Independent Healthcare Providers Network

PHIN strategy consultation 2021–25

IHPN welcomes the opportunity to respond to PHIN's strategy consultation. A sizeable proportion of members have contributed to the views expressed in our response. While providers' views inevitably vary, there was generally a high degree of consensus among members about the views expressed in this paper.

Members overwhelmingly believe that delivery on the CMA Order should be the dominant priority. Views are more diverse about the extent to which there should be any other activity until that goal has been met. Some believe that achieving the Order should be sole focus, others believe it should be the predominate focus, but all are deeply cautious about entering into any activity that might distract from this goal.

More generally, we welcome our ongoing and productive engagement with PHIN, and thank you for the open and constructive dialogue that we continue to enjoy. We look forward to continuing to work closely with PHIN in the months and years to come.

1. To what extent do you agree full delivery against the CMA Order should be a 'non- negotiable' priority for PHIN?

Full delivery against the CMA Order must be the top priority.

We recognise both PHIN and independent providers have worked hard to meet the Order's requirements and it is right also to acknowledge that the original deadlines for delivery have long since passed.

It is therefore important that we are clear about what needs to happen to achieve full delivery, and indeed what constitutes full delivery.

While we welcome the proposed definition of full delivery, we believe it requires further clarification. The definition as currently articulated, refers to "publication of all the specified measures", "the information published for all consultants" and "coverage approaching 100% of both hospitals and consultants". The words "all" and "100%" could reasonably be interpreted as implying that all (or close to all) metrics will be completed with high quality data from all providers wherever relevant, so that meaningful quality indicators can be created for all providers. This was IHPN's initial interpretation.

However, we understand from discussions with PHIN that the words "all" and "100%" are intended to mean that all (or close to all) metrics will be completed to some degree by some providers. The meaning of "100%" therefore refers solely to PHIN's ability to publish all the required metrics, even if a potentially large proportion of providers have only rudimentary information visible and in turn are presented as having gaps in their data. The key benchmark for achievement therefore is publication of the metrics, not completeness.

Clearly, the task to achieve full delivery will be significantly harder if high levels of data quality and completeness are required for all providers across all metrics, but the potential benefits will be significantly greater.

It is important to know where we are heading so we need further discussion to achieve clarity on the definitions of "all" and "100%".

It is also crucial that we have a roadmap to achieve full delivery. Responsibility for delivery rests both with PHIN and individual providers, but crucially it is a joint process. Clearly at extremis, a provider that refuses to engage must take responsibility for that position. However, most IHPN members have devoted considerable resources to providing information to PHIN and want to see the project succeed. Where challenges exist, these need joint problem-solving approaches to identify and address the root causes of any issues.

The strategy is currently light on detail how PHIN proposes to meet full delivery by the proposed deadline of 2023. We therefore suggest that considerably more focus is paid to this area because IHPN members are absolutely clear that this should be the overriding priority.

2. To what extent do you agree that we must strive for real and demonstrable awareness and adoption by consumers?

IHPN believes that "real and demonstrable awareness and adoption by consumers" is highly desirable but can only be achieved in a meaningful way if the information presented by PHIN accurately and comprehensively reflects the sector's performance. To this end, consumer awareness and utilisation follows from delivery of the requirements of the Order. In turn, any efforts to engage consumers must not divert resources away from this goal.

3. To what extent do you agree that we should aim for complete delivery by the end of 2023?

While complete delivery by the end of 2023 is a reasonable timeframe from where we now are, a long time has already passed since the original 2017 deadline. We should therefore aim for complete delivery as soon as possible. 2023 should be the latest date to achieve this, not a moveable target.

As noted in response to question 1, we believe achieving the Order will require focus and joint effort between PHIN and providers. It is important therefore that the strategy should include a roadmap identifying how to achieve this deadline, a realistic implementation timetable, milestones for delivery with scope for a contingency plan to avoid slipping on these deadlines, and this should be informed by an analysis of the root causes of the delays to date.

Priority 2 – consumer insights

4. To what extent do you agree that PHIN should deliver a website which provides a more comprehensive suite of information to patients, some of which may sit outside of the scope of the CMA Order? For example: consultant availability or hospital amenities.

While we understand how this additional information may be useful for both consumers and providers, it goes beyond the scope of the Order. Further, while collection of this information may be reasonably straightforward, it still represents additional activity for both PHIN and providers that will inevitably distract from the number one objective, i.e. delivering the requirements of the Order.

Members have expressed concern that it would likely be resource intensive for PHIN to do this well. While it may be a sensible development to consider over the longer term, it is therefore a question of sequencing. This option should therefore be considered only once the requirements of the Order have largely been satisfied.

Given PHIN's expertise on collation, cleaning and processing data from providers, a more prudent route to disseminate information may be to syndicate summary data and thereby steer clear of potentially sizeable development costs that go beyond PHIN's core purpose, at least for the foreseeable future.

5. To what extent do you agree that PHIN should be producing information focused on clinical and governance improvement to support patient safety initiatives, addressing for example the issues raised by the Paterson Inquiry and Cumberlege Review?

Although these areas strictly fall outside of the Order, there is a reasonable case for making this information available to support patient safety initiatives. Further, we believe that facilitating patient safety is an important duty for all organisations involved in healthcare.

The strategy document does not go into detail about how PHIN aims to support such initiatives. Without the detail of what would be involved, it is difficult to make specific comments about what information should be provided by PHIN and exactly how PHIN should engage.

We note that several members hold reservations about these proposals precisely because these wider initiatives go beyond the scope of the Order. In turn, members hold concerns that an effective contribution to such initiatives could only be achieved by risking dilution of the focus on the Order.

Therefore, while we welcome discussions about specific, limited and focused work to support patient safety initiatives, any such activity should be clearly defined and appraised on a case-by-case basis, with members consulted on such engagement before any activity begins.

6. To what extent do you agree that PHIN should cease the publication of consultant procedure fees in isolation, if a broader agreement can be found on publishing more complete pricing – including package prices and diagnostic costs?

IHPN recognises the need to publish meaningful measures. There is little point publishing information in isolation that could potentially be misleading, even if it complies with the letter of the Order. Indeed, it is arguably worse to publish something that we believe will likely be misinterpreted, than not to publish anything at all.

The crucial caveat in this question is "if a broader agreement can be found". Irrespective of the pros and cons of moving to package pricing, many providers are contractually committed to honour commercial confidentiality, e.g. via contracts with insurers. It is therefore not within their powers to publish such information. Further, members have cited numerous examples where it would be difficult to align the presentation of package prices to ensure genuine comparability.

Any solution reached must be achievable by all providers without the risk of jeopardising pre-existing confidentiality agreements. Otherwise, there is a danger that the presentation of such information could inadvertently imply a lack of transparency on behalf of a given provider, when in fact that organisation may be legally prevented from disclosing such information.

The exact requirements would require careful scrutiny to ensure they are 1. intra vires; 2. achievable without further pushing back the timetable for delivery on the Order; and 3. genuinely comparable rather than inadvertently encouraging market distortions to create a headline competitive price point.

So, while we support the principle of publishing meaningful measures, we offer caution about the potential complexity and practicality of these proposals.

7. To what extent do you think that collecting a broad range of outcome measures based on patients' own structured assessment of their outcomes (PROMs) remains vital?

IHPN supports the publication of outcome measures including PROMs. Indeed, this is an area where the private sector has led UK healthcare and members are committed to using PROMs as a tool to support improved care within their own organisations.

As with all our comments in response to the consultation, the priority must be to focus on delivering the Order in a way that is meaningful to end users.

While we support publishing PROMs in principle, we recognise that are practical and methodological challenges that need to be addressed. The long lead time between pre-op and post-op questionnaires for example can present challenges, and meaning inferred from low numbers can be both questionable and volatile.

We therefore support taking a pragmatic approach, guided by the principle of aiming to present information that is genuinely meaningful for end users. To that end, we advise a cautious approach, especially in relation to the range of PROMs under consideration.

8. To what extent do you agree that PHIN should shift from an 'opt-in' process for publishing consultant activity, to an 'opt-out' process where the default expectation is that information should be published unless the consultant has signalled underlying issues with the accuracy of their data?

We recognise it is important to increase levels of consultant engagement, and that moving to an "opt-out" process may be a sensible way forward.

However, it is important any such process is managed carefully. Moving to opt out will likely increase consultant engagement, and while this is a good thing in general, a deluge of activity clustered around a specific publication date, could cause operational difficulties for providers and a deeply frustrating process for consultants. In turn, there is a risk of further disengaging consultants. Any move to a default opt out should therefore be phased and closely monitored to identify operational issues. This includes keeping track of the rate and resolution of the issues highlighted by consultants and providers, and crucially, making appropriate changes in response to that feedback .

Priority 3 – value for stakeholders

9. To what extent do you agree that PHIN should look to provide information and insights back to providers submitting the underlying data?

We strongly agree with this element. We believe it is a core part of validating the data that providers submit, and therefore is an essential element of fulfilling the requirements of the Order.

Information and insights provided back to members should be done in a way that allows providers to interrogate this information in more depth. This is important because PHIN's focus and expertise under the Order is in the collection of data rather than as an authority on quality or as a quasi-regulator. Further, it will allow providers to pursue their own lines of enquiry and encourage confidence in any conclusions.

There are few, if any, more compelling ways to foster engagement in data submission among providers and consultants than to deliver specific actionable insights based on that information. The interplay between those insights and providers' assumptions should prompt discussions about data quality – even more importantly – the quality of care. This is exactly where PHIN's strategy needs to aim because it will drive the multiple goals of fulfilling the Order, engaging providers and consultants, and improving care quality and safety.

10. To what extent do you agree that PHIN should be providing information and insights to broader stakeholders, including consultants, consultant representative groups, responsible officers, GPs, commissioners (PMIs), and regulators such as the GMC and CQC?

We believe these objectives are broadly consistent with the principles underpinning the Order and in the interests of patient safety, so should form part of PHIN's core focus.

As referenced in response to question nine, we believe that consultant engagement based on insights into their activity will foster engagement both with the data flowing to PHIN and in the quality of their work.

Our main areas of caution in relation to this question are that:

- There are numerous potential purposes and organisations that could legitimately lay claim to a valid reason for access to information from PHIN.
- Any sharing of data should be consistent with wider obligations for providers to share information.
- This activity should not distract focus away from fulfilling the Order.

It is therefore important to consider each case on its merits to avoid being overwhelmed. To ensure a fair, consistent and manageable approach PHIN could develop a set of principles against which to assess such approaches.

While we do not intend to comment extensively on the proposed Consultant Information Sharing System because of IHPN's interest in that initiative, we note that its raison d'être is squarely focused on improving patient safety.

11. To what extent do you agree that PHIN should exploit additional use or value of our information systems?

We recognise there is significant commercial potential within the data that PHIN holds, which could potentially generate income that would offset a portion of member fees.

While there may be a rationale to develop this area, members are deeply cautious about the risks of such an approach. Concerns have been expressed that the monetisation of the data PHIN holds would remove the objectivity necessary to fulfil the Order. There are also profound doubts about whether any consensus could be achieved about the details of implementation.

Leaving aside the pros and cons of any such future development, we anticipate the CMA would take a keen interest in the implementation of commercial products and services built on the development of information collected to fulfil its Order. Any such utilisation would therefore need to be considered with the utmost sensitivity.

We therefore believe that this approach, while initially appealing if it could reduce fees, would likely be difficult, if not impossible to implement, but the preparatory work investigating this approach could be both costly and time consuming.

12. To what extent do you agree that PHIN should aim to relinquish control over its private healthcare data (an asset with quantifiable value) to NHS Digital via the ADAPt programme?

IHPN has liaised closely with members around the development of the ADAPt proposals, and throughout that process, providers have supported the aims of ADAPt because they are in the public interest. We have also consistently argued that providers must be able to use the outputs from such projects to gain insights into their performance for the purposes of quality improvement and patient safety.

As ADAPt rolls out, there would be merit in regular engagement of providers in a discussion with NHS Digital about how information will be used. This could both ensure providers are fully engaged in any implications, and improve the validity of any conclusions that may be drawn from analysing combined datasets, e.g. by drawing out implicit differences between private and NHS data such as how consultant activity is coded.

We believe quality improvement in patient safety must be the key drivers of any initiatives to share data. As noted in our response to the ADAPt consultation, and consistent with our response to earlier questions, a key benefit to providers is to gain contextual and longitudinal insights into care quality. Just as private data must flow into the NHS, so there needs to a reciprocal flow of NHS data back to achieve these insights.

Finally, as noted in the response to question 11 above below, development of this area should be approached with caution, and without distracting focus from fulfilling the requirements of the Order.

13. To what extent do you agree that PHIN should devote greater resources to marketing and promotion of our website?

IHPN believes it is important to draw a clear distinction between funding of activities focused directly on the fulfilment of the delivery of the Order, and other activities that may have wider benefits including potential commercial returns.

Clearly the site needs to be fit for purpose, with reasonable development costs incurred specifically in relation to achieving that goal. However, we are concerned that the aspiration articulated in the strategy seems to go further than this limited purpose and risks detracting from the key priority of fulfilling the Order.

14. Are there any other ways you believe PHIN could create value for stakeholders?

IHPN members believe PHIN should focus on fulfilling the Order, rather than pursuing the development of other activities.

Priority 4 – pursue collaboration and system efficiency

15. To what extent do you feel should PHIN seek to support broader initiatives to improve patient safety and collaborate with the NHS to support efforts to align systems?

We support ADAPt and believe it is consistent with fulfilling the Order.

Any other initiatives should be considered on their merits, with the default position that PHIN should be cautious about expansion until the Order is largely fulfilled.

Funding over the next 5 years

16. To what extent do you agree that PHIN should review fees paid by providers (in line with the Order) to ensure full delivery of the Order in a quicker timeframe?

Clearly fees need to be appropriate for the purpose and we look forward to a productive discussion about fee levels in relation to the final work programme that emerges from the strategy.

In addition to fee levels, fee structure is also important. As noted in response to question 13, IHPN believes it is important to draw a clear distinction between funding of activities focused directly on full delivery against the Order, and other activities that may have wider benefits including potential commercial returns.

Members have expressed concern that some of the initiatives alluded to within the strategy consultation paper could be both expensive and a distraction from fulfilling the Order. We caution against any fee increases that will not directly be used for delivery of the Order – members have clearly indicated that they would be deeply unhappy if fees were to be raised with the aim of expanding PHIN's wider range of activity.

17. To what extent would you agree that PHIN should explore additional revenue avenues to create greater value for stakeholders, for example, explore a 'value-adding' membership model based on additional insights for broader stakeholders such as GPs?

We anticipate that this would likely require upfront investment which could distract from full delivery of the Order. In turn, it should clearly be a second Order priority and be considered only following the fulfilment of the Order.

18.Do you feel that there are other issues PHIN should be considering and giving priority in developing their strategy for the next five years?

We have no further comments.