

## Response to the Notice of Intention to vary the Private Healthcare Market Investigation Order 2014 and to bring Article 22 of the Order into force

### Fees for most frequently performed standard procedures

A requirement for consultants is to provide fees for standard procedures. By the nature of GOSH, consisting of the most clinically complex paediatric patients with numerous co-morbidities and related conditions, there are very few “standard” procedures. Taking one of our subspecialty services as an example, across all of our consultants and over the course of an entire year, we carried out 102 different operations privately, which consisted of 80 different procedures, of which the most frequent type of procedure occurred 3 times. The sheer level of different co-morbidities and related conditions that we treat in our patients means that a large number of our consultants cannot have “standard” fees, as almost no patients have the exact same condition. If a standard fee were to be the procedure with no complications or comorbidities, then it would also be a wasted exercise, as no patients seen at GOSH have no complications, and thus it would be a variation away from the standard fee every time (removing the transparency or comparability that the measure is intended to introduce). Linked to the issue of comparability, how will the guidelines be set around how to prepare this fee information against these procedures? In order to ensure procedures are priced in a way that allows for comparison, the same consultant could very plausibly have the same procedure listed at different prices at different places, based on one interpretation being as a “standard” procedure with no complications, and another by assuming the complications that would be likely from its patient cohort.

The APC dataset for PHIN as it stands already doesn’t adequately address the issue of complexity issue for GOSH as it is limited to 30 diagnoses codes and 20 procedure codes per episode, whereas some GOSH patients exceed these values (and therefore the true complexity is not able to be captured). This same issue would impact putting prices on procedures, as a patient with 30+ diagnoses codes or 20+ procedure codes is not going to be able to be priced as a “standard”. Even if “standard” fees were to be generated for these kinds of procedures, they would not be comparable with those from other providers, again thereby removing the purpose of providing them in the first place.

It is also not clear in this requirement as to whether the published fees are for the procedure itself, or for the procedure and any other fees associated with the ensuing care (e.g. inpatient daily fees payable to the consultant during the patient’s recovery on ward). If it is the latter, it becomes even more complex for the following reasons:

- a) The variability between our patients is significant, with expected lengths of stay differing considerably between patients for the same condition, therefore making a standard fee very difficult. There can be huge variation in this based upon information unavailable pre-treatment. For example a patient may recover after surgery and be discharged in a week, or may not and require further surgery, or be transferred to ICU, or may have their length of stay extended by months. We recognise that this is the case for all medical treatment; however the variability is greater when the patient dependency is greater. For example our gastroenterology service will take patients where the expected length of stay upon admission could vary by over a year, dependent upon how the patient reacts to treatment. There are also numerous occasions where the presenting condition isn’t the condition that ultimately needs to be treated. Taking an average based on clinical probability of different eventualities does not solve the issue as it would consistently be wrong for individual patients. Similarly, as treatments are so bespoke, there may not be the patient volumes to create reliable probability information to derive the expected fee.

- b) If the fees are associated with the entire episode of care, how would this reflect that numerous other consultants would be involved in certain treatments? In the last year we have had 459 patients that have seen over 20 different specialists (including those in consultant “groups”); 168 patients that have seen more than 30; 57 patients who’ve seen more than 40; 13 patients that have been treated by over 50; and 4 patients that have seen more than 60 specialists. Therefore the fees of the lead consultant are misleading (being only a part of the total fees payable to consultants), and there is simply no way that other consultants involved in potential care could submit fees to PHIN based on every different clinical possibility for patients under innumerable combinations of diagnoses under the care of different consultants. Therefore for complex work involving numerous consultants (which forms the majority of GOSH’s inpatient workload), the fees published will either be misleading and incorrect (if just putting lead consultant fees down), or impossible to gather in an informative way (if including all fees for all consultants). Just to labour the point, a fairly standard patient pathway for us under certain specialties would involve an admitting clinician, transfer to one or more surgeons, an anaesthetist, a spell in ICU under the care of numerous consultants, interventional radiology, a consultation with a clinical geneticist, before transfer back to the admitting consultant, with any number of other consultations with other consultants potentially following if there are complications. How would this be “priced” against each individual consultant, and coming onto a point we make later in our response, how many of these individuals would need to send the patient/parent a letter advising of their fees and the insurers that they are registered with?

#### Provision of fee information for non-admitting and “non-consulting” consultants

By “non-consulting” consultants, we refer to those who would not see a patient in an outpatient attendance, and who would also not be the lead consultant for a patient’s care, but would nevertheless be involved in their care and would charge a fee. For example an intensive care consultant, an anaesthetist, or a radiologist. Do these consultants have to submit fee information to PHIN, even though no patient/parent will “choose” these consultants, as they are a by-product of the care received from the lead consultant? In addition intensive care consultants and radiologists work on rotation at GOSH; therefore it would not be planned for a patient to see a specific one in any case. How would this work in terms of submitting fee information (and indeed in terms of potentially producing letters for patients/parents as we come onto later in the response). In addition, fees for intensivists and radiologists are paid in the background of hospital fees, as is the industry standard (i.e. an intensivist receives a portion of the charge for an ICU bed day, rather than a separate fee plus the ICU bed day). Does this alter what is provided to PHIN for publication?

Anaesthetist procedure fees are typically but not always linked as a percentage of the surgeon fee. This is done in order to reflect that the expertise and support that anaesthetists provide are correlated to the complexity of the procedure. Therefore anaesthetists will be unable to list a standard fee, firstly because they will struggle to generate an estimate in the same way as a surgeon (and not only that, but their potential procedure list would run across numerous sub-specialties rather than just one, inflating their list of potential prices dramatically), and secondly because their fee will be dependent upon the surgeon, whose fees and methods of working may differ from other surgeons doing a comparable operation. Can anaesthetist fees be listed as a percentage, rather than as a fee, but with the necessary exclusions on those small number of procedures where they do carry out set fees (e.g. an MRI under anaesthetic)?

## Provision of information to patients/parents not responsible for financial payments

The list of information to be included in letters prior to consultations includes:

- i) The estimated cost of the consultation;
- ii) Details of the financial interests the consultant may have in any facilities or equipment used at GOSH;
- iii) A list of insurers that recognise the consultant;
- iv) A statement reminding insured patients to check with their insurers whether the policy will provide cover;
- v) The website address of PHIN, together with a statement indicating that it will provide information on the performance of hospitals and consultants.

Whilst we completely accept the logic behind this for self-pay patients/parents, GOSH attracts significant numbers of referrals that are sponsored on government schemes or other mechanisms which mean that they have neither need nor interest in seeing price or insurance-related information. In much the same way as an average NHS patient/parents not caring about the “cost” of their upcoming appointment on the NHS, these private patients / parents will not require the above information (with the possible exception of point [v]) as it is not relevant at all to their treatment, as the patient/parent is not paying, and they are not associated with any insurance company. This is even more so when dealing with patients on internationally sponsored schemes. Since for all government sponsored patients, the decision making “client” is not the patient/parent but the sponsor (e.g. an embassy), it would presumably make more sense that the requested correspondence (excluding the insurance information sections) should be sent to the sponsor, allowing them to make the price comparison etc. on the PHIN website, rather than the patient/parent, for whom the information is irrelevant as they are not deciding anyway. That way the cost estimates and other information is provided to the financially responsible agent.

## Quantity of letters being provided – adverse impact on care and experience

The private patient cohort at Great Ormond Street consists of most clinically complex paediatric patients in the country if not internationally, with numerous co-morbidities and related conditions. As such a number (if not the majority) of our patients will be seen by numerous consultants. This can often run into being seen in an outpatient setting by 10+ consultants, which would end up with significant numbers of letters with more letters when follow up care is involved.

However our main area of concern relates to the letters relating to further treatment. If the patient is booked in for inpatient care, do any consultants involved in that patient’s care (and hence receiving a fee) need to send a letter or is it just the lead consultant? We would strongly suggest that it must be the lead consultant only, with additional letters only when the lead consultant changes, or when the treatment pathway is changed. If it were instead to be all consultants involved in the patients care, the number of consultants involved can be extremely large. As mentioned, in the last year we have had 459 patients that have seen over 20 different specialists; 168 patients that have seen more than 30; 57 patients who’ve seen more than 40; 13 patients that have been treated by over 50; and 4 patients that have seen more than 60 specialists. It is not practical for patients to be receiving that quantity of letters regarding their tests and treatments, and would in fact massively detract from the patient experience. If these subsequent letters also apply to when there is a change in treatment plan or length of stay (and hence the treatment pathway changes), then the patient/parent could end up receiving 30+ letters every few days. This is not only poor for patient experience, but could also be extremely distressing (e.g. parents of a child on ICU receiving relentless information about consultant fees as their child clinically deteriorates). For consultants such as our radiologists and intensivists,

we have consultant “groups”; therefore there would be no way to inform in advance which consultant would be carrying out the care. Similarly our consultant anaesthetists are not pre-booked in advance (when surgeon is recommending further care) and therefore will not know until later who will be responsible on the day.

In addition, the requirement for parents to sign to acknowledge receipt of every letter would prove another burdensome task for patients who are with us for significant periods of time. This also links in with my earlier point about this whole process being unnecessary for government-sponsored patients/parents. Therefore our recommendation is that the lead consultant takes responsibility for being the sole point of contact. This would avoid any issues around which consultants are required to send letters.

With regards in particular to our international patients, it is also not practical (or helpful for the family) to send this correspondence directly to them since they will not be at their home address (as they are instead in London). Sending this information to be care of the sponsor will also cause a vast number of letters to be sent to the sponsor, for whom this information is also not relevant. It is not relevant to them as they already know our estimated cost, which we would have provided to them separately with a breakdown of the anticipated consultant fees, and the insurance information is not applicable. Our current process seems to satisfy the requirements of informing the sponsoring organisation and therefore we propose it as a solution: specifically providing the expected consultant fees (for all consultants) in advance of treatment based on the patient’s medical report, and then requesting approval for each stage of treatment.

#### Duty on providers to ensure compliance of consultants

It is the duty of providers to ask private patients / parents to sign a form confirming that the consultant provided them with the relevant information. If the consultant does not provide the information, there are clearly measures that can be taken internally to address the issue with the consultant; however what is the consequence for the patient if the consultant has not provided the information? Are they then not allowed to go ahead with their planned appointment / procedure? What happens if the appointment / procedure is clinically urgent or necessary? In fact given the short lead times in cases of clinical urgency, it is often the case (particularly with known “repeat” patients) that they will come in at short notice, allowing no time to provide the requested information.

#### Timeframes

The three key proposed timeframes are:

- June 2017 for the outpatient consultation fees
- June 2018 for the procedure fees
- Two months from the date of the instrument for the consultant information being provided to patients / parents (so roughly February/March 2017)

We believe these timeframes are too short for effective implementation, especially given the number of issues raised in our response. In particular the “two months from instrument” deadline seems extremely short notice for such a major and disruptive change into our method of working (particularly if it is implemented in its current fashion), regardless of the fact that the original Order came out some time ago. We suggest this be delayed to December 2017 at the earliest.

### Joint appointments

Could you provide some clarity on the guidance for when an appointment is conducted jointly by two different consultants? Both in terms of fee provision and the responsibility to provide patients/parents with information.

### Paediatric patients

One final point relates to the use of the term “private patient” throughout the Order and variation. A lot of the measures are put in place on the basis that the private patient will receive, understand and sign off the information. We’re not sure whether this is clarified in the body of the main Order, but clearly it is not relevant for us to be aiming these measures at the patient, as it is their informed parent or guardian who will be making decisions at our hospital.

### Recommendations

Our recommendations are:

- 1) Timelines for implementation to be pushed back;
- 2) Where patients are sponsored and have no financial exposure, the requested information to instead be sent to the sponsors responsible for payment, rather than patients/parents for whom the information is irrelevant. When issuing information to these sponsors, insurance information to be excluded if not relevant;
- 3) Information provision to patients/parents to be responsibility of the lead consultant only, with further letters sent only when the lead consultant changes or the treatment plan alters;
- 4) For complex work, or work involving multiple consultants – the introduction of clear and enforceable guidelines regarding the process relating to capturing complexity, and ensuring transparency and comparability of procedure fees, addressing the concerns raised above;
- 5) Clarity over, and a plan to resolve, all other issues raised within this response.