

FIPO newsletter

WINTER 2021

Dear Colleague,

I hope that since we last wrote to you from FIPO that your professional life has begun to approach the way things were before the pandemic hit. FIPO have been working hard on your behalf to try to obtain clarity on a number of issues and to highlight problems that we have been alerted to by you and your organisations.

Acute Data Alignment Programme (ADAPt)

NHS Digital's ADAPt public consultation ran for three months in 2020 on the NHS Digital consultation hub, seeking feedback on proposals to change the way in which private healthcare data is collected, processed, reported, and disseminated, specifically proposing that information about private healthcare Admitted Patient Care (APC) activity should be reported to NHS Digital alongside information about NHS funded patients, using common data standards. Data collection involved NHS private patient units PPU's, Private Hospital providers, and the Private Healthcare Information Network PHIN. FIPO had expressed concerns about the different data sets used in the public and private sectors, and the potential difficulties that could arise if incorrect data were used to publish individual consultant performance measures.



On 9 November, James Austin, Director of Strategy and Policy in the Digital Services Directorate of NHS Digital, and Matt James, CEO of PHIN wrote jointly to announce the commencement of the first Pilot project, with the first transfer of private patient care records from PHIN to NHS Digital, under the authority of the ADAPt Discovery Directions 2021. <https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notice/data-provision-notice-dpns/acute-data-alignment-programme-adapt-discovery>. NHSD wrote "In the coming weeks, NHSD will test the linkage of private data to other HES records, paving the way for production of performance measures that rely on having both data sets joined in one location."

Continued overleaf...

For any enquiries, please do get in touch with the FIPO office.

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Acute Data Alignment Programme (ADAPt) *cont'd*

However, concerns raised by FIPO in March 2020 remain.

The private sector uses CCSD for procedure coding, whereas the NHS uses OPCS-11; these are not directly comparable although the data requirements of PHIN mean that OPCS coding has now also been adopted. Also, diagnostic coding (such as ICD-4 in the NHS) is needed to assess case complexity. This is currently not comprehensively recorded in the private sector. There is some coding variation across private providers, which makes meaningful comparisons even more challenging. There is no doubt that a combined NHS/Private dataset would be of great value to policy makers in the NHS and private sector.

However, there is a key difference in attribution between the NHS and private sectors. In the NHS, patients are treated by a team led by a consultant(s). In private practice, patient care is entirely consultant delivered. Indeed, Consultant delivered care is one of the main attractions for private patients.

NHS HES therefore cannot, at present, be directly aligned to private practice episodes and ascribed to the performance of an individual consultant. FIPO would have grave concerns if such a combined dataset were to be used in this manner.

Provision and the Pandemic

Speaking at LaingBuisson’s recent Private Acute Healthcare Conference and reported in the November issue of Independent Practitioner Today, Healthcode managing director Peter Connor shared Healthcode’s experience with PMI billing trends. 2020 private hospital volumes were up 6% on 2019. The increase was greater from the start of the second quarter: 30% higher in June, and 114% higher in September than the same months in the previous year. It is assumed that these figures reflect the need to address pent-up demand, especially for non-urgent treatments which have had to be postponed.

130 of 141 acute NHS trusts have now published their 2020-21 Annual Reports. The top ten Trusts with private patient incomes are all in London, and together, earnings declined by 41.8% (by £178.9m to £248.6m). The top earning Trust was the Royal Marsden, (down 22.9%, £102m down from £132.6m last year). Moorfields’ private patient incomes fell least, 21.1%, from £30.8m to £24.3m.

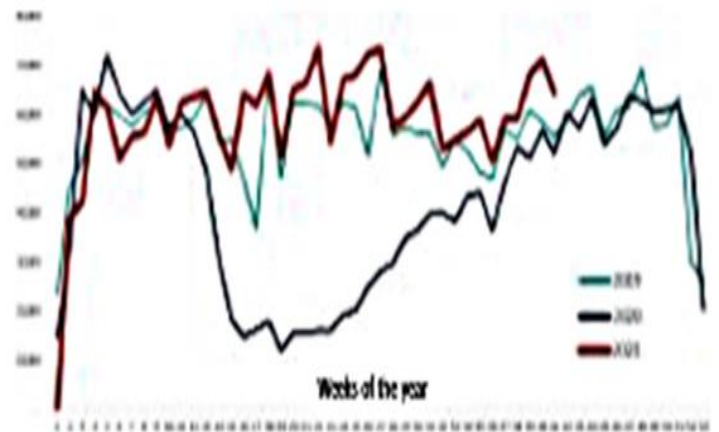


CHART 1: Billing volumes in UK Private Hospitals – 2021 comparison

Christopher Khoo, FIPO Vice Chair

Healthcode and Vitality

FIPO recently held a meeting with Fiona Booth and Peter Connor, Head of External Affairs and Managing Director respectively at Healthcode to discuss a number of issues and concerns raised by both Council members and individual consultants, who had gotten in touch with FIPO for advice. These included:

- Data sharing and confirmation to do so by Data Subject
- Conflict of interest by PMIs re. billing process – accepting exclusively billing via Healthcode of which they are shareholders
- Why is PPR registration a requirement for PMI recognition

Healthcode shared a presentation which had earlier been given to the Laing Buisson Private Healthcare conference. Apart from its role as the “official” clearing organisation for medical billing, Healthcode describes itself as being “a leading provider of IT services for the private healthcare sector focusing on industry solutions. Healthcode’s expertise and industry knowledge helps independent specialists, private hospitals and insurers improve their operational efficiencies”.

FIPO followed up the meeting with another letter to re-address some of the following items that were discussed:

Healthcode informed us that they had approached the CMA to ask if they should charge a fee for their billing service as providing a free service was anti-competitive. They also stated that the PPR service was free. By implication this would suggest that the PPR service is also anti-competitive. We asked for comment.

We raised concerns around confidentiality as the extensive information required for entry to the PPR seems to have generated targeted marketing activity. Healthcode told us that confidentiality is maintained but that any Healthcode subscriber may be able to view different aspects of this information without the doctor’s permission or knowledge. We remain concerned about the privacy aspects and would like an investigation into how the targeted marketing was prompted and by whom.

On questioning, Healthcode told us that it was NOT necessary to be on the PPR in order to use Healthcode’s billing functionality. One of our number was informed otherwise by a member of their staff and as requested, we attached a copy of the email trail to inform their investigation.

We told Healthcode that Vitality refuses to pay invoices submitted by means other than Healthcode’s own billing system. Dr Ali Hassan is the medical director of Vitality and sits on the Board of Healthcode. We believe this is both a conflict of interest and could represent an AEC, which the CMA explicitly wished to avoid. As suggested, we took this up with Dr Ali Hassan directly and were informed by the Clinician Relationship Manager at Vitality that *“Healthcode has introduced a charge for independent practitioners using its electronic billing service for invoice submission. Vitality has an alternative, free, direct online invoice submission method, clinicians are able to access this service via our provider website <https://www.vitality.co.uk/healthcare-providers/i-am-a-consultant/> Vitality still very much advocates the use of Healthcode to support the speed and accuracy of invoice processing but understands that there is a need to support clinicians who prefer an alternative billing method.”*

Healthcode stated that it is not profit generating, but according to the figures supplied, it is likely that Healthcode’s billing mechanism is now generating approximately £5M p/a. Whilst this may be reinvested, it seems disingenuous to suggest that the new charges are not generating income.

FIPO looks forward to Healthcode’s response and will keep you updated.

PHIN Update -



December 2021

PHIN have not yet managed to deliver the CMA mandated requirements completely. At the AGM in early December, change in senior leadership was announced. A new strategic plan will be developed and the CMA made it clear that they expect a clear road map outlining when the requirements will be delivered.

Consultant engagement with PHIN remains low, only 43% have provided their fee ranges for their most common procedures to date. FIPO would emphasise that provision of fee information is a legal requirement for all consultants in private practice. Even fewer consultants have validated their 'quality' data, these data are currently only published as procedure volumes and length of stay. PHIN have worked hard on developing their consultant portal in order to facilitate this process and some of the professional organisations have developed productive relationships with PHIN to ensure that metrics developed to demonstrate clinical quality in their own specialities are meaningful and relevant. The CMA have stated they will now start to pursue high-volume non-compliant consultants. It is likely that the enforcement of these requirements will be via the provider hospitals in the first instance.

A study to create the first comprehensive national data set of 'whole practice' information for doctors and hospitals providing both NHS and private hospital care in England will commence shortly as described elsewhere in this newsletter. FIPO would be interested in the views of consultants in private practice about this project and its implications for them. **Please make your views known to your Council Representative and/or direct to the FIPO office.**

The PHIN website is being upgraded and users' searches will be prioritised by location and procedure and directed to hospital provider in the first instance. Patient satisfaction by individual consultant will be displayed later this year, but small numbers will be suppressed and only those with thirty responses received over a rolling three-year period will be shown. In December, readmission rates, mortality rates, unplanned patient transfers and frequency adverse events for serious injury and return to theatre will be published at Hospital level only. It is, of course, part of the longer-term strategy that these will be published at consultant level in line with the CMA requirements.

The influence of PHIN in providing a platform to enable true patient choice remains questionable when so many referrals are PMI directed. FIPO was therefore pleased to note that PHIN have stated that they will be working on "presenting a fee solution for insured patients" next year. FIPO will be advising and providing the professional perspective.



Rosemary Hittinger, Company Secretary FIPO

BMA PPC Conference

In November, Mr Charlie Chan, FIPO Director, was an invited speaker at the BMA's Private Practice Conference where speakers included: Mr Stephen Dorrell, Mr Bertie Leigh, Dr Alexandra Harkins and Mr Tom Smith. Please find a summary of highlights below

Overview of economics on private healthcare, Mr Stephen Dorrell

Total health spend. **UK** – just over 10% if one includes NHS and private health spend, **EU** average – 11% and **USA** – 17%

Doctors being independent practitioners, even if they are working whole time in the NHS. Stressed the following principles:

- Mixed practice ensures that the best doctors are available to the NHS
- NHS has no monopoly right to doctors
- Mixed practice fundamental to health care in the NHS
- Private practice important in demonstrating good practice parallel to and outside the NHS
- Private practice is a door to new ideas
- One should guard against the default instinct that clinical practice means the NHS – the NHS is just a means to establish clinical practice

The CMA is not there to establish how clinical services should be established – only there to check that market is working properly without any abuse.

Stephen Dorrell's personal view is there is a) a statutory duty on CMA to review balance between PMIs and doctors b) a responsibility to ensure that the area is not tilted either towards insurers or doctors.

IR35 and implications for private practice, Mr Tom Smith

- Employment status
- Obligations under IR35
- Key considerations
- Intermediary or personal services company

End client (e.g. NHS or hospital group – Public body or medium/large business defined as 2 out of 3 - £10.2 m turnover, balance of > £5.1m, >50 employees). So far HMRC have won every decision where they believe that the end client has got the IR35 decision wrong. Sum of tax and penalties about 70% of sum paid for services. 6-year limitation.

Please note that an authority subject to Freedom of Information Act is automatically categorised as an End Client (may possibly include GP practices, but this would be a legal question) (FOI Act includes 29 pages and several thousand entities). Intermediary (e.g. consultant's company), receive SDS, can challenge SDS. If IR35 – deduction including employers and employees NIC - will need to account for this. Radiology and pathologist (may be partnership) services - HMRC looking at radiology particularly. Fixed payment by PMIs for radiology services – if radiology is outsourced to hospital or insurers (esp. tele-radiology services) – key question is who is responsible for providing the service and hence classed as end client (likely to be NHS or hospital group).

IR 35 decision will be made by End Client i.e. hospital group or NHS – this was decided by HMRC and HM Govt to take away decision from provider consultant, who might wish to influence the IR35 decision.

Impact of Paterson and accelerating secular trends already in train, Mr Bertie Leigh

Discussion about secular trends resulting from Shipman, Bristol, Alder Hey, Minimal Access Surgery Inquiry.

Private practice will be less attractive to consultants and that the Black Swan Paterson event will make things even worse.

Charlie Chan, FIPO Director

Chairman's Update

Since private healthcare provision has been allowed to restart, there has been a significant return to throughput in the independent sector. Although this has been led by a surge in self-pay patients, there has also been an increase in insured patients coming forward for diagnosis and treatment.

As will have been seen from the sections above, FIPO has been busy on your behalf. We have continued our engagement with PHIPN although progress has been very slow. It remains to be seen whether the change at the top of this organisation will lead to more rapid movement to achieve the CMA's order requirements.

In recently issued policy documents relating to practising privileges (PP), both Circle/BMI and Aspen have spelt out that compliance with the CMA mandate will be a condition of PP retention. There is also the removal of the right to appeal when PPs are withdrawn and no need for reason to be given. I have written to IHPN about this. I will let you know the result.

Healthcode, described by them as the official clearing house for private practice billing, have also been in FIPO's sights. We have had concerns about the use of data submitted to Healthcode for registration purposes being shared without the consultant's permission with third parties like indemnity insurers. We are awaiting the outcome of investigations regarding this and other issues relating to Healthcode.

On behalf of the FIPO Board, I wish you all a festive and merry Christmas and a happier New Year 2022!

Richard Packard MD DO FRCS FRCOphth FEBOS-CR

Chair FIPO



Dedicated to **quality, safety and patient choice**
within the Independent Healthcare Sector

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