BOA position statement regarding PHIN's implementation of CMA's hospital and consultant performance information remedy

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This position statement is intended to provide information to BOA members on the stance that the BOA has taken on some of the key issues regarding this topic and on the nature of our engagement with PHIN. Feedback is welcomed. Members may wish to review this document in conjunction with a background document regarding PHIN, the CMA and the private healthcare remedies, which we have also prepared; available for BOA members online here.

Executive Summary

The Private Healthcare Information Network (PHIN) was approved as the Information Organisation to publish information about private healthcare by the Competition and Markets Authority in December 2014. Since this time (and indeed beforehand), the BOA has been providing specialty-specific input and advice to them. We see it as important to be closely involved in the work on this initiative, given the large number of our members and their patients who are likely to be affected by it.

In our engagement work with PHIN, we have highlighted to them significant challenges associated with large-scale publication of private healthcare information as envisaged by the CMA, especially regarding data quality/interpretation and publication of surgeon-level information. We have emphasised throughout the importance of ensuring that all information published is fair, robust and accurate, and provided suggestions for overcoming difficulties in implementing the CMA Order.

PHIN are under a mandate from the CMA to publish on certain metrics and to certain timelines; however, we have stressed that paramount consideration must be given to ensuring that the information published meets these criteria of fairness, robustness and accuracy, in order to ensure that it is meaningful and useful for patients. This will take time and careful consideration to achieve. We believe that PHIN share these values and we continue to work with them on this.

For some time we have called for a phased or incremental approach to publication, and we have therefore welcomed the following recent developments:

- The delay of consultant level publication, which was previously due in April 2017, 'until the data is sufficiently complete and robust'[1]. This is an approach that we wholeheartedly endorse in the interests of ensuring that surgeons' work is accurately represented and that patients can rely on the information made available.
- The publication in the first round of a *limited* number of metrics for hospital-level data and consultant level information.

[1] https://www.phin.org.uk/news/123/news-release-phin-delays-publication-of-consu

We highlight to members some of the particular areas in which we have taken a position (and discussed further below) include:

- issues regarding consultants checking their data prior to publication;
- careful consideration must be given as to whether some of the metrics are really appropriate for publication at the consultant level;
- specific issues such as: risk adjustment factors that should be collected for T&O, podiatrists practicing podiatric surgery.

Positions and discussion

BOA involvement and engagement regarding PHIN

We are working collaboratively with PHIN and see it as important to be closely involved in the work on this initiative, given the large number of our members who are likely to be affected by it. Some examples of our engagement activities are summarised here.

The BOA has met with representatives from PHIN on numerous occasions during the period from 2014 to now regarding the implementation of the CMA Order, primarily focusing on the 'hospital and consultant performance information remedy'. This has included, at times, meetings with the NJR and its Medical Advisory Committee and HQIP.

The Federation of Independent Practitioner Organisations (FIPO) has convened a Clinical Outcomes Advisory Group (FIPO-COAG) to provide advice and information to PHIN, and the BOA is represented on this group also. As part of this, a member of the BOA team regularly attends monthly PHIN Implementation Forum meetings being held as part of the development of this work.

We have provided specialty-specific advice and input to PHIN on a variety of issues. We are keen to emphasise throughout the importance of ensuring that information published is fair, robust and accurate.

BOA Position on key issues

General

- The BOA position is that all information to be published must be useful to patients and as such must be reliable, accurate and meaningful, and must be presented in a manner that allows it to be readily understood and interpreted by patients.
- The BOA and FIPO-COAG both believe the scale and timescale of the task to be undertaken by PHIN under mandate from the CMA is highly ambitious. We note that a staggered approach to publication is now planned. We welcome this as we had previously taken the view there were serious risks associated with aiming to complete the full publication set in the current timescale.
- The BOA and FIPO-COAG have raised issues about the quality of data, which is, in most cases, being collected by hospitals and presented publically by PHIN for the first time. The BOA position is that it is imperative that data published are accurate and meaningful.
- These issues are likely to require further consideration between PHIN and the CMA.

Consultants checking their data

- PHIN has advised that consultants will be given early access to data about their practice using an online portal and will be asked to sign it off before it is published. The portal is intended to include the data submitted from all the private hospitals where that consultant practices. The BOA has welcomed and strongly supports the principle of consultants checking and approving their data prior to publication.
- BOA therefore actively encourages surgeons to review their data and engage with this process.
- We note that whilst PHIN has taken the position that consultants will be asked to sign off on their data before publication, this is not a right enshrined in the CMA's Order. As such, the possibility exists that PHIN could be required by the CMA to publish data where consultants had not signed it off. PHIN and the BOA believe this is less likely to occur if there is positive engagement from consultants in the process of checking and signing-off data, and this is a further reason we encourage all members to support this process. Should the CMA indicate that it intends to take this approach, the BOA would make strong representations to them on this issue.
- PHIN is proposing that this data approval applies when data are published for the first time but the intention is not to obtain approval for all subsequent occasions when the data are refreshed (which is likely to happen quarterly for most data). We are liaising with PHIN and FIPO-COAG regarding this. Issues under discussion include having a periodic process to approve data, consultants having access to data in advance of publication for checking even without a specific sign-off process, and/or a mechanism for flagging to consultants where a set of data differs in some significant way from that published previously.
- The BOA has particularly emphasised that as part of any data checking and approval:
  - (1) consultants should be given a sufficient time (our recommendation is at least 2 months, and ideally 3 months) and supporting data from hospitals or other sources to undertake the validation of data;
  - (2) the online portal for consultants to use to check their data must be user friendly and easy to navigate;
  - (3) where data quality or accuracy issues are identified by consultants, there must be an adequate process in place for data to be flagged up for correction by the hospital/PHIN and further checked by the consultant.
- In relation to the need for supporting data, the BOA highlights that in order to be able to check their data, consultants require access not only to the PHIN online portal of the collected data, but also to relevant local systems against which they can check that data. We encourage private providers to provide practical support to consultants to enable them access to local systems and to help identify where data problems may have occurred. We understand that private providers are already looking at the support and infrastructure requirements for this process.
- In the example of checking of more complex data for example about readmissions or adverse events (if these are to be published), particular consideration must be given to providing the consultant with sufficient information to check the data. Consultants may have no awareness of or ready access to information on subsequent events regarding the

patient’s care or outcomes (for example if an emergency readmission occurs at a different hospital or site).

Publication of volume information

- In relation to publication of information about volumes of procedures undertaken, the BOA favours an approach in which consultants who practice both in the NHS and independent sector have volume information published on their total practice in order to provide a full description of the nature of their practice. Without this, those with a small private practice may be disadvantaged by low numbers reported, and patients are not presented with a true picture of the scale and nature of an individual’s practice.
- The BOA recognises that this would rely on data such as HES, and there may be challenges regarding data quality and combining private and NHS data. As such while this may not be straightforward, our position is that it is highly desirable.
- Specifically in relation to knee replacement, the BOA along with BASK (British Association for Surgery of the Knee) have taken a position that the volume information presented both for hospitals and for consultants should be divided into three categories: Total Knee Replacement; Patello-Femoral Replacement; and Unicondylar Knee Replacement. We are liaising with PHIN about how this is put into practice. We understand from PHIN that this may not be possible for the first launch of unit publication but hope that this division will be possible in future, for the benefit of patients wishing to understand the area(s) of practice for particular units and surgeons.
- The BOA and specialist societies have contributed to work on ‘procedure groupings’ in identifying which OPCS codes should be attributed to which procedures and using patient-friendly terminology to describe the procedures. (NB This work is ongoing and was not fully implemented in time for the first phase of publication in September 2018.)

Publication of revision surgery rates

- The BOA has advised PHIN that rates of revision surgery at the individual consultant level should not be considered for publication for T&O because the data are not sufficiently robust to allow this to be undertaken accurately. This is a view shared by the National Joint Registry (NJR), which itself publishes revision surgery rates at the unit level only.

Publication of infection rates, adverse events and readmission rates

- The BOA view is that these rates can be difficult to ascertain accurately and require very careful consideration as to the mechanism and analysis for deriving them. Publication of these rates at consultant level is unlikely to be appropriate, as the numbers involved are expected to be very small and lacking reliability.
- Regarding readmission, we understand that PHIN intends to undertake data-linkage to identify all instances of readmission within a given period including at NHS providers. Although, PHIN have been looking at the criteria for which readmissions should be linked to the previous episode as opposed to those that are unrelated (e.g. excluding all trauma), we consider that any such analysis is inherently fraught with difficulties and is likely to be

serious flawed. We are keen to encourage PHIN to engage with the BOA and FIPO-COAG on this as the methodology is developed.

- Regarding infection rates, we are concerned these are often recorded/defined differently in different settings and in some instances a GP prescription for antibiotics may be counted where surgery-related infection is not conclusively present. Again, we consider that any such analysis is inherently fraught with difficulties and is likely to be serious flawed. We are keen to encourage PHIN to engage with the BOA and FIPO-COAG on this as the methodology is developed.

Reporting at individual consultant level vs hospital level

- Within the CMA Order there is an extensive list of the items due for publication at both consultant and individual level. The BOA and FIPO-COAG share a view that some of these items would not in fact be appropriate for publication at the individual consultant level. In particular, this applies to the recording of adverse events and PROMs outcomes because of the small numbers that would be counted at the individual level, meaning the data and interpretation would lack robustness.

Publication of relevant information from national audits and registries

- In relation to publication of registry data, for T&O PHIN's position is that the information published will be limited to the information already published through the NJR surgeon and hospital profile. The BOA supports this approach.
- The BOA and NJR have also called for PHIN to share with the NJR, data that PHIN has on the volumes of procedures undertaken in the independent sector in order to improve the robust review of NJR compliance rates.

Podiatrists practicing podiatric surgery in the private sector

- The BOA has been in dialogue with PHIN regarding podiatrists practicing podiatric surgery in the private sector. As this presently stands:
  - Individual podiatrists data will not (initially at least) be presented at individual level in the same way as consultant surgeons are, because it appears that individual podiatrists do not fall within the scope of the CMA Order.
  - Procedures undertaken at private hospitals by podiatrists practicing podiatric surgery will be included within the unit-level information for those hospitals.
  - Procedures undertaken by podiatrists practicing podiatric surgery away from private hospitals (e.g. at 'high-street' settings), will not be reported at present at either the individual- or unit-level as they do not appear to fall clearly within the primary scope of the CMA Order.
- The BOA has written to PHIN to express concern about potential differences in presentation of information regarding consultant orthopaedic surgeons and podiatrists practicing podiatric surgery, and we have been assured that this is an issue that PHIN will return to in future.
- PHIN is considering offering podiatrists practicing podiatric surgery and the units at which they practice the option to voluntarily opt-in to publication, although we understand this is

likely to be explored in full at a future date given the significant activity that PHIN is currently undertaking and its need to prioritise.

- The BOA has highlighted to PHIN that if and when data for individual podiatrists practicing podiatric surgery is published, it should be very clear that these individuals are not medically trained as orthopaedic surgeons, in order to avoid an interpretation that their presence in the PHIN information indicates an equivalent background and training.

Risk adjustment

- PHIN has begun to consider issues regarding case-mix adjustment. The BOA position here is that, given that given the purpose of the data is to allow comparisons between different hospitals or consultants, issues associated with differing case-mixes require careful consideration.
- PHIN has specified a range of case-mix variables that it will require for all episodes. In addition to this core list, the BOA has recommended that BMI and ASA grade should be collected for all patients undergoing T&O procedures because we believe that they have the potential to provide important case-mix information above and beyond the already agreed factors. PHIN has undertaken to publicise our recommendations to providers collecting data, and we encourage our members to be aware of this as their hospital may approach them regarding it. We have provided a specific position on this for PHIN to share with hospitals, available as Appendix 1 to this document.
- We have highlighted that until these data are collected it will not be possible to determine the completeness and quality of the data submitted, and this will need to be carefully assessed when considering whether and how it is used in the risk-adjustment process that is undertaken.
- The BOA intends to continue to work with FIPO-COAG and PHIN regarding these issues and the process by which PHIN plans to undertake risk-adjustment.

Appendix 1

PHIN and case-mix adjustment: Position statement from the BOA

Position supported by FIPO-Clinical Outcome Advisory Group

18 March 2016

1- ASA grade should be collected as a case-mix factor for all patients undergoing a T&O procedure and included in the relevant data submissions to PHIN. It is important that this is the ASA recorded at the pre-op assessment by a suitable health professional although may be modified by the anaesthetic consultant at the time of the operation. It should not be recorded at another stage or by another member of the team such as a manager.

2- BMI should be collected as a case-mix factor for all patients undergoing a T&O procedure and included in the relevant data submissions to PHIN. This should be the BMI relevant to the current episode and not from an earlier/later operation or episode.

3- We note that both ASA and BMI are potentially crude indicators of patient health status, and we understand these are to be used alongside other already agreed risk-adjustment factors specified by PHIN that include whether the patient has certain other comorbidities, and their age and gender, which are also important risk-adjustment factors.

4- The BOA is advising that the ASA and BMI data are collected because we believe that they have the potential to provide important case-mix information above and beyond those already agreed factors for the risk-adjustment process. We wish to highlight that until these data are collected it will not be possible to determine the completeness and quality of the data submitted, and this will need to be carefully assessed when considering whether and how they are used in the risk-adjustment process that is undertaken. The BOA will intend to continue to advise PHIN regarding these issues and the process by which PHIN plans to undertake risk-adjustment in the coming months.