go wrong in a tiny number of cases, but we wanted to know why there's been large increases. David O'Hare is from NHS Partners - the group representing private healthcare providers.

O'HARE: I think what we are seeing at the moment - and the CQC are driving this and the NHS generally is driving this - is that transparency and openness is a fundamentally good thing and getting some of that data out there and ensuring that it's used properly is, of course, critical. Now ...

JACKSON: But why isn't this stuff published? Your members could publish it, couldn't they? They could say, 'Here we are, being transparent. Here's the number of serious injuries and here's the number of deaths, unexpected deaths.'

O'HARE: It's critical that people don't sort of jump to conclusions about increases in numbers. Each of those cases will have been reported to the Care Quality Commission. These are numbers that will be interrogated and that's critical, and we've seen in the NHS, for example, the number of serious incidents rise from virtually zero 15 years ago to half a million a quarter now. That doesn't indicate that the NHS is much less safe; what it demonstrates is that we are getting data out there.

JACKSON: In terms of those figures, they're quite staggering figures, aren't they? 191% rise in serious injuries, for example. At the very least, isn't that an indication of how poor your reporting of figures was before the pressure came on?

O'HARE: I will be the first to accept that this sector has been on a journey in terms of reporting information and ensuring there is absolute transparency about what is, what is out there. There is a little bit further to go, but the journey this sector has embarked on is a positive one and the performance of the sector compares very favourably across healthcare in England.

JACKSON: Around 6% of the NHS non-emergency surgery is currently done by the private sector. Funding operations like Susan's - whose knee replacement surgery is now about to get underway. My producer and I grabbed a word with her consultant, Mr Predhan, just before he started operating.

ACTUALITY IN HOSPITAL

WOMAN: Come on in, you two then, we're all happy …

JACKSON: How are you doing?

CLEMENTSON: Very good, thank you.

PREDHAN: So what happens is the NHS has a set price for a joint replacement and that price is given to any hospital that does that procedure. So let's say the patient goes to Warrington Hospital and if the amount is £6,000, that £6,000 will go to Warrington Hospital. If it is Spire, it comes to Spire, so the price is fixed.

JACKSON: But isn't the difference - and it has to be the difference doesn't it - that here a profit has to be made from this procedure?

PREDHAN: I think most of the times you will make a profit, but I think the hospital might take a hit on some procedures.

JACKSON: I'm sure you know the criticism that's sometimes made is that the profit motive means that there's less of a backup, less of a procedure here.

PREDHAN: Ah.

JACKSON: I mean, is there any validity in that.

PREDHAN: Definitely not. I think not at all. I think as a surgeon what you want is that the patient really gets the best. If that means that we are operating in the NHS and then outside as well, then we do that, okay? So it's very difficult as surgeons to say that we won't go here or we won't go there if that's going to affect patient care. So if I found that patient care was not good enough in a particular hospital, if it's a private setup, I wouldn't go there. So it's those sort of things that affect us than anything else.

JACKSON: Well, we'd better let you get on with it.

PREDHAN: Thank you.

JACKSON: Cases like Susan's should be relatively straightforward. As a fit 76 year old with no other health issues, complications are unlikely. Her operation should be profitable for the Spire Hospital. But more broadly, the Royal College of Surgeons has concerns about what it says is the private sector's tendency to select the least complicated cases. Ian Eardley is one of its council members.

EARDLEY: The private hospital looks very carefully at such things as the length of the operation, the length of the stay, the risk of staying longer, and they make judgements about whether the fitness or the health of the patient means that they'll get in and out of hospital quickly and effectively, because if they do, then they will be able to do the procedure at a profit. If the patient has to stay in longer because they are unhealthy, they potentially would do the case at a loss and many private hospitals will tend to turn down the cases who might stay in hospital longer or those who are more prone to complications, and that's cherry picking.

JACKSON: That means the NHS gets stuck with the more complicated and costly cases. And Ian Eardley says that's not the only downside.

EARDLEY: If a patient does have an operation done in a private hospital and something goes wrong, then in the first instance the medical team and the nursing team who are looking after that patient will try and resolve that problem. If it's resolvable in the private hospital, great, but if not then sometimes it does require transfer to an NHS hospital where there's more support, where there's more specialities available. It's a cost to the NHS, it's a financial cost, because they're not getting usually any income for the primary treatment of the problem, but they're having to deal with the consequences which comes at a cost to that NHS trust. But for the system as a whole, it seems to be a cost they're prepared to accept.

ACTUALITY IN OPERATING THEATRE

JACKSON: So we're in the operating theatre now and the surgery is just getting underway. The staff themselves are wearing very elaborate gowns, large helmets which are for infection control, and I'd say there's, what, getting on for eight members of staff, including the surgeon, hundreds of pieces of equipment laid out in front of

JACKSON cont: us. And behind Susan there, there's two or three trolleys with monitoring equipment on. So even just standing here, you start to get a measure of the costs involved of what is still described as a routine procedure.

ACTUALITY – DRILLING NOISES

JACKSON: So I can see now what is effectively Sue's new knee coming out of plastic box that the nurse is just getting ready to hand over to the surgeon, and it looks like a couple of inches wide probably, coming out of the box there, and I can see they are just preparing the knee joint ready to be fixed in now.

WOMAN: We'll do the sign out then please. So the operation was performed as planned. We've done a right total knee replacement. Nothing has happened unexpected under the duty of candour that we need to let the patient know about. And has anybody got any concerns for recovery on this occasion?

STAFF: No.

WOMAN: Thank you.

JACKSON: It might have at times looked and sounded rather brutal, but a couple of hours later Susan is told the surgery's gone well.

PREDHAN: You are very sleepy but you are okay.

CLEMENTSON: Yes, fine.

PREDHAN: So it's gone really well, all right? We replaced your knee. Just rest for today and then we will get you up and going very soon.

CLEMENTSON: Yes, exercises.

JACKSON: The Spire Hospital would have been paid the same fee as an NHS hospital would have received for carrying out Susan's operation. But there was a time when the private sector was paid more. In 2012, the Health and Social Care Act put a stop to it. Lord Andrew Lansley was the Conservative Health Secretary at the time. I met him in Westminster.
What was the danger of that? It was bleeding money out of the NHS and an unfair playing field?

LANSLEY: The problem with that, of course, is that the NHS, as an institution, was paying more for procedures than it would have done through the NHS itself, and there was no benefit in that. Indeed, it was a loss to the NHS - lost finance equals lost potential capacity in the NHS - so we definitely didn't want that to happen, so we stopped all that. And indeed, the 2012 Act made it illegal for the NHS to pay more to the private sector for a procedure than it paid to the NHS. And so, and indeed, the competition between providers, which of course could in the past, before 2012 legislation, have been conducted on the basis of price. Under that legislation, that was excluded as well, so if there was to be competition between providers for patients, for activity on behalf of patients, then it had to be done on the basis of quality and service rather than price.

JACKSON: What did you do to make sure that those standards didn't drop and the patient wasn't let down?

LANSLEY: We were doing this at a time when we had seen the experience, for example, of the Mid Staffs Hospital, so we were increasingly aware of the need for patient safety to be right up at the forefront. But it was a job of Clinical Commissioners as well, for determining where there were failings, whether in the NHS or any other provider. So one of the jobs of the Clinical Commissioners was to be quite sure that there was, in addition to the CQC inspection regime, that they as purchasers of the care on behalf of patients knew that it was sufficient quality.

JACKSON: But isn't the truth of this relationship is that on the one hand the NHS Health Secretary, Commissioners want them to do the work, the private sector, but you can't make it too onerous, so we see the NHS has lots of work on outcomes, lots of data collection, lots of scrutiny and yet when you try and find those sorts of figures for the

JACKSON cont: private sector, it's not quite the same? And there's accusations that they're not, the data's not there, so Commissioners don't actually know how safe the service is they are buying.

LANSLEY: Well, after 2011, we introduced quite a lot of additional clinical audit, so of course that, insofar as that is provided in the private sector for the NHS, NHS clinical audit should extend there too. And where the private sector is involved in providing NHS services, it must do so on the same basis as an NHS provider would do.

JACKSON: But when operations don't go to plan in the private sector, it can be hard to work out who is accountable.

TINA: Basically, he came through the door after we presumed the surgery had finished. He asked if he could sit down, so we thought, oh he's going to tell us everything's gone okay. My daughter looked at me and she shook her head, she knew straightaway, she started crying. And then he just said that he'd had a problem and he couldn't continue with the surgery.

JACKSON: The NHS paid for Tina Salt's husband, Keith, to have private gallbladder surgery at the Spire Parkway Hospital in Birmingham. It happened five years ago, but he's had severe health problems ever since.

SALT: When he proceeded to disconnect the gallbladder and take it out and that, he severed the bile duct with a 75% tear, which was obviously that bad that …. but he couldn't repair it and was unable to repair it, so hence the reason for the consultant from the QE having to come.

JACKSON: The specialist consultant had to be called in from the Queen Elizabeth Hospital in Birmingham - a large acute NHS hospital 20 miles away. And when you signed up for the operation, when you signed the consent form, did they mention this to you? Did they say, 'This is a hospital where we'll have to draw on extra support from an outside hospital, it may take time to get here,' – was any of that made clear as far as you're aware?

SALT: No, nothing like that. Obviously, he came round with consent forms. He said obviously what, what complications could be, which is the same with any operation. He'd said something about never having had a single problem and I made a quip of saying , oh well, I'm probably going to be that one then that's going to be the problem.

JACKSON: Keith showed me the crisscross of scars on his stomach from the various operations he's had since.

SALT: Well, the first operation went from over on my right hand side over and to about 4 or 5 inches up from my belly button.

JACKSON: He's still recovering from the latest operation just three weeks ago. Fortunately for Keith, unlike most private hospitals, Spire Parkway in Birmingham has an intensive care unit. He was cared for there until the new surgeon arrived. Since then, all his treatment has been done back in the NHS.
So in terms of what they've had to do since that operation, just take me through all the things you've had to have done.

SALT: Following the initial operation, a short time after that I ended up having to go back into hospital for 10 days to have intravenous antibiotics to cure infections. Over the next eight or nine months I had to have a tube inserted in my side and then I was in, in and out of there four times into hospital to have procedures to try and cure the problem.

JACKSON: So really a significant amount of money really has been spent on you since then?

SALT: Yes, and plus it'll be ongoing, because I'll be under the NHS hospital for the rest of my life. I have to go for regular appointments and scans to see if things have improved, blood tests to see how liver functions and things are doing. So yes, it will be considerable.

JACKSON: Keith took legal advice. His solicitor, Caroline Brogan from Irwin Mitchell, says getting answers about what happened wasn't easy.

BROGAN: In this case, we had great difficulty trying to actually identify who was going to be responsible, because the procedure has been carried out on behalf of the NHS, so one question is whether it's going to be the NHS Trust, and the procedure itself has been carried out by a private surgeon at a private hospital, so that also raises the question whether the case is against the private surgeon or the private hospital. We were eventually told that it would be Spire Parkway Hospital who should be named as Keith's opponent on his claim. [MUSIC] It does call into question what's really going on behind the scenes, erm, in terms of who is responsible for the delivery of services and provision of contracts. We were told that we were not privy to that information.

JACKSON: Keith has now accepted a significant sum in compensation, although nobody has admitted liability for what happened to him. Keith says doctors have told him the first surgery has reduced his life expectancy by ten years. In a statement, Spire told us it pays into a Clinical Negligence Scheme for Trusts - a mechanism which has been in place for five years to compensate patients. It added that it always responds promptly to issues raised by patients. With NHS waiting lists rising once again and the NHS already funding nearly half of all operations and medical procedures carried out in the private sector, Andrew Lansley believes the relationship must continue to evolve.

LANSLEY: I think the NHS as an organisation and the Commissioners in particular can once again start to say, we can use this budget to deliver the best possible services for our patients. And what that may mean sometimes is that we use private sector capacity, in particular let's use the private sector where they can just show that they are innovating or using a better, or finding a better quality service, but I think that's the test to the private sector in the UK, is that they shouldn't expect the NHS to use them unless they can demonstrate that they are doing something better for the NHS and for patients than the NHS is able to achieve. One of the great, as yet unachieved objectives of NHS progress is to shift tariffs to the point where they are payments for outcomes, not payments for processes. And of course if that were to happen, then that would have a big impact in the private sector as well as in the public sector, because if you went to the private sector and they weren't delivering good outcomes, then they wouldn't get paid.

JACKSON: Each operation - wherever it take places - can change people's lives. Overwhelmingly that is normally for the better. My producer and I had been fortunate enough to witness just one. We were especially keen to know that patient's outcome.

ACTUALITY OF PHONE CALL

CLEMENTSON: Hello?

JACKSON: Hello, is that Susan?

CLEMENTSON: It is.

JACKSON: Hi, it's Alistair Jackson from File on 4. How's the knee?

CLEMENTSON: Oh, it'll be fantastic. I should be able to, you know, walk up mountains and do things that I haven't done for quite a long time. So it'll be absolutely wonderful.

JACKSON: So you're back on both feet now?

CLEMENTSON: A bit painful, but we're getting there, we're walking round and everything, so that's okay.

JACKSON: What is the thing that's going to change your life most, do you think? What are you going to be able to do that you couldn't do before?

CLEMENTSON: Well, just being normal. I've not been normal for a long time. I've not been able to do a lot of swimming and things like that, you know, just having a normal life again really.

JACKSON: I'll say goodbye, Susan - thanks a lot.

CLEMENTSON: Okay, thanks very much, goodbye.

ACTUALITY OF PHONE BEING PUT DOWN