PHIN

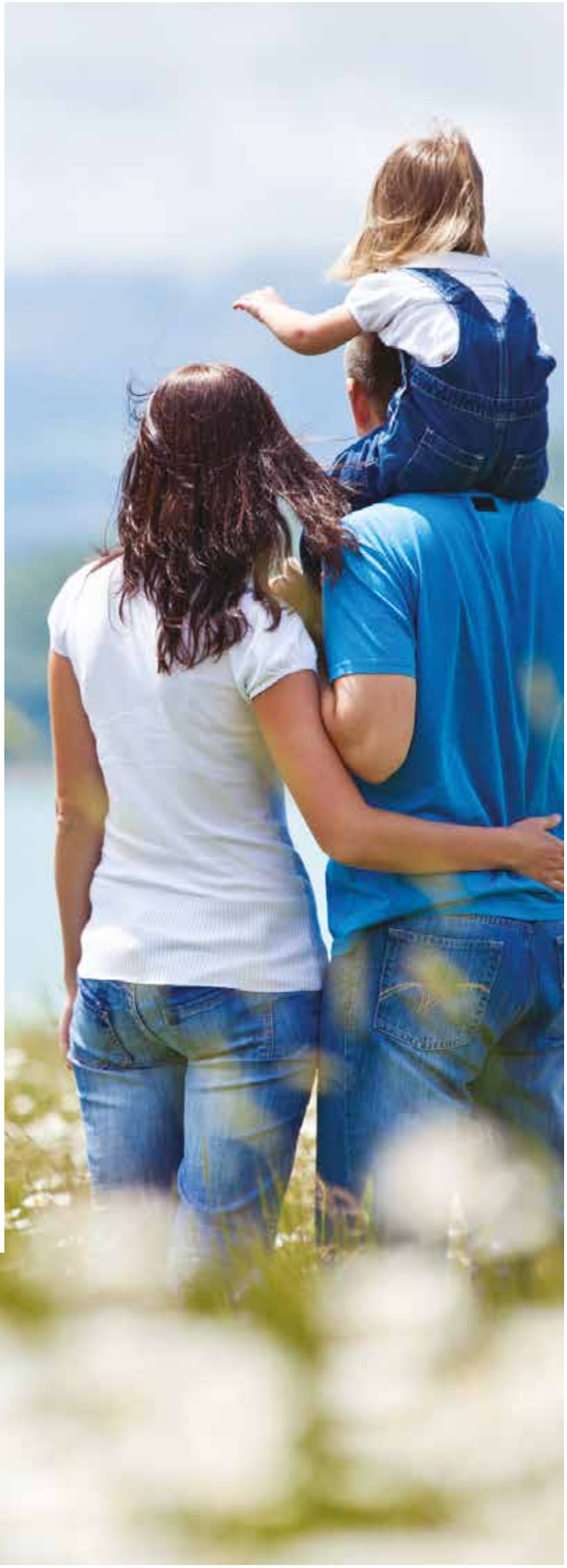
Strategic Plan 2015-2020

Private Healthcare Information Network

October 2015

The leading source of independent, trustworthy information on private and independent healthcare provision, helping patients to make informed decisions when choosing their care providers.

Contents



Chairman's Foreword

The Private Healthcare Information Network (PHIN) has already come a long way in the three years since it was founded, growing from an idea to an established small organisation with a high profile and an important role to play. The next five years – those covered by this plan – will be transformational, not just for PHIN but for the whole private healthcare sector.

Our over-arching mission is two-fold: to enable patients to be able to make better informed choices about their healthcare providers and, through the provision of comparative information, to help private providers continuously improve their care and clinical outcomes. Initially, though, the dominant theme for us will be PHIN's role as the independent 'Information Organisation' (IO) approved by the Competition & Markets Authority (CMA) to implement the information remedies set out in the Private Healthcare Market Investigation Order 2014.

Indeed, that role will see two distinct phases within the five year period. The first two years will take us from the point of assumption of our role in April 2015 to the key milestone date of 30 April 2017, by which point PHIN is required to be publishing the full range of information set out in the Order using data provided by its members. This will be a period of well-defined implementation to meet clear, mandatory objectives, and equally to help private hospitals and consultants to meet the obligations laid upon them.

The second phase, beyond 30 April 2017, is less defined but just as important; it will be about developing maturity. With the infrastructure for producing and publishing comprehensive comparative information in place, PHIN and the private healthcare industry together will work out how best to use and develop that new platform. What can we learn to improve quality of care? How can we better measure and communicate the outcomes achieved? What can we do to improve each patient's experience of private healthcare? What will patients (and key stakeholders such as GPs) find most useful in terms of information?

We cannot yet be precise about what that period will hold, not least because PHIN's approach will be to consult widely and listen to a broad range of opinion. However, in this Strategic Plan we set out our current thinking, our starting assumptions and the principles that will guide us.

Toward the end of the five-year period (the date will not be confirmed until closer to the time), the CMA will review the remedies and their implementation. We understand that the CMA's review is likely to consider not just the extent to which the sector has, or has not, met the specific and detailed requirements set out in the Order, but also the extent to which the sector has addressed the fundamental concerns raised during the investigation and set out in the final report. In other words, is there now sufficient information available to enable patients to make fully informed choices, taking account of quality and value, enabling effective competition?

That question is very much aligned to PHIN's founding purposes and mission. It reminds us that we had established PHIN before the advent of the CMA's report, with the help of the leading private hospital providers, for a purpose that will endure beyond the term of this report and the mandate given to us by the CMA: to produce robust, trusted information for potential patients, in a manner supported by the whole private healthcare industry. As such, we must continue to build within PHIN the capability to pursue those objectives.

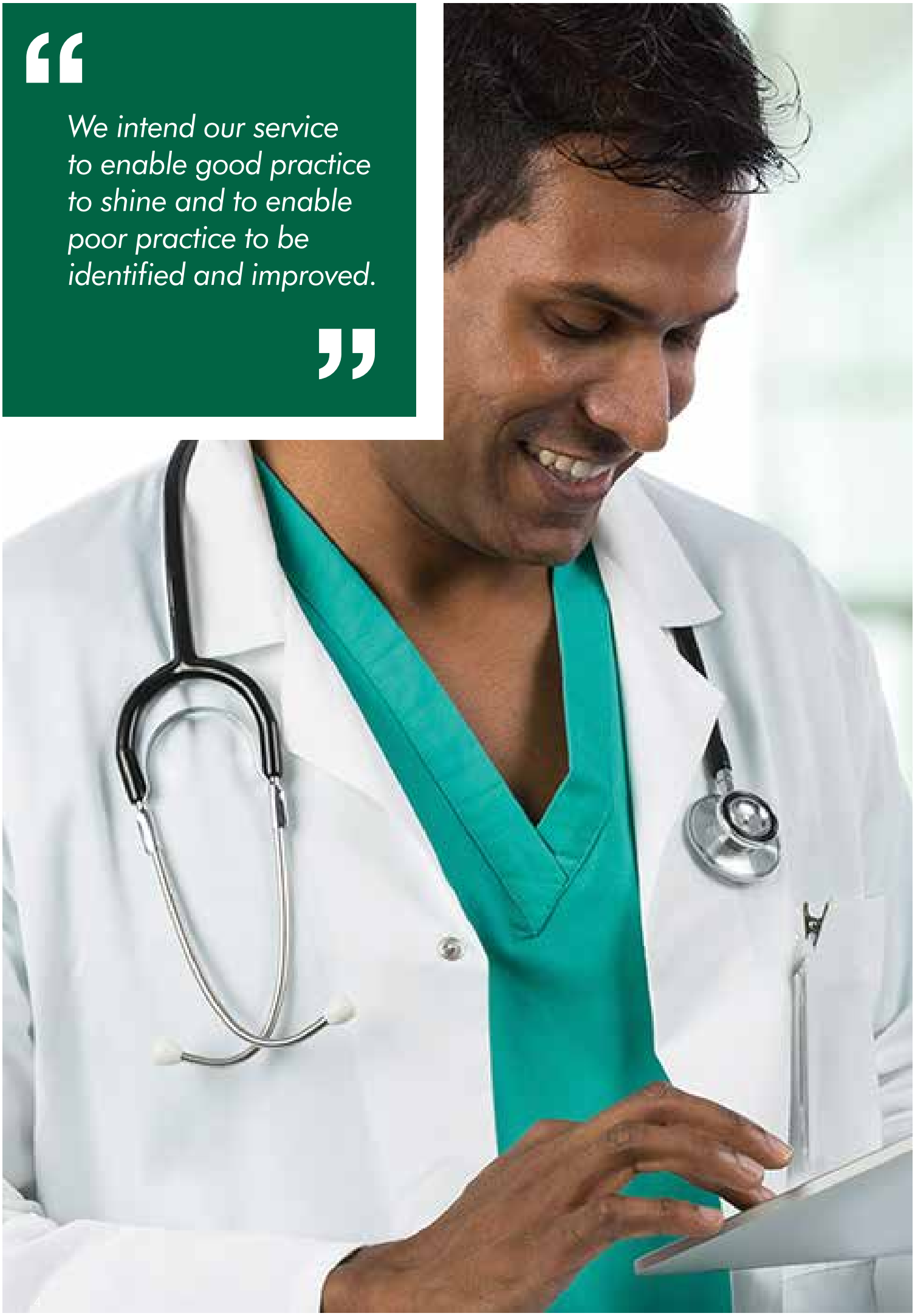
As noted above, we have already come a long way. PHIN remains a young organisation, but over the last year or so in particular we have made real progress; we have a highly able and well-balanced Board that is well constituted to lead this organisation; and a strong, dedicated Chief Executive who has developed our executive capability, building a small but effective team that is developing unique knowledge and building positive relationships across the whole healthcare sector.

We will continue to develop our capabilities to create value in the organisation and for our members. However, we will remain focus on our purpose; we are not a commercial organisation with great ambitions for growth. We will operate with an unusual degree of transparency for a non-public body, publishing an annual report, Board minutes and accounts. By being open to scrutiny, and in turn helping to open up private healthcare to scrutiny, we aim to increase trust in the sector and give potential patients greater confidence and certainty.

I look forward to the journey ahead.

Andrew Vallance-Owen MBE, MBA, FRCSEd
Chairman

We intend our service to enable good practice to shine and to enable poor practice to be identified and improved.



Chief Executive's Summary

Since our approval by the CMA as the independent Information Organisation (IO) for Private Healthcare in December 2014, PHIN has been fully focused on the implementation of the information remedies laid down by the CMA in the Private Healthcare Market Investigation Order.

The Order gives us, and the private healthcare industry as a whole, plenty to do over the next couple of years, but leaves room for interpreting how to do it.

In this strategy, we share our plans for the immediate implementation of the information remedies, and our thinking for the period beyond. The strategy is very much the product of dialogue with our members and stakeholders, as we seek an approach that will achieve the improvements needed by patients while being deliverable and valuable to the industry.

The latter part of this document is an implementation plan that goes into some detail on the data required and how this will be used to produce the performance measures specified up to 2017. This is intended as a reference, and explores some of the issues we will face and the decisions we have taken. Much more detailed operational planning and documentation is also being made available to members.

The Order places information obligations on PHIN, hospitals, consultants and private medical insurers. Clearly, PHIN's first duty is to ensure that it fulfils its own obligations, but we also recognise a wider duty to help the other parties to meet their obligations.

PHIN's approach is one of inclusion and consultation. We make no claim to have within the organisation alone all the expertise required to implement the CMA's remedies successfully; rather, we aim to work with our member hospitals, with the medical professions, and with a wide range of stakeholders and partners to ensure that the information we publish is complete, robust, fair and useful.

We intend our service to enable good practice to shine and to enable poor practice to be identified and improved, hopefully by the practitioner themselves in most instances.

Whilst PHIN now holds a mandate to help the private healthcare sector to deliver the improved information required by the CMA, we would not wish to be viewed simply as a route to compliance. PHIN was founded with the support of the private hospitals to serve a purpose that remains absolutely consistent with the IO role: to collate and publish information about the quality of care in the sector to better inform patient choice. This grounds us in the objective of providing a service valued by our members, and we will not lose sight of that service ethic. In addition to performing our IO role, we want our service to stand on its own merit, both for members and patients.

The hospital operators' support of PHIN represents an investment equivalent to about 0.04% of total turnover[1], and the total cost to hospitals and consultants of producing improved information critical to demonstrating the quality of the service provided is unlikely to exceed 0.1% of turnover. As such, modest gains in consumer confidence and propensity to buy should see the endeavour pay for itself.

We are excited by the future and the impact we believe PHIN can make on private healthcare.

Matt James
Chief Executive

[1]Laing & Buisson Healthcare Market Review, 27th Edition: Independent Acute Medical Hospitals and Clinics, £4,561m in 2013.

> *We set out from the start to build credibility and integrity through a balanced and inclusive approach.*

Our role as the CMA's Information Organisation

In April 2014, the Competition and Markets Authority published the Final Report of its Private Healthcare Market Investigation. This was the conclusion of nearly four years of investigation into the effectiveness of competition in the private healthcare market, having begun in 2010 as a "market study" by the Office of Fair Trading (since merged into the CMA).

The Report set out a number of areas in which competition was adversely affected by the way in which the sector operates, and a set of related remedies, given legal force through the publication of the Private Healthcare Market Investigation Order in October 2014.

Whilst some of the remedies have been controversial and contested, there has been consistent and overwhelming cross-industry support for the view that the published information available to patients considering private healthcare is inadequate, and that this must be addressed.

PHIN, having been established in 2012 to address exactly that deficit, was recognised during the investigative process as having objectives aligned to the requirements of the CMA. We set out from the start to build credibility and integrity through a balanced and inclusive approach, and consequently had a structure, governance and culture that was suitable, with some changes in scope, to take forward the role of facilitating the publication of improved information for the sector.

The Report and the Order set out the basis of an independent IO for private healthcare in the UK, and PHIN was approved by the CMA in that role on 1 December 2014, taking up the role on 6 April 2015. The approval itself was contested: other credible parties expressed an interest in becoming the IO; our application was considered and accepted on merit. It is possible that those other organisations will yet have a role to play.

The Order places explicit obligations on PHIN, as the IO, around governance, inclusion, transparency, consultation, data processing and publication. The manner in which we intend to discharge these obligations is set out in this document.

The Order also places a number of information-related obligations on private hospitals, consultants and private medical insurers. We are taking as implied that PHIN has a duty to help those parties to understand and fulfil their obligations, and the manner in which we aim to do so is also given thorough consideration in this document.

The Order itself is not perfect; there are some areas where we may need to seek further clarity or reach our own interpretation. In doing so, PHIN will refer back to the Final Report for guidance, and we hope that the private healthcare sector generally will remain focused on the underlying goal of positively addressing the need for better information.

We also understand that the CMA will review the effectiveness of the remedies after around five years (2020), and is likely to consider at that point both whether the letter of the law as expressed in the Order has been met, but more generally whether the private healthcare industry has successfully addressed the concerns identified by the investigation. In other words, we expect them to consider whether the private healthcare sector collectively is actually publishing useful information for patients which helps them make informed choices.

The principal purpose of this Five Year Strategic Plan is to set out how PHIN plans to meet its responsibilities under the Order over the coming five years (2015-2020), and to explain how PHIN plans to support our members in meeting their obligations. In addition, the Plan outlines PHIN's other envisaged goals up to 2020.

Summary of the CMA's Information Remedies contained in the Order

Summary of obligations placed by the Order on PHIN as the Information Organisation

Governance, membership and engagement

- To establish a Board with a prescribed structure, including Non-Executive Directors nominated by specified stakeholders; the CMA, the private hospitals, consultant representative bodies and the private medical insurers (A23.2).
- To prepare this five year plan, and have it approved by the CMA (A24.1).
- To publish various documents on its website in the interests of transparency (A24.3).
- To offer membership to all private healthcare providers, private medical insurers and to appropriate bodies representing consultants (A24.4).
- To consult its members and relevant experts on the methodologies to be used to process the data, and to have those data sets and processing procedures periodically externally accredited, certified or audited (A24.5).

Operational deliverables

- To publish specified performance information on its website, in stages and no later than 30 April 2017 (A24.6), ensuring that the information is then regularly updated (A24.7).
- To process personal data in accordance with the Data Protection Act 1998 (s21.3).

Summary of obligations on private hospitals in relation to information

- To provide patient record level data and other data to the IO (21.1) in a specified format (A21.2) by specified dates (21.1) in order to support the publication of specified performance measures at both hospital and consultant level (21.1) by 30 April 2017 (24.6).
- To pay subscriptions to cover the reasonable costs of the IO (A21.4).
- To require, as a condition of permitting a consultant to practise, that the consultant informs patients in writing of outpatient and treatment fees in advance (A22.2).
- To check that every patient has received appropriate information on fees (A22.7).
- Article 22 is not yet in force, pending the final outcome of an appeals process.

Summary of obligations on consultants in relation to information (not yet in force)

- To provide to the IO by specified dates information covering standard outpatient fees, standard procedure fees and standard terms and conditions (A22.1).
- To provide information to patients prior to outpatient consultations and admissions for treatment, covering reasons, costs, terms and conditions and insurer recognition, and providing the website address of the IO (A22.3, 22.4).
- Article 22 is not yet in force, pending the final outcome of an appeals process.

Summary of obligations on private medical insurers in relation to information

- To inform policyholders and patients that helpful information is available from the IO's website using standard wording (A25).

Notes on scope of the Order in respect of breadth of membership

The Order defines Private Healthcare Facilities as "any facility providing privately-funded healthcare services on an inpatient, day-case and/or outpatient basis, and may include a PPU [NHS Private Patient Unit]." The Report made it clear that the CMA also regards cosmetic surgical facilities as "within scope" (of paragraphs 21 and 22 of the Order).

Some types of private healthcare facility providing specialist services such as laser refractive eye surgery, fertility treatment, or termination of pregnancy seem prima facie to fall within the scope of the Order, but were not directly contemplated during the CMA's deliberations. PHIN reserves the right to prioritise focus and resources accordingly.

Article 21.5 states that the duty in article 21.1 does not require a private hospital operator to supply the information organisation with information concerning any outpatient activity. However, where a private healthcare facility conducts interventions in an outpatient setting of a type which are commonly conducted elsewhere as admitted care (day case) procedures, then we will invite them to submit data. Laser refractive eye surgery is a good example of this, since most small clinics conducting the procedures in high volumes are outpatient only, while other hospitals treat these as day cases. There is no material difference in processes or price.

Goals and Milestones (2015 to 2020)

What should PHIN look like, and what should it have achieved by April 2020?

Goals

- All requirements laid down by the CMA have been met in full, with appropriately robust publication of information covering quality and consultants fees (subject to the ongoing appeals process) for all UK private healthcare providers and consultants to the standards set out. Interim milestones, including publication of substantially improved data by 30 April 2017, have been met.
- Any hospitals and consultants subject to the Order who were not compliant by April 2017 have since become compliant, and the reporting processes and measures specified in the Order have become accepted business-as-usual processes across private healthcare.
- PHIN is widely recognised as the definitive trustworthy source of reliable and unbiased information about private healthcare.
- PHIN's service is recognised as fit-for-purpose and value-adding in terms of conveying information to patients and other stakeholder audiences.
    - PHIN is successfully acting as the single-point-of-reference for the publication of performance and price measures for the sector, and for the collection and analysis of data and information to support that.
    - PHIN's service is used and appreciated by patients and GPs, and its Member Information Portal routinely used and positively regarded by hospitals, consultants, insurers and other audiences.
- These achievements have been objectively measured by site statistics and surveys/ feedback.
- The existence of PHIN and the availability of better information is having a positive effect on
    - Consumers' understanding of private healthcare and confidence in making decisions.
    - People's propensity to buy private healthcare, and on their perceptions of choice, value and quality.
    - The private sector's awareness of clinical outcomes and the need for continuous quality improvement.
- Some providers and consultants have begun to compete by pursuing positive differentiation both on the availability of good information and on the results, outcomes, quality and value of their services for patients and purchasers as demonstrated in the data. PHIN's approach allows scope for such differentiation, and the data is sensitive enough to enable discrimination on performance to support meaningful choice and differentiation.

Milestones

Governance

1. PHIN's members endorse PHIN's strategy, including the approach to membership and required changes to the Articles, the implementation plan, and the budget and financial assumptions, at the AGM in October 2015.
2. The Five-Year Plan is submitted to the CMA for approval in early November 2015.
3. PHIN's Board reaches its full complement by the end of 2015.
4. The Five-Year Plan, Board Minutes from April 2015 onwards and implementation timetable are published on PHIN's website by the end of 2015.
5. PHIN invites leading insurers and organisations representing consultants to become Voting Members by the end of 2015.

Membership

1. PHIN contacts all non-member private healthcare facilities (PHFs), including NHS Private Patient Units (PPUs) and identified cosmetic surgery providers, with invitations to join PHIN by end August 2015.
2. All PHFs subscribing to PHIN by end December 2015.
3. All consultants contacted and made aware of PHIN, and offered access to the Members Information Portal (subject to the availability of data from participating hospitals) by April 2016.

Deliverables: enabling technologies

1. 2nd generation IHES warehouse operational by end September 2015.
2. Fully functional Member Information Portal available to all hospital members (subject to them having achieved data submission milestones) by end 2015.
3. 2nd generation PHIN website operational by end of 2015.
4. Working view of all Performance Indicators published on PHIN's secure Member Information Portal from end October 2016 (using January to June 2016 half year data to check completeness, quality and application of linkage and risk adjustment methodologies).
5. Final 'launch' data covering episodes of care completed in 2016 made available to members for checking by 1 April 2017.
6. 3rd Generation PHIN website available by April 2017.

Data submission

1. All Private Healthcare Facilities have successfully and securely supplied to PHIN by 1 September 2016 data for episodes completed in the period January to June 2016, where that data is certified by the provider as >99% complete and valid according to PHIN's requirements.

Performance indicators

1. PHIN works with the medical specialties and professional associations, principally through the Federation of Independent Practitioners Organisations (FIPO) and its members to identify and approach relevant clinical audits and registries by year end 2015.
2. Definition of Adverse events agreed with Members by end 2015.
3. Pseudonymised "Linkage" established between PHIN's Private Hospital Episode Statistics (PHES) and NHS Hospital Episode Statistics (HES) to generate re-admission, unplanned admission and mortality performance indicators by end September 2016.
4. PHIN collects infection rate data from Public Health England (PHE) (Surgical Site Infections and Healthcare Acquired Infections) by end July 2015 and publishes by end December 2015 (other home nations to follow in due course).

Consultant fees (subject to ongoing appeals process)

At the time of writing, the fees remedies are yet to be put in force by the CMA. Whilst an appeal against those remedies by FIPO was rejected by the Competition Appeals Tribunal in March 2015, FIPO has been granted leave to appeal that decision to the High Court. That process will not take place until 2016. We believe that this extended process will invalidate the dates set out in the Order, but that is yet to be confirmed by the CMA. The dates proposed below were based on the timings given in the Order, and will need to be adjusted accordingly if and when the remedies are brought into force.

1. PHIN, working with the Implementation Forum and FIPO, confirms proposed method to identify and contact all doctors in England "admitting patients" privately by end December 2015 and for the rest of the UK by end April 2016.
2. PHIN develops and commences consultation on required "Fees Format" by beginning of January 2016.
3. PHIN publishes required "Fees Format" by beginning April 2016.
4. A system to capture fees input by consultants, or by hospitals on their behalf, is agreed and designed by March 2016 and implemented by July 2016.
5. PHIN publishes all Consultant Fees Information on PHIN's secure Member Information Portal from end January 2017 and publishes same on PHIN public website from 30 April 2017.

Our Vision, Mission and Values

PHIN's vision is that all patients considering private healthcare will have access to trustworthy, comprehensive information on both quality and price to help them make their decisions.

Over the next five years, PHIN will become the first service that patients and doctors turn to when they want to understand and choose private healthcare.

We will help to raise standards and expectations for the availability, transparency and usability of health information.

Through our analysis and publication of information, we will develop professional and public understanding of private healthcare, and drive improvement in the quality of services delivered and the outcomes of care and treatment delivered.

Values

Trustworthy

- Respect individual privacy and commercial confidentiality at all times
- Be fair and accurate: let both good and poor performance show in our information, and make every effort to make sure that the information is correct
- Be relentless and energetic in improving data quality
- Act to identify and eliminate risks

Informative

- Strive to increase understanding of private healthcare in every respect
- Produce information that will be used, and will make an impact for patients
- Present data in a way that is understandable, and easy to interpret
- Search for meaning, insight and utility in information
- Help users to understand what the information means to them

Responsive

- Respond quickly and helpfully to communications and requests
- Consider the needs of patients and stakeholders, and involve them wherever possible
- Strive to improve PHIN's service, and be open to ideas

Effective

- Remember that each pound we spend comes ultimately from patients
- Balance ambition with responsibility to use time and resources wisely

Governance

Good governance is more than a necessity to PHIN, it is effectively part of our 'product'; before any information could be collected or produced, we had first to create an organisation suitable and trusted to perform that role where none had existed previously.

Corporate Structure

PHIN is governed by its Board, which delegates executive management responsibilities to the appointed Chief Executive. Our governing document is our Articles of Association. Having accepted the role of the CMA's approved IO, we also have regard at all times to the CMA's Order, and to the Final Report.

As a Company Limited by Guarantee without Shareholding, PHIN has no shareholders but must have Members. Members derive no financial benefit from the company, but perform a "checks and balances" function on the power of the Board. The powers and duties of Members are set out in our Articles of Association and are consistent with Company Law. Those limited but important duties are summarised in the relevant section below.

The structure and development of the Board and Membership are explained below. Please note that the terms "Member" and "Members" in this context is not the same as the ordinary use of members, meaning organisations that subscribe to and participate in our services. Since the two terms are easily confused, we will use "Voting Members" when referring to legal governance processes.

PHIN's Articles of Association were updated and approved by its Board in September 2013.

PHIN's Board

PHIN's Board presently has the following members:

	Dr Andrew Vallance Owen Chairman	
Mr Matt James Chief Executive	**Ms Fiona Booth** Non-Executive Director nominated by AIHO	**Professor Sir Cyril Chantler** Non-Executive Director
Professor Nancy Devlin Non-Executive Director	**Mr Don Grocott** Non-Executive Director	**Mr Michael Hutchings** Non-Executive Director nominated by the CMA
Dr Gerard Panting Non-Executive Director nominated by FIPO	**Ms Jayne Scott** Non-Executive Director nominated by the CMA	**Professor Sir Norman Williams** Non-Executive Director

Hence, as at 31 May 2015, PHIN's Board structure is fully compliant with the requirements laid down for the Board of the IO in the Order (A23.2) save for the inclusion of "one non-executive director nominated by the private medical insurers collectively". At the time of writing, deliberations are ongoing, and we look forward to welcoming a candidate nominated by the insurers to the Board in due course.

Presently the Board meets ten times each year, though it is expected that from early 2016 the frequency of meetings will be reduced. Directors are remunerated on a per diem rate, allowing time for the reading of materials and so on, except where a Director is remunerated within the normal scope of their employment for participation in PHIN.

Voting Members

A Company Limited by Guarantee must have members who perform an important governance function with limited but important rights and duties, including:

- The right to vote at General Meetings, including the Annual General Meeting
- The right to call a General Meeting (the Board also having this right)
- The right to appoint or remove Directors (the Board also having this right)
- The right to receive the Annual Report and Accounts

Eligibility for Membership of PHIN is defined in the Articles of Association, supplemented by the Member Regulations. When PHIN was established, Membership was limited to UK private hospital operators. However, in accordance with the CMA requirements and PHIN's wish to serve the wider private healthcare sector further to serving patients, eligibility for Membership is extended to Private Medical Insurers and to organisations representing Consultants, and the Board will appoint members in those categories.

At the time of writing, PHIN's fifteen Voting Members are:

- Aspen Healthcare
- Benenden Hospital Trust
- BMI Healthcare
- Circle Health
- Fairfield Independent Hospital
- HCA International
- Healthcare Management Trust
- Horder Healthcare
- Hospital of St John & St Elizabeth
- King Edward VII Hospital Sister Agnes
- The New Victoria Hospital
- Nuffield Health
- Ramsay Health Care UK
- Spencer Private Hospitals
- Spire Healthcare

We frequently refer to these fifteen organisations as our Founding Members (although the phrase has no legal meaning), recognising the crucial role that they played in establishing PHIN.

Extending Voting Membership

PHIN will take an informal but purposeful approach to inviting new Voting Members to participate in our governance. PHIN's Board will initially invite the leading five or six PMIs, and FIPO as representative of consultants, to become Members alongside the fifteen founding hospital Members. Further appointments may be made, be that of more insurers, other consultant bodies, or further hospitals (NHS PPUs, for example). We will not attempt to explicitly balance numbers (votes) between stakeholder groups, but rather PHIN's Board will keep the composition of Voting Membership under constant review, in an attempt to reach a constructive consensus and a broad perception of 'fairness' with as little bureaucracy as possible.

A note on interpretation of the Order:

Article 24.2 of the Order reads: *"The information organisation shall offer membership to all private healthcare providers and private medical insurers and to some bodies representing consultants."* We believe that inviting all private healthcare providers (over 250) and all insurers (around 40) into Voting Membership is impractical and could be distracting. On the other hand, we can and indeed must invite that broad constituency to participate in membership as service users. In truth, we believe that there has been some conflation of these two notions of 'membership', and as such PHIN will interpret the Article pragmatically.

Membership in the broader sense of participation in our services is addressed below.

Publication of specified information and documents

PHIN is required by the CMA to maintain high standards of transparency and accountability. Article 24.4 of the Order specifies that –

The IO shall publish on its website:

(a) its board minutes;

(b) the five-year plan, as approved by the CMA;

(c) a timeline for publication of the performance information specified in this Order;

(d) details of its annual budget; and

(e) an annual report, which sets out the progress made in fulfilling the five-year plan; explains any changes to the timetable or the nature of the information collected; and gives sufficient financial information to enable members to understand how their funds have been applied.

Board minutes and the five-year plan, once approved, will be published on our website from late 2015. This will comprise PHIN's Board minutes from April 2015 onward, when we took up the role of the IO.

The timeline for publication is both contained within this strategy and will be separately available on our website from late 2015.

An Annual Report, accounts and budget for the coming year will be published annually following acceptance at the Annual General Meeting. Whilst "progress" can be interpreted to mean PHIN's progress, we will endeavour also to report the progress being made by the hospitals and consultants subject to the Order in collecting and submitting the data required as we move toward sector-wide compliance.

Participation and Engagement

The CMA's Order brings within its scope at least 500 private healthcare facilities across up to 300 private healthcare providers, and an estimated 12,500 consultants in private practice as principals (what the CMA termed "referring clinicians").

Additionally, the private medical insurers, professional bodies, patient representative bodies and a wide range of stakeholders including regulators, commissioners, and potentially GPs all have an interest in PHIN and the data to be produced.

PHIN works with all parts of the private healthcare sector, and with a wide range of other stakeholders. The leading private hospitals supported our establishment and are, of course, our largest customers. This does not detract from our primary duty to patients and consumers and, ultimately, PHIN can only perform the role that the sector needs if it is respected and trusted by patients, GPs and other key stakeholders. As such, we must be both independent and inclusive.

Working with hospitals

Hospital recruitment

As at April 2015, eleven private healthcare provider organisations representing 191 hospitals were fully participating in PHIN, with their data included on our website. A further four organisations were engaged but not yet able to submit data.

PHIN has attempted to identify all hospitals and providers that may be subject to the CMA's Order and hence required to participate.

The list is still evolving as we consider whole categories of provider not yet included, such as providers of refractive eye surgery. Equally, a few organisations may drop off that list: for example, there are many NHS hospitals conducting private work in small volumes, probably without a dedicated PPU, that may not continue to do so.

All hospitals on our list have been contacted, and we will continue to reach out to those yet to engage with us. Ultimately, however, it is not PHIN's responsibility to make them aware of their obligations nor to enforce compliance. Those hospitals that have chosen to participate must be the focus of our endeavours.

For the hospitals that do respond positively, PHIN offers a briefing (in person or online) and a Starter Pack of information. This tells hospitals what they need to do to get into PHIN's process and to aim for compliance with the CMA's requirements.

A map and list of current and prospective hospital members can be found in the Annexes.

Member engagement

The precise form of member engagement is likely to vary over time, but the principles will remain the same:

- PHIN will communicate often, through online channels, newsletters, technical support materials and events
- We will involve members in designing PHIN's information services
- PHIN will actively seek feedback to help us improve our services

Our primary source of member input is the Implementation Forum. This is a monthly meeting of senior representatives from participating hospital groups, plus invited guests such as FIPO and the CQC. Main agenda items are planned in advance and aligned to the CMA compliance implementation plan.

As at April 2015, eleven private healthcare provider organisations representing 191 hospitals were fully participating in PHIN

The Implementation Forum may establish Expert Reference Groups or other groups to look at particular issues, from time to time.

PHIN will also operate other engagement forums. These are likely to include:

- New Subscribers Forum: for those organisations new to PHIN and in the process of establishing data submission and data validity
- Data Quality Forum: for established members, a group focused on clinical informatics ensuring that the data requirements and standards are understood and met.

For purely practical reasons the Implementation Forum cannot include representatives of all members.

Additionally, PHIN will meet regularly with members on an individual basis, including with CEOs, the senior officers responsible for CMA compliance and working with PHIN (SROs), and with clinical or technical teams. Wherever possible, we will respond positively to requests for support or invitations to engage, for example to present to hospital directors, senior management, staff or consultant groups such as medical advisory committees.

Regular communications is an area where our members have asked us to improve and we will resource appropriately.

PHIN also maintains close working relations with the Association of Independent Healthcare Organisations (AIHO), the trade body for private hospitals, regularly briefing their Board.

Membership terms and benefits

The terms of membership of PHIN are set out in a Subscription Agreement signed by all parties.

The principal benefit of membership is inclusion of hospitals' data on PHIN's website, achieving compliance with CMA requirements and allowing patients to understand the scope and quality of care offered on a comparative basis.

However, we want participation in PHIN to be more than just a compliance exercise (and cost) for hospitals. Over the course of these five years, we aim to make PHIN a highly valued and integral part of the informatics and marketing structure for hospitals, valued for what our service achieves in respect of presenting information to a range of audiences, for the quality of products that we provide, and for the insight that we provide through our use of data and information.

In participating in PHIN, we believe that our members will gain a better understanding of healthcare informatics. Whilst the extent to which we can realise this at present is limited by the current lack of availability and maturity of data and processes, we aim to use informatics to enable a better understanding of quality and value, and to help our members to use the insight gained to improve their proposition for patients and purchasers.

The principal product that we are developing to support this is our Member Information Portal. This will present data and information to authorised audiences, starting with hospitals, enabling them to check data quality, to see and understand performance measures in context including with peer group benchmarks, and to better understand their market.

Working with consultants

There are two principal aspects to working with consultants:

- Operational engagement with individual consultants and service delivery
- Professional engagement with representative and professional bodies

Operational engagement and service delivery

There are an estimated 12,500 consultants active in private practice as "referring clinicians" (the consultant admitting the patient for treatment and responsible for their care), registered under fifteen main specialties and working across hundreds of hospitals. Many consultants practise across multiple hospitals, with the most prolific we have seen to date being a consultant working at 10 separate hospitals over a four-year period.

Each consultant is individually subject to the CMA's Order, although many may not yet be aware of this. PHIN will seek to help each and every consultant in private practice to understand the CMA's requirements, get involved with PHIN, and see the required information published in accordance with the Order.

We will ask every consultant to sign off on their information as fair and accurate before it is published. This will be conducted through the Member Information Portal, to which each consultant will have access to check, understand and use their data. We will work continually to improve the content and execution of the Portal to ensure that it meets consultants' needs.

Communicating with this number of consultants is a logistical challenge. The first route of communication will be via the hospitals, to the consultants holding practice privileges at each hospital. This is necessary and appropriate, since a consultant will only be able to see the information related to activity at a given hospital once that hospital is successfully submitting data to PHIN. We will produce draft communications for the hospitals to disseminate if they wish.

We have also started to build good relations with the General Medical Council (GMC), the professional regulatory body for consultants. The GMC has several regular channels of communication with consultants, and maintains a register of all consultants. They do not, normally, know which consultants practise privately. In addition to working through the hospitals, we will also therefore work with the GMC to ensure that communications go out to all consultants in private practice, hopefully reaching any that are otherwise missed.

Professional engagement

At the same time as working with consultants through the hospitals, PHIN will continue to engage with the profession through representative and professional associations.

Taking the lead on this is the Federation of Independent Practitioner Organisations (FIPO), which in turn maintains strong links to other representative organisations including the British Medical Association (BMA), Independent Doctors Federation (IDF), Federation of Specialist Surgical Associations (FSSA), and specialty organisations such as the British Orthopaedic Association (BOA) and the British Association of Urological Surgeons (BAUS).

FIPO has convened a Clinical Outcomes Advisory Group (FIPO-COAG), which includes representation from the FSSA and specialties, to look at the issues around measuring and reporting clinical outcomes in private practice and to advise on how the performance measures required by the CMA can best be implemented.

FIPO-COAG may consider, for example, how to work with the clinical registries and audits, approaches for the required performance measures, issues around low volumes, and how to apply case mix adjustment where that is applicable. The approach will need to be specific to each specialty.

Building confidence

PHIN will liaise closely with FIPO and its member organisations. In addition to communications from hospitals, PHIN and the GMC, consultants may therefore also receive information about the information production process from the specialist and professional associations. Consultants will have ample channels to ask questions and raise issues. We hope that in this way confidence in PHIN and the process of publishing information will build among consultants.

We know that many consultants have real concerns over the idea of publishing performance measures about individual consultants in both the NHS and the private sector. All those involved want to understand how the process can be made fair. We understand these concerns.

PHIN is making every effort to operate in a way that seeks a fair result and builds trust, from the presence of several recognised doctors on our Board, to the planning of engagement and executing the stated principle that every consultant will have the opportunity to check and sign off their own data as fair and accurate before publication.

We aim to give every doctor access to the Member Information Portal by April 2016, one year before the first required publication of information, to enable them to become familiar with the process of logging on to check and use data as it becomes available.

However prepared they are, April 2017 will be an intense period as consultants check their data; they will have access from 1 April to complete and risk-adjusted data covering a full year of activity, and they will have four weeks to check and approve it before the 30 April deadline. Our focus will be to do as much as possible in advance, from familiarising doctors with PHIN and their basic data, to developing the statistical methods and case-mix adjustments to be used.

We will proceed cautiously toward that deadline; it will be preferable to take the time to get things right rather than to risk damaging professional and public confidence with unreliable information. That said, we understand and support a sense of urgency for getting information out to patients, and will need to push forward. We will rely heavily on our Board and partners, and the process of engagement, to manage the balance between progress and perfection.

Benefits, data licences and governance

As currently envisaged, consultants will not need to contribute data to PHIN themselves, other than specifying the fees that they wish to charge. However, data is held about them (they are data subjects) and they will need to access and check the data and the information produced about them.

Consultants will, however, be granted access to PHIN's Members Information Portal, and will be encouraged to log on, check their data, and use it routinely. Consultants will be asked to agree to the terms of a data licence on first accessing the data, covering information governance and other issues.

We anticipate that, even in advance of publication, the information produced will be helpful for revalidation and appraisal, creating a whole-practice picture drawing data from all of the private hospitals at which a consultant practises plus the work attributed to them in the NHS, all expressed in a consistent terminology[2].

We believe that the publication of information about consultants on our website will have real value for consultants, providing a robust and trustworthy view of the quality of care that they deliver and the value that they offer. It is reasonable to believe that private practice in the UK offers an excellent service that compares very well in terms of price and value to similar services in other countries (although the more common value comparison made is, of course, with the NHS).

The new data standards mandated by the CMA will enable robust risk adjustment using proven methodologies to be applied to performance measures in the private sector for the first time, hence for the first time enabling consultants to truly understand and communicate their quality of care fairly.

The data collection processes for fees have not yet been designed, and this work is unlikely to commence until the appeals process in relation to fees is finally concluded.

Working with insurers

The Private Medical Insurers had little involvement in the early stages of PHIN, being directly involved only in the successful PROMs Working Group (see below). Now that the IO role has been established, however, we are building relations with the insurers and aim to involve them fully with our work as we move forward.

Involvement in governance

As noted above, the leading private medical insurers have been invited collectively to nominate a Director to PHIN's Board, in accordance with A23.2 of the Order. Following that appointment, PHIN will also move to appoint a number of willing insurers as Voting Members.

Involvement in development and implementation

In March 2014, PHIN broke new ground in the private healthcare sector by inviting insurers to participate alongside hospital and consultant representatives in work on Patient Reported Outcome Measures (PROMs). This meant that we could develop a solution incorporating views from all parts of the sector, building a broad

[2]Subject to the availability of necessary data from the HSCIC in England and the equivalent bodies in the other nations.

base of support, and also reduce the future risk to providers of different insurers and commissioners mandating different approaches to PROMs for their particular policyholders.

The PROMs work was seen as a success by participants, and we would like to involve insurers on a similar basis in future development work.

Access to information under licence

Understandably the insurers are keen to see better information available on consultant and hospital performance. The principal manifestation of this will be information for patients made available on our website. Insurers will be required to refer policyholders and patients to PHIN's website as the source of independent information on quality of care by A25 of the Order so they will, naturally, have an interest in the information we produce and its quality.

Insurers or other sources of funding are usually identified on each care record as part of standard hospital administration processes. Currently however, this data is not passed to PHIN as it is unnecessary until we have a use for it in producing information for insurers[3]. This means that PHIN can potentially produce information for and about insurers, from market information to (in due course) quality indicators for hospitals and consultants recognised by that insurer, but does not yet do so.

It is fair to say that there is a high level of anxiety among hospitals and consultants as to how insurers might use such information, and what decisions they may make using it. As such, as in all things, we must proceed with caution and consideration.

We firmly believe that over time both hospitals and consultants will come to trust PHIN's data as they check, correct and use it, and that soon enough they will actually want insurers to use these data: better to be judged by information that is independent, complete, fair and trusted, rather than on the basis of partial or proprietary data.

What this means though is that a phased approach is required while trust builds. The approach that we have discussed with leading insurers has two stages:

- **Prior to April 2017:** PHIN can provide insurers with overall market information, including some market share information. This is dependent, however, on insurers being comfortable with the purchaser being identified in our data. Our expectation is that this will become easier as the insurers are more involved in our governance. Insurers will be invited to be involved in the work to develop approaches and standards.
- **From April 2017:** With work on standards and adjustment complete, and with data checked and corrected by all parties, the information should be robust enough for use beyond the website. We would aim to have built understanding and support among our hospital and consultant members to give insurers access at that point to commission information that would provide greater context and detail for the headline performance measures as presented on the website. Consultants and hospitals will have full visibility of what information is shared with insurers.

[3]By agreement between PHIN and Healthcode

No access to individual patient records via PHIN

For the avoidance of doubt, PHIN will not provide data on individual patients or episodes to insurers. PHIN is not an appropriate route for such information.

Whilst we recognise that insurers have an interest in the care of their policyholders, person-specific information must come directly from the care providers, with the appropriate consents and controls, and not via PHIN. Our role is to use aggregated data to produce information and insight on the relative performance of care providers.

Working with patients and consumers

PHIN's purpose is for and about patients, so we would like to involve patients, consumers and their advisers as much as possible as we progress.

To date, we have conducted limited direct patient engagement, as part of website design processes in 2013 and 2015. This has been valuable and instructive, and we would like to do more. Prior to 2017, the terms of reference for patient engagement are likely to remain in the remit of helping to optimise the public presentation of information for usability. Beyond 2017, we may be able to be more open in scope, and involve patients more in terms of what information they would like to see, and how the service should develop.

We maintain a good relationship with the Private Patients' Forum, which aims to inform, support and empower patients and all users and potential users of the UK independent private healthcare sector. We have spoken with the Patient Information Forum, and hope to work with them more. We have also had offers to work with a variety of other organisations, including the Patient Liaison Group at the Royal College of Surgeons, professional associations and our own hospital members, to take a joint approach to understanding patients' information needs and getting their feedback on our service.

Other national groups, such as the Patients' Association, National Voices, Patient Opinion, and the Consumers' Association, generally focus wholly on the NHS; we hope to be able to raise awareness of private patients and work with those stakeholders over the next five years.

Data licences and information governance

The Order specifies at article 24 that the IO "may with the agreement of its members grant licensed access, which is in accordance with the Data Protection Act 1998, to its database." What might that mean in practice?

In addition to the overriding imperative of compliance with the Data Protection Act and respect for personal information, PHIN must take into account other restrictions including commercial confidentiality, competition law, and the terms of any licence under which we hold data, notably for NHS HES data.

PHIN will only grant access to specific views of the data to specific audiences for specific purposes, as detailed below. We may do this in pursuit of our objectives, but we do not envisage granting any licenced access to our database for commercial purposes or as a source of revenue.

We will, of course, publish information as required by the Order, and may publish any additional information or analysis that we believe is aligned to our objectives, within our legitimate scope, and in the interests of patients and consumers. This may be produced at the request of third parties (e.g. academic researchers, professional organisations, government, the media), as we will aim to help build a general understanding of private healthcare that is currently conspicuously missing. However, this will only ever relate to selected information derived from the data after consultation with relevant parties, not any access to the "database".

Consultants

As noted above, in addition to the public access to the PHIN website that everybody will have, we will need and want to grant licensed access to our information to consultants. Secure, authenticated access will be granted to information specific and appropriate to the particular consultant: this will include detailed (but pseudonymised) views of the care for which they are directly responsible, alongside relevant totals, averages and benchmarks. Commercial confidentiality will be respected alongside patient confidentiality, and no party will have inappropriate access to details related to their peers and competitors. As such, no party will have access to the "database".

Consultants will be required to accept licence terms covering information governance, intellectual property and so on when they access the Portal. It is not currently envisaged that there will be any charge for this licensed access.

Insurers

Similar to consultants, we will need in due course to grant licensed access to our information to insurers. The timing will depend on progress and the agreement of our members, but is likely to be around April 2017. Secure, authenticated access will be granted to information specific and appropriate to the particular insurer: typically this will be aggregated data related to the care for which they are directly responsible, alongside relevant totals, averages and benchmarks. Commercial confidentiality will be respected alongside patient confidentiality, and no party will have inappropriate access to details related to their peers and competitors. As such, no party will have access to the "database".

Insurers will be asked to enter into a licence agreement in advance. It is anticipated that insurers will be asked to pay for this licensed access, probably on a similar fee-per-record basis as applies to hospitals. Please note however that this has not as yet been factored into our financial planning.

Other potential licensees

There are other parties to whom we may in future wish to grant licensed access to our information (beyond that available publicly on our website) on a secure basis, with the agreement of our members. This is very unlikely to happen before April 2017.

These might include, for example:

1. **General Practitioners:** whilst GPs are not subject to the Order, they have a clear interest in understanding quality of care, and an ability to understand information. It is likely to be in the interests both of patients and care professionals that GPs should have access to good information.
2. **CQC or other regulators:** PHIN is co-operating with the CQC (in England) and its members to design reports and processes to help improve the efficacy of regulation. Currently, any information produced is made available to members to pass on to the CQC, rather than being shared directly. We envisage that in due course, once the information is well-established and trusted by all parties, it may become sensible to share information directly under licence and with full view of the regulated parties.

PHIN can envisage that at some point we may be approached by universities or other legitimate researchers seeking access to our unique data to better understand a particular aspect of private healthcare. Any such application would need to be considered individually on its merits and assessed against our objectives and information governance considerations.

Similarly, there are various reputable commercial organisations providing informatics, analysis and benchmarking services to our members. These organisations may well already have access to significant overlapping data received from members and elsewhere. We would not rule out the possibility of some data sharing. Again, any such proposal would need to be considered individually on its merits and assessed against our objectives and information governance considerations, and would be subject to the consent of our members and the approval of our Board.

We do not envisage considering applications for access to data or information for third party commercial purposes, nor as a source of revenue for PHIN.

Process for granting licences

1. PHIN Executive team works with applicants/ contractors/ interested parties to produce a licence proposal (including commercial terms and scope of information proposed);
2. Proposal submitted to PHIN Board for approval in principle;
3. If approved in principle, proposal submitted to member representatives (Implementation Forum and/ or others) for consultation (not less than one month);
4. Consultation responses collated by PHIN and reviewed by PHIN Board; the proposal may be accepted and a licence granted, refused, or remitted for amendment.

Sub-contracting of analytic processing

PHIN may choose on occasion to sub-contract particular types of analysis that we cannot conduct in-house or that would be better conducted independently. We have in the past, for example, contracted Northgate Public Services to undertake a complex data linkage pilot. In those circumstances, PHIN needs to grant a limited licence for access to our data under contract. Where the data to be analysed includes data obtained under licence from the HSCIC (HES) or other third parties, additional permissions may be required. Such activity is part of the normal conduct of business and is not subject to the approach outlined above.

Enablers

People and capability

PHIN has a high-profile and complex role, and it is essential that we have the skills and resources required to operate effectively.

Development of capability was, by necessity, a key focus through 2014 and early 2015 as we understood the emerging CMA requirements and prepared accordingly.

Key for our success in the future will be:

1. Technical expertise covering data processing, security, analysis and presentation.
2. Governance expertise, especially in information governance, ensuring that we operate within law and best practice, and protect PHIN and its members from avoidable risk
3. Engagement expertise, building a great service by communicating effectively with patients, members and stakeholders
4. Market expertise, with broad knowledge of healthcare, and deep understanding of the private healthcare market.
5. Listening capability, learning from feedback and turning insights into service improvements.
6. A working environment that enables us to recruit and retain highly capable people able to deliver, innovate and uphold our values.

We have already made significant progress. At the point that the CMA published its final report, PHIN remained a very small company, essentially the Chief Executive Officer with part-time support and a small Board. All development and technical services were outsourced. Since then we have grown to a team of 7 staff, with additional contracted support, increasing our technical, governance and engagement capabilities.

Most of our key people are now in place, and we anticipate that any future growth in the team will be modest and within existing budgets. We will focus on three areas:

1. Ensuring that we have sufficient customer-facing staff to deal with the significant implementation task over the first two to three years. It is somewhat difficult to know in advance the likely scale of communications involved in dealing with around 500 hospitals and 12,500 consultants, including handling their questions and concerns. We aim to significantly improve our ability to maintain regular communications with members and to provide support on the use of our informatics.
2. Continuing to bring capability in house to reduce reliance on external contractors, reduce costs, and establish sustainable expertise within PHIN on behalf of the private healthcare sector.
3. Reducing over-reliance on key personnel to improve resilience.

Information Governance

Information is PHIN's principal asset. PHIN is committed to clear and strong information governance policies and practices and has a Board approved Information Governance Policy that addresses the domains of Data Privacy, Confidentiality, Security, Quality and Integrity. All staff complete information governance training, based on the policy. Information Governance is a standing agenda item for our Board meetings, and is managed day-to-day by our Company Secretary, who is also our registered Caldicott Guardian.

PHIN had completed assessment under the NHS Information Governance Toolkit and is awaiting accreditation.

PHIN has always maintained strong principles around the handling and use of information, and we are constantly developing and refining our knowledge of information governance through our interactions with stakeholders such as the HSCIC.

We must also be willing to adapt and grow, and the increasing scope and sophistication brought by our IO role is demanding review of our approaches to information governance.

Central to this is our position on personal data[4]. To date, PHIN has carefully avoided ever handling or receiving personal data such as names, addresses and dates of birth, electing instead to receive pseudonymised patient records. This is part of a broader principle that we will only request, hold and use information for which we have a clear and appropriate need.

However, our needs are changing to meet the CMA's requirements. Several of the required performance measures (transfers of care, readmissions, mortalities, PROMs and adverse events) require linkage of data from different sources or records obtained at different times for a single patient, meaning that it must be possible to identify patients within the data. Typically, this is done using the NHS Number as a unique identifier[5], with other personal details used only to find or validate the NHS Number. This means that the personal details can be stored separately to the main record for better security, and that personal details are not visible for analysis.

Each patient will be asked by their hospital during registration to consent to the use of personal data to support data linkage processes, and where that consent is withheld it will be recorded and respected in accordance with the Data Protection Act 1998.[6] PHIN maintains a Subject Access Request policy should any patients ask to see the data that we hold on them, although because the data is currently pseudonymised we would not be able to identify any individuals within our data. This will change in due course.

Within the NHS, data linkage is usually performed by the HSCIC, and we would seek to use that route to achieving linkage wherever possible. However, we may not be able to continue to avoid receiving and processing personal data entirely, as it is becoming increasingly complicated to co-ordinate data for linkage from disparate sources, and this in itself creates risk. For PHIN, such a step would be significant, and could only be considered with input from our members

[4]As defined by the Data Protection Act 1998
[5]See the section on NHS Number under Data Standards below

and stakeholders including the HSCIC, and with appropriate legal advice where required. Currently, technical appraisals and stakeholder discussions continue.

Technology

PHIN's service is heavily dependent on technology to receive, process, store, analyse, govern and publish sensitive data from a wide range of sources. We also need to have our own internal approach to enabling technology. Here we give a brief overview of the technical platform on which PHIN is based.

Website

PHIN's first generation website, launched for us in April 2013, has served us well for a time, but we need a new website now and will need to develop it further in phases in order to meet the agenda.

Our next generation website is being built by a leading web design and development company, UI Centric. Consequently, it is built to the latest standards of security, functionality, and search optimisation, in addition to being more consumer-focused and up to date. The website will be hosted on secure third party servers managed by PHIN.

Overall, the relative cost of development and hosting will be reduced in comparison to current arrangements, although we are of course substantially increasing the scope and scale of the website to meet the CMA requirements.

Members Information Portal

Publication of more detailed data for checking in a secure environment will be delivered using Tableau Server, one of the world's leading business intelligence and analysis tools, delivered via a Microsoft SharePoint web portal to facilitate the presentation of contextual information for users, and security. The underlying data is hosted in a secure remote data centre. In other words, we are using market-leading, best-of breed, up-to-date solutions. This makes it easier to source development expertise and means that our approaches have been tested many times before in similar environments.

Security has been, and will continue to be, subject to independent 'penetration testing'.

PHIN recruits staff with prior expertise and accreditation in Microsoft development, and seeks external advice as needed. Tableau expertise is largely developed in-process, with additional training and consultancy procured where required, especially around server configuration and security.

In-house enabling technology

PHIN aims to take a modern and flexible approach to running its own business. As a new organisation, we are not constrained to any legacy systems or behaviours. We make extensive use of cloud-based software and solutions, offered by Microsoft and others, to ensure that we are up do date with functionality and security, getting the best that vendors have to offer without needing to invest in bespoke deployments.

Partners and key stakeholders

In addition to its relationship with its members and the private healthcare sector, PHIN will rely heavily on some key partnerships and relationships to execute this plan.

Federation of Independent Practitioner Organisations (FIPO)

FIPO is an umbrella body for professional associations, including representative and specialty groups, and will be our main conduit to professional engagement.

PHIN wrote to FIPO's Board, requesting their assistance in engaging with professions on a non-operational basis in February 2015, and FIPO assented.

FIPO will lead work with the registries and audits, and will co-ordinate the approach to professional engagement in all aspects of implementation but notably in agreeing specific clinical performance measures by speciality and procedure. FIPO has formed a Clinical Outcomes Advisory Group (FIPO-COAG) which met for the first time in August 2015.

PHIN is grateful to FIPO for their ongoing support and assistance.

Healthcode

Healthcode has been PHIN's key partner in the processing of data since 2012, and holds a unique place in private healthcare. Healthcode provides a range of online services to hospitals, insurers and consultants, including processing around £3bn of invoices annually that pass between them. Healthcode has a unique knowledge of the sector, its processes and its information.

To date, all data for private episodes have come via Healthcode, as NHS episodes have come via HSCIC as HES data. Healthcode similarly applies validation, pseudonymisation (removal of identifying personal data), mapping and other services in preparing the data.

Whilst, for practical reasons, PHIN is now developing additional data submission and processing routes, including direct submission to PHIN, Healthcode will continue to play a core role for the sector and be significantly involved in the achievement of the CMA's remedies.

The Care Quality Commission (CQC)

The CQC is the regulator of healthcare providers in England. In 2014 and 2015, the CQC has been implementing a new approach to regulating independent hospitals that represents a significant improvement over what went before. Part of that process is a request for information prior to inspection – the Provider Information Return (PIR).

Following feedback from PHIN and hospitals, the PIR has now been split into two parts: Part 1 will seek a standardised overview of activity at the hospitals, to help inform and direct inspections. Part 2 will be a more specific request for data on issues of interest to inspectors. The CQC has asked PHIN to help produce a standardised approach to Part 1 using our data.

PHIN is working with members and the CQC to design appropriate information. This will be made available to members to check and pass on to the CQC. PHIN will not provide data directly to the CQC until requested to do so by members for their convenience. However, having PHIN produce this data facilitates a common approach to data preparation that means all hospitals will be treated equally, reducing the potential for misinterpretation and misalignment that would exist with multiple bilateral requests.

PHIN hopes that this will be the beginning of a productive partnership with the CQC that will help PHIN to achieve our objectives and the CQC to achieve theirs.

We hope that this pattern of co-operation can be replicated in Scotland, Wales and Northern Ireland.

[6]Where consent is not given, records of the activity conducted are still passed to PHIN on a pseudonymised basis (no personal details). This means that the record cannot be linked to other data sets and cannot be used in the calculation of several important performance indicators.

Financial Plan

PHIN has a very simple financial strategy: to plan to deliver our duties and achieve our objectives at the lowest reasonable cost to subscribing members, while allowing for unknown factors and contingencies to ensure reasonable certainty of success and corporate financial security.

Subscription basis

The operators of Private Healthcare Facilities (PHFs) are required by the Order to fund PHIN by subscriptions:

21.4 Subject to article 24.3, operators of private healthcare facilities shall pay an amount, calculated by reference to the number of private patients admitted by each relevant private hospital operator in the preceding calendar year, to cover the reasonable costs of the IO in processing this information into a format, which enables comparison of the data and is likely to be comprehensible to patients.

24.3 The IO may seek subscriptions from its members in order to carry out the duties specified in this order, and may with the agreement of its members grant licensed access, which is in accordance with the Data Protection Act 1998, to its database.

Following the Order, we will initially seek subscriptions only from participating hospitals members, but may in due course, in consultation with our members and Voting Members, seek additional income from licensing access to PHIN's information to private medical insurers, and/ or to consultants.

Our subscriptions will initially be calculated on an equal basis for the providers of all private healthcare facilities, with reference only to the volume of private activity conducted in the preceding calendar year. In time, we may allow for additional subscriptions for additional services, facilitating differentiation between those who wish to go further or faster in terms of information, and those who do not. The per-record rate will be calculated by dividing PHIN's budget for the coming year between the total number of episodes conducted across all participating hospitals in the relevant prior period.

From 2012 to 2015 we also levied a fee in respect of NHS-funded episodes conducted at private hospitals. There is no basis in the Order for continuing to do so, and indeed this approach has passed its time and would no longer constitute a fair approach in our view. As such, NHS-funded activity will be reported, but without a corresponding charge.

Expenditure and budget

As per the Order, PHIN aims to work on the basis of "reasonable costs" to deliver our objectives. We are a not-for-profit organisation and very aware that our funding inevitably comes from the pockets of the very patients we are trying to serve, via our members.

However, PHIN has an important and complex job to do, and limited time to do it. We must resource accordingly.

For the most part, PHIN's resources are either already in place or clearly planned and budgeted, with some contingency allowed: if expenditure meets budgeted levels, a reserve of six months' working capital, standard practice for good corporate governance, will be established over three to four years.

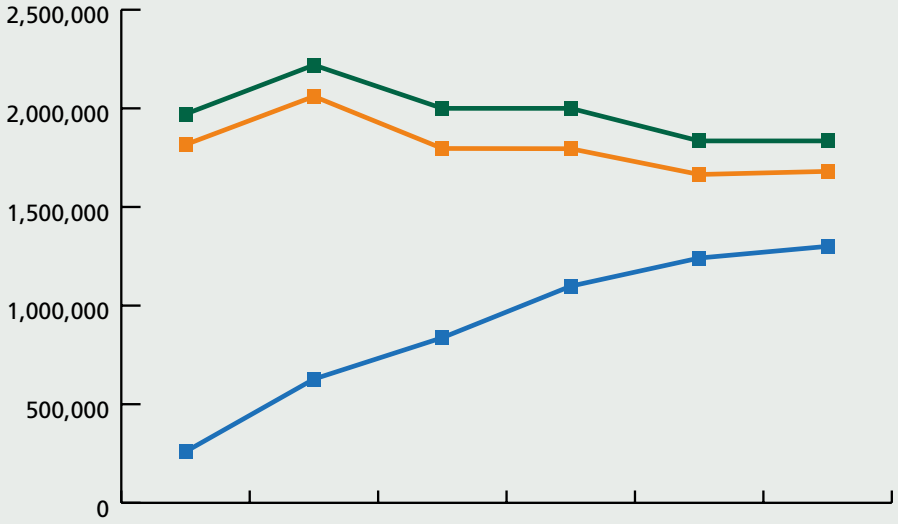
Assumptions

- All Figures are based on 2015 values - no adjustments have been made for inflation
- The budget for the year ending 31 July 2016 begins a gradual accumulation of required reserves to establish financial security, in line with best practice in corporate governance
- No income is generated from Consultants or Insurers

PHIN high-level Five Year Income and Expenditure Forecast

Financial principles

- PHIN is, and intends to remain, a not-for-profit organisation.
- PHIN aims to have its main operating systems and infrastructure in place by the end of 2015.
- PHIN intends to build up six months of capital reserves (between 2016 and 2018).



	2014-15	2015-16	2016-17	2017-18	2018-18	2019-20
Income (Subscriptions)	1,982,014	2,219,456	2,000,000	2,000,000	1,800,000	1,800,000
Expenditure	1,623,157	2,033,797	1,796,573	1,796,573	1,725,133	1,735,133
Forecast reserves	438,178	623,837	827,264	1,030,692	1,105,559	1,170,427

- All income is based on a cost per case charge based on previous calendar year volumes of procedures
- The cost per case is adjusted to reflect the overall budget to avoid income shortfalls
- PHIN remains in existing office space at The Kings' Fund throughout the five year period on similar terms (current lease expires February 2018)
- No assets are capitalised
- Members are effective in managing inbound queries from their hospitals and consultants, without significant resource from PHIN

The last point constitutes PHIN's principal area of risk: with 500 hospitals and 12,500 consultants to work with, the volume of inbound queries to deal with, especially if significant issues arise, could be significant. We hope that these can largely be dealt with by members themselves; however, we should be mindful that we may need to gear up a substantial communications and call-handling operation. This would be likely, at the least, to consume much of our planned contingency/reserves.

Financial risks

PHIN's budget is based on the assumptions listed above and the wider contents of this Five Year Plan.

Income risks

Subscriptions from founding members provided 100% of income prior to April 2015, and we estimate that in steady state that will fall to 80-85% of income. As such, 15-20% of our anticipated income is reliant on receiving subscriptions from new members. Whilst all private healthcare providers are obliged to fund PHIN under the Order, we have made some allowance in our income forecasts for a period of ramp-up to receipt of full income.

PHIN would be financially vulnerable to a loss of income, or significantly delayed payment, from one or more of the larger member groups; this could prejudice our ability to deliver the services required by other members. For this reason, PHIN has issued a Subscription Payment Policy laying out a process for reminders, escalation and, potentially, CMA enforcement in respect of non-payment of invoices.

Expenditure risks

PHIN believes that it has budgeted adequately to resource for the task ahead, and has allowed some contingency through reserves, such that we can absorb modest variances. In the event of significant unforeseen expenses, PHIN might need to revise subscription levels.

Potential risks include

- **Managing consultant communications:** we have assumed that hospitals will be able to take the lead on handling outbound communications to, and inbound communications (queries and issues) from consultants, and we have not allowed for materials production or enquiry handling on the scale necessary to communicate directly with c12,500 consultants. If PHIN were required by circumstance to step into that role, we would need additional resources.
- **Statistical capability:** PHIN does not yet have sufficient expertise in-house to determine and deploy all of the statistical methodologies that will be needed to process the data, and will have to buy in capability. Provision has been made in our budget, but at this time the level of complexity involved is unknown, so the resource and cost requirements are partly unknown.

Strategic Risks

PHIN maintains a risk register that is regularly reviewed by our executive team and Board. Here, we present only major, pertinent risks, unique to PHIN (all small organisations having risks around dependency on key individuals, for example).

Financial risks are discussed above.

CMA's enforcement of the Order

The CMA has given PHIN a high profile role with specific obligations under the Order. Whilst this is well understood by some, the CMA and its Order are not yet widely recognised or understood by many of the hospitals and consultants that are directly affected. PHIN is frequently in the position of bringing the Order to the attention of hospitals and consultants for the first time, and asking them to implement remedies which are new, which have a cost, and which will bring new levels of transparency and therefore exposure. Additionally, we must ask private hospital operators to pay subscriptions to fund our work.

As we approach the publication deadline in April 2017, it is possible that not some parties may not be in position to fully comply, for various reasons, and will be concerned about the possible consequences. PHIN will be in the position of reporting the progress being made towards compliance at each stage, and some degree of tension can reasonably be expected.

It is important for success that all parties subject to the Order know that the Order exists, is in force and affects them, and that compliance is required and can be enforced.

PHIN will take legal advice on how to interpret our role under the Order and what role PHIN should play in managing compliance, if any. We will need to work closely with the CMA throughout this period and maintain good communications. We will also ask the CMA, and other public bodies where possible, to take an active role in communicating key messages.

Availability of NHS HES data

PHIN is highly dependent on the availability of NHS HES data for many aspects of analysis and benchmarking. Availability was assumed throughout the period of the CMA's Market Investigation, and framed the viability of this undertaking. Unfortunately, the process of applying for access to HES data from the HSCIC is onerous and PHIN, in common with other notable organisations, has not yet been successful.

We have proposed a partial mitigation to this issue through the direct collection of data from independent providers of NHS services and NHS PPUs, as discussed above. However, we will need HES data as we progress. PHIN will continue to resource the applications process, and will use available routes of escalation as required.

Availability of consents and licences to perform data linkage

Similar to the requirement for HES, we will need extensive and specific permissions and support to effect the data linkage and other processing requirements to support a number of our key performance measures, including PROMs. The processes for securing such permissions tend to be onerous and bureaucratic, and require significant resource. They may also potentially be repeated in all four nations. To a real extent, finding out what these requirements are and how to navigate them is a process of trial and error, despite taking advice and input.

PHIN's ability to produce information and fulfil our role will be dependent on securing these permissions. Significant delays and frustrations could easily occur. To date, the backing of the CMA and stakeholders such as the CQC does not seem to have created much leverage; we must find a way to make this count more.

Implementation Plan to April 2017

PHIN's current focus is on implementing the requirements of the CMA's Order, meaning both the direct requirements on the IO and enabling the greatest possible compliance with the Order among member hospitals and consultants by April 2017. There is a great deal to do, with much already in progress.

It will be a huge challenge for all hospitals and consultants subject to the Order to be compliant with all information requirements across all performance measures by April 2017. However, PHIN is ready to join with all those involved in private healthcare to step up to that challenge.

As such, our implementation plan aims to:

- Fulfil our own obligations under the Order.
- Make all hospitals subject to the Order aware of their obligations and create the opportunity for all to comply.
- Help hospitals to plan for compliance by understanding the information standards and requirements on them.
- Ensure that consultants are aware of and engaged in the process through various channels, and that all have the opportunity to be compliant with the Order.
- Deliver such tools, documents and processes to aid understanding, communication and data checking as are required for the above.

Having already considered our governance changes and engagement with key groups above, the following sections will cover:

- The specified performance measures: what they mean, how we will approach them, and what issues we will face.
- The data requirements on hospitals
- Our operational deliverables
- Key milestones
- The timelines for implementation

Data standards implementation and data submission

Starting at a high level, publishing by the end of April 2017 means making final data available for checking by the end of March 2017, with the ambition that nobody is looking at their data for the first time at that point. Given the unavoidable time taken to collate and process data, both within hospitals or elsewhere, the first quarter of 2017 will be required for processing, meaning that the data we must work with for that publication milestone relates to patients treated in 2016.

Further, to have anything useful to say about activity and quality, we need a full year of data to analyse, to be maintained on a rolling 12-month view thereafter. This means that for publication by 30 April 2017, providers need to be capturing and recording data in a fully compliant format, taking account of clinical coding and the other considerations in the Order, by 1 January 2016.

As specified in the Order, the data being collected from that date must be reaching us by 1 September 2016.

As 1 January 2016 is now close, any private hospitals not yet engaged with PHIN will struggle to be compliant by 30 April 2017. There may be more room for error for NHS PPUs, who should already work to NHS information standards and submit data via SUS and HES, provided that:

1. They do in fact adhere to NHS information standards in respect of private patients, as they are required to do by HSCIC under the Health & Social Care Act 2012 (in England), or to the equivalents in Scotland, Wales or Northern Ireland;
2. That PHIN can obtain data from those centralised sources – HES and others; currently this is by no means assured, and whilst we would like to offer those hospitals the convenience of submission via HES, the duty to supply data to us ultimately rests with the hospitals.

Implementation timelines

PHIN and its members have a very clear job to do by 30 April 2017, with a significant implementation required up to that point.

PHIN plans to publish information as it becomes available, but much of it cannot be available before April 2017

2015

- CQC rating
- Activity / volumes
- Length of stay
- Patient satisfaction (FFT)
- Experience Measures
- PROMs (NHS Hips and Knees)

2016

- Infections data
- Registries data
- Adverse Events

2017

- Improved PROMs
- Readmissions, Transfers, Mortalities (linked & adjusted)
- Consultants: all performance measures
- Fees (& Prices)

Implementation Plan to April 2017 *continued*

Members Information Portal development and data checking

PHIN is rolling out access to the Members Information Portal in stages, first to hospitals and later, via hospitals, to consultants. For each, we will move through a phased process:

1. Introduction and invitation to access
2. Authentication and security testing
3. Activity-based information for checking validity of submitted data
4. Activity-based information for checking data quality
5. Checking of performance measures

Leading hospitals are at stage 3 above as at August 2015. Other hospitals have yet to start the process. We aim to have all hospitals who are currently submitting data to stage 3 by end October 2015, and Stage 4 by December 2015.

Hospitals will be invited to grant access to consultants from January 2016.

Hospital members will be invited to appoint local administrators to grant further access to users.

Publication

PHIN has published several of the required performance measures for participating hospitals on its website since April 2013. A number of additional indicators, including infections data, information from some registries, and adverse events data, is expected to become available in late 2015 and 2016.

However, much of the data to be published cannot be made available prior to 30 April 2017, at the earliest. This means that our website, and the information available, will change dramatically in April 2017.

Appendix 1: Performance measures and data standards

The specified performance measures

Article 21.1 of the CMA's Order specifies 11 categories of 'performance measures', to be reported at both hospital and consultant level. Each of these merits some discussion around definition, assumptions, scope, data sources, risk adjustment, timing and so on.

In this section, we look at the performance measures, and the issues and considerations relating to each as understood at the time of writing.

a) volumes of procedures undertaken;

b) average lengths of stay for each procedure;

c) infection rates (with separate figures for surgical-acquired and facility-acquired infection rates);

d) readmission rates;

e) revision surgery rates;

f) mortality rates;

g) unplanned patient transfers (from either the private healthcare facility or PPU to a facility of one of the national health services);

h) a measure, as agreed by the IO and its members, of patient feedback and/or satisfaction;

i) relevant information, as agreed by the IO and its members and, where available, from the clinical registries and audits;

j) procedure-specific measures of patient reported health outcome, as agreed by the IO and its members to be appropriate; and

k) frequency of adverse events, as agreed by the IO and its members to be appropriate.

Below we look at the issues and timings for each of these measures. A more complete set of definitions and guidance can be found in PHIN's Operating Plan.

Volumes of procedures undertaken (21.1 (a))

The volume of procedures undertaken by a hospital or consultant is ostensibly the simplest of the measures, and yet there are a number of considerations worth noting.

Simplified, volume is a count of completed patient records, recognised by the date of discharge.

Since April 2013 PHIN's website has reported volumes by hospital for the top 149 procedure groups, shown as a benchmarked visual indicator rather than an explicit number, principally to protect commercial confidentiality. For now we will continue to report in that manner, but recognise that the Order could be interpreted as requiring specific volumes.

Volume is not a clinical indicator, but is a potentially useful piece of information, and is presented as such. For patients, volume is a helpful indicator, but should not be given undue precedence simply because it is relatively easy to measure.

There is emerging consideration of 'minimum' safe volumes in certain specialties, notably bariatric surgery and cosmetic surgery, and we will follow developments in those areas. Whether or not it holds true that volumes matter at hospital level seems to be less clear.

For the time-being, PHIN will report comparative volumes while not making or inferring any direct relationship with quality.

Length of stay (21.1 (b))

Similar to volumes, length of stay is useful information, but not a clinical measure.

However, for patients, knowing how long they are likely to be in hospital is important - if I'm going to stay in hospital, how long for, and when will I be home?

Clearly, for any given hospital or consultant, the average length of stay, depends on factors including clinical preference, patient demographics, relative complexity of caseload and so on. As such, PHIN will not attempt to draw or infer any conclusion on quality in publishing length of stay information.

We will try to inform the patient so that they have both reasonable expectations and material for asking informed questions. We will give average lengths of stay by provider for a given procedure, and also show the range and distribution (frequency) of visits by length of stay, which better indicates modal and median values in addition to mean, and gives an indication of variance within and between providers.

In either case, what we count is nights spent in the hospital, and express length of stay as such. (In slight contrast to the NHS, where length of stay counts nights in hospital but expresses it as 'days'.)

Infection rates (21.1 (c))

Measuring infections consistently and fairly, and explaining those measurements, is complicated.

As required in the Order, PHIN will report principally on two types of infections: Health Care Associated Infections (HCAIs), measure at hospital level, and Surgical Site Infections measured at procedure level where available and reportable by hospital and consultant.

The notifiable Healthcare Associated Infections (HCAIs) are:

- MRSA
- MSSA
- C. Diff
- E-coli

The reporting of Surgical Site Infections (SSIs) data in England remains voluntary for independent providers, and mandatory for NHS providers only in respect of orthopaedic procedures. PHIN will initially report data for orthopaedic procedures where available, and hopes to see the list of procedures covered expand over time.

The methodologies for collecting and reporting SSI data in particular are highly specified, including the requirement that data must be submitted by accredited nurses. They are also subject to minimum reportable volumes which present problems for many independent providers.

In England, infections data is managed by Public Health England (PHE). To date, we have sought to obtain infections data under an agreement with PHE. However, the data is not perfect in either completeness or quality, and we may need to look at direct data submission in due course.

For PPUs, we will need to consider whether to allow reporting in respect of private patients distinct from the wider Trusts' activity, and how this might be possible.

Readmission rates, mortality rates and unplanned patient transfers (21.1 (d), (f) and (g))

Readmission rates, mortality rates and unplanned patient transfers are all well-known adverse events, and among the most important safety measures available. They are part of mandatory reporting by providers to the CQC. The common measures are:

- Unplanned readmissions within 28 days of discharge
- Emergency transfers of care between hospitals (a readmission is deemed to be a transfer if it occurs within two days, even though this may be unknown to the transferring hospital[7].
- Mortalities within 30 days of (i) procedure or (ii) discharge – both measures being used within the NHS[8].

There is a significant problem with the current reporting system: private hospitals are often simply unaware when a discharged patient is later readmitted to another hospital as there is no standard mechanism for informing the originating hospital. Indeed, the prior treatment may not be known to the hospital providing the second episode of care, unless the patient tells them.

It is, of course, relatively common for a patient suffering post-discharge pain, infection or complications to present at an NHS hospital, usually admitted via A&E. We need to capture those admissions in order to produce a fair view of a provider's overall performance.

There is a second issue with the data as currently reported, which is that it is raw and not adjusted for risk. Hence, comparing performance fairly between providers is problematic. This already affects the regulators' ability to understand the nature of variance within the sector, and could result in unfair comparisons if published.

As such, we have committed to trying to improve the current reporting to fulfil the requirements of the Order. This requires the creation of a more refined but more complex approach than any we are taking with the other performance measures, and relies on patient-level data linkage between private and NHS data sources.

This approach will enable us to look at readmissions, transfers and mortalities by procedure, at both hospital and consultant level where appropriate. We will be able to make appropriate adjustments to the data to ensure fairness, and will support detailed checking; there are so few unexpected deaths arising from private treatment that it should be possible to validate each one, and to identify any that are 'missing.' As we move forward, hospital and consultant representatives will, of course, be fully involved.

These indicators cannot be produced until April 2017 at the earliest. Achieving publication by that date is dependent on many factors, including agreeing suitable statistical methods for each indicator and procedure, both in theory and in practice. We anticipate that securing broad support for any given methodology will require extensive engagement, and time.

As these indicators and the supporting process are so important, we have outlined the data linkage process below.

Data linkage

In 2013 PHIN completed a pilot on an approach to data linkage. It was successful, identifying that whilst the majority of readmissions following discharge from a private hospital were made to the same hospital, the majority of in-hospital mortalities following discharge and readmission or transfer occur within the NHS. Whilst the accuracy of the analysis can certainly be improved, the pilot validated the overall approach as workable and necessary.

In order to produce these key performance measures on a fair, repeatable and systematic basis, we will refine the process and create a repeatable process. This has a number of operational dependencies:

- Consent obtained from each patient on admission to hospital for the subsequent use of their data for these purposes
- Consistent use of the NHS Number as the common unique identifier (hence the CMA's requirement for the use of the NHS Number in A21.2)
- Linkage to identify related records of care, which must be conducted by HSCIC under contract
- Statistical data processing to identify relevant linkages and to apply appropriate exclusions
- Application of risk-adjustment
- Checking

PHIN will not be able to undertake this work alone. In addition to working with HSCIC to effect the linkage, and with hospitals and consultant representatives to contribute thinking, we will need access to a level of statistical analysis not currently available within PHIN. We may hire a statistician, and/ or we may buy in expertise as appropriate. For now, we will make provision in our budget and consider options in due course.

Revision surgery rates (21.1 (e))

Revision surgery rates show the proportion of patients requiring further surgery after the initial discharge to achieve the desired outcome or to correct issues. The measure is potentially relevant to a wide range of procedures, but is only in common use in the NHS for Hip and Knee replacements. Data for those procedures is collected by the National Joint Registry and is reported at hospital level, although the NJR has been working toward surgeon-level publication for some time.

[7]Compendium of Clinical and Health Indicators User Guide, National Centre for Health Outcomes Development - Annex 4 (www.nchod.nhs.uk), Crown Copyright, October 2009.
[8]https://indicators.ic.nhs.uk/webview/

For April 2017, we will be seek only to re-publish existing performance data made available by the national registries and audits: at present, that seems to mean hospital-level revision rates for hip and knee replacements. It is disappointing that the publication of revision rates is so limited in the UK, but we are unable to influence that, in the short term at least.

In the longer term, PHIN may be able to facilitate a new approach to calculating revision rates across a wider range of procedures, using a methodology derived from data linkage, as above. However, this would require data gathered over a significantly longer term, and with even greater challenges in terms of data completeness and accuracy, and would lack much of the detail available in the NJR. We cannot yet ascertain whether this option is worth exploring in detail, much less whether it is viable.

Relevant information from the clinical registries and audits (21.1 (i))

For registries and audits, we will align as far as possible with practice within the NHS.

There are many clinical registries and audits, each specific to a specialty, and are generally led by the profession. At the time of writing, 13 are included in the NHS Consultant Outcomes Publication (COP) Programme (England), and these will be our starting point.

Other, emerging registries have also approached us (including registries covering spinal surgery, non-arthroplasty hip surgery, and foot & ankle surgery), and we will be happy to consider these in due course. We will also need to consider which registries and audits cover Scotland, Wales and Northern Ireland.

The Consultant Outcomes Publication Programme (COP), and most of the registries and audits included in it, are overseen for the NHS by the Health Quality Improvement Partnership (HQIP) with which we have a good working relationship. Each registry has its own governance and management.

Prior to the establishment of FIPO-COAG, we approached several of the registries directly, seeking permission to re-publish data already in the public domain, and offering to work jointly on data quality. We attended many meetings, and drafted a number of agreements. However, over two years this approach has yielded no data.

Going forward, we propose to enlist FIPO-COAG to engage with registries and audits, supporting as appropriate.

However, we also reserve the right to republish data already in the public domain without permission if necessary, in order to fulfil our obligations to patients and the CMA and to help consultants to do likewise. It would be unfortunate if this were necessary.

Patient feedback and satisfaction (21.1 (h))

Understanding the views of other patients is seen as one of the most important performance measures by patients themselves. Consumers are increasingly accustomed to taking reviews and ratings into account while making any purchase decision.

There are many ways to approach the gathering and reporting of patient views, all of which can be valuable, but none of which is perfect.

In consultation with members, PHIN has prioritised standardisation and comparability, between hospitals and with the NHS. As such, our members have all adopted for private patients the NHS measure of overall satisfaction, the Friends and Family Test (FFT), supplemented by a set of six experience questions selected from the NHS Inpatient Survey.

Since its launch in 2011, the Friends and Family Test has gone through several revisions, mainly in terms of the way that data is reported, rather than collected. We will keep pace with future changes in the NHS, which means that changes may be required.

The six experience questions were chosen by our members in 2013. The value to patients of these particular questions has never been tested, and it is very possible that we could improve them over time. We will keep this under review.

In the longer term, we would like to see a role for direct user-generated ratings and feedback, as is now common-place in all aspects of online decision-making and purchasing, including in healthcare. We believe that consumers want this, and that it can be implemented responsibly.

Whenever this topic is raised, we hear a similar set of objections, most notably the concern that you never know that a review is genuine. Those concerns are understandable, but we believe they can be satisfactorily addressed, such that the benefit outweighs the associated risks.

We believe that it would be very much in the interests of private healthcare in the widest sense to choose an approach and a service supplier in which we have confidence, and align behind it. This would build the volume of reviews by corralling them into one place, making the service much more useful for patients and allowing proper management to agreed standards of protection. We are working with the Private Patients Forum and Intuition Healthcare, publishers of the website privatehealthcare.co.uk, with an ambition to promote a coherent and responsible approach to this opportunity.

Procedure-specific measures of improvement in health outcomes (PROMS) (21.1(j))

This requirement, as presented by the CMA, sets out a clear intent whilst leaving a good degree of latitude for interpretation. Their given formulation is:

"procedure-specific measures of improvement in health outcomes, as agreed by the information organisation and its members to be appropriate."

In the CMA's Provisional Decision on Remedies, published in January 2014, the wording chosen was more specific:

"for the ten highest-volume, or otherwise most relevant, procedures, a procedure-specific measure of improvement in health outcome."

In our view, this earlier wording should be taken as indicative of the CMA's view that our response should go beyond the four Patient Reported Outcome Measures (PROMs) mandated by the NHS (covering hip & knee replacements, groin hernias, and varicose veins), of which they were well aware.

Appendix 1 *continued*

In March 2014 PHIN convened a workshop to discuss an approach to PROMs that included representatives of the five leading insurers and FIPO in addition to hospitals. The format was to hear presentations from six leading suppliers of PROMs collection services, in whom, we thought, much of the best practical knowledge in the sector resided. Over the following months, four or five further suppliers would get involved.

The Working Group first looked at which procedures we might wish to measure, based on reasonable volumes across many hospitals and perceived importance, and for which respected PROMs measures were available. Having derived a shortlist, we sought professional views from both consultants in the hospitals, via the Working Group members, and the relevant professional specialty bodies. This gave us a shortlist of eight procedures (see table below), most of which have a specific PROMs instrument. Each of these involve comparison of pre-operative and post-operative questionnaires, and some may involve additions such as clinician questionnaires. We have specified the format of data to be produced, and for each instrument key variables such as timing of the post-operative questionnaire are made clear (usually around three or six months).

That shortlist will be augmented by PROMs for cosmetic surgery: these will be based on the recommendations of the Cosmetic Surgery Interspecialty Committee of the Royal College of Surgeons in England (CSIC). This group is considering suitable PROMs measures among other clinical quality and outcomes considerations in responding to the recommendations made in the Department of Health's 2013 Review of the Regulation of Cosmetic Interventions, which followed the well-publicised issues with Poly Implant Prostheses (PIP) breast implants.

In working with suppliers, the working group learned that current global best practice seems to offer a more evolved approach to PROMs than has so far been adopted by the NHS, giving the private healthcare sector an unusual opportunity to lead the development of best practice in the UK.

Within the NHS, PROMs are used solely for the secondary, non-clinical purpose of understanding the relative performance of providers based principally on the concept of "average adjusted health gain"; this is the difference between the health state of the patient before and after treatment, assessed by structured questionnaires, with adjustment made for the characteristics (age, relative health etc.) of the patients treated.

Elsewhere in the world, PROMs have a clinical purpose: having completed the pre-operative questionnaire, the patient and consultant discuss realistic expectations for the benefit of the procedure. After the operation and the completion of the second questionnaire, the patient and consultant can have an objective conversation about whether the desired outcome has been achieved, and whether the outcome is within the expected range. If it is not, something might then be done about it. This means that the patient is more informed and involved throughout, and some potentially poor outcomes can be identified and corrected early. At the forefront of this approach is ICHOM, the International Committee on Health Outcomes Measurement, and we hope to work with them going forward.

We also hope to work closely with the English NHS PROMs Programme. We have had productive conversations, and there is interest in our work. There is also overlap between PHIN's Board and NHS England's Advisory Committee on PROMs, with Andrew Vallance-Owen and Nancy Devlin sitting on both.

The CMA's requirements also leave room to consider outcome measures beyond patient reported outcome measures.

For now, there remains a good degree of flexibility and latitude in what we require of hospitals, recognising that it is not easy to implement a wide range of PROMs measures effectively and quickly.

We have not required that hospitals should participate in all or even a minimum number of the PROMs measures we have specified: some smaller hospitals may do none of the relevant procedures in sufficient numbers to produce publishable data, and any hospital may wish to phase implementation. Rather, we have agreed that hospitals will select for themselves which of the PHIN-approved PROMs instruments measures they will implement in the first instance. Hospitals are also in full control of choosing an expert systems supplier (if they aim to use one). We hope and expect that they will respond positively to this open approach. One hospital operator, Aspen Healthcare, implemented four PROMs measures for private patients as early as April 2015.

PHIN will report data as hospital operators make it available. Hospitals, and indeed consultants, will realise that the absence of reported data will become conspicuous as competitors publish. Further, if the response from the sector as a whole does not meet the CMA's expectations, we can expect remedial action.

The PROMs questionnaires are not sufficient in themselves: each must be linked to a corresponding patient record, with diagnostic coding applied to enable risk adjustment. For this reason, we will need to design a process to enable effective linkage within the scope of our information governance policy and applicable data licences; this work remains underway.

PHIN may also need to source external support to apply case-mix adjustment and analyse PROMs data. Not only do we need the skills, but we might prefer to have this work undertaken by an independent and respected academic body or expert service supplier. For NHS PROMs, this work is performed by the HSCIC; we will approach them, but note that they may choose not to process data for private patients, and are likely not to want to develop a methodology and process for non-mandated measures.

Procedure	Preferred tool	Reasoning
Hip replacement	Oxford Hip Score (OHS)	Comparability with NHS
Knee replacement	Oxford Knee Score (OKS)	Comparability with NHS
Shoulder surgery	Oxford Shoulder Score (OSS)	Comparability with the NHS and is collected by NJR
Carpal tunnel	QuickDASH	It is reported that most hand surgeons already collect DASH scores for carpal tunnel
Groin hernia	EQ-5D and EQ VAS	EQ-5D has demonstrated favourable results and high response rates in the NHS
TURP (cancer and non-cancer)	American Urological Association Symptom Index / International Prostate Symptom Score (AUA IPSS)	UCL currently uses AUA IPSS PROM for both cancer and non-cancer TURP patients
Cataract	Catquest	International use and simplicity
Septoplasty	SNOT 22	On hold pending advice from ENT-UK
Cosmetic Surgery	Q-PROMs	Note additional requirements are likely to come from RCS CSIC

Frequency of adverse events (21.1 (k))

This is another area where the CMA was happy to leave the specifics to be "agreed by the information organisation and its members to be appropriate," having tried a number of not-quite-right formulations.

However, Adverse Events are not such an open field as PROMs, as all private providers already report a number of adverse events measures by various channels, and the key issue here will be finding a common set on which to standardise. These must work across all categories of provider.

It is worth noting that several of the performance measures specified above are themselves forms of adverse event measures: infections, readmissions, transfers and revisions.

As such, our measures of Adverse Events will focus on reportable safety incidents, using current standard reporting frameworks. What exactly those will be remains under discussion.

Data Standards

The CMA's Order specifies a number of requirements for standards of record-level data submission, in article 21.2. Whilst these requirements fall principally on hospitals, they deserve brief discussion and elaboration here, along with PHIN's approach to supporting implementation in the hospitals.

Article 21.2 reads:

Operators of private healthcare facilities shall, subject to article 21.3, include in the information supplied to the IO in accordance with this article:

a) the General Medical Council reference number of the consultant responsible for each patient episode occurring in the relevant facility;

b) the National Health Service or equivalent patient identification number or alternative information from which an NHS number may be derived or a pseudonymised equivalent, or, in the case of patients from outside the UK, a suitable equivalent identifier, as determined by the IO;

c) appropriate diagnostic coding, using the International Statistical Classification of Diseases (ICD) or other internationally recognised standard, as determined by the board of the IO, including full details of patient co-morbidities, for each episode; and

d) appropriate procedure coding, using the OPCS Classification of Interventions and Procedures, or other internationally recognized standard, as determined by the board of the IO, for each episode.

GMC Number

A consultant's GMC Number is the standard unique identifier in use across UK healthcare. Its use enables us to positively identify a consultant across multiple hospitals, and enables us to obtain helpful contextual information such as the consultant's registered specialty and year of qualification.

It is not hard to obtain and record a consultant's GMC Number, and indeed the number is required in many contexts. Where hospitals do not use the GMC Number natively as their principal unique identifier for consultants (many don't, also true for insurers), it is straightforward to map to GMC Number on outputting data to PHIN.

As such, we do not propose to offer any particular support on this requirement. The use of a known GMC Number corresponding with the current version of the GMC Specialist Register will be a validation requirement for the submission of all records.

NHS Number and patient consent

The NHS Number is the required unique identifier for patients throughout the NHS in England and Wales, with the near-equivalent CHI Number used in Scotland (we will use NHS Number as shorthand for these). Collection of these numbers has never been required for private patients until now.

The NHS Number is required for a single purpose: to enable linkage between data sets, identifying connected records to support work on the performance measures as detailed above and applying risk adjustment to results. This applies to readmissions, transfers, mortalities and PROMs, and potentially to adverse events and revision rates. PHIN has no need to know the identity of any patient.

Almost all patients presenting for private treatment will have an NHS Number (we estimate 95%, the remainder being patients from overseas), but few will know it or have it to hand. To date, just 3% of records submitted by members to PHIN have included an NHS Number. There will even be patients who object to providing an NHS Number, notably among cosmetic surgery patients, but these are a small minority.

There are well-established processes for obtaining the NHS Number for a patient. The HSCIC offers a variety of ways to trace NHS numbers using basic personal details[9]. Some independent hospitals treating significant numbers of NHS patients now have direct access to the Personal Demographics Service (PDS), whilst others may need to work with an intermediary (a 'Spine Mini Service Provider').

Where the NHS number is obtained directly from patients it will need to be validated at least once using an accredited service.

For the time being, our hospital members will also need to pseudonymise NHS numbers, replacing it with a cryptographic digest to agreed specifications. It may be that we cannot avoid receiving NHS numbers indefinitely.

Hospitals will also need to give continued attention to obtaining consent from patients to pass personal data to PHIN for our specified purposes, including linkage to NHS data. PHIN and its members adopted a standardised approach in 2013/14, but unfortunately it seems that this will need to be revised to meet new HSCIC requirements.

Overseas patients

We should acknowledge that some of the patients treated – around 5% nationally but as many as 40% in some private hospitals in central London – come from overseas and as such will not have an NHS Number. The NHS has an established protocol for dealing with those, recording the country of origin, which PHIN will follow.[10] Additionally, PHIN's Minimum Data Set will include fields for providers to record alternative identifiers such as Passport Number or National ID Number, but the use of these will piloted rather than mandated initially.

Unfortunately, the realities that we will have no NHS Numbers to enable data linkage, that any admissions, treatment or clinical incidents following discharge may well occur outside the UK and are likely to be unknown to the treating hospital, and that overseas patients typically do not complete PROMs or post-discharge questionnaires mean that we are unlikely to be able to say anything meaningful about the quality of care received by overseas patients. In general, like the NHS, we will probably exclude overseas patients in all analysis other than activity counts.

Diagnostic and Procedure Coding

Requirements (c) and (d) of A21.2 both leave details to be "determined by the board of the information organisation."

Diagnostic coding will be required to be submitted in ICD-10 standard, to NHS standards of accuracy, completeness and sequencing. This varies slightly between the four nations.

Procedure coding will be required to be submitted using NHS England's OPCS4.7 standard, migrating to OPCS4.8 and future updated standards as in due course. Again, this must be completed to NHS-specified standards of accuracy, completeness and sequencing.

Where providers input procedure data using a coding system other than OPCS4.7 (e.g. CCSD and proprietary codes being common) we also enable additional submission of these codes so that we can report against them, if required to facilitate checking or to compensate for deficiencies in OPCS4.7.

The CMA and PHIN have co-operated to specify these standards because the task ahead is largely impossible if we do not. We must have a common "currency" for categorising procedures and correctly understanding activity; and we must have diagnostic and co-morbidity coding to apply risk adjustment to make measures fairer. How else should we compare hospitals such as those in central London that offer highly complex care, critical care and cancer services, and will as such have relatively high rates of mortality, with those hospitals that offer much less complex care?

The issue with asking hospitals to apply NHS-standard coding is that there is an expense involved in the coding process, and that uniquely this coding effort is not attached to payment. This may cause us problems over time. In the NHS, the combination of ICD-10 and OPCS codes produces "HRG" codes that determine the financial tariff paid; these can vary significantly depending on the secondary codes applied. Similarly, in private healthcare CCSD procedure coding drives the remuneration applied by insurers. In those environments, financial impacts tend to drive coding quality, whereas here that driver is absent.

It will take many providers some time to get coding up to a reliable standard from a standing start. However, providers in that position will need to recognise that if they are to be compliant with the CMA's Order and be included in publication from April 2017, the early reporting may not be able to fully reflect and adjust for the complexity of the work undertaken.

We believe that in a short space of time consultants will become the principal drivers of coding quality. Consultants we have spoken to are very keen to know that outcome measures will be adjusted to reflect the complexity of their patients and work relative to their peers to ensure a fair comparison. Coding of diagnoses and co-morbidities is the recognised route to this. Any consultant working at a hospital that is not applying all the relevant co-morbidity codes, for example, may appear to have a higher rate of adverse outcomes than might perhaps be fair. As such, consultants will have a professional interest in coding quality. The effect of driving interest in data quality may well spill over into the NHS.

[9]http://systems.hscic.gov.uk/nhsnumber/staff/guidance/factsheet.pdf
[10]http://systems.hscic.gov.uk/nhsnumber/staff/guidance/complex.pdf

In terms of procuring operational solutions for coding, that sits wholly with the hospitals. PHIN will happily share our views and facilitate mutual progress reporting and idea sharing. Other organisations, notably Healthcode and expert consultancies, have offered various services to hospitals in terms of coding, and some hospitals are considering co-operation on a joint approach.

There are various ways to approach coding, and that there is a place for trying them all and assessing as quickly as possible which seem to be effective in terms both of quality of output and cost. The NHS approach to coding is as a separate professional discipline, with trained clinical coders undertaking all aspects of coding, working either from electronic patient records or paper notes. This is inherently slow and expensive, but a trusted way of working. Nationally, we understand that clinical coders are in short supply and may be difficult to hire. But that is not the only approach. Whilst some involvement of professional clinical coders is always likely to be desirable, if only for checking output, there are at least three other potential approaches available to primary data gathering. These include:

- **Pick Sheets:** a custom coding sheet could be developed for each consultant covering diagnoses, co-morbidities and procedures performed, always leaving room for 'other'. Most consultants will do the vast majority of their work within a relatively narrow band of diagnoses and procedures. PHIN could potentially support this process with data drawn from multiple providers for each consultant. This could be a relatively cheap and simple approach, but its efficacy and validity need to be proven through testing.
- **SNOMED-CT:** this is a system of "Clinical Terminology" rather than "coding", using a standardised but quite flexible way of describing every aspect of patient care; effectively a way of gathering input data on clinical episodes where diagnoses and procedure codes are the output. It is the intended standard for use across NHS Primary Care, so is familiar to GPs. It has also long been in the process of being introduced into secondary NHS care; unfortunately long enough that some scepticism has developed. The most important thing for providers considering an approach to coding to consider is that SNOMED-CT is rigorously mapped out to ICD10 and OPCS, and that numerous tools exist to support the implementation and use of SNOMED-CT, many free to use, and some even supporting smart dictation. Hence SNOMED-CT could be a less direct but preferable route to obtaining coded output.
- **Other technology:** other providers, such as Healthcode and 3M, have offered various technological systems to support coding. These will undoubtedly develop over time, provided that there is a market for them. Ultimately, a combination of the use of good information systems, with professional input to check accuracy and completeness, is likely to improve coding while reducing costs.

Direct Data submission from PPUs and submission of records of NHS-funded episodes

The Health & Social Care Information Centre produces Hospital Episode Statistics (HES) for the NHS in England, and there are similar datasets for Scotland and Wales. HES provides the basic data structure and definitions for PHIN's data collection. In addition to reporting core NHS acute elective activity, HES includes, in theory at least, NHS-funded care delivered in independent hospitals, and privately-funded episodes delivered in NHS hospitals. Inclusion of these records is mandatory for providers.

HES data should, in theory, be available to PHIN under licence from the HSCIC. PHIN has long hoped to be able to source this data from HES without the need for parallel direct submission from providers. However, in practice PHIN has been engaged in the HSCIC's data access application process for more than a year and, in common with other notable public, academic and commercial organisations, has not yet been successful.

PHIN will therefore require direct submission of records of privately-funded episodes conducted by NHS providers. We will also request direct submission of NHS-funded episodes conducted by independent providers which, whilst not explicitly required under the Order, is necessary to produce a full and fair picture of activity and quality.

Direct data submission, avoiding HES, has the potential advantage of speed: NHS data processing to produce HES takes at least three months. Hence, any corrections made to data by providers or consultants will take three months or more to be reflected in PHIN's information. With direct data submission, we could potentially remove any delay, and show new data and changes as soon as they are submitted.

However, HES also contains important data that we cannot replace by direct submission; this is principally the NHS-funded NHS-provided data comprising 85% of elective care activity that we need to provide the benchmarks against which to compare the private sector. We need that data at hospital, consultant and procedure level, and cannot fulfil our mandate without it.

Further, exercises such as data linkage to support core performance measures are completely dependent on HES availability. As such, we will continue with the application process.

For clarity, PHIN does not need to work with personal data for patients, save to enable linkage between data sets, for example to identify mortalities and readmissions occurring in an NHS hospital within 30 days of discharge from a private hospital. Any data linkage work is expected to be undertaken on PHIN's behalf by the HSCIC.

Corollary benefit of collecting NHS-standard data

These data requirements have been specified to enable the analysis of activity and quality of private healthcare using proven methodologies, and the production of robust performance measures that are readily comparable to benchmark standards. But there is a corollary benefit that may ultimately prove to be more beneficial than the intended benefit for private healthcare: the move toward storing patient records with the same basic building blocks as those used in the NHS.

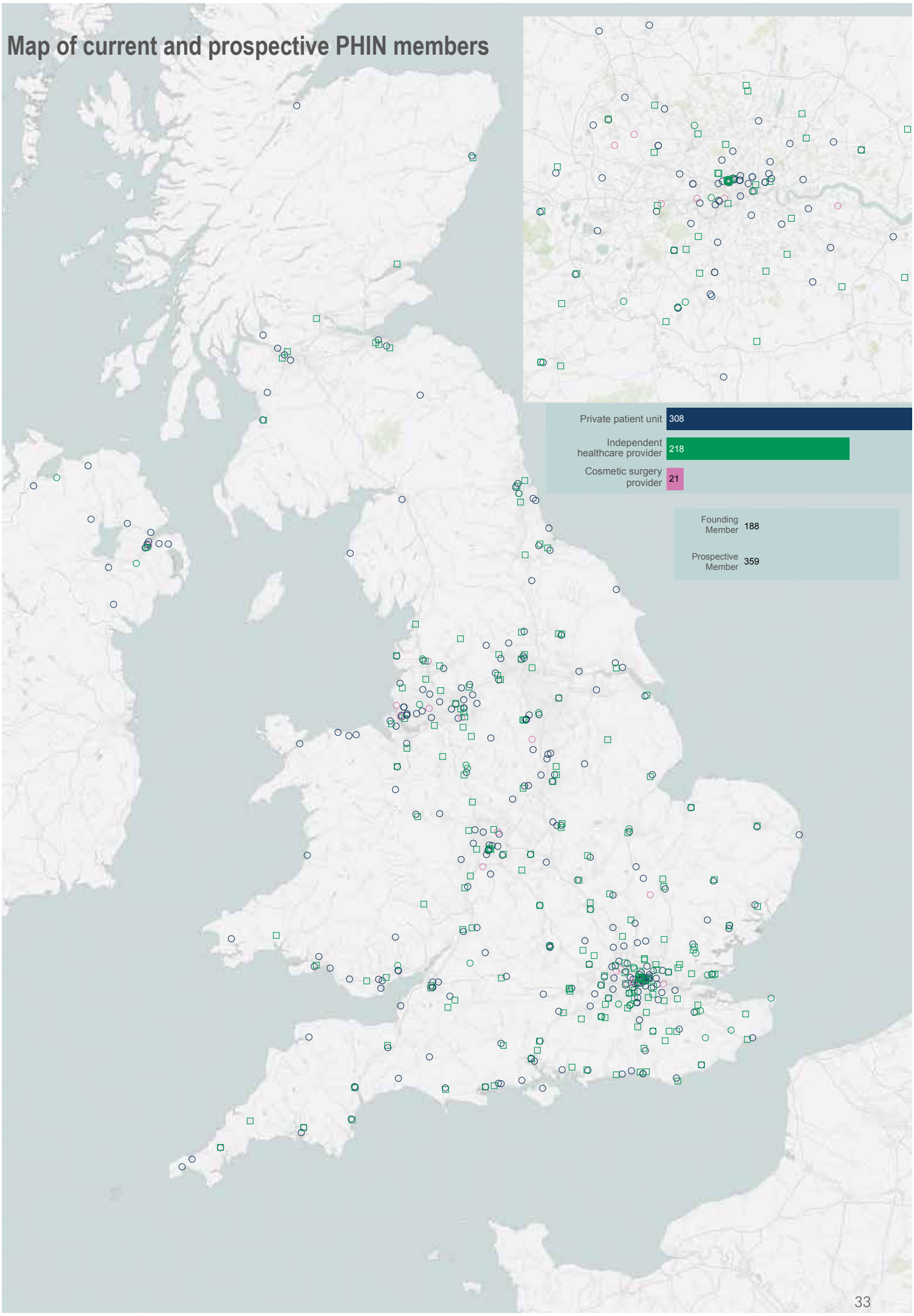
Most importantly, as patients demand ever greater control over their data, and expect it to be available where and when they want it to support their needs, it will become critical for providers to be able to participate in a wider health data infrastructure. It is important for private healthcare not to get left behind by its customers.

Reporting on progress

PHIN has begun asking members for progress updates as implementation progresses, and will collate that information both to help members understand their own relative positions, and for PHIN's Board to understand the progress of the sector as a whole. We will publish summary positions in future annual reports.

Appendix 2: Private Healthcare Groups and Facilities indicating their status with PHIN as at May 2015

Map of current and prospective PHIN members



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