PHIN

THE 2016 ANNUAL REPORT

THE PRIVATE HEALTHCARE INFORMATION NETWORK

This report refers extensively to 'the CMA Order'.
The Competition & Markets Authority's (CMA) Private Healthcare Market Investigation Order 2014.

An investigation by the UK's competition authority found that the lack of information available to patients considering private treatment was sufficiently serious as to create an adverse effect on competition. The Order created remedies to this problem, appointing an information organisation (PHIN), and requiring that:

> *"Every operator of a private healthcare facility shall… supply the information organisation, quarterly from a date no later than 1 September 2016, with information as regards every patient episode of all private patients treated at that facility, and data which is sufficiently detailed and complete to enable the information organisation to publish [specified] performance measures by procedure at both hospital and consultant level. The information organisation shall publish performance information on its website, as specified by this Order… no later than 30 April 2017."*

Further information can be found in PHIN's Strategic Plan 2015-2020 (available at www.phin.org.uk) and on the CMA website (www.gov.uk/cma-cases/private-healthcare-market-investigation).

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It has been a year of rapid progress toward publication

The past year has been dominated by our preparations for the publication of information in accordance with the CMA's Order from April 2017.

We have seen rapid development from PHIN and a huge implementation effort from hospitals.

From the Board's perspective, we have aimed to support and steer the Chief Executive and his excellent team, while continuing to improve governance.

We are pleased to have established our Audit & Risk Committee, chaired by Jayne Scott, who has also become our Deputy Chairman. We have also established the Remuneration Committee, chaired by Fiona Booth. Both will make a strong contribution to PHIN's governance and, in particular, to providing assurance to PHIN's members. I would like to thank Jayne and Fiona, and all of our directors, for their support and focus during the year.

It is very pleasing to see PHIN growing into its role. In addition to hospital members, our forthcoming AGM will be the first attended by representatives of the medical professions and of private medical insurers (PMIs) as voting Members; this follows a successful informal meeting in July.

In recent months we have welcomed dozens of new hospital organisations to PHIN, notably many of the leading NHS trusts and foundation trusts that offer private services, and others such as leading cosmetic surgery specialists. We have also started to work with hospitals and authorities in Scotland, Wales and Northern Ireland, although it will take time to find exactly the right approach in those countries.

The team has responded well to many challenges, but there have also been some frustrations. As a long-time champion of Patient Reported Outcome Measures (PROMs), I am personally disappointed with the collective response to date on that CMA requirement. I hope that the hospitals will drive this forward over the coming year, not least because I am confident that it will further differentiate the sector from the NHS.

I would particularly like to recognise the PHIN team's sterling work on information governance; it is a challenge for any organisation to achieve the prestigious ISO 27001 Information Security Management Standard, and to do so in six months in response to hospitals' requests is quite an achievement. I also note the strong, mutually supportive relationship that we enjoy with the CMA, and the positive attitude within our team.

The path to April 2017 is clear. Beyond that, we will need to give more thought to the needs of patients, and ensure that PHIN is a source of added value to all participants in private healthcare. The opportunity exists for us to work together to demonstrate excellence, both in information provision and quality of clinical outcome, and the Board believes that in doing so we will make the sector stronger.

Andrew Vallance-Owen
MBE, MBA, FRCSEd
Chairman

We have started a real transformation in data gathering in private healthcare, and must now turn that into great information for patients

On 1 September 2016 we reached the CMA's deadline date for hospitals to supply data to PHIN. Initial results were encouraging but, as expected, imperfect.

PHIN has spent the past year working with hospitals and consultants to submit data and prepare for publication, and building the tools and capabilities required to support that.

Our engagement team has worked with over 200 hospital organisations and numerous stakeholders, responding to hundreds of questions, and constantly looking for ways to increase knowledge and participation. They have done great work in turning individual issues and queries into communications, FAQs and training materials that benefit the whole sector. We have strived to ensure that every organisation subject to the CMA's Order is aware of it and has the opportunity to comply.

In February we launched a new public-facing website and a secure information portal for hospitals.

Behind the scenes we have built systems to securely receive and process hundreds of data files, a customer relationship management (CRM) system to ensure that we can be professional in all our interactions, robust authentication systems, compliance reports and many other tools and products that are essential but mainly unseen.

We have also made considerable progress on governance, improving processes and control, achieving important accreditations and working through tricky issues with hospitals and other stakeholders.

Over the next few months, as we head toward publication, we need to see renewed efforts to improve data quality and engagement with the medical profession. The hospitals have started producing better data, but they now need to fully engage consultants in checking and improving it, at the same time reassuring them that the data will be fair and accurate. PHIN must continue to evolve its products to support that.

Thanks must go to the Association of Independent Healthcare Organisations (AIHO), particularly for helping us to work with the devolved nations, and to Geoffrey Glazer, chairman of the Federation of Independent Practitioner Organisations (FIPO) who has marshalled increasingly supportive professional input into PHIN. Mike Kimmons and Julia Trusler from the British Orthopaedic Association have also been very helpfully involved. Their support will be essential going forward.

PHIN remains a small business, evolving rapidly while carrying significant responsibilities. We won't always get things right, but we will continue to listen, consult and improve.

Financially, we have delivered another year within our budget, despite many challenges. We reduced the subscriptions that most organisations pay and deferred the first invoices for newly participating hospitals. For the coming year our budget must increase as we reach full scale. This is funded largely by subscriptions from new hospitals, but a small increase in fee is required while we work to bring in those new subscriptions.

Matt James
Chief Executive

Most hospital organisations have fully engaged and worked hard to prepare and submit data, but a lot of hard work remains before publication

More than 500 hospitals run by 200 organisations were required to respond to the CMA's Order.

PHIN took up its role as the CMA's information organisation in April 2015.

We have worked to identify, contact, and bring on board every organisation subject to the Order, ensuring that each has the opportunity to participate and achieve compliance (whether or not they in fact do so). This has been a substantial engagement programme.

In September 2016, PHIN received data from 62 organisations, estimated to collectively represent >85% of all private patient activity.

Participants include all of the larger national hospital groups that helped to found PHIN, along with NHS trusts and foundation trusts, and smaller private hospitals and clinics.

The CMA has contacted the remaining organisations to explain that they are in breach of the Order and outlined next steps to achieve compliance.

The CMA has recognised that it will take time to bring hospitals in Scotland, Wales and Northern Ireland into full participation.

Data completeness and quality must improve rapidly.

We are receiving data that includes diagnostic coding to international standards for the first time in private healthcare. This includes secondary diagnoses (co-morbidities) essential to enable the risk-adjustment required for fair comparisons to be made.

However, data is far from perfect, with much work required on completeness, validity and accuracy. No organisation has yet submitted data of sufficient completeness and quality to support publication for patients with confidence.

Notably, no organisation has yet submitted usable data on measures of improvement in health outcome (PROMs). This must improve before April 2017.

We estimate that providers submitting data undertake

86%

of all private activity

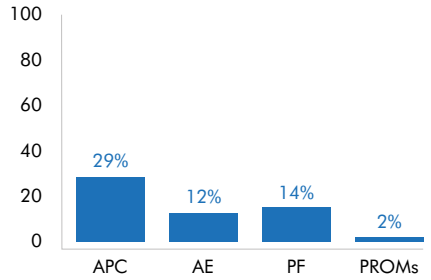
Of the episode data submitted,

52%

meet basic data validity

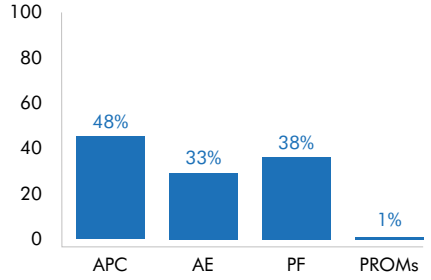
62 providers (29%) have started submitting episode data, with only 4% submitting PROMs.

% of providers submitting data, by data set



However, this accounts for 48% of hospital sites where episode data is available.

% of hospitals sites submitting data, by data set



Key

APC Episode data
AE Adverse Events
PF Patient Feedback
PROMs Patient Outcomes

We have worked to give every organisation the tools and opportunity to participate positively and achieve CMA compliance

PHIN has aimed to support all hospital organisations, including many smaller independent hospitals and leading NHS trusts.

PHIN has written to and spoken with 200 providers believed to be covered by the Order across the UK. We have provided information, responded to hundreds of queries and questions and guided them through the implementation process.

We have worked with NHS Improvement, the Care Quality Commission and various other public sector stakeholders in four nations to help get the message out to hospitals.

Early on we completed a programme of 10 information events for over 100 providers new to the process. Since then, we have responded to invitations to local meetings and held regular events aimed at helping hospitals become familiar with the data requirements and improve data quality.

Involving hospitals and keeping them informed.

Our online Member Manual provides hospitals with operational guidance and governance information, along with data specifications and sample datasets to help them prepare for and submit the required data. It has proved an valuable resource, having received over 2000 hits since its launch early in 2016.

We launched a fortnightly newsletter in March 2016, with updates from the CMA, our Board, and views from hospitals attending our Implementation Forum.

As we approached the 1 September deadline, we helped members to understand their comparative readiness, conducting surveys and providing regular feedback.

Our secure online portal enables hospitals to check the data they have submitted. To date this has focused on data submission, completeness and validity. As we move into 2017, the focus will shift to data quality, clinical performance and supporting consultants.

We have listened to hospitals and responded to their concerns.

We worked with hospitals to develop every aspect of our approach, from the data specifications through communications to the design of the public website.

Many raised concerns or sought additional reassurance on information governance; PHIN has responded comprehensively.

PHIN asked the CMA not to enforce the submission of patient-identifiable data until we had fully addressed governance concerns; they agreed.

We have worked with hospitals and the CMA to interpret the Order pragmatically in relation to issues including fertility services, mental health, timescales for reviewing data, information governance and subscription fees.

In preparing to publish performance measures, PHIN is engaging with more than 14,000 consultants across 15 specialties

PHIN has pursued both professional and operational engagement.

There are two key challenges:

1. To ensure that the information to be published is fair and robust from a professional perspective.

2. To ensure that every consultant has the opportunity to check the information about their practice and to address concerns in respect of data quality before publication.

In January, the Federation of Independent Practitioner Organisations (FIPO) formed a Clinical Outcomes Advisory Group (COAG) to co-ordinate professional input into preparations for publication.

FIPO-COAG has focused on building relationships with the national clinical audits and registries.

The group will be increasingly involved in steering the analysis of data and presentation of information to ensure fairness from a professional perspective.

Representatives from FIPO have regularly attended our monthly implementation forum, providing vital input.

In May we launched and pilot-tested a secure online portal for consultants.

The portal is the tool for consultants to check and eventually sign-off their data prior to publication. It will bring together data from every hospital at which they practice, including their NHS hospitals, and show their activity and performance benchmarked against their peers.

For the pilot, hospitals nominated 100 consultants to test the portal and provide feedback. This has helped us to refine the information provided and user experience, ahead of rolling out to all consultants.

Feedback was overwhelmingly positive, while highlighting significant (and expected) gaps in the data at that point in time.

We are addressing the significant communications challenge.

PHIN has supported hospitals with engagement resources, including factsheets and presentations for consultants.

We helped raise awareness through professional publications including Independent Practitioner Today and online articles for the Royal College of Surgeons.

We have invested in a new platform to enable us to manage communications with all consultants in partnership with the General Medical Council.

We aim to balance an absolute commitment to making the CMA's information remedies work for patients, with a pragmatic view on what is deliverable in the time available

PHIN has built an excellent working relationship with the CMA.

PHIN meets with the CMA remedies team at least quarterly, and is in frequent communication.

We have established a relationship of trust and credibility through our commitment to achieving the remedies, allowing us to represent hospitals' views on issues of concern and implementation challenges.

We have kept the CMA closely informed of hospitals' state of readiness and compliance, and helped to think through issues such as how to implement Article 22 - the requirement for consultants fees (now progressing following the conclusion of an appeal).

The CMA has shown understanding and flexibility on key issues, for example recognising that hospitals' concerns on data protection needed to be fully addressed before they enforce the submission of NHS numbers, as required by the Order. This allowed hospitals to submit data on time and defer the submission of personal data.

PHIN worked with hospitals, the CMA and the Human Fertilisation & Embryology Authority (HFEA) to recognise the excellent existing information that the HFEA makes available and the special rules that apply, excluding these services from PHIN's scope.

We have worked closely with the Care Quality Commission (CQC).

The CQC, the health service regulator in England, has begun to ask hospitals prior to inspection whether they comply with the CMA's requirements. They have attended our implementation forum and we regularly discussion key issues and challenges.

We welcome changes at NHS Digital.

We have built a strategic partnership with NHS Digital, formerly the Health & Social Care Information Centre (HSCIC), this year and have seen significant improvement in their processes. Our focus to date has been largely on information governance and gaining permission to access NHS data, but we will soon co-operate on producing performance measures.

We have made progress with stakeholders in Scotland, Wales, and Northern Ireland.

We have started to work with the governments, regulators, information directorates, health services, hospital operators, and representative associations in the devolved nations. The CMA is also closely involved.

PHIN has made significant progress in providing assurance and leadership on information governance and data protection

PHIN has responded positively to hospitals' need for assurance on data protection.

The CMA's Order requires that hospitals include some elements of personal data in their submissions to PHIN, to facilitate the production of key performance measures. That raises complex questions on data protection, governance and consent.

Responding to those concerns, PHIN has made significant undertakings to provide assurance on information governance, and has greatly increased its focus and resources in this area during the year.

We have worked closely with NHS Digital on developing a robust consent process for hospitals.

PHIN has worked hard to minimise the requirement for personal data to produce the performance measures.

After a great deal of consultation, we have taken the view that hospitals should seek consent of patients for the sharing of personal data, and have worked with NHS Digital to develop consent wording.

We achieved the international standard for information security management systems (ISO 27001) in six months.

Having been assessed in June 2016, our information security management systems are now fully embedded into the business and continues to evolve.

In August we passed a full audit by NHS Digital, and were praised for the completeness of our information governance training for staff and for our use of expert external testing of our system security.

We will soon be accredited under the NHS Information Governance Toolkit, and have undertaken to complete a privacy impact assessment (following ICO Guidelines) in respect of any major future changes.

PHIN's Board has established new structures to improve internal governance.

During the year PHIN's Board introduced the Audit & Risk Committee and the Remuneration Committee. Both are now fully functional. The Board reviews all information governance events, no matter how small.

PHIN's voting membership has expanded.

PHIN is a not-for-profit organisation, with voting Members instead of shareholders. This year, in accordance with the CMA's Order, our membership has expanded to include private medical insurers (PMIs) and FIPO alongside the founding hospitals.

PHIN is delivering the tools to enable hospitals to submit data securely, to check data quality and to ensure that information is displayed accurately and effectively

We are investing in developing tools to help hospitals and consultants to achieve compliance and improve understanding of quality.

The CMA's Order requires that we publish data on a website, but we believe that our secure online portal is equally vital.

Historically there has been no platform for the hospitals to understand their own activity and quality by direct comparison with others, and potentially to improve clinical quality. We are providing that system.

However, the initial focus has necessarily been on supporting data submission and improving validity.

We focus on users' needs.

Our portal needed to be simple and easy to use. It had to be robustly secure and straightforward to update – the needs of hospitals are changing rapidly as we move through implementation phases and as we go we learn more about users' needs.

By the end of the year the portal will contain all the data submitted by hospitals in early 2016. This will be the data that will be used to develop the performance measures as they will appear on the patient website.

Our website is built but not yet fully launched.

In late 2015 we withdrew comparative data from our website pending a new agreement with NHS Digital for NHS data. This also allowed our hospitals to focus on achieving compliance with the new data requirements of the Order.

In February 2016 we launched our new-look website, but without comparative data.

We have since developed the platform to provide comparative hospital data, and have begun work on the display of information about consultants.

However, launching a data-driven website is a process that itself requires extreme focus to ensure that everything is thoroughly checked as accurate. Our website will soon contain over 2 million charts and numbers!

As such, launch of the comparative data is on hold until we reach a position of confidence on the completeness and quality of data supplied by the hospitals.

We have continued our strategy to bring skills in-house.

Historically PHIN was entirely dependent on external suppliers to process our data and deliver our products.

Over the last year, in response to the challenges of the CMA's Order, we have gradually brought skills in house to improve delivery and reduce costs.

PHIN is a not-for-profit organisation aiming to deliver on a challenging set of objectives while keeping costs reasonable

PHIN is committed to financial transparency and fairness.

Under the CMA Order, hospitals are required collectively 'to cover the reasonable costs of the information organisation'.

PHIN is wholly focused on delivery of the Order while remaining aware of the need to keep our costs reasonable, and commit to financial transparency.

It is the Board's duty to ensure that PHIN is adequately funded and resourced to meet our agreed objectives, with appropriate financial controls and management of risk.

In October 2015, PHIN's Strategic Plan 2015-2020 was agreed by voting Members at its AGM. In January 2016, this was approved by the CMA in accordance with Article 24.1 of the Order.

PHIN is also required to publish Board minutes, an annual report on progress (this document), and financial details.

PHIN cut its subscription fees for most hospitals and finished the year within its budget.

In August 2015, PHIN removed its previous charges in respect of NHS episode records to better align with the Order, which refers only to privately-funded episodes. This had the effect of reducing subscriptions for most of our existing members.

Subscription fees in respect of each private episode record were held at £3.12.

PHIN finished the financial year to 31 July 2016 with a retained surplus of £753,324 (ahead of plan by £129,487).

Cash and debt require management.

PHIN is a small business, and is very sensitive to any delay to receiving income. Hospitals have a mixed record on prompt payment. As we have extended our membership, this issue has grown. During the year we delayed expectations of starting to receive income from new members from November 2015 to April 2016, foregoing £86k in budgeted income. At year-end, a further £86k remained unpaid.

In the current year, we will escalate action to enforce our right to receive subscriptions, created by the Order, through the courts if necessary, and have set aside a 'fighting fund' to do so. We believe that is essential for fairness to ensure that all members contribute their share of our revenue.

Higher fees needed for 2016-17.

To make provision for the cost of collecting debts, along with anticipated (largely internal) and unanticipated (largely external) cost increases, we will need to increase our budget and fees for 2016-17. The fee-per-record will rise to £3.30. We believe that this continues to represent excellent value by comparison to similar organisations receiving, processing and publishing healthcare data.

PHIN Annual Accounts, 31 July 2016

	Note	2016 £	£	2015 £
FIXED ASSETS	2			
Tangible assets			11,437	-
CURRENT ASSETS				
Debtors		262,140		59,518
Cash at bank and in hand		897,751		881,550
		1,159,891		941,068
CREDITORS: Amounts falling due within one year		418,004		483,644
NET CURRENT ASSETS			741,887	457,424
TOTAL ASSETS LESS CURRENT LIABILITIES			753,324	457,424
	3			
RESERVES				
Profit and loss account			753,324	457,424
MEMBERS' FUNDS			753,324	457,424

Notes to the accounts

1. ACCOUNTING POLICIES

Basis of accounting

The financial statements have been prepared under the historical cost convention, and in accordance with the Financial Reporting Standard for Smaller Entities (effective January 2015).

Cash flow statement

The directors have taken advantage of the exemption in Financial Reporting Standards for Smaller Entities from including a cash flow statement in the financial statements.

Turnover

The turnover shown in the profit and loss account represents amounts invoiced during the year to the company's members, exclusive of Value Added Tax.

Fixed assets

All fixed assets are initially recorded at cost.

Depreciation

Depreciation is calculated so as to write off the cost of an asset, less its estimated residual value, over the useful economic life of that asset as follows:

Fixtures & Fittings - 33% straight line

Operating lease agreements

Rentals applicable to operating leases where substantially all of the benefits and risks of ownership remain with the lessor are charged against profits on a straight line basis over the period of the lease.

Financial instruments

Financial liabilities and equity instruments are classified according to the substance of the contractual arrangements entered into. An equity instrument is any contract that evidences a residual interest in the assets of the entity after deducting all of its financial liabilities.

Where the contractual obligations of financial instruments (including share capital) are equivalent to a similar debt instrument, those financial instruments are classed as financial liabilities. Financial liabilities are presented as such in the balance sheet. Finance costs and gains or losses relating to financial liabilities are included in the profit and loss account. Finance costs are calculated so as to produce a constant rate of return on the outstanding liability.

Where the contractual terms of share capital do not have any terms meeting the definition of a financial liability then this is classed as an equity instrument. Dividends and distributions relating to equity instruments are debited direct to equity.

Bad debt enforcement provision

The bad debt enforcement provision has been calculated on a basis equivalent to that of a bad debt provision, equating the likelihood of recovery with the age of the debt. However, it is PHIN's intention to use all means at its disposal to pursue all debt, including using the court process where appropriate.

2. FIXED ASSETS

	Tangible Assets £
COST	
At 1st August 2015	1,532
Additions	13,347
At 31st July 2016	**14,879**
DEPRECIATION	
At 1st August 2015	1,532
Charge for year	1,910
At 31st July 2016	**3,442**
Net Book Value	
At 31st July 2016	**11,437**
At 31st July 2015	-

3. COMPANY LIMITED BY GUARANTEE

The company is limited by guarantee (limited to £1 per member). The company only receives income from its members. Therefore under the mutual trading concept is not liable to pay corporation tax.

Private Healthcare Information Network

11 Cavendish Square, London W1G 0AN

info@phin.org.uk