

Response to the Notice of Possible Remedies

The Private Healthcare Information Network (PHIN) is referred to throughout the Competition Commission's Preliminary Findings and Notice of Possible Remedies published on 28 August 2013, so we will assume that you are broadly familiar with our structure and purposes.

We have some specific comments to make on Remedies 5, 6 and 7 and the related questions, in addition to some general observations. As you know, at this time PHIN is working largely with hospital information rather than with consultant information, so we will begin with Remedy 7.

Lack of sufficient publicly available information on private hospital performance

Remedy 7—An information remedy

75. *Much more information is currently available to consumers on the quality of services provided by NHS hospitals than is available for private hospitals.*
76. *Information on the performance of NHS hospitals in England, and on the performance of private hospitals in respect of work they undertake on behalf of NHS England, includes collection of data for the assembly of hospital episode statistics (HES) comprising detailed information on procedures and patients as well as patient reported outcome measures (PROMS) which provide qualitative information on patient care in the context of four commonly performed procedures.*
77. *In late April 2013 the Private Hospital Information Network (PHIN) launched a website providing information on the performance of its member hospital operators across a number of indicators including the equivalent of HES. We have been told that PHIN intends to widen the scope and coverage of the information that it collects and publishes. At this stage it is not clear to us that the data to be published by PHIN will necessarily be equivalent to that available on the performance of NHS hospitals in England.*

How the remedy would work

78. ***The CC would require that all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients and that appropriate arrangements are made for its publication to consumers.***

Issues for comment

We invite responses to the following questions:

(a) Is the remedy practicable? Are all private hospitals in the UK capable of collecting the equivalent of HES data? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?

The remedy is certainly practicable in principle. Indeed, as the CC has acknowledged, 194 UK private hospitals are already collecting a data set approaching HES-equivalency and submitting it to PHIN for publication. As the CC has correctly identified, the principle obstacle to producing HES equivalent data, both in terms of timing and completeness, is the current lack of diagnostic coding for private patients – explored further under question (c) below.

However, there are a number of other issues and considerations with the remedy as framed, and for that reason PHIN recommends that the CC should absolutely hold to the intended principle, but consider restating the specific terms, and we offer a proposed solution below following our response to the five specific questions.

Firstly, PHIN would encourage the CC not to rely on the specific terminology of “HES equivalent”; In July, NHS England set out an ambitious agenda for improving NHS information called the “care.data” programme. This would, among many other changes, see HES subsumed within a wider “Care Episode Statistics (CES)” dataset¹. Similarly, as the CC has observed, “HES” is specific to England. As such, we recommend that the CC should avoid locking private hospitals to a standard that has limited application and may immediately become redundant.

It is tempting therefore to refer to “CES equivalent” or “NHS equivalent” data, but both are too broad to be practicable unless applied with care and discretion, as CES will include data which is completely beyond the scope of private hospitals, such as social care data sets (and would again be limited in application to England).

Faced with these considerations, it may be favourable instead to state the broad intent (NHS equivalent) but direct responsibility for setting the specific terms to an appropriate organization, which would most practically be PHIN, since we already have an organisation with the specific knowledge required, independent governance² and the support of the industry.

We could, for example, make an annual statement of those standards with which we expect providers to comply, and publish a commensurate annual (or rolling) report of compliance with the required standards. This would be open to scrutiny by regulators and interested parties such as the PMIs.

¹ See *NHS Hospital Data and Datasets: A Consultation*: NHS England 22 July 2013, especially Page 18 – *Future Hospital Datasets* <http://www.england.nhs.uk/wp-content/uploads/2013/07/hosp-data-consult.pdf>

² At the time of writing PHIN is in the process of appointing further Board directors. Our intent is to appoint individuals in whom the CC and other observers/ stakeholders will have confidence in terms of holding PHIN and its members to account. These appointments will be made before the end of the year.

Moving on to timing, the CQC is aware that PHIN has laid down a timetable of development (see below), notably for inclusion of future indicators. Unfortunately, delivery against that timetable is no longer fully within our control (nor that of Members) since every indicator has a dependency on one or more public bodies (infections data on PHE, joint revisions on NJR, Readmissions on HSCIC etc).

Release version	1				2				3				4				5				6			
	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14						
Relative Volume	█	█																						
Length of Stay	█	█																						
Day Case Rate			█	█	█	█	█	█	█	█														
PROMS (Hips and Knees)			█	█	█	█	█	█	█															
Revisions (Hips and Knees)					█	█	█	█	█	█	█	█												
SSI				█	█	█	█	█	█	█	█	█	█	█										
HCAI				█	█	█	█	█	█	█	█	█	█	█										
Patient Experience		█	█	█	█	█	█	█	█	█	█	█	█	█										
PCI Outcomes		█	█	█	█	█	█	█	█	█	█	█	█	█	█									
ACS Outcomes		█	█	█	█	█	█	█	█	█	█	█	█	█	█									
Readmissions											█	█	█	█	█	█	█	█						
Transfers											█	█	█	█	█	█	█	█						
Mortality											█	█	█	█	█	█	█	█						

Figure 1 PHIN's timetable for indicator development

Neither the CC nor we should assume that public bodies will be willing and resourced to provide any services in respect of private patients. Although the NHS is much more open to the private sector than it ever has been previously, barriers remain. The level of openness and willingness to engage from public bodies (CQC, HSCIC, NHS England, PHE etc) has been very good of late, albeit that actually getting things done can be harder, as we are never high on the priority list.

Some slippage has already occurred. However, we remain confident that by the end of 2014 PHIN will have more complete, comprehensive and consumer-focused set of information than is available anywhere else, including within the NHS.

On that theme, we feel that the CC has taken a rather rose-tinted view of what is currently available to patients in choosing an NHS hospital, and therefore excessively marked down the private sector by comparison. Choices (nhs.uk) is limited in scope and has not cracked the problem of making nuanced information easy to compare, whilst PROMs, NJR, Friends & Family, infections, and registry data sit outside of Choices and are in no way designed for use by patients, and the consultant-level data published as recently as July this summer mainly requires expert interpretation. Bear in mind also the CC's own observation that all of these disclosures have occurred only in England, with very little to talk about elsewhere.

PHIN aims to do better than this for patients: our information will be consistent and easy to compare, and we will bring all of these types of information into one place.

In terms of publication of indicators therefore, we recommend that the CC should hold providers to account to hold both themselves and PHIN to account for delivering against the published timetable.

In terms of enablers, we believe that the sector should have committed to PROMs and diagnostic coding for private patients and be advanced in planning by the end of 2013, with collection activity for both starting in 2014Q1, enabling first outputs by the end of 2014.

(b) Similarly, are all private hospitals in the UK capable of collecting PROMs data for the same procedures that it is collected for NHS England? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?

Again the answer is yes in principle, with only minor caveats.

PHIN has considerable expertise in PROMs, not least through our Chairman Dr Andrew Vallance-Owen, who has played a leading role in the development of PROMs both for Bupa and the NHS (as Chair of the Department of Health's PROMs Advisory Group). We feel that we are the right organisation to co-ordinate a response on this issue.

The aim is to be able to meaningfully and robustly compare the standards of care delivered at private hospitals both within the sector and with the NHS, and PROMs measures are undoubtedly an important part of that.

However, that utility for patients should come before the need to follow the NHS too rigidly.

Since 2009, the NHS has routinely collected PROMs on four procedures – Hip Replacements, Knee Replacements, Varicose Veins and Hernias.

The case for providers to follow suit with hip and knee PROMs for private patients is strong – they provide a good level of discrimination between providers, and the cost to collect is small relative to the price of the procedure. Many private hospitals already collect these PROMs measures for NHS patients.

However, there is always a cost to collect, and ultimately the private patient will pay for any data collection or informatics undertaken. We should therefore strive to ensure that we collect PROMs where they add most value.

Some concerns have been raised that PROMS for Varicose Veins may have limited value, and indeed could be phased out by the NHS. The number of Varicose Vein procedures undertaken in the NHS has been falling, as financial pressures prompt exclusion of procedures deemed to be of marginal benefit. Similarly, we understand that PROMs are of limited discriminatory value for VVs, as the patients' overall health and comfort is not really the issue, and it is hard to perceive the benefits of VVs. This needs further investigation on our part.

In respect of Hernias we expect that there is a good case for collecting PROMs for private patients, but again need to discuss this further with providers.

There may also be other procedures on which PROMs could be collected for private patients that are not currently collected routinely within the NHS. The provider group has already expressed an interest in developing PROMs for Cosmetic Surgery, and noted that high volume procedures such as cataract operations may be better targets.

However, this illustrates a practical problem: PROMs surveys for NHS patients must be conducted by an NHS-approved contractor (from a list of four) and are collated, adjusted and published by the HSCIC. Will HSCIC be willing to process and/or publish PROMs for private patients? If yes, would they be willing to do so for procedures outside the current list (unlikely)? What would the cost be? And if HSCIC is not willing to do that, who will?

Reiterating a point made above, the CC cannot simply assume that public bodies will be willing and resourced to provide any services in respect of private patients.

We fully anticipate being able to reach a positive practical solution for most of these concerns, but we would ask for two things from the CC:

1. Latitude to reach the right solution for private patients, not necessarily exactly following the NHS
2. Support in engaging the HSCIC to work with us on PROMs for private patients.

In terms of timing for PROMs, we restate the indication given above: we believe that the sector should have committed to PROMs for private patients and be advanced in planning by the end of 2013, with collection activity for both starting in 2014Q1, enabling first outputs by the end of 2014.

(c) Besides HES and PROMs equivalent data, what other data should be collected by private hospitals and to whom should it be made available? Would it be appropriate for the CC to specify the coding, for example ICD10, to be used in data collection and classification?

PHIN believes strongly that diagnostic and co-morbidity coding should routinely be collected for all private patients. We are interpreting “HES equivalent” to imply that diagnostic coding must be applied to NHS standards (and will continue to hold that line even if the specific term “HES equivalent” is dropped as we encourage above). The current applicable standard for that is ICD10, and therefore that is what we expect to apply.

However, as with the other definitions of NHS equivalency above, we feel that the best solution may be to have one organisation – probably PHIN – setting expectations and reporting compliance, rather than locking to a specific term or standard.

ICD11 is due sometime after 2015, so at a minimum we need the room to ‘upgrade’; however, more urgently, the NHS currently seems interested in pushing ahead with the implementation of SNOMED CT, which also aims to capture diagnostic information but sits uneasily with ICD10. This may not happen (implementation has been stop-start over a number of years, and until recently seemed to have stalled completely), but we need to be alert to that possibility.

Again, costs will be significant. Costs of current ICD10 coding processes seem to add around £5-10 per patient episode, while costs of SNOMED CT (a proprietary system requiring a licence) could be much higher. This will, inevitably, be passed on to patients.

On a wider point, PHIN was disappointed that in its recent publications the Competition Commission seems to have given little or no consideration to the role and responsibilities of PMIs to ensure effective coding.

We know of no other healthcare economy where providers have taken the lead, much less acted alone, to develop diagnostic coding. In the NHS and elsewhere, commissioners and the central system have driven diagnostic coding, largely to facilitate effective commissioning and public health management.

In private healthcare, the principal roles of coding will be to record the pre-operative diagnosis in a standardised format for billing and validation purposes, and to allow case-mix adjusted analysis. PHIN wants diagnostic coding for this latter purpose, because it is required for standardisation of metrics across varying populations, for identifying significant care factors such as presence of cancer, and for describing care where no procedure is involved, as with medical admissions. As such, PMIs benefit from diagnostic coding at least as much as hospitals.

The patient's consultant will, of course, have a perfectly sufficient understanding of the patient's diagnoses and co-morbidities to offer expert care without any access to diagnostic coding, which is generally applied post-discharge. However, the standardisation of comparison offered by proper diagnostic coding will allow consultants to robustly demonstrate the quality and complexity of their practice more effectively than is currently possible.

Private hospitals that treat NHS patients already do a perfectly good job of providing full, standardised information to the NHS, including coding of procedures, diagnoses and co-morbidities and PROMs, demonstrating conclusively that they have the capability and willingness to do so. They have been required to do this: the NHS demanded it, paid for it, and led a collaborative and inclusive process to ensure that it was done properly.

By contrast, the PMIs have not yet made any serious attempt to require, commission or fund diagnostic coding to NHS standards of which we are aware. Some have required very limited use of high-level ICD9 diagnostic codes, which offer only a token benefit.

In our assessment, a great deal of co-operation and co-ordination is required to implement and maintain high information standards. These collaborative processes have become routine within the NHS, but have been inhibited in the private sector by the often-adversarial relationships between insurers, hospitals and consultants. It is regrettable that the CC has not addressed this directly.

We were pleased to learn that Bupa has recently appointed an ICD10 Implementation Manager; this is an encouraging step. However, the next challenge will be persuading Bupa to work collaboratively with other PMIs, hospital groups, medics and PHIN to ensure that the sector is competing on achievements measured by common standards, rather than competing to own the measuring tool.

We believe that PMIs (acting collectively, not individually) can and should be sponsors and co-funders of the move toward full diagnostic coding for private patients.

The NHS Number must also be considered as an important data item.

Within the NHS, collection of the NHS number will imminently be required for all patient interactions by all providers. It will be the pivotal identifier for linking datasets and producing comprehensive, patient-centric information.

Within private care, the NHS Number has rarely been collected, for obvious reasons – there has been no benefit to collecting it, and hospitals don't want to hassle patients for it unnecessarily.

If private healthcare is to keep in step with the NHS, then we must begin to collect an NHS Number (or personal data that would allow the NHS Number to be determined) for all private patients, perhaps collecting passport numbers or similar identifiers for non-UK nationals. More importantly, we must be able to use that information to routinely join up with NHS information. In data protection and information governance terms, this is a major challenge. Patients may resist or opt out, and many will certainly question why we need the information.

We cannot yet specify an exact solution for the NHS Number, and we need to work the problem through with NHS England, HSCIC and others. However, PHIN would like to flag now that it may ask the CC to include in its final remedies some requirement both on private healthcare and on public bodies to facilitate that collection, giving providers a firm legal/ regulatory basis for requesting that information and using it.

(d) What measures could or should the CC adopt in order to ensure that PHIN or its equivalent retains sufficient funding to continue its activities after the completion of the CC investigation?

Firstly, we would like to thank the CC for the recognition and support implicit in this statement. We believe that we are working to achieve something important.

The value of publishing comparative data must surely be measured by the extent that patients can and do use it to make decisions about their care providers. If patients have access to comparative information and use it, then providers should feel the effects.

The goal must therefore be to reach a point where patients (and/or commissioners/ referrers) expect and demand to see comparative data, and will punish any provider that fails to provide data or that compares unfavourably. From that point forward, the future of PHIN or its equivalent will be assured.

At our best estimation, that will take a minimum of five years.

There are two feasible options for ensuring that PHIN is adequately funded during that period:

1. Require that providers contract now with PHIN for a minimum period (e.g. of five years), with scope in the contract for varying subscriptions to match the level of activity that PHIN's Board, in its discretion but advised by Members, deems necessary to deliver the agreed objectives.

Our assessment:

- a. Simple and easy to achieve
 - b. Flexible
 - c. Providers protected from under-performance by PHIN by our governance structure: whilst the Board is independent, Members of the Company appoint and can remove directors
2. Place providers under an obligation, to be reviewed perhaps annually or perhaps after five years by a nominated body with appropriate authority and expertise (in this case absolutely not PHIN – perhaps Monitor or the OFT?) to ensure that their data is made available to common standards for scrutiny and inclusion in comparative metrics, and to ensure that it is in fact independently published (i.e. unless and until a third party volunteers to collate and publish the data, providers must procure that somebody does so). Ultimately, this might allow third parties to have access to, reinterpret and re-publish the data, but in practical terms would probably see PHIN continue as the chosen vehicle for the foreseeable future.

Our assessment:

- a. Objective
- b. Relies on the capabilities of third parties, yet to be co-opted.

Looking more broadly, we believe that it will soon become very important to involve the PMIs as members of PHIN, on a paying basis. There are very good reasons for this.

Firstly, in the medium to longer term we can achieve much more with the insurers on board. Five years from now, somebody with PMI needing an operation should be able to go to a website (be that PHIN's or another), put in a policy number, see the applicable policy terms and choose their providers on the basis of quality from a list of pre-filtered options (reflecting their entitlements under that particular policy). Ideally, they should also have a transactional option to book a first appointment. This has been achieved in many other industries with complex supply chains, the classic example being air travel (involving websites, booking agents, airlines, code-share partner airlines, baggage handlers, airports etc). It is certainly technically possible to do the same for private healthcare – it is organisational relationships that will present the obstacles.

Patients expect a joined up service and joined-up information. So long as there is a gulf between insurers and providers into which good intentions may fall, that will not be achieved; for really great information (and for really great care), all parties will need to work together. Comparability requires standardisation, which in turn requires co-operation.

Over the last two years, in large part through PHIN, the private hospital groups have become much better than ever before at collaboration and working toward a common purpose for the benefit of patients and the threat of competitive sanction. (It is a nice irony that the private sector has had to learn to collaborate better for the sake of better competition, given the perennial suggestion that

'competition' and 'collaboration' are opposites in the debates about involving independent providers in NHS care).

The production of standardised self-pay prices this year under PHQC's leadership is a good illustration: despite considerable nervousness and reticence initially, providers worked well together and successfully delivered a common standard. It is not perfect, but it is definitely progress.

Similarly, we are confident that consultants will be able to work productively with each other and with PHIN through their professional bodies, and umbrella organisations such as FIPO; this has already begun.

However, PHIN is much more concerned about the ability of PMIs to work co-operatively together, and whether there are suitable representative bodies or forums to help them do so.

PHIN will work hard to resolve this, but we feel that the CC really has to help. Unfortunately, the Preliminary Findings and Possible Remedies have generally been perceived as a win for the big PMIs and a rebuke for the main private hospital operators; this may be fair enough, but it may also have the effect of deepening the divides and mistrust within the industry, and that will not make the task of co-operating on information standards any easier.

PHIN feels that positive action will be needed to get all parties playing a positive, collective and involved role. Over the time remaining in this Market Investigation we would therefore like to discuss with the CC how best to involve the PMIs.

(e) What cost and other factors should the CC take into account in considering the reasonableness and proportionality of this remedy or the timing of its implementation?

As described above, there is a cost to collate and produce high quality comparative information.

We believe that the private healthcare sector (meaning all involved parties, as above) will need to make significant investment to drive progress over the next few years if it wishes to remain competitive with the NHS and international markets, over and above complying with the CC's final remedies. Most of this investment will probably go to improving processes and resources within each organisation, rather than visibly to PHIN.

At the same time we must remember that we are working within a market under financial pressures, and that there should be a defined and achievable positive benefit for any project on which we embark, measured in terms of tangible benefit to patients and, by extension, potential commercial benefit to industry participants.

Our best suggestion is that we should rely on continuing and strengthening the base for progress that we have developed in PHIN. PHIN has the expertise and structure to bring together providers, partners and stakeholders to assess requirements, identify routes to implementation, and ensure

that the sector responds positively and proportionately to the need for better information and the barriers to achieving that.

We feel that we've made good progress over the last 12 months, and see no reason that it should not continue.

As suggested above, PHIN could facilitate wider scrutiny by publishing an annual statement of objectives and standards, and an annual statement of delivery against those, to enable public scrutiny. We are in the process of strengthening our governance and formal relationships with the key stakeholders, which will further increase our capability to play this role.

We recognise that this may place PHIN in an uncomfortable position at times (we may well set standards and objectives which are an unwelcome stretch for the Members that fund our existence) but we believe that this is a role that we can and should play.

Consultant fees

Remedy 6—An information remedy

71. We were also concerned that information relating to consultants' charges was not uniformly made available to patients prior to consultations and/or treatments with the result that patients may face unexpected shortfalls in their PMI reimbursement. Some consultant bodies, for example AAGBI, produce a code of practice on charging and fee notification to patients. However, we did not find this practice to be widespread.

72. We therefore considered a remedy that would require consultants to provide patients with price information prior to the commencement of treatment.

How the remedy would work

73. We would require all consultants practising in the private healthcare sector to publish their initial consultation fees on their websites and we would require each private hospital where they have practising rights to publish these fees on their websites. We would, further, require consultants to provide a list of proposed charges to patients in writing, in advance of any treatment.

Issues for comment 6

74. We invite responses to the following questions:

- a. *Is the remedy practicable? Do consultants' outpatient fees vary significantly between different patients such as to render an average fee or a range of fees unhelpful?*
- b. *Is it possible for consultants to estimate fees before undertaking a procedure since unforeseen complications may arise? Would there need to be a means of adjusting fees in response to complications? Are there particular medical specialties where*

*consultants would face particular problems in providing such an estimate in advance?
How else might patients be informed of the likely costs of their treatment?*

- c. *Is it reasonable to require all consultants practicing in the private sector to disclose their outpatient consultation fees? Should only those earning above a certain level do so?*
- d. *How should the remedy be specified? How far in advance of treatment should a consultant be required to provide a patient with an estimate of the proposed fees for treatment? Is it practical, in all cases, to inform patients of costs in advance of treatment? Should any other information or advice be included with the estimate? For example, should the consultant notify the patient of his or her PMI fee maximum for the procedure concerned, or advise the patient to check this him or herself?*
- e. *What provisions would need to be made for the oversight and enforcement of this remedy and which body(s) should be responsible?*

We will confine ourselves to a brief response on this remedy: we believe that these requirements are broadly fair in principle, but will be full of practical challenges.

We believe that the work undertaken among the private hospitals to standardise publication of self-pay prices, started by PHQC and to be continued henceforth under PHIN, offers a potentially helpful model. Consultants and hospitals will have to work closely together to deliver against Remedy 6, and we will offer such support as we can. We reached a good, workable solution for hospitals, and it is reasonable to assume that the same can be achieved for consultants.

In terms of quality information, we believe that PHIN can offer a practical solution, building out rapidly to include consultant information alongside and integrated with that for hospitals. They are, of course, two sides of the same coin. Our IHES data includes details of consultants (limited mainly by facets of HES data, notably that the responsible consultant identified in HES may not be the operating surgeon).

Inclusion and publication of consultant-level data will need funding, and willing co-operation from involved parties. These remain to be discussed.

Consultant quality

- 65. We were satisfied that information concerning consultants' professional qualifications and areas of expertise was accessible to consumers in the UK via websites such as Dr Foster, hospitals' and consultants' own websites. However, with the exception of cardiothoracic surgeons, information on the clinical performance of individual consultants was not available.
- 66. In December 2012, NHS England announced plans to collect and disseminate performance data for individual consultants in ten medical specialties. It was intended that this information would be published in the summer of 2013 and data on the performance of cardiothoracic surgeons is now available publicly. We found there were no plans for the NHS in Scotland, Wales or Northern Ireland to publish similar data.

67. We considered that the provision of this information to patients would be sufficient to provide a solution in England to this aspect of the AEC that we had provisionally identified. However, we did not consider that the publication of this data would comprehensively address the AEC since it would not provide relevant information for patients across the whole of the UK.
68. We are therefore considering a recommendation to the health departments of Scotland, Wales and Northern Ireland that they collect and publish consultant performance indicators arising from their NHS practice equivalent to that published in England.

Remedy 5—a recommendation to the health departments of the nations

How the remedy would work

69. We would make a recommendation to the health departments or their equivalent bodies in Scotland, Wales and Northern Ireland that they collect and publish on their most appropriate patient-facing website individual consultant performance indicators to include activity and clinical quality measures across the same or an equivalent.

We are not optimistic about this remedy.

The publication by NHS England of consultant-level data in ten specialties is a very important and laudable departure. It is having a profound impact.

However, we think the CC has overstated the extent to which these registry datasets are sufficient to constitute adequate information for patients on consultant quality. They are not in a format that is meaningful to patients, they do not offer a sufficiently comprehensive view a consultant's practice to allow meaningful choice without other information (is the CC really suggesting, for example, that there is no role for reporting patient views and feedback?) and they do not include all specialties. Several do not currently include a consultant's private practice.

On that basis, they are hugely helpful, but not sufficient. Parity with the NHS is not a sufficient standard here – sufficient information to allow meaningful choice is.

PHIN can only offer its support both to the CC and the profession, via FIPO, in defining and addressing information needs going forward.

In terms of the specific remedy, we fear that this may be hard to bring to achievement. The Scottish and Welsh governments have no great love of private healthcare, and it would be surprising to us if they reacted positively to a suggestion that they should make a potentially controversial and costly move across the NHS in those countries in order to perhaps improve competitiveness among consultants in private practice in their jurisdiction.

We feel that a solution will need to come largely from within the industry, with the lead set by NHS England acting as a helpful precedent. We again offer our support to the fullest extent that we are able.

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In all of the above, PHIN should be thought of firstly as a role, and secondly as an organisation. We are a not-for-profit organisation created to serve the purpose of co-ordinating the response of private hospitals to the information challenges facing them, providing expertise and governance. We believe that what we have put in place is fit for purpose, as demonstrated by significant progress since the formation of PHIN just a year ago. However, challenges and requirements inevitably evolve. We anticipate being able to flex and grow through to meet the challenges laid down by these remedies over the coming years but, if at some point PHIN as it is currently framed were to cease to be the right vehicle, it would be vital that some other organisation would be there to take its place.

PHIN is building strong relationships with the key stakeholders, and we look forward not just to helping to make private healthcare more transparent and accountable to its customers, but to bringing down some of the barriers that have been erected between private and public healthcare; barriers that too frequently are obstacles in the middle of a patient's care journey.

We hope that these comments are helpful, and wish to reiterate our commitment to helping the CC to reach the right final conclusions and remedies. We would be very happy to meet and discuss any of the points raised.

Matt James

Chief Executive

20 September 2013