Roadmap and delivery plan 2022-2026

for the Private Healthcare Market Investigation Order 2014

PHIN

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1 DOCUMENT OVERVIEW

This document sets out how Part Four of the Private Healthcare Market Investigation Order 2014 (as amended) (the "Order") will be delivered by the June 2026 deadline set by the Competition & Markets Authority (CMA).

The Order was the result of an investigation by the CMA into private healthcare[1] in the UK. During the investigation, the CMA found that there was a lack of information available to patients considering private treatment, and that this was sufficiently serious as to create an adverse effect on competition (AEC). Part Four of the Order sets out the information remedies to address this AEC.

Following consultation and engagement with the sector, supported by the PHIN/IHPN Partnership Forum and representatives from providers, consultants and the healthcare insurance industry, the plan on the following pages outlines how the information remedies will be delivered in that timeframe.

[1] https://www.gov.uk/cma-cases/private-healthcare-market-investigation

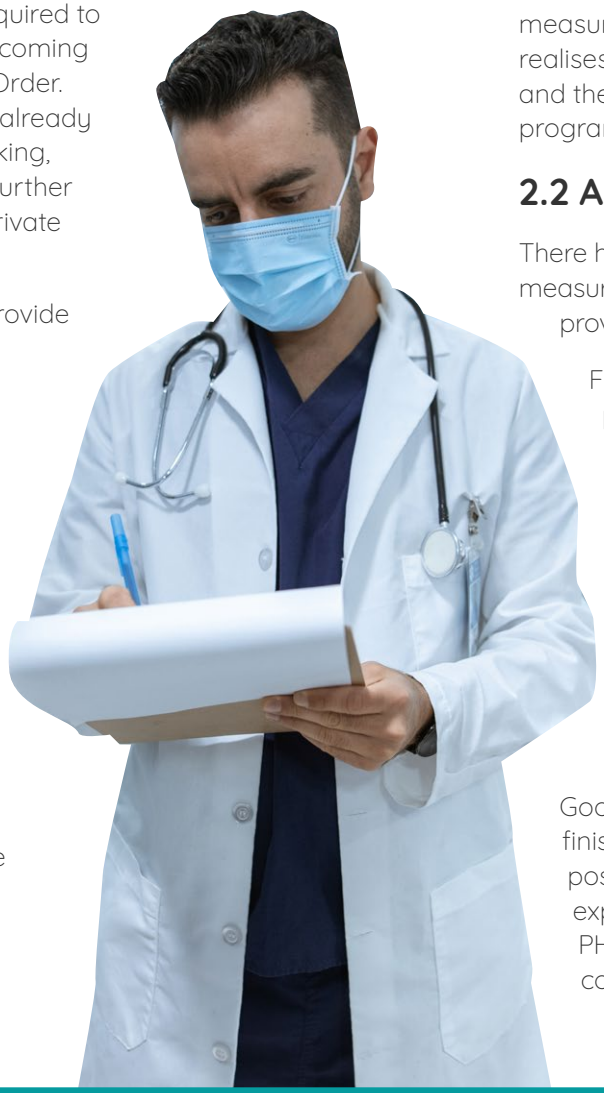
2 EXECUTIVE SUMMARY

The Order has now been in place for several years, but full delivery has not yet been achieved. Whilst significant progress has been made across the sector, there is still more to do to ensure patients considering private healthcare have helpful and transparent information to make informed choices about their care.

All healthcare providers and consultants required to participate need to work together over the coming four years to achieve compliance with the Order. Patients are using the information that has already been published to inform their decision making, and the completion of the Order will bring further transparency on the quality and value of private healthcare services in the UK.

There is a clearly a collective ambition to provide better information to patients. Healthcare providers and other stakeholders are also keen to use the information to drive improvement, and to provide evidence of the quality of care being delivered. Since the CMA tasked healthcare providers, consultants and the Private Healthcare Information Network (PHIN) to deliver a roadmap to compliance by June 2026, there has been a renewed sense of urgency and focus.

The Roadmap and Delivery Plan (the "Plan") outlined on the following pages provides the starting point for harnessing this renewed energy and focus. Whilst there remain several unknowns and complexities to overcome, it is only through cross-sector cooperation and discussion that this will be achieved.



2.1 Overview of the Plan

The core obligations of the Order's Information Remedies are on the private healthcare providers and consultants to provide the required information and data to PHIN so that it can produce and publish the specified performance measures (Article 21) and information on fees (Article 22). However, the sector realises that to achieve this, several enabling programmes need to be in place and the overall pace of delivery needs to increase. Those critical enabling programmes have also been included in this Plan.

2.2 Article 21 measures

There has already been significant progress with the publication of Article 21 measures, with nearly all of the measures already published at private healthcare provider level. For more details on progress to date see Appendix 1.

For the remaining measures there is a shared understanding that the pace of delivery needs to increase. PHIN will continue to work with stakeholders and relevant experts to establish what can meaningfully be published at hospital and consultant level. A series of 'task and finish' groups has been established to tackle some of the more complex questions that still need to be answered in relation to Article 21. PHIN will report recommendations from these groups back to the sector and the CMA over the coming months.

These issues are explored in more detail in the Principles for Publication section and Appendix 2, where the overall approach to resolving them is set out, and how this will apply to each of the measures.

Good progress has already been made solving these issues. The task and finish groups have identified where case-mix adjustment is appropriate and possible for all Article 21 measures. In addition, we have recommended expanding our approach to providing external links to NJR data from the PHIN website to a series of other registries which either report data at consultant level, or for independent hospitals.

2.2.1 Private healthcare provider level publication

PHIN has already published many of the less complex Article 21 measures on the website. The next stage of delivery at hospital level is to enhance several existing measures and to deliver the more complex outstanding measures. This will initially focus on mortality and readmissions measures, which depend on linkage between the private Admitted Patient Care (APC) dataset submitted to PHIN and datasets held by the NHS and Office of National Statistics (ONS). In parallel, PHIN is working to incorporate case-mix adjustment into relevant measures to ensure published information is meaningful and representative of complexity and acuity.

The intention is for these to all be published by early in 2025. However, there will be challenges to overcome over that period, primarily data quality and data completeness, which will be key to the development and publishing of any linked measures and case-mix adjusted measures.

2.2.2 Consultant-level publication

Currently consultants' volume, length of stay and patient feedback, along with registry participation for the NJR is published on PHIN's website. There is still work to be done to fully identify what is both appropriate and possible to publish for the remaining measures.

PHIN, consultants, and their representative bodies, as well as other sector stakeholders will review the remaining measures and confirm which can be published in a way that is understandable and helpful to patients, whilst also being fair and representative of a consultant's practice. For instance, not all Article 21 measures are appropriate to publish at individual consultant level. Never Events, for example, relate to system-wide processes and are more appropriately reported at the hospital level.

In addition, even where it may be potentially appropriate to publish a metric at consultant level, the numbers may be so small that statistical constraints may mean that no meaningful comparison can be made. Engagement in this area will continue, including how the information that can be published is best provided to patients.

2.3 Article 22 fees

Much progress has already been made publishing consultant fees and PHIN will continue to improve the process for consultants to submit consultation and procedure fees via the PHIN Portal.

PHIN expects to reach an agreed solution for collecting and publishing anaesthetic fees by the end of 2024. It will take a further year before anaesthetic fees have been collected at scale and can be published alongside surgeons' fees on the website. PHIN will also amend its Portal fee submission process to enable consultants who only offer outpatient services to input their consultation fees.

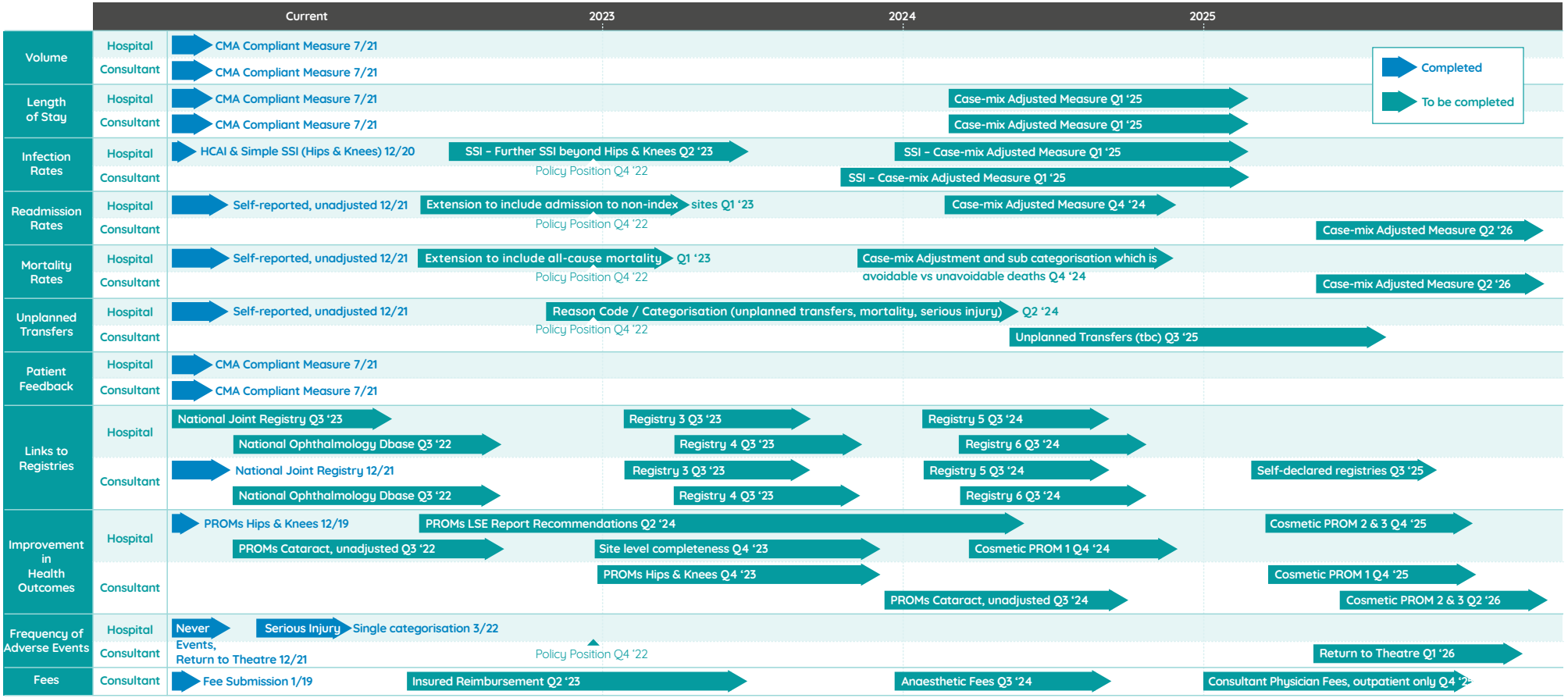
Stakeholders in the sector recognise that publishing consultant fees provides only a partial understanding of the cost of private treatment. Providing patients with comparable hospital self-pay package prices, whilst not within the Order, will be of huge benefit to patients. There are proposals to reconsider this with the sector once the obligations in Article 21 and 22 of the CMA Order are delivered but not before then.

A detailed breakdown of delivery on Article 22 fees is provided in Appendix 3.

2.3.1 Overview of Article 21 and Articles 22 delivery roadmap

The plan outlined below shows both the progress made to-date, as well as the key delivery milestones for Article 21 measures and Article 22 fees up until 2026. A more detailed breakdown of the programme can be found in Appendix 5.

Summary of measures publication for hospitals and consultants by 2026



2.4 Key enabling projects

In Order to meet the June 2026 delivery deadline, there are also a several critical programmes needed to support the collective endeavour ahead.

2.4.1 Data quality

Firstly, there needs to be a step-change in the level of participation and compliance. Whilst progress has been made, the sector overall is still a long way off full compliance, with a 'long-tail' of healthcare providers and consultants who are yet to meet their obligations. PHIN will support the data submission process and make it as easy as it can for consultants to submit fee information, but the obligations are on the healthcare providers and consultants to participate and be compliant with the Order. This will be a key dependency on the ability to publish comprehensive information across the sector.

For PHIN to publish understandable and helpful information to patients, the completeness and accuracy of the underlying data quality also needs to improve, even though it is understood that this will take time. High quality data is essential to publish case-mix adjusted measures and accurately represent consultants' practice. This will be something PHIN, private hospital providers and consultants will need to work on over the period of the Plan.

2.4.2 Consultant engagement

The most common complaint from patients using the PHIN website is incomplete or missing information about consultants. Feedback from consultants suggests that their lack of confidence in the quality of data is a key barrier to greater engagement with PHIN. Whilst there is no single solution to this problem, PHIN will do its part to support healthcare providers to get the data right. However, consultants need to engage in the process and work with private healthcare providers to make sure their data is accurate.

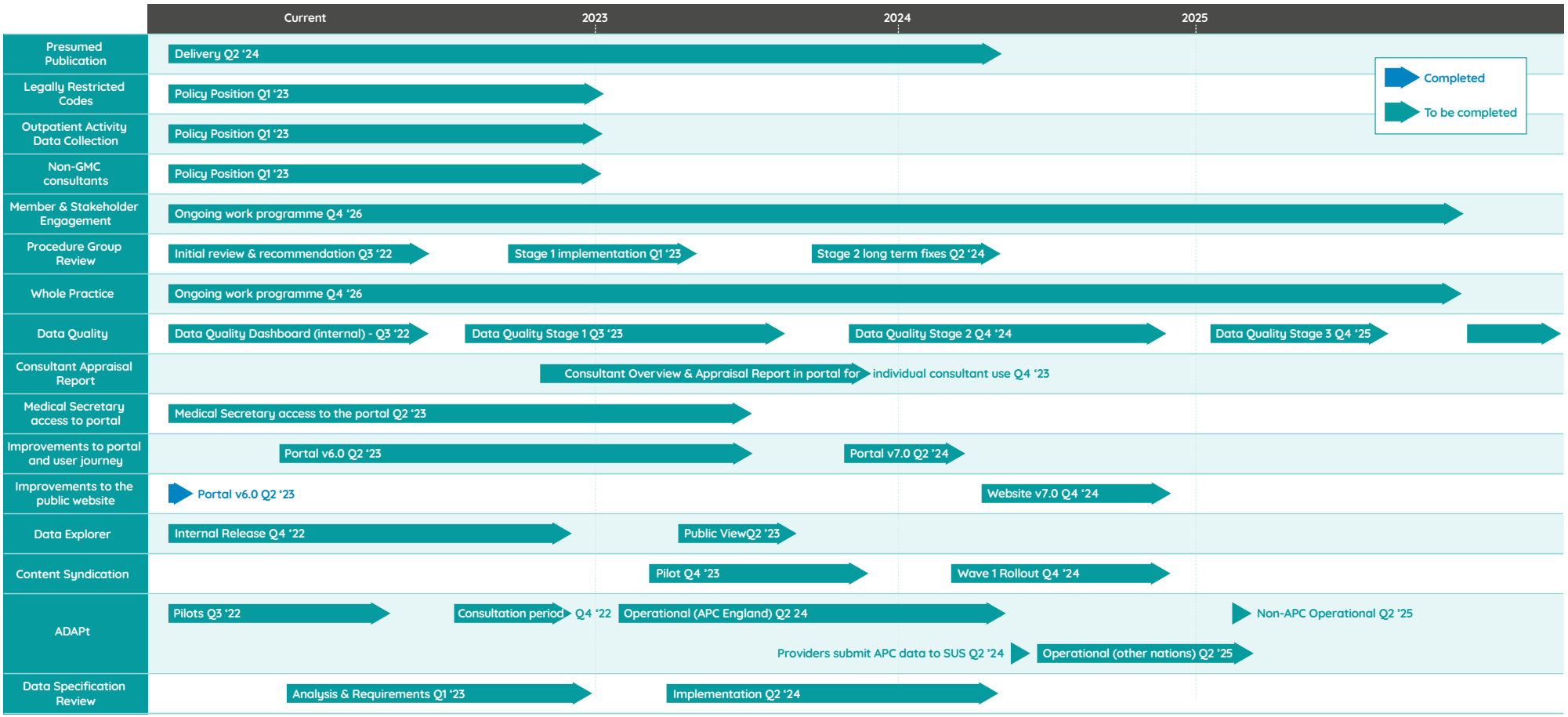
For consultant level publication of basic activity measures (volume and length of stay), PHIN is planning to move to a 'presumed publication' model for the information it receives, but only after working with consultants' representative bodies and private healthcare providers to ensure that the right processes are in place to correct and improve the private activity data submitted. The resulting ability to publish activity at consultant level will lay the foundation for publication of more complex measures at consultant level. While consultants continue to report quality issues in the NHS funded activity data, PHIN will explore the option for consultants to self-declare their NHS funded activity for publication.

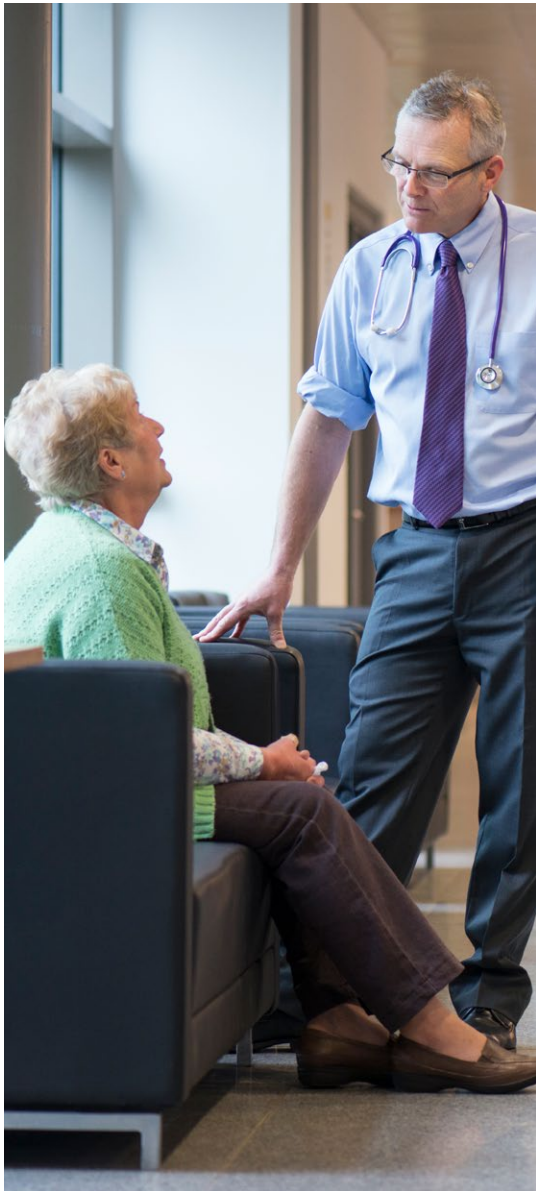
Lastly, the Plan will need close monitoring and reporting to show progress, identify risks and issues, as well as monitor the impact it is having. The CMA is committed to the delivery of this Order and have asked for regular progress reporting from the sector. PHIN has established the programme management principles and KPIs to support this, to be managed through the Partnership Forum, Implementation Forum, and enhanced relationship management.

2.4.3 Overview of the delivery roadmap for the key enabling projects

These programmes are explored in more detail in the Enablers section and Appendix 4, with the detailed delivery roadmap of the enablers also included in Appendix 5.

Summary of enablers by 2026





2.4.4 Patient engagement, communication and feedback

Whilst it is easy to get consumed in the mechanics of delivering the Order, the goal is to be publishing information that is helpful to patients and ensuring that patients can access the information when choosing their private care.

PHIN and the sector will continue to work with the CMA on how to best deliver the purposive intent of the Order and maximise the value of the information published for patients. This will include continuing to understand the best ways to represent and contextualise complex healthcare metrics for patients, supporting different patient journeys and providing information that helps inform the decision-making process.

2.4.5 Resourcing

To deliver the remainder of the Order in the timescale set by the CMA, the sector will need to increase the support and resource it contributes so that PHIN can increase the pace of publication. This will require continued, collective effort, from providers and consultants getting to full compliance and improving on data quality, through to PHIN providing high-quality support, as well as consulting, developing and publishing the information required by the Order.

Ongoing dialogue will be needed over the duration of the plan to identify what resources are needed where and when.

Further detail about resourcing implications is outlined in the Resourcing section.

2.5 What does this mean in practice?

2.5.1 What does this mean for private healthcare providers?

- Complete and accurate data will need to be submitted to PHIN consistently to support measures publication.
- Private healthcare providers should support and promote active participation across the sector.
- Private healthcare providers may be required to update the CMA on progress towards compliance – the Order applies to all providers of private healthcare in the UK.
- Private healthcare providers will need to actively support building relationships with consultants and their trust in the underlying data.
- Private healthcare providers can expect PHIN to develop targeted information to help them achieve compliance.
- In the later years of the Plan there will be discussion with private healthcare providers about collecting and publishing 'inclusive self-pay package' prices for common procedures. This will only be considered once the obligations in Article 21 and 22 of the CMA Order are delivered.

2.5.2 What does this mean for private healthcare consultants and their representative bodies?

- Consultants need to engage with the data submitted by private healthcare providers to PHIN and ensure it accurately describes their practice. Where there are errors in the data, consultants should report them to the relevant healthcare provider so that corrections can be made.
- Consultants who fail to engage must still comply with the CMA Order and, therefore, will be included in a 'presumed publication' model (see 5.2.2), which will be implemented after appropriate discussion and planning with consultant representative bodies and healthcare providers.
- Consultants should be aware of the limitations in the quality of the data PHIN receives about NHS funded care and the processes for making corrections to it.
- Consultants will need to provide fee information as required in Article 22. This includes self-pay consultation and procedure fees and insured patient fee arrangements.
- PHIN will give medical secretaries/administrators access to our Portal to ease administrative demands on busy consultants.
- Consultants can be confident that PHIN will only publish performance measures at consultant level where it is aligned with our publication principles, for example, where it is statistically possible and where the information is meaningful for patients.
- Consultants will receive the help and support they need from PHIN to achieve compliance with the Order.

2.5.3 What does this mean for PHIN?

- PHIN will make it as easy as possible for healthcare providers and consultants to meet their obligations – including continuous improvement of our data collection processes via our Portal.
- PHIN will work collaboratively with all stakeholders to ensure that data is of a high quality and published measures represent hospitals and consultants fairly.
- PHIN will engage patients in the design of the information to be published to ensure that it is understandable and genuinely supports patient choice.
- PHIN will monitor participation and data quality and report progress regularly to the CMA.

2.5.4 What does this mean for Private Medical Insurers (PMIs)?

- As funders, the PMIs represent a large proportion of patients using private healthcare and have a crucial role in positive engagement with hospitals and consultants that encourages participation.
- PMIs can bring a 'voice of the patient' perspective in the design of the information to be published to ensure that it is understandable and genuinely supports patient choice.
- PMIs must also promote PHIN and its information to customers at the relevant points in their treatment journey.

3 OVERVIEW OF DELIVERY ROADMAP, MEASURES PRODUCTION AND PHASING

This section outlines at a high level the roadmap to compliance and definition of complete for each measure, supported by the enabler projects that will be critical to making this happen. In addition, this chapter outlines the delivery and monitoring process to track progress, the principles to deliver publication and the questions that still need to be answered.

The key deliverables for the next four years are the development and publication of Article 21 measures and Article 22 fees. A great deal of collective progress has already been made across this complex set of activities. The Plan sets out the roadmap for complete delivery by June 2026, which is realistic but does not underestimate the scale and complexity of what remains to be done.

3.1 Delivery of Article 21 measures

- PHIN has published basic information across most of the Article 21 measures at hospital level (see 'current publication' in Appendix 1). The priority now is to complete the publication of these measures, for example by including case-mix adjustment where it is appropriate to do so, and by linking to NHS data and other sources, such as the Office of National Statistics (ONS) to provide more comprehensive information into outcomes following private procedures. PHIN will aim to provide different views of the information to enable patients to more easily find information that is relevant and understandable to them.
- At consultant level there is a greater challenge, as for several of the measures the CMA Order requires the publication of information about consultants' practice which has not been published previously in any sector. Progress has already been made at consultant level, with information published about volume, length of stay and patient feedback, as well as links to registries. This will be built on to publish information on the other measures where appropriate, as agreed following consultation, research and statistical analysis of the data.
- Publication at consultant level will be contingent upon the presumed publication programme, where accurate consultant activity volumes will need to be published before considering publication of further measures.
- In parallel with the above, PHIN will develop their online Portal to enable hospitals and consultants to see more information about their performance and the data reported to PHIN as part of the route to potential publication of the measures. This will improve the consistency and transparency of the sector.

3.1.1 Definition of complete for Article 21 measures

- The tables below illustrate the progress made to date for each of the Article 21 measures, the targeted definition of complete publication, as well as the planned delivery year in the Plan.
- The darker the shade of green indicates how 'complete' the publication of each measure currently is at hospital and consultant level. It is therefore intended that by 2026 all measures are 'complete' based on the definitions being developed concurrently.
- It should be noted from the tables that PHIN's research and consultation indicate that at least one Article 21 measure is unlikely to be publishable. There are no easy definitions of what should be included for revision surgery rates due to the inherent complexity of care and the need for long-term follow-up. For this and any other measure PHIN will consider how they may be able to produce useful information for patients by linking to external sources of information (for example, specialty-specific registries such as the NJR).
- Some measures are only relevant to hospitals, such as Never Events. PHIN will therefore not attribute these events to consultants on the public-facing website. However, consultants will be able to see the events associated with their practice in the Portal.
- Further detail on all the Article 21 measures is outlined in Appendix 2, with the detailed rationale for the vision of "complete delivery" for each.

Summary of measures publication for hospitals by 2026

	Hospital current	Hospital final	Notes	Delivery year
a – volume			CMA compliant measure currently published including private and NHS funded care. Website will be updated to show more detailed breakdown and comparison information.	Delivered
b – length of stay			CMA compliant measure currently published for private care. The measure will be refined to include case-mix adjustment and NHS funded care. Website will be updated to show more detailed breakdown and comparison information.	Delivered
c – infection rates			CMA compliant measure currently published including self-reported; unadjusted numbers. The measure will be enhanced with case-mix adjustment and include NHS funded care.	2023 and 2024
d – readmission rates			CMA compliant measure currently published including self-reported; unadjusted numbers. The measure will be enhanced with case-mix adjustment and include NHS funded care.	2023 and 2024
e – revision surgery rates			Looking unlikely to be publishable.	
f – mortality rates			CMA compliant measure currently published including self-reported; unadjusted numbers. The measure will be enhanced with case-mix adjustment and include NHS funded care.	2023 and 2024
g – unplanned transfers			CMA compliant measure currently published including self-reported; unadjusted numbers. The measure will be enhanced with case-mix adjustment and include NHS funded care.	2023 and 2025
h – patient feedback			CMA compliant measure currently published. The website will be updated with further helpful feedback and experience information for patients over time.	Delivered
i – links to registries and audits			CMA compliant measure published where the registry meets minimum criteria and a direct link can be given to hospital specific information for patients.	2022-2025
j – improvements in health outcomes			CMA compliant measure currently published for Hip and Knee operations. Further PROMs will be published for Cataracts, Breast enlargement...	2022-2025
k – frequency of adverse events	RTT, UPT, NE		CMA compliant measure currently published for privately funded care - self-reported hospital-level Never, Events, Returns to Theatre and Unplanned Transfers. Where appropriate, these measures will be refined to include case-mix adjustment.	2023

Summary of measures publication for consultants by 2026

	Consultant publication		Working definitions of complete	Delivery year
	current	final		
a – volume			CMA compliant measure published including private and NHS funded care (optional). Website will be updated to show more detailed breakdown and comparison information and processes improved to increase publication rate and to improve publication of NHS-funded activity.	Delivered (enhancements possible)
b – length of stay			CMA compliant measure published for private and NHS funded care where data available. Website will be updated to show more detailed breakdown and comparison information and processes improved to increase publication rate and to improve publication of NHS-funded activity.	Delivered (subject to case-mix 2025)
c – infection rates			CMA compliant measure published to show rates are within expected range or an outlier (including consideration of case-mix).	2025
d – readmission rates			CMA compliant measure published to show rates are within expected range or an outlier (including consideration of case-mix).	2025-2026
e – revision surgery rates			Looking unlikely to be publishable.	TBD
f – mortality rates			CMA compliant measure published to show rates are within expected range or an outlier (including consideration of case-mix). The measure will be enhanced to include distinguishing between avoidable vs unavoidable deaths and to use ONS mortality data to include 'all cause mortality' (if possible TBD).	2025-2026
g – unplanned transfers			Needs further discussion on whether this is relevant at consultant level.	TBD
h – patient feedback			CMA compliant measure currently published. The website will be updated with further helpful feedback and experience information for patients over time.	Delivered
i – links to registries and audits	NJR		CMA compliant measure currently published for NJR. Further links will be available where the registry meets minimum criteria and a direct link can be given to consultant specific information for patients.	2022-2025
j – improvements in health outcomes			Publication of PROMs at consultant level where clinically meaningful, in line with publication by NHS bodies e.g. registers and audits. Publication of participation rates where possible.	2023-2026
k – frequency of adverse events			CMA compliant measure published to show rates are within expected range or an outlier (including consideration of case-mix).	2025-2026

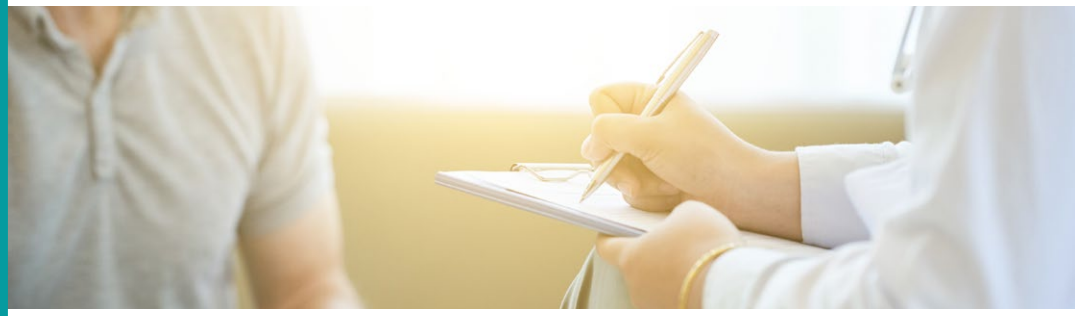
3.2 Delivery of Article 22 fees

- The collection and publication of insured fee arrangements for consultants will commence as planned in 2023. In addition, PHIN expects to reach an agreed solution for collecting and publishing anaesthetic fees by the end of year 2024. It will take a further year before anaesthetists' fees have been collected at scale and can be published alongside surgeons' fees on the patient website.
- PHIN will amend its fee submission process to enable consultants who offer outpatient services only to submit their consultation fees and identify how best to include them on the patient website. Engagement with medical consultants will commence during 2024 to collect fees and begin publishing the information on the website by the end of the same year.
- The CMA Order also specifies that consultants' practice fees terms and conditions should be made available and published for patients. This will need to build this into the fee initiatives over the course of the Plan.

Article 22 measures	Current publication	Final publication	Definition of complete	Delivery year
Consultants' self-pay consultation and procedure fees			Compliant fees published	Delivered
Consultant reimbursement arrangements with insurers			Compliant solution published	2023
Anaesthetic fees			Compliant fees collected and published	2024
Out-patient medical consultants – consultation fees			Compliant fees collected and published	2024

3.3 Key enabling projects

We have identified several essential crosscutting projects that are key enablers that will accelerate the delivery of the Order and address the barriers to publication we have faced. These are summarised below:



3.3.1 Engagement and participation

- **Private healthcare providers** – whilst participation to-date has been positive, there remain several healthcare providers who need to improve data submission and data quality to be compliant with the Order. The legal obligation is on the healthcare providers to be compliant, but PHIN will do its part to support providers and make the process as easy as reasonable.
- **Consultants** – the sector needs consultants to engage more in the process and to comply with their legal obligations including fees submission and measures publication. In addition, empty consultant profiles are the leading cause for complaint for patients and private healthcare providers visiting the PHIN website.
- **Private Medical Insurers** – insurers have an obligation to promote PHIN's website to patients at relevant parts of their journey under the CMA Order. However, they also have a crucial role in positive engagement with hospitals and consultants that encourages participation.

3.3.2 Data quality

- The accuracy and completeness of data being submitted is the key factor that determines whether meaningful information for each of the measures can be published. Although there has been an improvement in data quality over the past few years, this will need to improve further to enable more measures to be published in line with the requirements of the CMA Order.
- Where there is only partial information across the sector (for example, about adverse events or PROMs) it is not possible to make a qualitative judgement about the hospitals where information is available, as the data only provides a partial story. Incomplete data from sites will limit PHIN's ability to generate measures, for instance PHIN cannot link data to external sources such as mortality data, or because there is insufficient information required for case-mix adjustment.
- Consultant attribution in the submitted data will also need to improve to allow the consultants to trust what the data says about their practice.
- The Plan includes a programme of work to improve data quality, with PHIN working with stakeholders to identify and implement the specific improvements needed.

3.3.3 Other strategic enablers

- **A review of the way individually coded procedures are 'grouped'** – "Procedures" are the fundamental currency of all reporting across the Article 21 and 22 measures. PHIN will work with sector representatives and expert stakeholders to review the definitions, to ensure "procedure groups" are understandable by patients, as well as clinically meaningful for consultants and private healthcare providers.
- **Patient website ongoing development** – PHIN will work with all stakeholders to continually develop its website so that patients can easily find the information they need at multiple stages of their various treatment journeys through private healthcare.

- **Sharing published information (syndication)** – PHIN will explore syndicating published information so that it reaches patients even when they do not visit the PHIN website.
- **Improving the hospital and consultant portal** – PHIN will continue to use feedback from healthcare providers and consultants to enhance the Portal so that users can easily submit the data required and monitor their progress and compliance. For example, medical secretaries will be given access to the portal in 2023 to support consultants with fee submission and information publication. The Portal will also be enhanced to enable hospitals and consultants to view their own practice, to inform local quality improvement and safety initiatives, and to support consultant appraisal.
- **Government partnerships, including the ADAPt programme** – The ADAPt programme has wide-scale support from across the public and private sectors. Supporting implementation of the Paterson Report recommendations and other related NHS initiatives (including Getting It Right First Time (GIRFT) and National Consultant Information Programme (NCIP)) will help contribute to the delivery of the Order by providing added impetus for transparency and information for patients. PHIN is committed to the idea that good data should be collected once and used for many purposes and are seeking to reduce effort, duplication, and barriers across the system for all. However, it is also recognised that programmes need consistent support across the sector, appropriate resourcing and long-term planning as some hesitancy remains, therefore dialogue over the future strategy of these areas will be needed.

3.4 Delivery milestones, and monitoring (including KPIs)

3.4.1 Delivery milestones and completion of the CMA Order

- Hospital level measures will be published from 2022-2025, with the corresponding consultant measures to follow in a staggered approach from 2023-2026. Detailed delivery milestones are outlined in the Roadmap in Appendix 5 for Article 21 and Article 22 measures.
- In addition, a series on ongoing improvement programmes and key enablers will run in parallel until the end of the June 2026.
- To support this delivery, the key performance indicators (KPIs) outlined below have been developed to monitor the effectiveness and impact of delivery over the 2022-26 period. Once a baseline has been agreed, an end target and six-monthly milestones will be established to monitor delivery against.

Defining 'complete' delivery

- Appendix 2 provides a detailed breakdown of the pathway to complete publication at hospital and consultant level for each measure. 'Complete' will be defined as the ability to publish all possible measures, based on the provision of high quality, complete data to PHIN, to enable understandable and helpful information to be published in the public domain.
- While the CMA Order applies to all private healthcare providers and consultants in the UK, fulfilling an expectation of complete participation for 100% of healthcare providers and consultants, for all procedures, may not be realistic given the levels of continuous change in the sector. The CMA has stated its intention to monitor progress and take steps to enforce compliance where necessary.
- Work will be done to ensure that definitions for data submission are clear, understood and validated.

- PHIN will strive to increase participation rates of all private healthcare providers (which will support consultant compliance, as they gain trust in the data) and on consultants for fees information. PHIN will also continue to monitor and report progress to stakeholders and the CMA.

3.4.2 Progress monitoring

- This Plan will be put to a member vote at the PHIN member meeting in July 2022. Subject to approval, progress will be monitored via several regular forums:
  - Initial monthly reporting to the CMA, followed by quarterly progress reporting to the Partnership Forum and CMA once the programme is underway.
  - Alternate month executive reporting to PHIN's Board.
  - Monthly Implementation Forums with healthcare providers, consultant representative groups and insurers on practical development of measures and publication and website enhancement.
  - Task and Finish Groups as necessary to tackle specific technical or clinical challenges.
  - Involvement of other stakeholders, including CQC and BMA in ongoing implementation and development.

3.4.3 Change management processes

- The Plan has been developed in collaboration with healthcare providers, consultant representative bodies, private medical insurers and other stakeholders, but inevitably with a complex four-year roadmap and several current unknowns, the delivery and phasing may be subject to change.
- Given the sector-wide effort required to deliver the Plan, material changes will need to be consulted on and communicated. If any changes are identified, PHIN will inform the CMA at an early stage of the process.
- A combination of the groups already in existence will support any change processes and be involved in any consultation that is needed, notably the Partnership Forum and the Implementation Forum, complemented by any specific Task and Finish Groups, as needed.
- Significant changes will be reported, discussed and approved by PHIN's Board and the CMA.
- Depending on the impact of the change, PHIN and sector representatives will work with the CMA to revise the plan and rephase delivery.

3.4.4 KPIs

- The table below outlines some examples of the KPIs that will be used to monitor the progress being made in delivering the Plan, tracking the effectiveness of the enabler projects and PHIN's customer services, as well as the impact that is being made on the Portal, and patients using the website.
- These KPIs will be developed and monitored by PHIN and will be factored into the monitoring of progress outlined in section 3.4.2. Additional KPIs will also be considered over the course of the Plan.

Theme	KPIs
Critical enablers	Quality of data submitted to PHIN (Numbers of private providers submitting complete and accurate data to PHIN, % errors reported in the data)
	Evaluation of the process of submitting data and participation (% maturity for publishing measures):
	• Top 5 provider groups
	• Other independent private healthcare providers
	• NHS providers of private healthcare
	Consultant Data Subject Access Requests following contact
	ADAPt and other NHS enabler progress
Delivery	Measures published overall
	Hospital measures published
	Consultant measures published
Participation	Hospital engagement
	Hospital participation (% episodes)
	Hospital participation (number of private healthcare providers)
	Consultant engagement
	Self-pay consultant fees published
	Insured pricing arrangements published
	Anaesthetic prices published
	Secretary delegated users
Impact	Public website users
	Syndicated content usage (views)
	Datasheet downloads
	Patients contacting providers/consultants
	Positive user survey satisfaction and feedback
	Consultant satisfaction score in surveys
	Hospital satisfaction score in surveys

4 PRINCIPLES OF THE DELIVERY ROADMAP AND PHASING

PHIN, private healthcare providers and consultants will follow several principles towards delivery of the Order and the publication of measures. These are grouped into four broad areas:

- Patient focus and benefit.
- Principles of the process and phasing.
- Principles for consultant-level publication.
- Approach to national (and hospital-level) publication.

4.1 Patient focus and benefit

- **Consultation** – PHIN shall seek the views of patients and industry stakeholders (such as private healthcare providers, consultants and PMIs) to design and refine all specified metrics as part of the development process.
- **Information must be understandable to patients** – Measures as outlined in Article 21 of the Order will be based on agreed-upon industry best practice and UK clinical standards, but understandable and helpful to patients, to inform their decisions about private healthcare. This means they should:

1. Be presented in a patient-friendly way.
2. Include contextual information to provide guidance on how to interpret the measure if it is not commonly understood or familiar to patients.
3. Where statistical differentiation between private healthcare providers or consultants is not possible, the metric should provide 'reassurance' for patients, for example by adopting a 'green tick' approach to indicate simply and effectively that the quality of care is within accepted limits as far as can be determined from the data received.
4. Where analysis of data identifies potential outliers, PHIN will consider carefully how to present this information, with the appropriate caveats and explanations. PHIN will, in parallel, develop an outlier process with the sector to flag any such scenarios.
5. While publication for patients will include a simplified presentation to aid understanding, PHIN will also publish the supporting analyses and data (where possible, within Information Governance constraints) to ensure transparency. PHIN will also provide detailed, industry standard data and calculations for consultants and private healthcare providers to support quality and safety improvement initiatives, as well as consultant appraisal.

4.2 Principles for the publication process and phasing

- **Phased approach** – PHIN, private healthcare providers and consultants will take a pragmatic, phased approach to the development and publication of the measures required under the CMA Order. We will continue to address the simpler measures first, those reliant largely on self-reporting by the providers, before moving on to the more complex measures which may require third party data linkage and/or case-mix.
- **Interim measures to be considered** – Where it is possible and helpful to patients, or, whilst data quality and participation rates improve to support full publication, interim measures will be considered. These include publication of participation rates to highlight those complying with the Order and submitting data to PHIN, and the quality of the data submitted, such as PROMs participation. Information will also be published at procedure level so that patients have and understanding of what to expect for a procedure nationally, by region or by measure.
- **Linked measures** – PHIN, private healthcare providers and consultants will, where possible, aim to publish the more comprehensive and complicated measures, such as readmissions, returns to theatre or mortalities where the information submitted by the hospital is linked across all healthcare settings via national datasets.
- **Case-mix** – PHIN aims to incorporate appropriate case-mix and risk-adjustment across measures where relevant and possible. PHIN will also enable filtering/sub-categorisation of the data presented (where it is statistically meaningful to do so) to enable patients to have a view of the measures that is more tailored for them.
- **Hospital publication first** – For most measures, information will be published at hospital level first, both as there are more existing methods for these than for consultant level publication, but also because it is statistically more straightforward to generate meaningful measures with the larger volumes of data that are available at hospital level. Once principles and methodologies have been established at hospital level, PHIN will explore the ability of publishing at consultant level. This will be done in consultation with the aim of aligning with accepted standards across the whole healthcare sector.
- **Alternative options** – Where no metric can be developed according to a credible and accepted UK clinical standard, and a bespoke method would either be unlikely to help patient choice or would take an unreasonable amount of effort to develop, it will not be published subject to the change management process outlined above. In this scenario alternatives will be considered.

4.3 Consultant level publication

- **Limiting factors** – methods - Many measures remain to be published at consultant level. It is imperative that the method for calculation of all new measures is fair, appropriate and based on an existing, or emerging, UK clinical standard methodology.
- **Limiting factors – volumes** – One major constraint on the publication of meaningful comparative information at consultant level is that many consultants only perform small numbers of private procedures. This means that PHIN may be unable to publish information about their practice due to Data Protection law. Furthermore, the information that is published needs to be clinically meaningful to ensure clinically different procedures are delineated. This may mean there is not enough data to produce statistically robust measures about these procedures.
- The following two criteria will be used to assess whether a measure can be published at consultant level:

  1. **Method** - Whether there is already an existing, or emerging, UK-relevant method to evaluate consultant performance.
  2. **Volumes** - If it is statistically possible to derive a performance metric, and the impact on the number of consultants for whom information can be published, considering the Information Governance standards that apply.

- **Consultation and engagement** – PHIN will continue to engage with specialty associations, consultant representative bodies and the Royal Colleges so that a full range of perspectives are heard. PHIN will only publish measures with the broad support of stakeholders and where a fair and appropriate method exists or can be developed. Several 'task and finish' groups have been established to help define what is feasible for each of the measures. Where it is not possible to publish a measure, evidence will be gathered and presented to the CMA for why this is the case.
- **Private patient focus first** – Initially, PHIN will concentrate on publication of information about private patient activity.
- **Whole-practice is important but is complex** – PHIN and stakeholders in the sector recognise the importance of being able to publish consultant activity volumes on a whole-practice basis.

This will remain a key component of the measure sign-off/ presumed publication process, whilst acknowledging that data quality issues need to be considered and mitigated where possible. PHIN will develop tools within the Portal to allow consultants to exclude erroneous data and explore the ability to self-declare their NHS activity volumes as an interim step, as PHIN continues to explore the utility of using Hospital Episode Statistics (HES) data to determine consultant-level activity in the NHS.

4.4 National and hospital-level publication

- **National private patient focus first** – Subject to sites sending information, the goal is for patients across the UK to have access to a uniform range of information to help inform their choice of private healthcare. PHIN will publish nationally aggregated information about individual procedures, including the ability to filter the information (by measure, age, gender, geography, etc.) and see trends over time.
- **Complex measures for Scotland, Wales and Northern Ireland (NI) will take longer** – Some of the measures (such as mortality and readmissions) require the linkage of the "index" private procedure to later events that may occur in the NHS. Information about these events is not accessible in a single place or via a unified process as it is distributed across the NHS. This is further complicated by the fact that there are different NHS reporting structures across the devolved nations, meaning that nation-specific approaches will be needed. Given the relative size of the English private healthcare market compared to the rest of the UK, the sector will therefore prioritise the work on these "linked" measures in England. Later, PHIN will increase engagement with key stakeholders in Scotland, Wales and Northern Ireland and support patients in those countries with these more complex measures.

5 STAKEHOLDER ENGAGEMENT AND PARTICIPATION

5.1 Hospital engagement and participation

Key areas of participation and engagement going forward include:

- Submission of data to the required specification and level of data quality to enable publishing of hospital and consultant level measures.
- Increased data management resources to improve data quality and support for data queries.

5.1.1 Enhanced relationship management

- The requirements specified in the Order under Article 21 fall on private healthcare providers, including submitting accurate and complete data. However, over the next four years, PHIN will support improvements in data completeness and data quality by dedicating more resources to on-boarding and data submission, supporting data correction and providing valuable feedback such as benchmarking information.
- PHIN will ensure that services to private healthcare providers are more responsive to hospital needs, including induction for new hospital staff, enhanced video and educational materials, increased 1-2-1 meetings and expand the availability of 'data clinics.'
- PHIN will also implement an online 'ticketed' query system that provides feedback on the progress of resolving an issue.
- PHIN will work with the CMA on how best to achieve full participation and complete data submission with the 'long-tail' of providers treating an intermittent volume of private patients in the UK.

5.1.2 Improvements to PHIN Portal and user journeys

- PHIN's Portal will be continuously reviewed to make sure it remains fit for purpose.
- PHIN will look at optimising data submission through system-to-system transmission ('API' data feeds) and enhance the navigation and information available in the Portal, including market analysis and benchmarking.

5.2 Consultant participation

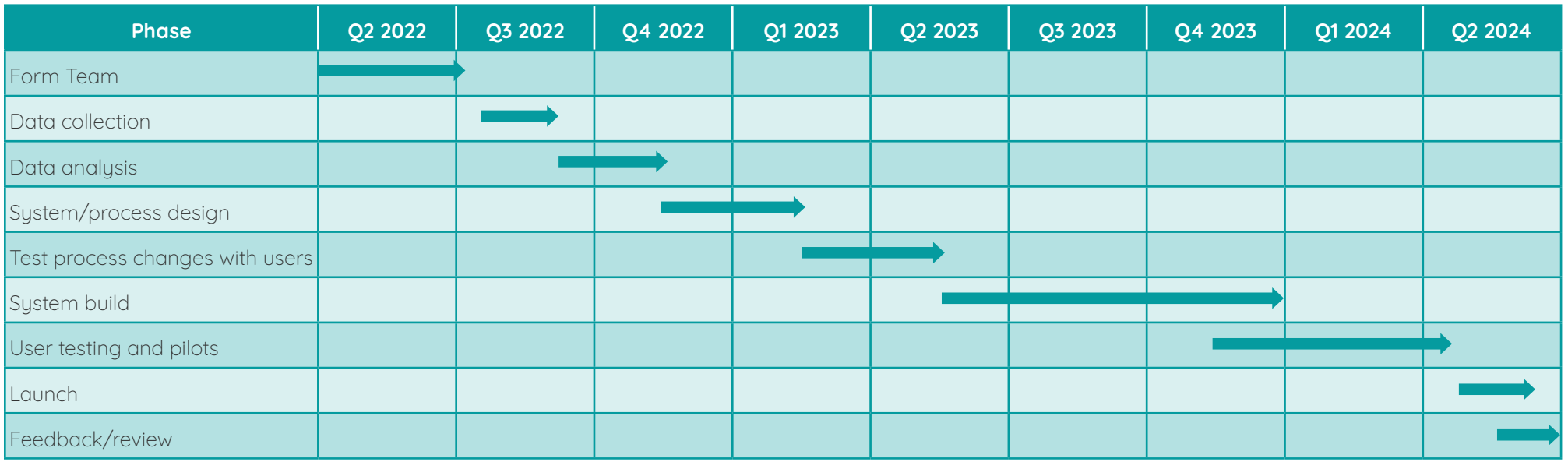
5.2.1 Consultant participation requirements

- Key areas of participation and engagement include:
  - Participation and compliance with CMA Order.
  - Review of hospital submitted data to maximise data quality and the ability to publish measures.
- PHIN will always endeavour to publish appropriate and accurate information, with support from the specialty associations. A significant uplift in consultant participation will only be achieved when there is confidence in the methods and the quality of data. However, it is appropriate that consultants in private practice are asked to take an increasing responsibility for ensuring that their data about patient care is accurately recorded and published in accordance with legal obligations.
- In addition, there will need to be continued engagement with key consultant representative bodies, such as Federation of Independent Practitioner Organisations (FIPO), the Federation of Surgical Specialty Associations (FSSA) and the Royal Colleges over the course of the implementation period.
- PHIN will continue to consult with the CMA and the GMC to develop appropriate mechanisms to remind consultants of their obligations under the Order.

5.2.2 Presumed publication of private activity information

- Accurate data about a consultant's activity is needed not only to publish the volume of their activity, but also as the denominator for calculating other measures, such as length of stay.
- PHIN's approach to publishing these measures has been to encourage consultants to review the data submitted about their practice and verify the information prior to its publication.

- To date, approximately 2,600 of circa. 12,000 consultants have verified their data as being accurate for publication, thus leaving most consultants who either have looked at the information submitted, but not verified it, or have failed to engage in the process.
- A reason often cited by consultants is inaccuracies in the data submitted by private healthcare providers or confusion about the data presented by PHIN but provided by NHS Digital to support a 'whole practice' view.
- PHIN plans to move to a position where data is published for a significantly higher number of consultants, based on the assumption that the private activity data received from providers is sufficiently detailed and complete (as is required in the Order). This is known as "presumed publication". The resulting ability to publish activity at consultant level will lay the foundation for publication of more complex measures at consultant level. This will only be possible after the presumed publication programme has gone live in 2024.
- The successful implementation of presumed publication will depend on a range of factors, chief of which is improved data quality of submitted private activity data.
- There will need to be collaborative working with consultants and private healthcare providers to review existing systems and processes, identify barriers to publication and address these through an agreed set of actions. For example, PHIN and healthcare providers may work together to consider how to involve consultants earlier in the data submission process. PHIN will additionally enhance the current process for consultants to notify private healthcare providers of data issues, and alert them when they have been addressed.



- In line with the GDPR, processes will be needed for the correction of any information published at consultant level. If a consultant identifies an issue with something published on the PHIN website, there will be a mechanism to temporarily remove it and raise an issue with the relevant private healthcare provider(s), to be investigated and resolved within agreed timescales.
- The approach towards implementation will be:
  - To test and review any proposed changes with key stakeholders to ensure that changes will deliver against appropriate success criteria.
  - PHIN will also research and identify where improvements could be made to various systems and processes. For example, ensuring that PHIN and private healthcare providers have the resources to respond to incoming data queries.
  - Once these processes have been developed, PHIN will pilot the approach and then implement a phased rollout as outlined below.

5.2.3 Building trust in PHIN and the data

- As described above, PHIN will work with consultant representative bodies, providers and the GMC to raise the awareness of the CMA Order and consultants' obligations. PHIN will continue to be open about the methods used to develop measures and be clear that only information will only be published that is understandable and helpful for patients, and which is clinically and statistically valid.
- One issue is around consultant misattribution, where consultants are recorded either as having performed procedures they didn't do or not being recorded as having performed procedures they did undertake. As misattribution reduces confidence in data and PHIN, particularly as they may see it for the first time on the PHIN Portal, there is an imperative to make improvements. Part of this is about continuing to engage and educate consultants on the data received about them and the benefits of publication for patients.
- PHIN will also develop processes to maximise data quality and consider alternative ways to gather more accurate information about consultants' practice. For example, changes to the private data we collect to make it more granular, and the self-declaration of NHS activity.

Consultant data overview report

- Key to building confidence and trust in the data will be through dialogue with consultants, to ensure data accuracy and discuss how it may be used to produce performance measures.
- PHIN will provide consultants with 'dashboards' to prompt action for completion or highlight new information. PHIN will also enable consultants to extract information from the Portal that will help with appraisal and revalidation.

Medical Secretary access to the Portal

- PHIN has gathered feedback to understand consultants' needs which includes granting access to the Portal for their medical secretaries/ administrators to provide fee information, verify activity and complete a consultant's website profile. PHIN will provide medical secretaries access to the Portal by early in 2023.

Enhanced relationship management

- PHIN is committed to supporting local engagement. Examples may include attendance at Medical Advisory Committee meetings or regional events, at national / international conferences and working in partnership with the professional associations.
- In addition, consultants are not alike and tailored development of PHIN's engagement approach will be needed.
- PHIN will work with consultants to develop useful information that can support revalidation and appraisals. Providing this information will help increase consultant engagement with the Portal.

Improvements to PHIN Portal and consultant user journeys

- PHIN's portal will be continuously reviewed to make sure it remains fit for purpose for consultants.
- PHIN will implement an online query support system that provides feedback on progress with resolving an issue.
- PHIN will explore opportunities to work with data processors and medical billing organisations, such as Healthcode, to reduce the number of systems consultants need to engage with.

5.3 Engagement with private medical insurers

- In Article 25 of the Order, the CMA set out obligations on private medical insurers (PMIs) around promoting PHIN and its website to customers.
- The PMIs play a role in many private patient journeys, funding a large amount of private patient activity in the UK. PHIN will continue to work with the PMI providers to ensure that patients are made aware of and invited to the information PHIN publishes to support patient choices, and to make sure the information PHIN publishes is relevant to insured patients.
- There is scope for further involvement from PMIs in encouraging provider and consultant participation and engagement. PMIs are an inherent part of the private healthcare sector, and we all need to harness the benefits we can bring for patients.
- PMIs would like to see an increased pace of delivery of the Order which can support their customers. PHIN will look at how best to publish information that can support this objective.

5.4 CMA

- PHIN and key partners in the sector will monitor delivery against the agreed plan at quarterly meetings with the CMA. The CMA will continue to monitor progress against the Plan and agreed milestones.
- PHIN and the sector will work with the CMA to identify alternative options if any existing metrics prove unable to be published.
- PHIN will work with the CMA to ensure participation of non-compliant providers in the UK. The CMA is committed to undertaking such action as is required to ensure that the Order is delivered by mid-2026.

- PHIN and providers will work with the CMA to clarify the boundaries set out in the Order that determine when providers are required to participate. For example:
  - The Order only focuses on 'admitted' patients and not the grey area of procedures delivered on both an admitted and outpatient basis. This means that PHIN does not have the complete picture of all admitted activity for many procedures and therefore there is not a level playing field on data submitted nor information to publish for these types of procedure. Greater clarity is needed on the definitions of what is construed as admitted activity in the sector and this must be consistently applied.
  - Similarly, much oncology, gynaecology, ophthalmology, dermatological surgery, interventional cardiology and radiology activity falls largely into the area of either 'outpatients' or 'admitted' activity depending on which organisation performing the treatment. Without a level playing field for these specialties, the information PHIN receives and can publish is not as helpful for patients.
  - Clarification is required from the CMA on whether consultants who are not registered with the GMC (those registered with the General Dental Council, or allied professions' regulators) are included under the Order, meaning that PHIN need to publish information about their practice, and that they need to submit fee information.
  - Clarification is needed about certain treatments and care being included in the scope of the Order. For example, certain legally restricted codes relating to sensitive diagnoses and treatments, as well as patients who opt-out of having their data published/used.

5.5 Other stakeholder engagement

Where relevant and agreed with member representatives, PHIN will work with other sector stakeholders to further complement delivery of the Order. For instance:

- NHS and central regulatory bodies on the ADAPt and Paterson implementation programmes, as well as the CQC for data streamlining and information sharing projects.
- The GMC to agree the relationship between consultants' obligations under the CMA Order and Good Medical Practice. As well as the Royal Colleges who will support through the Plan on consultant related matters.
- Patient representative groups, such as Patient Safety Learning and the Patients Association, so that the patient voice is heard. This provides valuable input to develop meaningful metrics and information for patients.
- Academic researchers, who may request extracts of information PHIN holds, and with whom PHIN may work collaboratively with to develop publication methods. There is already an established process for member consultation, review and approval of any such scenarios.

5.6 Stakeholder comms and engagement plans

- **Partnership Forum** – PHIN will continue to work collaboratively with members of the Partnership Forum to share details of progress and resolve new strategic challenges. In future this forum is likely to include representation for NHS private patient services while the CMA may wish to attend meetings periodically to remain close to the implementation plan and progress. The Partnership Forum may continue to establish Task and Finish groups to consider issues relating to the publication of specific measures or more general methods. The groups will gather evidence to make a recommendation for progress on the issues at hand, to inform the planning process and ultimately for discussion with the CMA when required.
- **Implementation Forum** – The Implementation Forum has been PHIN's mainstay for regular dialogue on practical issues with hospital providers and consultant representative bodies, including the design and publication of the specified measures. PHIN will continue to hold the forum monthly and welcome input from a wider group of stakeholders, including NHS private patient services and insurers.
- **Presumed publication stakeholder group** – A consultation forum will be established to ensure that the implementation of 'presumed publication' is successful. It will include representation from all stakeholders, including consultants, private healthcare providers, and private medical insurers.

6.1 Patient engagement and impact

- Truly successful delivery of the CMA Order will mean publishing information that is understandable and helpful to people considering their healthcare options. There is a need to seek input from patients on an individual and representative level to ensure the measures and information published by PHIN are simple to understand and helpful when making choices.
- The data-driven measures PHIN publishes will continue to be helpful and valued, but they can be overwhelming without appropriate supporting/contextual information. This includes explanations of the measures and how to use them in conversations with professionals and information on how best to engage with private healthcare as an insured or self-pay patient.
- All our activities will be based on analysis of effectiveness and value. Therefore, we will work with stakeholders to continually monitor and evaluate the impact of those activities with a view to refining the effectiveness of the information PHIN publishes.

6.1.1 Website activity and insights

- Analysis of website traffic since the launch of the PHIN website 6.0 in July 2021 shows positive engagement and that it is having an impact.
- Since the launch, there have been 236k users and 983k page views in total. This has comprised 80k website searches by 33k users, with 26k 'contacts' made for hospitals and consultants.
- Analysis shows that patients using the website are primarily looking for consultant information in the first instance, while their biggest complaint is the lack of information on consultant profiles. Increasing participation and engagement will help address this issue and improve patient satisfaction.

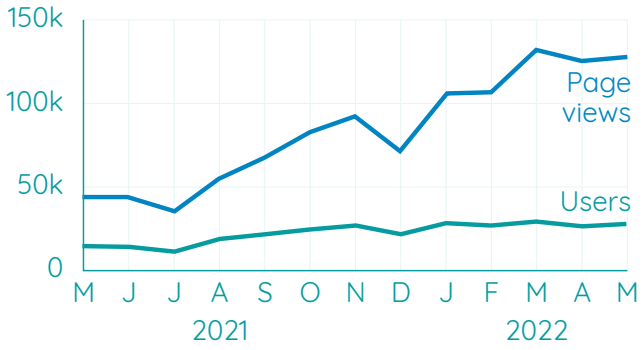
Website visits

Since website launch

Users	236k
Page views	983k
Sessions	296k

Month-by-month comparison

Users	28k	↑4%
Page views	131k	↑2%
Sessions	35k	↑3%



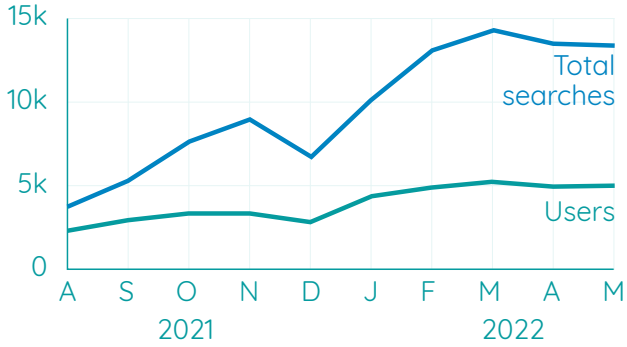
Hospital profile visits

Since website launch

Users	39k
Total	97k

In May

Users	1.8k	↑2%
Total	5.8k	↑74%



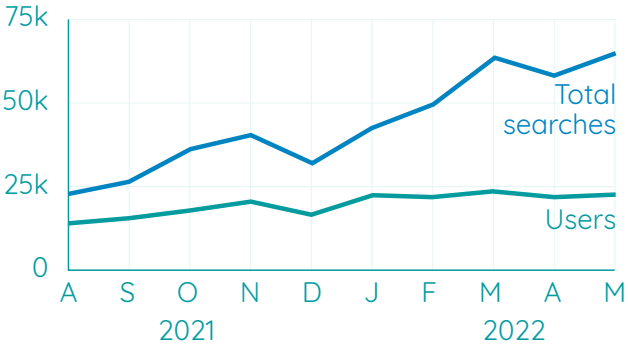
Consultant profile visits

Since website launch

Users	179k
Total	420k

In May

Users	21k	↑5%
Total	62k	↑11%



6.2 PHIN website improvements and user feedback

- PHIN will need to keep on listening to patients to meet their needs and make sure the information produced from the Order is understood and used to inform decision making. This includes insights from user surveys which are already providing a wealth of valuable feedback.
- To do this, PHIN will work with stakeholders to identify the best way for patients to receive what can be complex information, in addition to improving UX/UI and to support different user journeys on the website.
- PHIN will continue to develop the website, deepen engagement with patients and relay feedback to members to show the value and impact this information is having, and where improvements need to be made.

6.3 Information syndication

- The information provided to PHIN may also be appropriate to be used and promoted to patients via other channels, with both hospital providers and insurers keen to utilise PHIN information on their websites and tools.
- PHIN will explore opportunities to syndicate the publicly available information to partners in the sector, including cross-links to hospital and consultant profiles and performance information embedded into elements on partners' websites about their PHIN information and profiles.
- PHIN will also explore whether it would be appropriate to syndicate external sources of information that can enrich the information currently present on the PHIN website.

7 RESOURCES AND SECTOR-WIDE ORGANISATIONAL CAPACITY

Given progress made to-date across the sector on delivery of the Order, more effort will be needed across the board to be able to deliver the Order by mid-2026 and increase the pace of delivery. Outlined below are the proposals for the resources needed to deliver the Order across the sector.

7.1 PHIN

7.1.1 What does PHIN spend its resources on?

- As a not-for-profit organisation, PHIN is always keen to provide transparency in how it spends its members' funds. Based on the audited cost base in 2020-21, the bulk of PHIN's expenditure is on people and staffing costs which comprises c.75% of its cost base. The second highest pool of costs relate to data management and IT, which includes IT hosting, security, licencing costs, as well as web and portal design and development costs.
- The core of PHIN's activity is to deliver the CMA Order – to gather, process and analyse data to publish information on our portal and website, supported by engagement with the sector to support this process.
- The main functional teams within PHIN comprise:
  - **Informatics** – The engine room of PHIN, responsible for the analysis of data and data quality, and preparation of performance measures information for publication.
  - **Technology** – Comprising the development team, which is responsible for development and maintenance of our databases, consumer website and Portal, and the information security and services team, responsible for maintaining the day-to-day systems and security, including ISO27001 compliance.
  - **Engagement** – Comprising PHIN's hospital and consultant engagement teams, communication team, and product team which is responsible for the design and development of our website and portal products, as well as a strategic projects lead working on PROMs and other long-term delivery projects.
  - **Corporate** – Comprising the Chief Executive, Finance and Commercial Director and the Director of People and Process (Corporate Secretary). This team is supported by an Office Manager and the PMO team, as well as outsourced DPO, HR, admin, legal and finance and accounting functions.

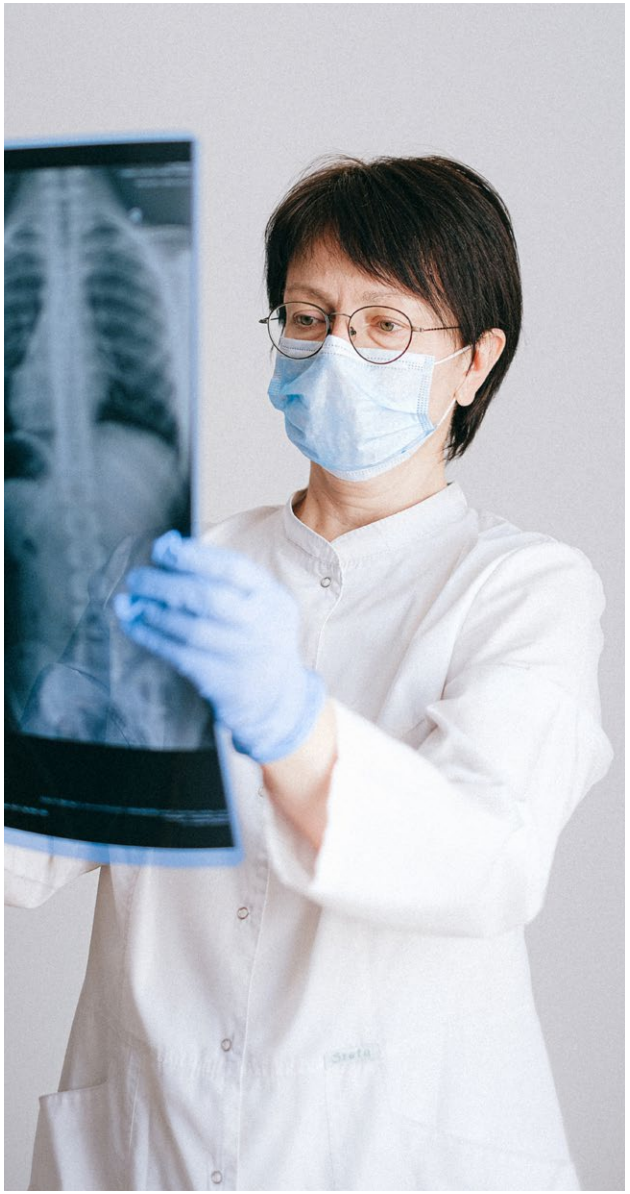
7.1.2 Future PHIN resources requirements

- To deliver the Order by June 2026, PHIN will need to move faster which will require an expansion of PHIN's capacity, but this is wholly contingent on the final definition of complete and the level of work required to get to that point. Due to PHIN's relatively small size any growth will also be limited by the organisation's capacity to recruit and onboard staff – its key resource pool and capacity constraint.
- A key driver to PHIN resourcing needs will be increased pace of measure production following the existing measure and fee development process as outlined below. This process requires input from the informatics, engagement, and technology teams to develop, analyse, process, publish and consult with the sector on CMA Order implementation. The proposed increase in resources will be directly linked to these existing capabilities, providing additional capacity to existing functions to increase the pace of delivery compared to the current rate.
- Good progress has been made in collecting self-pay fees. Work continues to achieve full coverage and ensure those fees are updated regularly. However, there is still a significant amount of work to support collecting and publishing consultants' insured fee arrangements, anaesthetic services and outpatient only consultation fees.

- Given these requirements, and feedback from members to give as much notice as possible to fit in with their budget cycles, PHIN is proposing to defer material uplifts in subscription fees to start in February of each year, notifying members in July in the previous year of the likely uplifts needed.
- The 2026 target date for delivery means that additional resourcing will likely be needed through the remainders of 2022 and into 2023 and 2024.
- PHIN can use its current surplus to start some of this investment, resulting in no uplift as of 1 August 2022, which is the start of PHIN's financial year.
- There will be an increase in PHIN subscription fees of 7.5% from 1st February 2023 followed by a further 6.5% from 1st August 2023 to support the increased pace of delivery of the CMA Order.
- Plans will be developed in conjunction with members over the coming months so that there is transparency in how PHIN's resources are being deployed and how delivery is linked to them.
- This process would then be repeated in subsequent years as and when additional resourcing will be needed. Continued engagement with members in the development of these plans will be key, monitoring performance and delivery through KPIs, and the need to identify capacity constraints and deploy resource to the right place at the right time to ensure value is delivered.
- Furthermore, PHIN welcomes discussions with members on opportunities for secondments/resource into PHIN to support the delivery of the CMA Order, in the areas of relationships management and customer services, informatics/analytical capabilities and technology.

7.2 Private healthcare providers

- Private healthcare providers will need to make sure that they have the adequate internal resource and systems to support the CMA Order, for data management and submissions, data query handling and supporting the drive to improve data quality, measure completeness and coding accuracy.
- This will be felt acutely at the smaller providers and consistent non-compliant providers, who have not historically invested in the people, processes and systems to support the data collection, submission and reporting processes that the CMA Order requires.
- PHIN is proposing to work with PMIs, NHS (through ADAPt and other workstreams) and other stakeholders such as the CQC, to reduce the data request burden on private healthcare providers and streamline collections and reporting wherever possible.



7.3 Consultants

- There will need to be proactive engagement from consultants in delivering the CMA Order, by updating their profile, fees and reviewing activity information, and working with private healthcare providers to improve the quality of data attributed to them.
- Similarly, consultants are a large group of individuals that require engagement and support, including medical secretaries. PHIN can only do this with support of the private healthcare providers as a key intermediary in this relationship. For example, increased support for consultants with data queries in the run up to presumed publication. This will require analysis of compliance across geographical patches where consultants split their practice across multiple private healthcare providers.

7.4 CMA

- Support with insights and approaches for assessing and researching into how PHIN, private hospital providers and consultants make measures useful for patients and alternative measures to incorporate where necessary.
- Enforcement action will be required for non-compliers for both private healthcare providers and consultants as this will be a more efficient process than PHIN taking on responsibility for chasing submissions. The CMA has indicated that enforcement action will be taken for non-compliance with the Order.

8 RISKS AND MITIGATIONS

Risk	Issues and mitigations
Delivery – pace and hitting milestones	• The deadline to achieve the complete delivery of the Order by June 2026 will be a challenge, despite the number of years already passed since the Order was laid, given the scope and complexity of the measures outlined in the Order. • The roadmap set out in this Plan aims to deliver the Order by 2026 in a logical and phased manner, based on a feasible definition of "complete" to be agreed by the sector and the CMA. • Whilst there will likely be some unforeseen hurdles to overcome, collaborative working amongst the sector and open an honest communication on progress will be key. • Collective resourcing will also be a key enabler to the delivery of this Plan.
Delivery impact as sector recovers from the Covid-19 pandemic	• The private healthcare sector has been subject to significant challenge and strain during the Covid-19 pandemic, and it has altered the landscape of healthcare in the UK. • The sector has not yet recovered to its previous activity levels and the day-to-day operating environment has changed. This may impact on the ability of organisations to deploy resources to support the CMA Order in the short-term. Therefore, additional time and support may be needed before they are able to reach compliance.
Enablers – data quality and hospital and consultant participation	• To succeed, participation rates from private healthcare providers and consultants will need to increase while the inbound data volumes and data quality increase. • To ensure consultant participation, there will also need to be consistent application of provider and consultant participation requirements across the sector. There is a risk to the industry trying to achieve compliance if not all consultants and providers are complying with the obligations of the Order. • The roadmap outlined in this Plan supports these enablers with focused workstreams on participation rates, stakeholder engagement and data quality. • In addition, PHIN aims to be able to develop methods and be ready to publish all measures, where possible, by June 2026. • The eventual ability to publish any of these measures in the public domain to a meaningful extent will be dependent on participation rates, data quality and underlying volumes to be able to publish statistically meaningful information.

Potential complexity of developing and publishing measures affects pace and delivery	• The roadmap outlined in this Plan and the principles to publication that have been agreed mean that the sector will only publish measures where it is possible to do so, and an existing approach is available and readily used in the UK. • The approach is to focus on areas which provide the most patient benefit for a given amount of resource, and therefore to minimise this complexity where possible if this does not compromise the validity of the information published. • Where PHIN believes it is not possible to publish meaningful information without unreasonable effort, PHIN will work with stakeholders to gather evidence for why this is and agree an appropriate way forward with the CMA. By adopting these approaches, we will ensure PHIN is able to publish the information that is most effective at informing patient choice by June 2026.
Participation with different PROMS, registries and audits	• Providers and consultants may use different PROMs to those mandated by the CMA Order, even though they support the outcome of the same procedures. Therefore, there is a risk that effort to measure outcomes by providers and consultants is not recognised. Ongoing dialogue will be needed on how to bridge these differences and how participation in a variety of types of outcome measurement are recognised. • Similarly, there are several registries and audits that are voluntary rather than mandatory, and a number that will not accept private patient activity, so only those doing NHS work can be recognised. This potentially creates a limiting effect on what can be published at hospital and consultant level for many registries and audits. Again, ongoing dialogue will be needed to resolve some of these imbalances.
Inability to publish all measures at consultant level	• Statistical limitations on publishing small numbers at consultant level may well hamper the ability to publish all Article 21 measures for consultants. • In addition, there are measures that are inappropriate to report at consultant level since they are usually dependent on hospital wide processes and procedures, rather than a metric which can be used to determine relative performance of individual consultants. • Therefore, it may not be possible to publish all Article 21 measures at consultant level, and where they are, statistical discrimination may not be possible. • PHIN and the sector will look at other ways to convey relevant information about these to patients. For instance, by reflecting participation and collection of performance measures and by showing consultants' performance with information about the hospitals in which they work to provide the appropriate context.

Information is not meaningful nor is used for patients	• The primary objective of the Order is to make sure information is in the public domain for patients to make informed decisions when choosing private healthcare. To do that, the information needs to be understandable and useful to patients, and they should be using the information to support their different journeys through private healthcare. • Usage rates of PHIN's website are positive and increasing, with user survey feedback showing what is working and what could be improved. • The PHIN website should not be the only repository of this information and we would welcome opportunities to syndicate the PHIN information to partners in the sector so that the information can reach as many patients as possible. • PHIN plans to work with stakeholders in the sector to identify the best way to convey the information required by the Order to patients across different patient journeys, as well as identifying potential opportunities to continually enhance and add to the information published online.

9 APPENDIX 1 – PROGRESS AND ACHIEVEMENTS TO-DATE

9.1 Achievements and progress over the years

- Progress since 2015 has been solid, but the capacity and time required to put in place key elements of delivery (such as data gathering, definition and validation processes) has been significant and progress has been slower than desired. The task upon us all was more complex than initially envisaged, compounded by changing data protection obligations on all parties involved.
- There has been a natural phasing the work delivered to-date, with much of our collective focus being on gathering data, before being able to shift to publishing information which is understandable and helpful for people considering their care options.
- The tables below outline the progress that has been made to-date on both the Article 21 measures and the Articles 22 Fee requirements.
- As can be seen, much progress has been made a hospital level, however more work needs to be done at consultant level, as well as delivering the 'complete' measure.

Article 21 measures	Hospital level publication	Consultant level publication	Notes
a – volume			PHIN currently publishes information on the volume of procedures at site and consultant level.
b – length of stay			PHIN currently publishes information on the length of stay of procedures at site and consultant level.
c – infection rates			Simple infection rates are published on the website at hospital level.
d – readmission rates			Readmission rates are published at hospital level.
e – revision surgery rates			No measures are published yet at either hospital or consultant level for revision rates.
f – mortality rates			Simple mortality rates are published at hospital level.
g – unplanned transfers			Methods discussion on casemix and consultant-level publication.
h – patient feedback			Patient feedback published at hospital and consultant.
i – links to registries and audits	1	1	Links to NJR at site level and links to NOD at site and consultant level are planned for 2022. NJR at consultant level is already published.
j – improvements in health outcomes	2/13		Hip and Knee PROMs published at hospital level. Cataract PROMs to be published at hospital level in 2022.
k – frequency of adverse events	3/3		Returns to theatre, never events and serious injury published at hospital level.

Article 21 measures	Progress to-date	Notes
Consultants' self-pay consultation and procedure fees		Main obligation delivered. Other areas such as anaesthetic costs to be factored into plans. Working group to be established to support progress on all aspects of fees and participation.
Consultant reimbursement arrangements with insurers		Broad stakeholder consensus on an approach. Implementation planned for Q2 2023.
Hospital fees and package prices		Not explicit in Order but above measures do not give a complete picture of price of care to patients. Important for patients but complicated and not directly part of CMA Order. Agreed to defer and revisit once majority of CMA Order is delivered.

9.2 Key challenges and lessons learnt

9.2.1 Collaboration is key

- It is clear from our work to-date that open communication channels and collaborative working are critical to delivering the Order and providing information that is understandable and helpful for patients. We must establish what works best for patients and that this should underpin all our collective efforts.
- Given the complexity involved in gathering, submitting, processing and publishing the data into meaningful metrics, the implementation must be a collective endeavour across the sector.
- The information provided to PHIN about consultants' practice by providers can help consultants too, for instance in supporting appraisal and revalidation.
- In addition, private healthcare providers often submit data to the CQC and PMIs, as well as PHIN. We will work to ensure there is consistency and that we minimise the burden of data collection.
- Being smart about how PHIN works alongside these organisations to build a collective approach to engaging consultants and private healthcare providers will be the most efficient and effective way forward.

9.2.2 Data needs to be complete, high quality and trusted

- To publish more measures and make sure they are understandable and helpful for patients and the sector, data submission rates will need to improve, along with the underlying quality of data.
- We rely on NHS data, such as the Hospital Episode Statistics (HES) and the ONS mortality data, to provide "whole practice" information and for us to be able to track outcomes of private care that happen in the NHS. Unfortunately, consultants generally have only limited input into the creation of these datasets, and have limited ability to validate its accuracy or correct errors.
- Coding and attribution issues in the private APC data set can cause consultant dissatisfaction at the information they see on the PHIN portal. We have explored ways to improve these, which will be implemented as part of the presumed publication programme.
- In order to build consultants' trust in the data we hold, we will continue to engage and educate consultants on the data we receive about them, the processes needed to maximise data quality, and about the benefits of getting this right for patients.

9.2.3 There are more opportunities to simplify data flows and use of the data

- The provision of high-quality information on private healthcare is as much about access and patient safety as it is about competition and choice, with the need to demonstrate the provision of safe and high-quality care becoming more than just a requirement for the CMA.
- The CMA continues to play a key role in compliance. Patient safety improvement initiatives directed by system leaders such as NHS England and the Department of Health and Social Care can provide additional impetus for change than the competition agenda alone.
- The Care Quality Commission is also building data monitoring into its regulation strategy and is active in supporting PHIN to ensure that it has access to data in private healthcare that matches NHS data.
- Continued working with these adjacent areas will help complement delivery of the Order.

9.2.4 Patients are using this information but more needs to be done

- The PHIN website is now receiving c. 28k user visits a month, with improved engagement and activity since the launch of the website 6.0 in July 2021. Patients are using this information and making decisions; however, more can still be done.
- PHIN has also launched a website user feedback survey to which we have received more than 2,800 responses so far. Of these respondents, 36% replied that they acted off the information provided to either book a consultation, speak to their insurer or speak to the GP. A further 26% say their use of PHIN information is part of their research process into their treatment choices.
- Dissatisfied patients using our website state the number one issue is the lack of information on consultant and hospital profiles. This is something we all need to help to improve.
- In addition, feedback also shows that we need to make the information more patient-friendly and support different user journeys.
- There is clearly demand and impact for the information that is being collated and published, however there is clearly more we can collectively improve on in this area and tailor information to different types of user and audiences in an efficient and effective way.
- There is an opportunity for collaboration in the sector to better understand private healthcare journeys and where PHIN's information best fits within those journeys. Insights from both provider as well as insurers would support this work so there are the right hand-offs in the right places.
- The targeted use of patient panels, with a suitable focus, can help to ensure that the positioning as well as the content of PHIN's information meets patient needs.

10 APPENDIX 2 – ARTICLE 21 MEASURES

This Appendix provides a more detailed breakdown of Article 21 measures outlining the progress made to-date, the roadmap to compliance at both hospital and consultant level, as well as critical enablers and dependencies.

The roadmap to compliance for each measure follows the principles to publication outlined earlier in the Plan. This sets out a pragmatic approach that prioritises areas within the CMA Order with most impact for patients.

10.1 The Article 21 measures

PHIN will use a defined process to determine the feasibility of publication for each measure at hospital and consultant level, which is dependent on the availability of:

- Clinically and statistically validated methods.
- Data on private activity.
- NHS data – for longitudinal outcome measures and for benchmarking to set the private measures in an appropriate context. The lack of availability of this information is likely to present a challenge for meaningful whole-practice publication across all measures.

If it is not possible to publish such information at hospital/consultant level, PHIN will work with stakeholders to find alternative ways to inform patient choice within the scope of the measures as outlined in the publication principles section.

Regarding statistical validity and small numbers, PHIN's commitment is to publishing information that is fair and accurate, while complying with relevant information governance rules. In practice, this means that we require information about all privately funded procedures, as set out in the Order, so that we have comprehensive information for our analysis and publication. When it comes to publication, we apply disclosure controls to ensure patient confidentiality is safeguarded appropriately, for example by saying that a low volume of activity was performed, without stating the exact number, or by stating that an outcome is within the expected range. This approach is also aligned to NHS publication standards.

10.1.1 A – Volume

Progress to-date	• PHIN has published a CMA compliant measure at both hospital and consultant level on the website, as we show volume of procedures for both.
Roadmap to Compliance	• While the measure published meets the requirements of the Order, PHIN will enhance the information presented to further aid patient comparisons (e.g., by introducing new views of the information, and filtering to enable patients to focus on patients like them), trends and benchmarking. • We will work to improve participation and coverage, in particular considering how to capture NHS-funded activity more accurately to show "whole practice" information for consultants and hospitals.
Enablers and dependencies	• The presumed publication programme – to improve the proportion of consultants for whom we can publish data. • Procedure group improvement programme, to ensure we are reporting on procedures that are defined in ways that patients can understand and which are clinically meaningful. • The data quality improvement programme, to ensure the information we receive from providers is complete and accurate. • Data specification review, if we need to change the way we capture information about consultant attribution. • ADAPt and other programmes that focus on NHS data collection.

10.1.2 B – Length of stay

Progress to-date	• PHIN has published a CMA compliant measure at both hospital and consultant level on the website, as we publish length of stay information currently for both.
Roadmap to Compliance	• While the measure published meets the requirements of the Order, PHIN will enhance the information presented to further aid patient comparisons (e.g., by introducing new views of the information, and filtering to enable patients to focus on 'patients like me'), trends and benchmarking. • We will work to improve participation and coverage, in particular considering how to capture NHS-funded activity more accurately to show "whole practice" information for consultants and hospitals. • Consideration will also be given to how to further develop our length of stay metric to reflect the impact of case-mix and complexity in a more sophisticated way than our current model.
Enablers and dependencies	• The presumed publication programme – to improve the proportion of consultants for whom we can publish data. • Procedure group improvement programme, to ensure we are reporting on procedures that are defined in ways that patients can understand and which are clinically meaningful. • The data quality improvement programme, to ensure the information we receive from providers is complete and accurate. This is a key enabler for any metric that requires case-mix adjustment, as high-quality data on e.g. ethnicity and comorbidities to be able to apply case-mix models effectively.

10.1.3 C – Infection rates

Progress to-date	• PHIN has partially published a CMA-compliant measure at hospital level, which covers HCAI and Surgical Site Infections for hip and knee replacements.	• No measure has been published at consultant level on the website.
Definition of complete	• We are currently working with stakeholders, including the Task and Finish group to define what a reasonable target for publication is for this measure, as outlined in the row below, with the aim of producing a policy recommendation in Q4 2022. This is likely to be: **For hospitals:** • Publication of HCAI at hospital level ("as expected" and rates) – enhanced to differentiate between community acquired and hospital acquired infections, and other case-mix variables if possible. • Publication of SSI for individual procedures as defined by the NHS and set out in our current data specifications, including case-mix adjustment if possible.	**For consultants:** • No direct publication of HCAI, as these relate to processes at a hospital site, but we will show information about the hospitals at which the specific consultant works. • Publication of SSI for individual procedures as defined by the NHS and set out in our current data specifications, including case-mix adjustment if possible.
Roadmap to Compliance	**Consultant level publication** • As set out in the publication principles and the process in 10.1 above, the first step will be to assess whether it is viable to publish at consultant level if it is (a) accepted medical practice and (b) statistically possible. • If viable, to publish a measure at consultant level, data quality and completeness will need to reach a higher standard and there should be a solution for accounting for complexity (case-mix adjustment) in order for consultants to be confident the measure is fair and represents their practice. • A programme is being developed and implemented to help providers improve data quality and completeness.	• PHIN are also collaboratively working with providers, consultants and other stakeholders to develop a solution for case-mix adjustment. • Collaborative working with consultants and representative groups to develop infections measures at consultant level. **Further hospital level publication** • A similar method will be used to refresh the private healthcare providers measure in the future, using case-mix and risk adjustment where possible.
Enablers and dependencies	• Data quality improvement programme. • Data specification review, if we need to collect more information about subtypes of HCAI.	

10.1.4 D – Readmission rates

Progress to-date	• PHIN has partially published a CMA compliant measure at hospital level, covering self-reported readmissions that providers are aware of where the patient returns to the original treating hospital for a clinically-related reason. • No measure has been published at consultant level on the website.
Definition of complete	• We are currently working with stakeholders, including the Task and Finish group to define what a reasonable target for publication is for this measure, as outlined in the row immediately below, with the aim of producing a policy recommendation in Q4 2022. This is likely to be: **For hospitals:** • Publication of Readmissions at site level and per procedure ("as expected" and rates) – enhanced to include case-mix if possible. This will be extended to include readmissions to other hospitals (including to the NHS). **For consultants:** • Publication of Readmissions per procedure ("as expected" and rates) – enhanced to include case-mix if possible. This will be extended to include readmissions to other hospitals (including to the NHS).
Roadmap to Compliance	**Consultant level publication** • As set out in the publication principles and the process in 10.1 above, the first step will be to assess whether it is viable to publish at consultant level as long as it is (a) accepted medical practice and (b) statistically possible. • If viable, to publish a measure at consultant level, data quality and completeness will need to improve and there should be a solution for accounting for patient complexity in order for consultants to be confident the measure is fair and represents their practice. • A programme is being developed and implemented to help providers improve data quality and completeness. • PHIN are also working with providers, consultants and other stakeholders to develop a solution for case-mix adjustment. • Collaborative working with consultants and representative groups to develop infections measures at consultant level. **Further hospital level publication** • A similar method will be used to refresh the private healthcare providers measure in the future, using case-mix and risk-adjustment where possible.
Enablers and dependencies	• Data quality and the collection of appropriate data fields (principally NHS number and other equivalent identifiers) to enable linkage to external data sets. • Availability of external datasets, e.g., HES for England and equivalent datasets for devolved nations.

10.1.5 E – Revision surgery rates

Progress to-date	• No progress has been made to date on developing a measure for revision surgery at either hospital or consultant level.
Definition of complete	We are currently working with stakeholders, including the Task and Finish group to define what a reasonable target for publication is for this measure, as outlined in the row immediately below, with the aim of producing a policy recommendation in Q4 2022. However, this measure presents a significant challenge and may not be publishable either at hospital or consultant level because: • There is no uniform approach to defining what a revision is and how to describe it in the data across procedures. • Some revision procedures are part of the anticipated long-term management of certain conditions. • In most cases the timeframe is over several years (NJR estimates revision rates over 5 and 10 years). The PHIN current data retention period is 7 years. This will need to be extended if we aim to include revisions over longer periods. • Many revisions for procedures conducted in private hospitals will be conducted in NHS hospitals, and therefore this needs information about activity across both sectors, e.g. via registries. Estimating revision rates is important but needs to be considered on a case-by-case basis for each individual procedure in conjunction with the relevant professional body. Although presenting longer-term revision rates is challenging for the reasons above, we can still publish information under other measures that will give patients insight into whether immediate corrections following surgery have been required, for example: • Returns to theatre – which may indicate if a revision is required during the same hospital stay. • Readmissions – which may indicate that a further intervention is required following the initial admission. • Unplanned transfers – which may indicate that further unplanned treatment is needed during/after the initial admission. • Links to registries – which may already present specialty-specific revision rates, based on extensive, longitudinal data collection and externally validated methods e.g., NJR.
Roadmap to Compliance	Further work will be completed by the task and finish groups and PHIN will work with the CMA to finalise a policy position on this in 2022.
Enablers and dependencies	• To be determined.

10.1.6 F – Mortality rates

Progress to-date	• PHIN has partially published a CMA-compliant measure at hospital level, comprising overall number and rates deaths that have occurred at that hospital. • No measure has been published at consultant level on the website.
Definition of complete	• We are currently working with stakeholders, including the Task and Finish group to define what a reasonable target for publication is for this measure, as outlined in the row immediately below, with the aim of producing a policy recommendation in Q4 2022. This is likely to be: **For hospitals:** • Publication of mortalities at hospital level and per procedure ("as expected" and rates) – enhanced to differentiate between anticipated (e.g., palliative care) and avoidable deaths, and other case-mix variables if possible. • Inclusion of "all-cause mortality" rates, via linkage to ONS mortality data. **For consultants (but see cell below):** • Publication of mortalities per procedure ("as expected" and rates) – enhanced to differentiate between anticipated (e.g., palliative care) and unanticipated deaths, and other case-mix variable if possible. • Inclusion of "all-cause mortality" rates, via linkage to ONS mortality data.
Roadmap to Compliance	**Hospital level publication** • An enhanced measure at hospital level is planned for release in early 2023 to include "all cause" mortality i.e., mortalities following the initial admission recorded elsewhere, in line with NHS standards. • The ability to capture more detailed information about mortalities will be introduced (avoidable vs unavoidable), followed by adjustments for case-mix where possible. **Consultant level publication** • As set out in the publication principles and the process in 10.1 above, the first step will be to assess whether it is viable to publish at consultant level if it is (a) accepted medical practice and (b) statistically possible.
Enablers and dependencies	• PHIN and members have convened a working group with a view to reaching a solution for case-mix adjustment. The sector will then implement the solution and publish a measure. • Data quality and the collection of appropriate data fields (principally NHS number) to enable linkage to external data sets. • Availability of external datasets, e.g. ONS mortality data and equivalent datasets for devolved nations. • Data specification review, if we need to collect more information about whether the death was avoidable or not.

10.1.7 G – Unplanned transfers

Progress to-date	• PHIN has partially published a CMA-compliant measure at hospital level. • No measure has been published at consultant level on the website and as set out below, this may not be relevant at consultant level.
Definition of complete	• We are currently working with stakeholders, including the Task and Finish group to define what a reasonable target for publication is for this measure, as outlined in the row immediately below, with the aim of producing a policy recommendation in Q4 2022. This is likely to be: **For hospitals:** • Publication of unplanned transfer rates at overall hospital level ("as expected" and rates) – enhanced to differentiate between those attributable to clinical vs. financial causes. Case-mix adjustment if relevant and possible. • As unplanned transfers largely relate to processes at a hospital level rather than a procedure-level, this is may not be publicly reported at procedure level. However, we will additionally explore whether there are particular risks related to specific procedures. **For consultants:** • As unplanned transfers relate to processes at a hospital level rather than at consultant level, this may not be publicly reported at procedure level. However, the relevance (or not) of reporting at consultant level is yet to be discussed in detail, so may be included.
Roadmap to Compliance	**Hospital level publication** • Further work required to identify appropriate 'reason codes' for any unplanned transfer so additional layer of transparency can be shown to patients. For instance, transfers may be the result of several factors, such patient complexity and acuity, lack of specialist facilities or equipment, or funding exhaustion. At present, an overall metric is presented which does not split out or explain these reasons at hospital level. **Consultant level publication** • As set out in the publication principles and the process in 10.1 above, the first step will be to assess whether it is viable to publish at consultant level as long as it is (a) accepted medical practice and (b) statistically possible. • Initial review of this metric at consultant level has identified that it may not be appropriate to report at consultant level as this metric has more to do with hospital wide systems than the performance of individual consultants.
Enablers and dependencies	• PHIN and members have convened a working group with a view to reaching a solution for case-mix adjustment. The sector will then implement the solution and publish a measure. • Data quality and the collection of appropriate data fields (principally NHS number) to enable linkage to external data sets for cross-validation of self-reported unplanned transfers. • Availability of external datasets, e.g., HES data and the equivalent for devolved nations. Data specification review, if we need to collect more information about whether the unplanned transfer is due to clinical or financial causes.

10.1.8 H – Patient feedback

Progress to-date	• PHIN has published a CMA-compliant measure for both patient satisfaction and patient experience at hospital and consultant level on the website. • These measures are being enhanced in 2022 to provide a breakdown of individual question scores for patient experience.
Roadmap to Compliance	• While already compliant, we have received requests from patients, healthcare providers and consultants to revisit this measure, to consider how information is collected and how we can enhance the information for patients. For example, patients have indicated that they would value verbatim feedback and testimonials. PHIN and its members will look to introduce comments and testimonials in a later phase of the Plan.
Enablers and dependencies	• There are options for collecting and publishing patient comments and testimonials, including direct collection via the PHIN website, partnerships with patient feedback specialist organisations to syndicate this information or revising the current data requirements for member private healthcare providers.

10.1.9 I – Links to registries and audits

Progress to-date	• This has been partially delivered. For example, PHIN has published links from relevant hospital and consultant profiles on our website to the publicly available information about them in the National Joint Registry.
Definition of complete	• Similar external links will be provided to publicly available information on other relevant registries and audits where technically possible, and the external information is likely to provide useful information to inform patient choice, including information about consultants' and hospitals' NHS practice. • The candidate list of additional registries is: - The RCOphth National Ophthalmology Database (NOD). - The British Association of Endocrine & Thyroid Surgeons (BAETS). - The United Kingdom National Bariatric Surgery Registry (NBSR). - The British Spine Registry (BSR). - National Audit of Percutaneous Coronary Interventions. - The Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS) registry. • We will also encourage consultants to declare which registries they participate in on their profiles where the registries and audits accept private patients.
Roadmap to Compliance	• PHIN remains committed to exploring further opportunities to co-operate with other registries. A working group has been set up to review the principles for linking to further registries and audits. • To support this work, PHIN has produced a high-level scoping review of clinical audits and registries conducted in the United Kingdom, and critically appraised alternative options as to how PHIN can move forward with this measure. • After thorough consideration of alternative options for the inclusion of registry and clinical audit data in PHIN publications, the report recommends PHIN should extend the approach taken with NJR data to other registries. • The task and finish group prefer this approach over direct integration of registry data into pre-existing PHIN data flows as this avoids the risk of misrepresenting data. • In addition, PHIN can consider publishing participation information for consultants and hospital site level. This would provide patients with valuable information regarding transparency and clinical governance within private healthcare providers and for individual consultants. • It should be noted that not all of the above registries collect comprehensive information relating to private activity. We will make it clear in our publications that the lack of participation in a registry should not necessarily reflect negatively on hospitals/sites.
Enablers and dependencies	• There will need to be data-sharing agreements with the relevant registries to receive regular updates of those submitting data in order to maintain the PHIN website.

10.1.10 J – Improvements in Health Outcomes

Progress to-date	• PHIN publishes on a quarterly basis a CMA-compliant measure at hospital level for patient-reported outcome measures (PROMs) for hip and knee operations at hospital level for around 120 private healthcare providers. • PHIN plans to publish a similar measure for cataract procedures by the end of 2022. • Participation in the other PROMs that were first identified by a cross-sector working group in 2014 and subsequently increased with the addition of cosmetic surgery measures is significantly lower. • No PROMs measures have yet been published at consultant level; however, there is a plan to do so where the outputs would be valid and meaningful. Within PHIN's Portal, private healthcare providers can see for each PROMs-eligible procedure their completion rates overall, down to the level of detail of which anonymised patient received or completed a PROM. However, this does not yet include a view that shows participation by individual consultant.
Definition of complete	• PROMs reported for a minimum of six measures with overall completion rates from eligible hospitals and minimum of national-level view of pre- & post-treatment outcomes published for each measure. • Further work is needed to determine the feasibility of publication at consultant level.

10.1.10 J – Improvements in Health Outcomes cont

Roadmap to Compliance

- We are currently working with stakeholders, including the Task and Finish group to define what a reasonable target for publication is for this measure, as outlined in the row immediately below, with the aim of producing a policy recommendation in Q4 2022.
- PHIN commissioned the London School of Economics (LSE) to review the PROMs take-up by private providers with a view to identifying a range of recommendations for increasing PROMs participation and collection rates, as well as the practical value of the data that can be published.
- The draft report was completed at the end of 2021 and has now been validated and supported by a wide range of stakeholders. The report proposed nine recommendations and the sector will start working to implement the recommendations during 2022. One of the key recommendations is for PHIN and providers to initially focus on the collection and publication of PROMs for all patients having the higher-volume procedures in order to create positive momentum and make changes to ensure that the right PROMs are in place. These are:

  1. Hip replacement surgery.
  2. Knee replacement surgery.
  3. Cataracts.
  4. Augmentation mammoplasty.
  5. Rhinoplasty.
  6. Liposuction.

- A PROMs priority for PHIN and the sector is to ensure that the right PROMs are in place and up to date. Agreement is in place with the support of the British Association of Aesthetic and Plastic Surgeons that the current rhytidectomy PROM be discontinued and the addition of a suitable breast reduction PROM be made.
- As PROMs publication can take a long time from the commencement of Q1 collection to submission of Q2 survey results and publication, the sector will look to publish a 'participation indicator' on its website for patients to show which private healthcare providers are engaged in PROMs collection and learning from patient outcomes. The participation indicator will be published in 2023.

At hospital level:

- PHIN and its members believe that the publication of six PROMs, along with the participation indicator represents the minimum compliance with the CMA Order at hospital level, but the feasibility of publication is dependent on the completeness and quality of the data we receive, particularly for the publication of more sophisticated metrics, such as health gain, that incorporate case-mix adjustment.
- PHIN will additionally publish national-level information for each PROM to indicate patients' health status before and after treatment using the questions relevant to each PROM. This will act as a useful reference for patient-clinician conversations and their expectations for their outcome of care. As for other measures, and where statistically possible, we intend to enable filtering of this view to enable patients to understand how the outcomes for patients like themselves may differ from the population at large.

At consultant level:

- Data completeness will need to be significantly improved to publish PROMs at consultant-level, as the smaller numbers of PROMs responses per consultant (compared to per site) makes it statistically challenging to identify whether variations are due to clinical practice or to chance.
- As an interim step, PHIN will publish information on the PHIN Portal to enable consultants to see information about their own PROMs results.

10.1.10 J – Improvements in Health Outcomes cont

Enablers and dependencies	• The LSE report describes in detail the processes that private healthcare providers should have in place to enable the delivery of further PROMs to be successful. Headlines from this report are listed below: - All private healthcare providers or private facilities carrying out procedures eligible for PROMs should collect Q1 and Q2 survey responses for at least 30% of their patients. This number is the average for participating private healthcare providers collecting hip and knee PROMs for the most recent published time period, September 2019-August 2020. - There is a need to release insights based on the PROMs via the hospital and consultant Portal which will identify participation or the lack of it, as well as provide easily understandable and relevant information to help manage patient and consultant expectations about treatment effectiveness. - The LSE report also sets out the need for an ongoing cross-sector collaboration between private healthcare providers, Royal Colleges and professional societies, consultants, PMIs and system suppliers to make sure that the right measures are collected in the right way, and that this information is presented in a way that can be understood and is valuable both to patients and their consultants. Promotion of PROMs and their practical value needs all parts of the sector to be active and aligned, from all types of organisations and role mentioned here. - A cross-functional working group with clinical leadership from Royal Colleges or professional societies and with the contributions of relevant stakeholders (including private healthcare providers, PMIs, system suppliers and PHIN) should use the PROMs report to address the sector's practical needs, ensure that relevant materials are available to private healthcare providers to participate in PROMs, and plan accordingly so that the right PROMs are in place. - PHIN will collect and publish information about the system suppliers which collect the PROMs data on behalf of private healthcare providers. In 2023 PHIN will share a profile of current and eligible system suppliers with private healthcare providers so that they can be aware of best practice, compare and ensure that they are getting the right PROMs functionality and value-for-money. - PROMs should not cause a disproportionate cost or barrier for the private sector, such that smaller private healthcare providers cannot make treatments profitable because of the high licence fee thresholds of PROMs (annual fees can be between £3-£20k for use of an individual PROM before any patient has been treated and regardless of actual volumes). The working group should enable a process so that the private sector can start to collectively negotiate proportionate and viable licence fees with the licensor, rather than let each hospital fend for itself – or select validated PROMs that do not incur licence costs. Private healthcare providers should have staff allocated to ensuring that PROMs data is not only collected but also used in practice, alongside the PROMs data published by PHIN, to understand effectiveness of care and identify improvements, sharing this information alike with relevant consultants and patients. This includes having proper reviews of PROMs data at clinical and governance meetings. - In the longer-term, the cross-functional working group mentioned above may identify and oversee the introduction and publication of further PROMs for procedures across a much wider base of hospital activity, so as to better inform patients about the quality and effectiveness of providers and treatments.

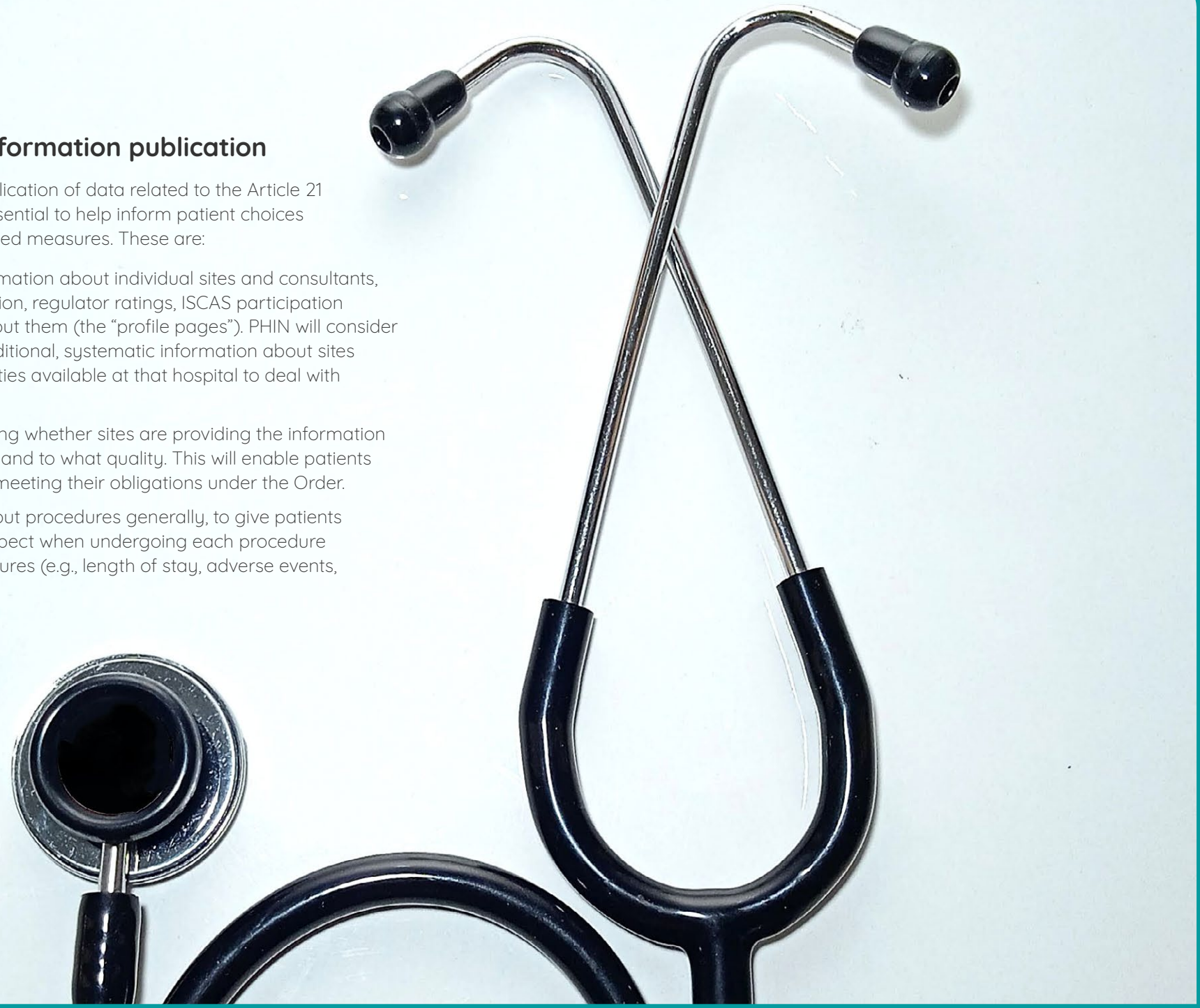
10.1.11 K – Frequency of adverse events

Progress to-date	• PHIN has published information on three types of adverse event at hospital level (Never Events, returns to theatre and serious injuries) and this constitutes partially CMA compliant delivery. We do not currently publish information on adverse events at consultant level.	
Definition of complete	• We are currently working with stakeholders, including the Task and Finish group to define what a reasonable target for publication is for this measure, as outlined in the row immediately below, with the aim of producing a policy recommendation in Q4 2022. This is likely to be:	
	For hospitals: • Publication of Never Event numbers at hospital level. These reflect system-wide safety issues and as such publication at procedure level is not appropriate. Publication of rates and case-mix adjustment are not appropriate, according to NHS standards. • Publication of Serious Injury numbers and rates. This will be enhanced to include more comprehensive information about different types of events. • For returns to theatre, publication of rates at site and procedure level ("as expected" and rates), including case mix adjustment where possible.	**For consultants:** • As Never Events and Serious Injuries reflect system-wide safety issues publication at consultant level is not appropriate. However, information will be presented about the sites at which a specific consultant works. • For returns to theatre, publication of rates at procedure level ("as expected" and rates), including case mix adjustment where possible.
Roadmap to Compliance	**Hospital level publication** • PHIN plans to enhance the serious injuries measure in early 2023 with additional categories of serious injuries, but this is dependent on changes to our data collection to capture this information. • PHIN will continue to engage with hospital providers to ensure that more private healthcare providers are published with these measures over the next two years.	**Consultant level publication** • As set out in the publication principles and the process in 10.1, the first step will be to assess whether it is viable to publish at consultant level as long as it is (a) accepted medical practice and (b) statistically possible.
Enablers and dependencies	• We are currently working with stakeholders, including the Task and Finish group to define what a reasonable target for publication is for this measure, as outlined in the row immediately below, with the aim of producing a policy recommendation in Q4 2022. • Data specification review, if we need to collect more information about these events.	

10.2 Cross-measure information publication

In our plan, we set out other publication of data related to the Article 21 measures delivery, which are essential to help inform patient choices and making sense of the published measures. These are:

- Publication of additional information about individual sites and consultants, for example, contact information, regulator ratings, ISCAS participation and narrative information about them (the “profile pages”). PHIN will consider the feasibility of collecting additional, systematic information about sites e.g., better indicators the facilities available at that hospital to deal with complex cases.
- Data quality reporting, including whether sites are providing the information required in the Order to PHIN, and to what quality. This will enable patients to see how well hospitals are meeting their obligations under the Order.
- Publication of information about procedures generally, to give patients a view of what they should expect when undergoing each procedure with regards to relevant measures (e.g., length of stay, adverse events, clinical outcomes, etc.)



11 APPENDIX 3 – ARTICLE 22 FEES

11.1 Consultants' self-pay consultation and procedure fees

11.1.1 Progress to-date

- PHIN has developed a process that enables consultants to submit and maintain self-pay consultation and procedure fee information via the consultant Portal. To date fees for around 8,000 consultants have been submitted and published on the website for patients and the figure is increasing gradually. Reminders are also sent to consultants to make sure fees are up-to-date.
- PHIN is also working with the CMA to escalate details of those consultants who are busy in private practice but who have not engaged with the submission process. That project is in progress. The expected goal of that work is that more consultants take their obligations seriously and provide the required information to PHIN.

11.1.2 Roadmap to compliance

- Continued engagement with consultants and improve the process for fee submission via the Portal. There will also be other tranches of consultants who have not engaged escalated to the CMA.

11.1.3 Enablers and dependencies

- No enablers or dependencies beyond the support from the CMA in engaging with consultants who have not submitted fee information.

11.2 Consultant fee arrangements with insurers

11.2.1 Progress to-date

- PHIN's research with patients indicated that they prioritise understanding if a consultant fee is likely to be met in full by their private healthcare insurer rather than understanding the price itself. PHIN commenced a project to identify and implement a process whereby consultants indicate their charging behaviour in respect of patients insured with the larger PMI providers.

11.2.2 Roadmap to compliance

- The project was delayed during the pandemic but is now near to a solution which has been tested with consultants and PMI providers.
- The intention is to implement the fee arrangements approach via the consultant Portal early in 2023 and begin collecting the required information from consultants. During 2023 PHIN will also develop the solution for publishing the insurer fee arrangements on the website.

11.2.3 Enablers and dependencies

- Only that achieving wide coverage for the fee arrangements approach will take time and support may be requested from the CMA to enforce compliance.

11.3 Anaesthetic fees

11.3.1 Progress to-date

- PHIN was in the process of working with the Association of Anaesthetists on a solution for collecting and publishing anaesthetic fees before the pandemic. No solution was reached at the time.

11.3.2 Roadmap to compliance

- Project and discussions to restart. PHIN expects to reach an agreed solution for collecting and publishing anaesthetic fees by the end of year 2024. PHIN expect it to take a further year before anaesthetic fees, along with surgeons' fees will be published at scale on the website.

11.3.3 Enablers and dependencies

- There are a few challenges to publishing anaesthetic fees on PHIN's website. They include the current lack of an anaesthetist GMC number provided in the data submitted to PHIN. Another is that while surgeons typically undertake 10-20 different procedures privately, an anaesthetist will work with several surgeons and tens of procedures being performed. The task of allocating a price to every procedure will be more time-consuming. There are also a number of anaesthetic group practices and they may wish to submit fees at group level instead of individual anaesthetist. In addition, there are several anaesthetists whose prices are incorporate into hospital packages, which will need to be factored into plans. Finally, the challenge for the patient website will be associating the anaesthetist with the surgeon to provide an accurate combined cost of the procedure.

11.4 Out-patient only consultant fees

11.4.1 Progress to-date

- Where out-patient medical consultants have been identified in the data submitted to PHIN for privately funded admitted care, PHIN has engaged the relevant consultants to provide fee information. However, where consultants only practise in an out-patient capacity, they will not appear in submitted data.

11.4.2 Roadmap to compliance

- PHIN will need to be able to identify and contact consultants practicing in outpatients only.
- Amend its Portal fee submission process to enable consultants to input consultation fees only. It will also identify how best to present these consultants on the website, given that there will be no related performance measures for their practice. This will be completed by 2025.
- Engagement will commence with medical consultants during 2024 to collect fees and aim to begin publishing the information on the website by the end of the same year.

11.4.3 Enablers and dependencies

- At present PHIN receives no data for out-patient private care from providers and therefore cannot identify which physician type consultants are engaged in private practice. PHIN is given to understand there is no large-scale database it can gain access to that identifies out-patient physicians in private practice in order to support an engagement process.

11.5 Hospital prices

11.5.1 Progress to-date

- The CMA Order is specific in requiring consultants to submit fees for consultations and procedures. At the time of the Order being written, private healthcare providers were publishing a range of inclusive package prices on their websites and with that the CMA could not find an adverse effect on competition with hospital prices. Since then, private healthcare providers have changed their websites and have varying degrees of information published on their prices.
- Private healthcare providers acknowledge that publishing consultant fees only provides patients with a small element of the overall cost of their private care. They are prepared to discuss a solution for collecting and publishing 'package prices' for a range of common operations but believe those discussions should come after the majority of the specified measures have been delivered.
- Stakeholders in the sector also recognise that comparable self-pay package prices, whilst not expressly within the Order, is important to patients. This will only be considered once the obligations in Article 21 and 22 of the CMA Order are delivered.

11.5.2 Enablers and dependencies

- There are a few enablers and dependencies to publishing hospital packages. The largest is reintroducing a standardised set of pricing components and format across the sector to enable patients to compare prices and what's included in the cost. Related to this are the standardising the current variations in terms and conditions for patients and the clarifying the extent to which the price is a guide or guaranteed.

12 APPENDIX 4 – STRATEGIC ENABLERS AND SUPPORTING WORKSTREAMS

12.1 Strategic improvement plans and workstreams

12.1.1 Data quality and coding improvement

- A key enabler to allow PHIN to develop and publish more complex measures at hospital and consultant level will be data quality and coding.
- A multi-year work stream will be developed to support private healthcare providers and consultants improve data quality, including reporting and feedback loops, campaigns and the need for continuous improvement across the sector.
- Without improved data quality and consistency, it may not be possible to publish many of the remaining measures in the Order nor case-mix adjusted measures, therefore this is a critical programme which will require patience, learning and a multi-pronged approach.
- Without the NHS number it will be difficult to publish linked measures.
- Without high levels of accurate consultant attribution will continue to lose trust from consultants and not be able to publish measures accurately at consultant level, and ethnicity and other key demographic coding will be required to case-mix adjust the more complex measures at both site and consultant level.

12.1.2 Procedure grouping

- Procedure groups are critical to what PHIN publishes as they form the foundation of how both patients interact with its information and how PHIN reports on hospital and consultant performance. PHIN needs to always ensure it can report clinically meaningful information for consultants and patients.
- At present, only c. 67% of incoming OPCS procedures end up in one of PHIN's Procedure Groups. This means that >30% of procedures are not available for publication.
- The level of granularity of our procedure groups is too fine and can often be too medically focused for patients. PHIN needs to improve the presentation of procedures so that they are understandable.
- A piece of work is currently underway to assess what an improvement programme could look like in this area. The Partnership Forum has recommended that we implement any short-term fixes available as a quick win, and that we produce a fuller proposal for the more comprehensive solution can be delivered, balancing this with other priorities for CMA Order delivery.

12.1.3 Whole practice

- Although the Order requires delivery to focus on private activity first, this must be set in the context of wider care delivery in the UK, for example to be able to show relative size of market across the whole UK and across both private and NHS activity, and to ensure that other measures can be evaluated compared to analogous NHS-funded care. Data are fragmented on the NHS side by measure as various organisations collect and report on information relevant to our measures, as well as geography across the devolved nations.
- In parallel to the ADAPt programme, there is a need to continue to work on whole practice reporting, to work to acquire NHS data for Wales, NI and Scotland, and work to align methods with those in the NHS.
- It will also be necessary to assess feasibility of publication of equivalent measures for NHS-funded care from NHS sources, to set the private procedures in the appropriate context.
- There is a particular issue relating to consultant activity volumes across their whole practice. Patients need to be able to see the totality of a consultant's experience regardless of funder, and any differences between their privately- and NHS-funded work. As described elsewhere in this document, getting accurate consultant attribution information is challenging, particularly on NHS-funded activity. To address this, the sector will:

- Consider how our specification can be modified to maximise the accuracy of consultant attribution at procedure level for the APC dataset.
- Develop the Portal so that consultants can accept and reject activity attributed to them at a more granular level, across both APC and HES datasets.
- Explore the possibility of consultants being able to self-declare their NHS activity.
- Establish improved processes for private healthcare providers to improve their data quality when issues are flagged by consultants.

12.1.4 ADAPt and other partnerships

- PHIN is committed to the idea that good data should be collected once and used for many purposes. PHIN are seeking to reduce effort, duplication, and barriers across the system for all, not just optimising for PHIN's operational activities. Incomparable data across the private sector and the NHS has been a key factor in cases where standards of care have failed patients and the sector will need to help step-up the work taking place at a national level to promote data interoperability across the entire health system. Agreed standards and definitions benefit patients as PHIN develop a common way to view and understand information. Having fewer data submissions and systems to interface with also provides benefit to providers through reduced repetition and effort.
- The Paterson Inquiry provides sufficient basis to put collaboration and a shared public-private data set at the heart of the future strategy. PHIN knows that information to support consumer decision-making must be comparable across different services and consultants. The ADAPt programme has wide-scale support from across the public and private sectors.
- Following the completion of three pilot initiatives, PHIN will be working with NHS Digital to explore how best to operationalise achieving either a single, national dataset of all elective activity in England, or a single, consistent view of the many existing datasets.
- Among the customers for the private healthcare data being made available through ADAPt are the regulators, notably the Care Quality Commission (CQC), and potentially the General Medical Council (GMC). This will continue to be a key part of our strategy as PHIN continually looks to align and integrate with NHS systems.
- Another high-priority customer for the data is NHS England, through the Getting It Right First Time Programme (GIRFT), and its relation the National Consultant Information Programme (NCIP), aimed at private healthcare providers and consultants, respectively. These are successful, clinically driven national initiatives aimed at improving understanding of activity and performance and reducing unwarranted variation in care.
- PHIN can deliver its priorities standalone, however PHIN sees collaborative working as a more efficient means of delivery, and so will always pursue these opportunities as they arise. Whilst we do not know how these partnerships will play-out, PHIN is committed to working with partners to achieve collective objectives in the future.
- However, it is also recognised that programmes need consistent support across the sector, appropriate resourcing and long-term planning as some hesitancy remains, therefore dialogue over the future strategy of these areas will be needed.

12.1.5 Technology

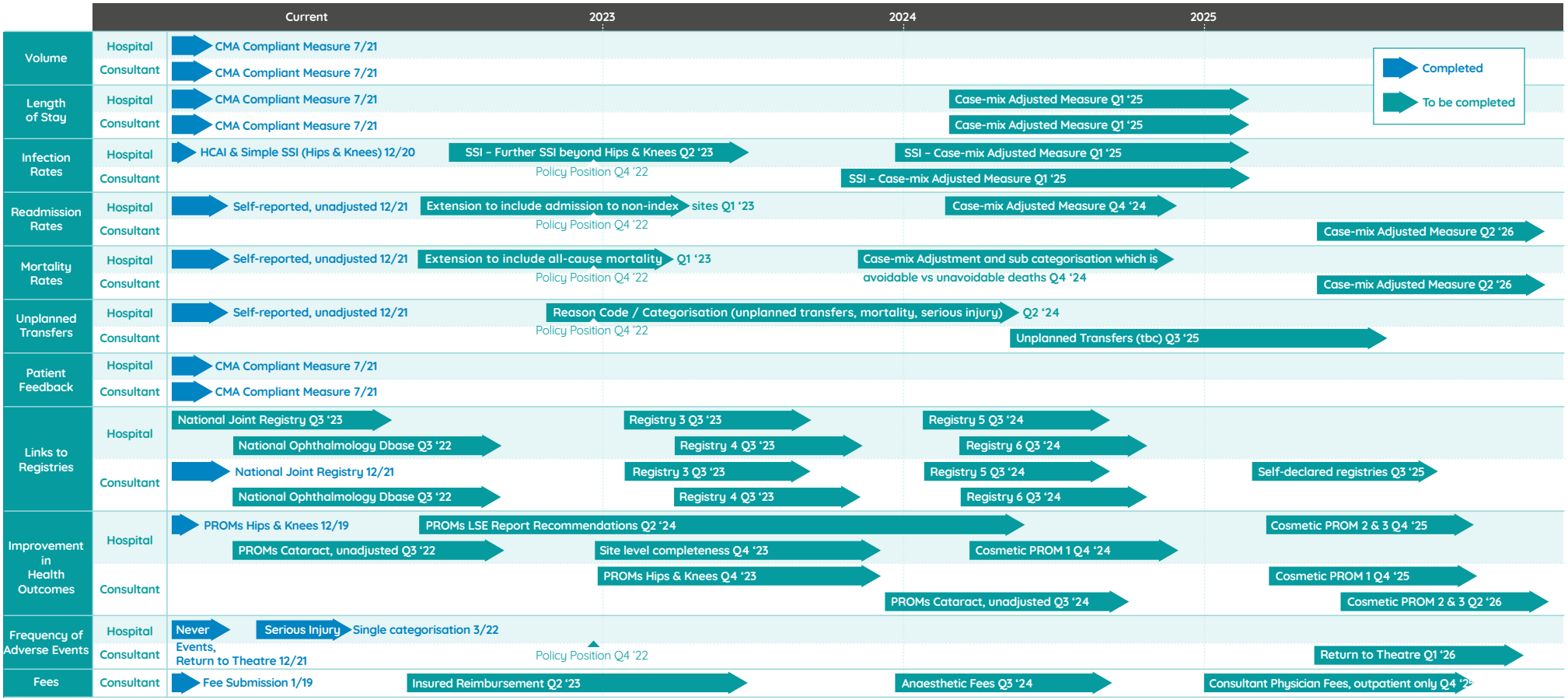
- PHIN will aim to explore and deliver product developments including improved patient search and, where there are clear use cases, increased incorporation of machine learning/AI into PHIN's systems.
- The team will explore the usage of APIs for data transfer and embedded website elements for third party products and syndication.
- Furthermore, Technology will play the key part in designing and developing the underlying systems to support our reporting, data management and data quality improvement plans.

12.1.6 Performance, benchmarking and data analysis

- PHIN will reward positive engagement with value-adding benchmarking and analysis tools and features in the Portal and Data Explorer on the website. There will be separate views for patients (to enable them to find more tailored information), and for consultants and hospitals (for use in quality improvement and appraisals).
- The first step of this area will be building up the core Business Intelligence platform and tools that will underpin this objective. This will then be complemented by developments from the PHIN Informatics team, who will produce reports and tools for our members and patients of private healthcare, including a public 'Data Explorer' visualisation, analysis and comparison tool, as well as customised reports in the portal to visualise and benchmark performance information provided to PHIN. We will develop these tools to both inform our partners and increase engagement.
- This will be supported by more comprehensive internal performance monitoring by PHIN, whereby PHIN, private hospital providers and consultants monitor agreed KPIs and performance across a range of captured metrics, using data to drive decision making and make sure we work efficiently and effectively.

13 APPENDIX 5 – ROADMAP

13.1 Hospital and consultant level publication



13.2 Enablers Programme