

## CC Provisional Decision on Remedies: PHIN Response

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This document is PHIN's response to the Competition Commission's [Provisional Decision on Remedies](#), published on 21 Jan 2014, specifically

- *Remedy 5: Information on hospital and consultant performance*; and
- *Remedy 7: Information on Consultants' Fees*

PHIN is not directly concerned with the other remedies.

We welcome the proposed remedies 5 and 7, which we believe are a well-considered and well-formulated response to the concerns on information availability in private healthcare.

In particular, we support the specification of the purposes and structure for an 'information organization' as set out in 2.463 and 2.470-2.475, and the funding arrangements proposed at 2.485. Below we make suggestions, as invited at 2.471, as to what matters should be reserved to CMA-nominated Board members.

We welcome the Commission's observation that "*PHIN, with an expanded membership base, is likely to be a suitable information organization for these purposes*" (2.463 and similarly at 2.474). We are keen to fulfill this role, and endorse the recommended changes to governance, membership and funding as constructive and appropriate.

Assuming that these proposals are confirmed by Order, PHIN would move rapidly to make the necessary changes to its governing documents and have those changes approved by a General Meeting of its Members. We are currently taking advice on how we might reconstruct the membership principles to promote a balance between participants and ensure the smooth operation of the organization.

We welcome and endorse the timetable set out at 2.466, 2.467 and 2.469 as appropriate and achievable.

We welcome and endorse the requirement for PMIs to direct patients to the information organization as the source of quality information as proposed at 2.468.

We also welcome and endorse the specific measures and scope set out at 2.465 and 2.466, with some minor caveats and questions:

1. At 2.465 the CC proposes “we will require all private hospital operators<sup>226</sup> with UK turnover of £5 million or more to collect and submit patient episode data.” Note 226 then proceeds to say “Our market investigation has not focused on treatments such as cosmetic surgery, hence we do not envisage that clinics specializing in such treatments would be included in this remedy. However, we would encourage the Information Organization to seek information from such clinics and to publish it alongside the other information.” PHIN does not endorse the exemption for providers of cosmetic surgery, and indeed considers it important that this exemption should be removed, for reasons explained below.
2. At 2.465, we believe that Mortalities and Unplanned Transfers should be part of this list for relevant procedures.
3. At 2.465(f) we are informed that data on DVTs and cardiac arrests are not currently routinely collected and submitted in the NHS or elsewhere, being used mainly as internal measures. As such, processes and measures would need to be created. Initial feedback from clinicians suggests that information on DVTs (or a related measure such as rate of providing prophylaxis for DVTs) might be useful to patients, but that data on cardiac arrests could be highly misleading: we will investigate further. On Adverse Events, data is already reported via the National Reporting and Learning Service (NRLS); we will investigate how to obtain and use that data. It would be helpful to understand where these specific suggestions originated as the proposing parties may well be able to inform our practical response.
4. At 2.465(h), on PROMs, the CC proposes that the information organisation should collect “for the ten highest-volume, or otherwise most relevant, procedures, a procedure-specific measure of improvement in health outcome”. We welcome such a steer in principle. However, we question whether ten is the appropriate number, and whether the collection of “procedure-specific” measures across ten procedures is achievable, bearing in mind that the NHS currently collects procedure-

specific measures on only three procedures (Oxford scores for hip and knee replacements, and Aberdeen scores for varicose veins), using the generic EQ-5D measure for Inguinal Hernias. However, we believe that the right outcome can be achieved through an appropriate process of discussion. We discuss this further below.

5. At 2.466(f), the CC requires that data be made available to various parties. Whilst we endorse the proposal that this should include the CQC and HSCIC, we note that Dr Foster is a commercial entity, not a public body, and consider that it would be wholly inappropriate to mandate data sharing with Dr Foster on a preferential basis to any other organization. That is not to say that PHIN might not choose to share information with Dr Foster, for example for inclusion in the Good Hospital Guide, but that such a decision should be a matter for PHIN's Board and subject to commercial considerations. We might, for example, choose to sell rather than give data to Dr Foster (as they would to us), and we should treat Dr Foster on exactly the same basis that we might treat Laing & Buisson, Intuition Communication or any other potentially interested party.
6. Further, at 2.466(f) we note that the sharing of data with any third party, including CQC or HSCIC, must be subject to appropriate agreement and suitable information governance arrangements, including the protection of commercial confidentiality where appropriate and necessary.

### **Changes to PHIN's scope of service Membership, Board and Governance**

There are a number of changes required to PHIN in order to meet the CC's specified criteria for the information organization. We are taking advice on the amendment of our Articles of Association and other governing documents, and will be happy to share the redrafted documents with the CC for information in the near future. Please note that any proposed changes will be subject to the approval of PHIN's Board and ratification by PHIN's Members at a General Meeting. We currently propose to hold an Extraordinary General Meeting in July 2014 for the purpose of making the necessary changes.

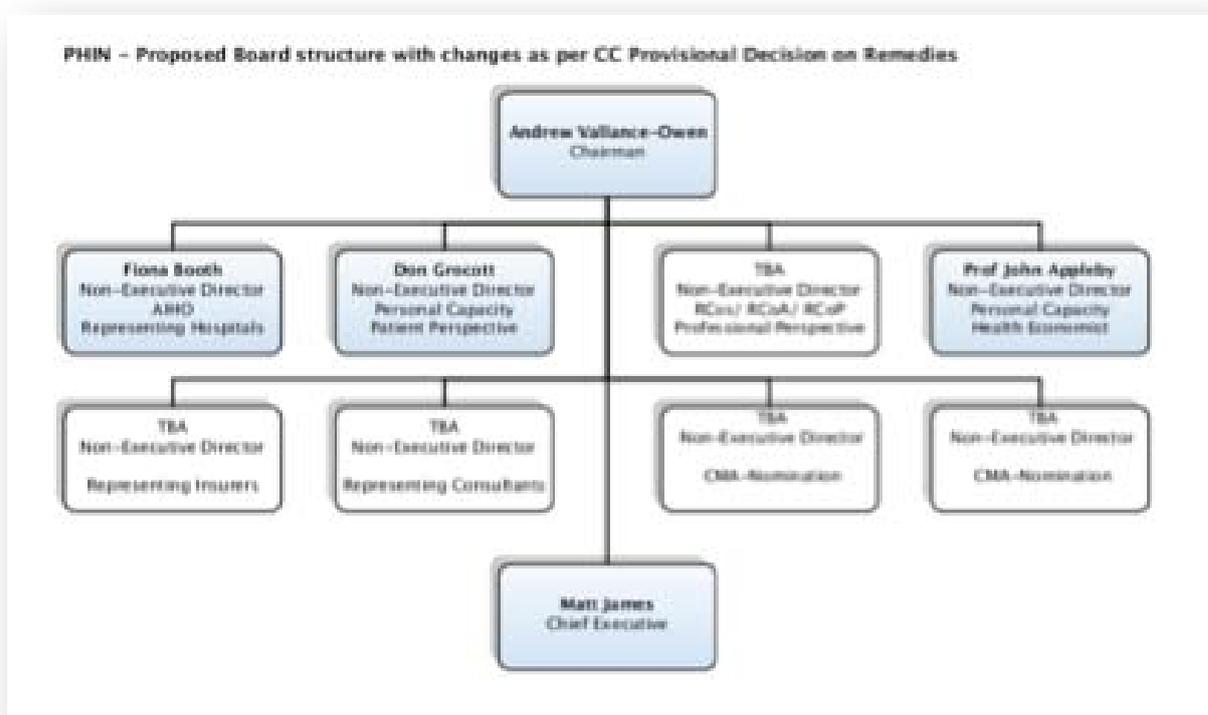
## Board Composition

PHIN welcomes the suggestion of CMA-nominated Board members. Our Articles will need to be altered to enshrine this right with appropriate mechanics.

It is essential that the CMA-nominated directors are fully independent and are not representatives of the CMA, and that the CMA will not direct their actions in any way (which, we are advised, could expose the CMA to the risk of being deemed to be a “shadow director” of PHIN).

We currently have a Board of five directors. We envisage that the changes proposed will see the Board expand over time to ten, adding:

- Two CMA-nominated NEDs
- An insurer-nominated NED
- An NED to represent consultants
- A medical NED to give a professional, non-representative perspective



We note that it is not currently clear what individual or organization might be able to represent insurers. The appointment of a Board Director in that

capacity would be dependent on the Chairman and Board being able to identify a suitable individual and/or organization that could carry the endorsement of insurer members.

The Commission suggests at note 231 (in respect of membership) that consultant representatives “may be drawn from the consultants’ professional bodies, such as the Royal College of Surgeons or the Association of Anaesthetists of Great Britain and Ireland.” We think that Professional bodies such as the Royal Colleges are unlikely sources of candidates for representing consultants’ interests either on the Board or as Members, but we remain committed to working with the professional bodies including the Royal College of Surgeons to find a Non-Executive director to bring a purely professional perspective.

Professional associations such as the AAGBI, on the other hand, may well be the right source of candidates for consultant members (discussed further below). We would probably expect a Director representing consultants’ interests to come either from one of the professional associations or from the umbrella organizations such as FIPO or the BMA Private Practice Committee.

Any nominated Non-Executive Director (including CMA-nominated NEDs) will need to be elected to the Board by Members at a General Meeting, and hence to command the broad support of the full Membership.

We will take advice on the setting of a quorum for the enlarged Board, and whether any matters should require the support of a set proportion of the Directors rather than a simple majority.

At 2.472 the Commission states “We thought that the Chair should nominate new board members, with the information organization’s members voting to confirm or reject the nominee.” Currently, Directors may be appointed by Members or by the Board, subject to the approval of Members at a General Meeting. Best practice in corporate governance favours collective decision-making, and PHIN feels that Director nominations should remain a matter for the Board as a whole or for Members, rather than for the Chair individually.

## Matters to be reserved for CMA-nominated Board Members

It seems to PHIN that there are two principal benefits of having CMA-nominated independent non-executive board members as proposed

1. To “ensure the smooth running of the information organization” as suggested; and
2. To increase public confidence in the independence and proper governance of the organization.

As such, these are the functions that should be supported.

However, it is essential for the proper operation of the organization that the Board, and not a subsection of the Board, is the source of executive authority and the controlling mind of the Company.

As such, the CMA-nominated members should have authority and influence no greater nor less than that of their fellow non-executive directors, and must be subject to the same fiduciary duties, save that the CMA-nominated directors should:

- Make a statement within the information organization’s published annual reports (2.473) on their satisfaction (or otherwise) with the overall independence, effectiveness and good governance of the organization in the proceeding year, and set out what measures the Board has agreed to adopt in the following year to rectify any deficit; and
- In extremis, if they believe that the Board is unable to effectively direct the Company to achieve its objectives, have the authority to call for a review of this remedy by the CMA within the five-year period envisaged at 2.469.

Additionally, we feel that it would be very helpful if the CMA-nominated Directors had authority, delegated by the CMA, to approve minor variations from the specific terms of Remedies 5 and 7 where they recognize that the intention of those Remedies can be fulfilled in a manner satisfactory to the Board but where a strict interpretation of the Remedies as framed could be detrimental or unnecessarily cumbersome or expensive.

Our suggestion is that the principal qualification for the CMA-nominated directors should be knowledge and experience of governance processes, ideally within membership organizations. They should be able to advise and guide the Chairman and the Board on these matters, in addition to holding the reserved authority described above.

### **Changes to PHIN's Membership**

Similar to the proposed Board changes, we welcome the suggestion that PHIN's membership should be expanded to comprise private hospitals, the PMIs active in the UK market and consultant representatives (2.471).

In practice, whereas it makes sense to us for all hospital operators and PMIs to become members and funders, we feel that it may be better for consultants to be represented at Board level as discussed above, but we are open to considering this further.

The representation of consultants in the membership would require an appointment process. Selection might involve, for example:

- Appointment of a consultant representative by each professional association specified for this purpose; or
- Election of consultant representatives by different constituencies, including specified professional associations.

We have a concern that either process could easily become bureaucratic and unwieldy. PHIN is not seeking to be another representative organization, and selection processes that mirror those of representative organizations may not be appropriate. As stated above, we welcome the idea of consultant representation on the Board, and are open to the idea of consultant representation in our membership, but feel that the Board must have freedom to discuss and select an appropriate approach over time rather than forcing a potentially inappropriate solution at the outset.

Again, our Articles will need to be amended appropriately to accommodate the changes in membership. We are taking advice on how we might balance the membership, for example using different classes of membership or voting

rights, to ensure that voting is balanced and reflective of the industry as a whole.

We would welcome further discussion with the CC on these matters.

### **Exemptions from mandatory participation in the information processes proposed in Remedy 5 for organizations with turnover <£5m per annum or clinics specializing in cosmetic surgery (CC's Note 226)**

It seems to PHIN that during the course of this investigation the Competition Commission has done an admirable job of considering issues of information availability from the patient's perspective. In that context, these exemptions seemed to us peculiar, as they seem to favour an organizational perspective over the needs of patients by focusing on certain categories of provider.

In our view, patients considering surgery deserve to have access to appropriate information to support their choices and understanding regardless of the nature of the particular provider that they may be considering. On this basis, an exemption for certain classes of provider makes little sense.

In terms of cosmetic surgery, we feel that a clarification is necessary: Note 226 refers to "clinics". PHIN uses the term "clinics" to refer to regulated facilities providing consultations but not surgical treatment. If the CC intends to exempt from the scope of Remedy 5 those regulated facilities and organizations that do not provide surgery, (which will include cosmetic specialists but also other clinics) then PHIN is content: we will focus on providers of surgical treatment, and offer some basis of inclusion for clinics that wish to participate on a voluntary basis.

However, PHIN feels strongly that there should not be an exemption for a facility or organization that provides surgery in a single specialty, cosmetic or otherwise, for the following reasons:

- As stated above, we believe that the protections and advantages of Remedies 5 and 7 should be available to all patients who pay for or are contemplating paying for their care, in whatever settings offer it.
- We are informed by ISCAS that a disproportionate number of patient complaints (c25%) arise from cosmetic surgery. If anything, this area needs more scrutiny than others.
- An exception is out of step with the recommendations of the

Department of Health's Review of the Regulation of Cosmetic Interventions (2013). This will seek greater information availability and transparency from cosmetic providers, with PHIN again positioned to provide those services. We are already in discussion with the MHRA and DH about providing HES-style data to support the creation and operation of a registry of breast implants as promised by the Secretary of State for Health: this relies on the assumption that record-level data will be available from all hospitals offering breast surgery.

- An exemption would create a competitive distortion: those hospitals which offer cosmetic surgery among other service lines will be required to report in accordance with Remedies 5 and 7, whilst their competitors potentially would not. This would create an asymmetric information flow, and an unfair disadvantage for some providers, as well meaning that the data available to patients is inconsistent and incomplete.
- At a recent meeting hosted by IHAS and the GMC, we identified a potentially helpful connection between these information remedies and the Revalidation and Appraisal processes. A particular area of clinical safety concern arises around doctors who maintain a UK license to practice but spend very little time in the UK, which is relatively common in cosmetic surgery. We believe that the CC's information remedies can and must apply equally to those doctors and the clinics in which they practice, for the greater protection of patients.

On the same basis of patient protection as described above, we have concerns about introducing a floor of £5m turnover for mandated participation. That said, our smallest Member by turnover is currently the Fairfield Independent Hospital, a charity with income of £10.5m in the year ended 31 December 2012, and we are not currently aware of any smaller organizations that might be suitable members. As such, this may be a largely academic concern.

### **Patient Reported Outcome (improvement) Measures for the Ten highest-volume or otherwise most relevant procedures.**

In response to the Competition Commission's Provisional Findings (August 2013), PHIN has initiated a project to define and establish a robust approach to reporting PROMs measures for private treatment.

We will address various considerations, including:

- The Competition Commission's newly stated requirement for PROMs covering the ten highest-volume or otherwise most relevant procedures

- The desire to establish and maintain direct comparability with PROMs reported for NHS patients, and the desire to operate single processes for data collection within those hospitals that treat both NHS and private patients
- The views of PMIs in respect of their own policyholders
- Accuracy and validity of information
- Clinical value and utility (primary use of PROMs to improve patient care within an episode, rather than secondary use to assess provider performance)
- Value for money: the cost that will inevitably be borne by patients (whether directly or through insurance premiums) must be justified by the value added

To that end, we will hold a workshop on 5<sup>th</sup> March 2014 at which a number of invited expert parties on PROMs, including service suppliers, will present their views and propose approaches to an audience of hospital and PMI representatives. We are happy to make related materials available to the CC.

The workshop will consider what subsequent steps are needed to establish a solution for PROMs, and PHIN will facilitate whatever design and implementation programme is required.

This is a unique and encouraging first step towards establishing a common approach to and shared standards for PROMs, and we hope that we will be able to repeat the same shared approach in other areas, for example clinical coding.

However, we would not want to short-cut that process, or commit our support to a specific number of PROMs or a specific approach (e.g. procedure-specific measures versus generic measures) until the industry has been through that process of needs assessment and solution specification.

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**Matt James**

Chief Executive

6 February 2014