

## **NUFFIELD HEALTH - Response to intention to vary order**

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

We write in response to the Notice, published to the CMA website on 9<sup>th</sup> October 2016 and which invited responses to its contents by Thursday 10<sup>th</sup> November 2016.

We are broadly satisfied with the suggested dates in relation to the supply and publication of procedure fees for consultants, which the CMA proposes are moved back to June and September 2018 respectively.

With regard to the implementation of standard letter communications (prior to initial consultation and again prior to any further tests or treatment), audit processes to verify compliance with this requirement and publication of outpatient consultation fees, we are concerned that the proposed 2 month timescale does not afford providers sufficient time for the necessary steps to facilitate orderly and effective compliance (which we would presume is desirable on all sides).

Whilst it is true that the industry have known about Article 22 since the publication of the final Order, the appeal raised by FIPO clearly had the result of placing this requirement in stasis pending the appeal's outcome. Accordingly, and as a natural consequence of the appeal, interim investment in, for instance, the necessary supporting IT infrastructure to deliver new standard correspondence has been paused pending resolution of the appeal and clarity as to the remedial action that would be required by the article.

Although the concept of creating a template letter is a relatively simple one, the practical application is complex and requires both internal and external liaison with multiple providers and consultants. In addition, we will need to agree the core script to be used across the industry to avoid consultants who practise at the facilities of different private hospital operators from having variations between the communications their medical secretaries are using (and the patient is receiving). This will be further complicated by the differing terms and conditions of service delivery and also providers' differing pricing strategies, e.g. fixed prices versus guide prices.

Where letters are generated by the hospital (rather than an external medical secretary), these are raised via our patient administration system, with letter templates. Many variants of template exist. Some for example include text regarding preparations (e.g. nil by mouth) prior to treatment, local patient access information and consultant specific content. These will all need to be updated in the IT architecture of the patient administration system across each of our hospitals. With a view to the clearest and most accessible communication possible for patients, it is our aim to reduce the number of communications and forms which patients receive so these are provided in a single, consolidated letter.

Additionally, forms/letters are often made available in a multitude of formats to ensure that patients have access to their information in a format that suits their need, e.g. large font, braille etc. This is a statutory requirement of our CQC registration and a short lead time could leave us (and, we would expect, other providers) exposed to an inability to comply with these needs, to the clear detriment of the patients affected.

In order to achieve successful operational implementation of Article 22, there will need to be a training programme rolled out to deliver the new requirement for patients to sign a form to confirm they have received this information, which will need to take into account both local variations in how the patient moves through the hospital and also the different settings in which tests or treatments are delivered. Consideration will also need to be given to how compliance can be assured in the situation where a patient has their outpatient appointment, tests and/or treatment across multiple sites. It is not uncommon for a consultation to happen either at another provider site or at a consultant's own clinic rooms.

During the latter part of 2016 and early 2017 time and resource will already be engaged on successful delivery of Article 21 of the Order, ensuring that each and every consultant is given secure access to the PHIN portal to check and approve their activity data prior to its publication by PHIN in April 2017. We would request that these two objectives not be required to be delivered concurrently, but in series.

We remain fully supportive of transparency and patient information , including within the PHIN members' forum. We would suggest that a minimum of 6 months would be a more realistic lead time to deliver the compliance requirements– and, crucially for patients more than anyone, to deliver them well.