STATES OF JERSEY

PRIVATE PATIENTS INCOME – HEALTH AND SOCIAL SERVICES DEPARTMENT

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Private Patients Income
Health and Social Services Department

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JERSEY AUDIT OFFICE

Private Patients Income - Health and Social Services Department

Introduction

1.1 Clinical consultants working in the Health and Social Services Department (HSSD) are permitted to undertake work for privately funded patients as long as they fulfil their contracted hours for publicly funded work. For full-time staff this is 40 hours per week, typically set out in blocks of four-hour 'Programmed Activities'.

1.2 Most outpatient services for private patients, and some minor procedures, take place in treatment rooms around Jersey that are not managed by the States. However, all private patient services which need an operating theatre are undertaken at HSSD's General Hospital. For these and other private patient procedures that use HSSD facilities and resources, HSSD makes a charge.

1.3 Private patient work is paid for by patients or private medical insurers. In 2014 private patient income amounted to £6.8m, equivalent to 5.75% of hospital services expenditure.

1.4 Clinical consultants who undertake private patient work at the hospital – chiefly surgeons and anaesthetists – also make a direct charge for their time to the patient or private medical insurer.

Scope and objectives of this review

2.1 This review encompasses:

- the private patient work undertaken by clinicians which is affected by their terms and conditions of employment; and
- all privately funded treatments undertaken using HSSD's facilities and resources.

2.2 This report considers the extent to which:

- HSSD has established and articulated policies and procedures for private patient activity and income that are consistent with other policy objectives;
- there are adequate arrangements to establish charges for private patient activity;
- there are adequate arrangements to identify private patient activity and bill patients or insurers;
- there are adequate arrangements to recover private patient income promptly;
- there are appropriate arrangements for establishing the budget for private patient income and monitoring performance against budget;
- private patient income is appropriately reflected in longer term planning; and
- there are adequate arrangements for monitoring compliance with operational policies and procedures, including the contractual conditions of consultants for undertaking private patient work.

Each of these areas is considered in turn in the sections below.

2.3 The report does not cover:

- other charges for hospital services; or
- the clinical quality of private patient services provided.

Private patient policy

3.1 Effective management of private patient activity and avoiding any conflicts between private patient work and public work commitments is promoted by:

- clearly-articulated policy; and
- appropriate operational standards and guidance.

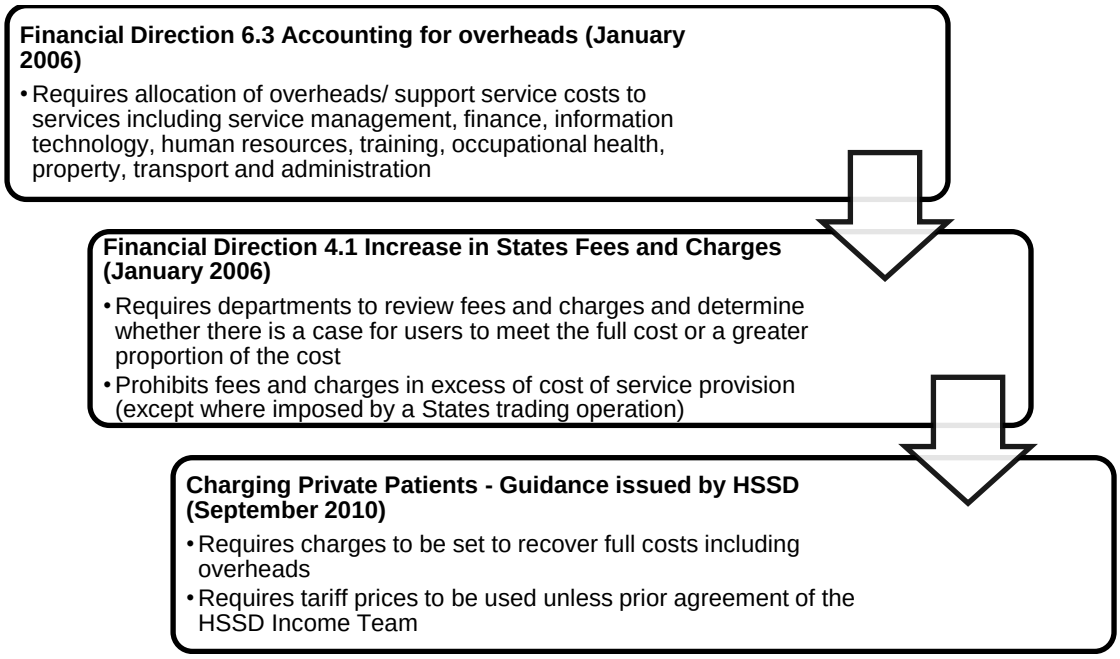
3.2 HSSD has a range of relevant policy and procedural documents from different sources, which have been developed over a number of years. These include guidance on operational and financial aspects of private patient business.

3.3 However HSSD does not have one overarching private patient policy that sets out clearly, and in one place, its aims and objectives in undertaking private patient business, or the principles that guide how this business is to be conducted. The various existing documents lack:

- a clear description of what HSSD wants to achieve with its private patient business, and why. None makes a case for the role of private patient practice in supporting consultant recruitment and retention; and
- detailed parameters within which private practice should operate, such as how consultants' delivery of 10 public Programmed Activities will be assured.

3.4 One key policy principle is the basis on which charges for private patient activity should be established. Scrutiny of three documents establishes that the principle is setting charges that cover the full cost of services to private patients, including indirect costs and overheads (see Exhibit 1).

Exhibit 1: Key documents on setting charges for private patient activity



3.5 The application of these policies determines how HSSD must manage its private patient work. However, these policies may not be consistent with the underlying objectives for undertaking private patient work within the General Hospital once these are clarified:

- the charges do not make any allowance for capital employed and therefore do not reflect the full opportunity cost of private patient activity;

- the requirement to set charges to cover the full costs in all instances may mean that opportunities to undertake work at prices that would cover direct costs but only make a contribution to overheads are not taken; and

- the requirement to set charges equal to full costs means that opportunities to set charges in excess of full costs where the market will bear those cannot be taken. Recognising that private patient activity is supplemental to free secondary healthcare provision, the States may determine that it wishes to have the freedom to set prices that maximise its income from private patient activity.

3.6 Operationally, various documents contain provisions on how clinical consultants should plan and deliver any private patient work they undertake, including:

- *A Code of Conduct for Private Practice;*
- *Terms and Conditions of Service – Medical and Dental Staff*
- consultant contracts; and
- job descriptions for consultant posts.

3.7 These documents are consistent in encouraging consultants to undertake private patient work, while being clear that this must not conflict with, or detract from, fulfilling public work commitments. They also cover in some detail how clinicians should manage private patient services alongside on-call responsibilities and how, for example, emergency private patient work should be handled.

3.8 However, there is potential confusion in how HSSD currently sets out requirements for managing private patients within public operating theatre sessions. *Terms and Conditions of Service* state that private patients 'should normally be seen separately from scheduled HSSD [public] patients'. However, a recent job description for a consultant surgeon post set out that '… consultants are permitted to operate on private patients during their public theatre sessions.'

3.9 In addition there are a number of gaps in the operational documents in practical areas including:

- how and when patients can move between private and public status within a course of treatment;
- the responsibilities on a consultant to identify any private patients seen in a public outpatient clinic;
- the mechanics of adding private patients to theatre lists (including required timeframes and record keeping); and
- rules about consultants undertaking private patient work when on sick leave from public duties.

Recommendations

R1 Develop an overarching private patient policy that defines in one place the objectives of; operational and financial principles for; and standards on conducting private patient business.

R2 Reconsider the appropriateness of current policies for charging for private patient activity.

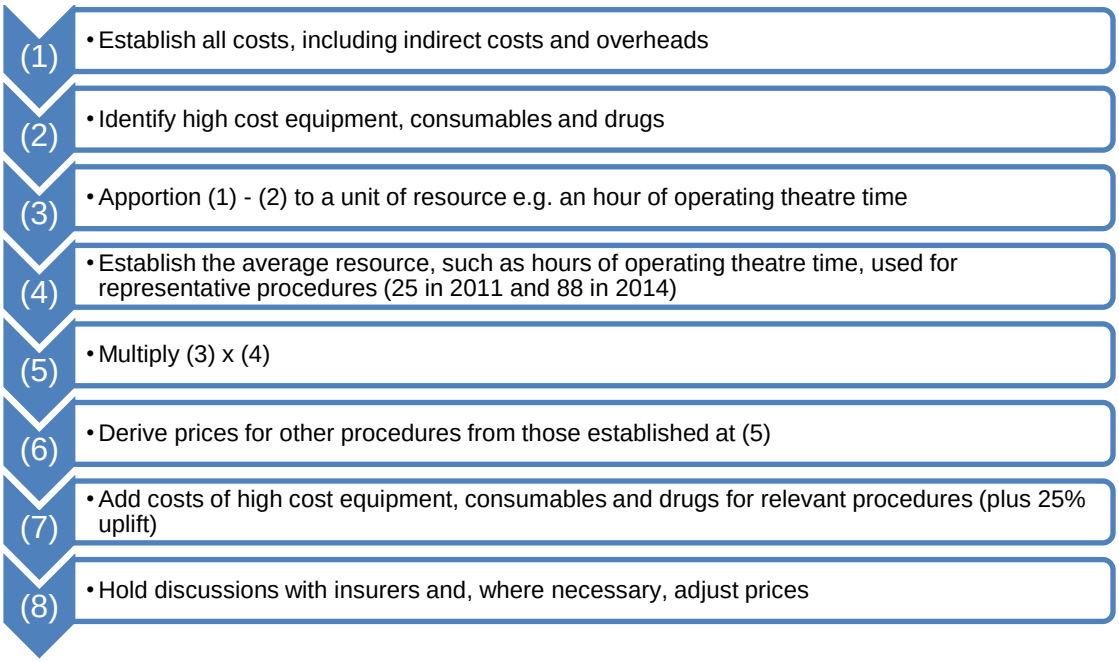
R3 Review, update and close current gaps in the coverage of procedural documents, ensuring these are aligned with a revised private patient policy to provide clear, consistent and comprehensive guidance to support decision-making.

Establishing charges for private patient business

4.1 Setting a clear overarching policy, including principles on charging for private patient work, is only the first step: the next step is to adopt effective arrangements for setting private patient charges based on the policy.

4.2 HSSD first sought to set a tariff based on full costs in 2011. Subsequently it applied annual uplifts and, using a refined approach, developed a new tariff in 2014 for implementation in early 2015 (see Exhibit 2).

Exhibit 2: Approach to tariff construction in 2011 and 2014



4.3 The Healthcare Financial Management Association (HFMA), a professional body for healthcare finance professionals in the United Kingdom, has issued Clinical Costing Standards for the National Health Service. Whilst these are designed for the costing of public healthcare provision, most of them are applicable to deriving a full cost-based tariff for private patients and they therefore provide a useful benchmark for evaluating the approach adopted by HSSD (see Exhibit 3).

Exhibit 3: Evaluation of approach to 2011 tariff-setting against HFMA Clinical Costing Standards (published in 2011)

Standard	Commentary	Evaluation
All general ledger costs should be classified as direct, indirect or overhead.	All general ledger costs have been classified as direct, indirect and overhead.	G
All service costs should be grouped into associated cost pool groups (in 2011, 19 are suggested)	In 2011 HSSD used 'pooled' costs to obtain average ward, theatre, radiology, pathology, occupational therapy and physiotherapy costs in calculating the private patient tariff. From evidence provided it has been difficult to identify if cost 'pooling' has been used in other areas, but for purposes of costing private patient business HSSD is using the key cost pools required.	G
Where possible, costs should be allocated on the basis of actual usage (the standard sets out ward, theatre and medical costs as key)	HSSD uses actual usage costs as a basis for its private patient charges in a limited number of areas. As private medical insurers require a 'rate' for a unit of service in the main the tariff reflects average charges. For example, the same amount is charged for a 24 hours stay on the private patient ward regardless of the procedure undertaken and the consequent amount of nursing time required. Nevertheless, to support decision-making, HSSD would benefit from a greater understanding of how its resources are used in its private patient business. Actual costs are allocated to private patient charges when specific high value consumables, drugs or equipment are used which are not common to most procedures. However, these items attract a 25% on-cost and the basis for this is not clearly set out.	A
Costs should be classified as fixed and variable	The memorandum Income and Expenditure (I&E) account for private patient activity prepared periodically classifies costs into fixed, semi-variable and variable categories.	G
Income should be clearly identifiable for internal reporting	HSSD's periodic I&E account and monthly budget holders' reports separately identify private patient income.	G
The integrity of the patient level information used in the costing	The quality of key data items at patient level is potentially unreliable: • there are significant unexplained variations in the average theatre times for procedures from the 2009 and 2010 data,	R

Standard	Commentary	Evaluation
process (e.g. clinical coding, data validation, linking patient resource information to patient records) should be ensured.	the averages of which were used in the 2011 costing exercise. In one case the average reported time for a procedure was 40% lower in 2010 than in 2009; and • there are underlying weaknesses in the quality, particularly completeness, of clinical coding. In addition: • HSSD cannot demonstrate how it calculated its direct costs to apportion to each 'unit of resource'; and • HSSD calculated the direct overhead for private patient activity as 11.07% but has applied a different rate of 13.46% when costing private patient procedures.	
The materiality and quality of costing process should be documented	No evidence has been provided which shows HSSD has documented materiality. The overall strategy and approach to costing for private patient business is not brought together in a strategic document. The costing methodology is difficult to follow, and there are some unexplained differences in costing calculations and figures used.	
Audit should be undertaken regularly	HSSD has not undertaken audits to provide assurance that: • costing data is materially accurate; • processes exist to ensure that cost data is robust. The spirit of the Clinical Costing Standards has been applied to the private patient costing methodology but there are significant inaccuracies that have not been resolved through audit.	

Recommendations

R4 Adopt and document compliance with relevant elements of a recognised approach to costing, such as that published by the Healthcare Financial Management Association.

R5 Adopt and implement documentation standards for tariff construction.

R6 Adopt and implement quality control procedures to ensure internal consistency of tariff derivation prior to finalisation.

R7 In deriving the tariff and additional private patient charges, calculate and apply appropriate on-costs for high value consumables, equipment and drugs.

R8 Adopt and implement quality control procedures for patient level information used in tariff development.

R9 Adopt and implement proportionate audit procedures of both cost and activity information used to inform the tariff.

Identifying private patient activity and billing for it

5.1 Robust arrangements are required to:

- identify all private patient activity;
- identify separately charged consumables: and
- raise invoices accurately and promptly.

5.2 There is room for improvement in arrangements in all three of these areas (see Exhibit 4).

Exhibit 4: Identifying and billing for private patient activity

Activity	Commentary	Evaluation
Identifying private patient activity	HSSD has systems and processes in place to bill patients and insurers for the activity captured in TRAKcare, HSSD's Patients Administration System (PAS). However, it does not have adequate arrangements to provide a reasonable level of assurance that PAS records are complete: • there is insufficient guidance available to be confident that frontline staff all understand and comply with good private patient management in identifying and billing for private patient work. The informal nature of arrangements increases the risk that HSSD is not able to make appropriate charges for all the private patient business undertaken within the hospital; • the HSSD Private Patient Committee, which brings together clinicians, operational managers and finance managers to discuss private patient issues, has identified incidents where incorrect tariff codes have been used in operating theatre paperwork. It notes that errors could result in a loss of income to HSSD.	
Identifying separately billed items	The HSSD Private Patient Committee has identified that high value consumables used in theatres are not always accurately noted and billed. HSSD officers have explained that 'high value consumables' include all items which remain in the patient, for example, ocular lenses, hip prostheses, orthopaedic plates and screws, and any disposable items or single use instruments which cost more than £15 individually. However, guidance and support for staff is not specific enough to ensure these items are always identified and charged for.	
Raising invoices promptly and accurately	Processes for invoicing for private patient business are reliant on the manual transfer of information between systems and between parts of the invoicing process, increasing the risk of error. There are a number of paper forms, for example to note consumables used in theatre procedures, which need to be gathered together to create	

Activity	Commentary	Evaluation
	an invoice. HSSD management states that, following reviews of practice, there have been some improvements in the standardisation and flow of paperwork but there is more to do. Although invoicing for inpatient and day case procedures is undertaken by HSSD's Income Team, Treasury and Resources undertake invoicing for outpatient activity. Communications with Treasury and Resources on invoicing has generated no less than 10 different forms, increasing the risk of error or omission that could lead to loss of income.	

5.3 The risk of error and omission is mitigated by a significant amount of checking by the Income Team along the patient pathway.

5.4 HSSD had plans in place in 2014 to support front line staff in understanding and complying with private patient management processes, but implementation has been delayed and this work still needs to be done. HSSD management has stated that it intends to include the coding of private patient activity as part of the work of its clinical coding department and has identified resources to implement this in 2015.

Recommendations

R10 Provide clear and unambiguous guidance to and support for frontline staff for all parts of the process for identifying private patient work.

R11 Take steps to improve the accuracy and completeness of:

- the coding of private patient procedures in operating theatres; and
- information on the consumables used in operating theatre procedures.

R12 Using 'lean' principles, review current processes and arrangements for billing for outpatient private patient procedures with the aim of reducing the risk of error and maximising efficiency.

Recovering private patient income

6.1 Effective management of private patient income requires robust arrangements for securing recovery of sums invoiced.

6.2 HSSD has effective arrangement for recovering its private patient income billed:

- collection of income from its private patient business is incorporated into the processes HSSD uses to recover all its income. Following the issue of an invoice, HSSD has good arrangements in place to promptly recover private patient income;

- HSSD has established robust systems to ensure that private patients are pre-authorised by an insurer, or have agreed to self-pay;

- appropriate debt collection procedures are in place and working effectively. There are clear procedures covering actions at appropriate breakpoints of non-payment. The Income Team understand the procedures and there is evidence procedures are followed.

6.3 High levels of recovery, low arrears and low levels of write-offs evidence the strong arrangements. At the time of the review, total HSSD bad debts were 1.2% of income.

Budgeting and budget monitoring

7.1 Effective budget setting and monitoring is an integral part of sound management of private patient income.

7.2 There is good practice in the way HSSD sets and manages its private patient budget:

- the budget is set by multiplying the proposed private patient tariff for the year ahead by the expected level of activity and making an allowance for bad debts. The activity forecast is based on the current year's activity adjusted for known changes, through discussions with clinical consultants and hospital managers;

- HSSD produces appropriate budget management reports to enable relevant budget holders to monitor private patient income budgets. Budget holders receive these on a monthly basis, with details on income, budget and variances for each business unit;

- periodically, HSSD downloads income and expenditure data on private patients from the States' main accounting system and manipulates it to produce an income and expenditure account. This in intended to identify the full cost of the function and the recovery rate based on private patient expenditure and overhead allocations, and enable HSSD to demonstrate compliance with Financial Direction 4.1 for this part of the business; and

- the Private Patients Committee receives an 'income dashboard' that includes income from sources other than private patients, for example overseas patients.

However:

- accountability and responsibility for monitoring and managing the reports generated from the private patient income and expenditure account are not clear;

- the basis for including overheads in this income and expenditure account periodically prepared by HSSD could not be verified or linked to the costing exercise from which the Private Patient Tariff is derived; and

- the 'income dashboard' does not include cumulative income figures.

7.3 The 'income dashboard' focuses on income but currently the associated expenditure is not as clearly reported. HSSD has published early drafts of a new 'Integrated Report' intended to provide a comprehensive suite of performance reports and dashboards using standard data sets to improve corporate management information across HSSD. These bring together data and information about

activity, finance, workforce and quality: 'income' is one of the reporting headlines. Such reporting is an important mechanism by which HSSD can improve information relevant to private patient activity as part of enhanced governance arrangements.

7.4 HSSD is starting to investigate the feasibility of moving private patient business to a trading operation. Such a move would require changes to the way in which budgets are set, managed and reported against. In the context of wider changes to establish clear appropriate objectives and improve the quality of information, establishing a memorandum trading account would provide a clear focus for operating private patient activity as a business.

Recommendations

R13 Document the basis on which overheads have been included in the private patient income and expenditure account, demonstrating how this links to the 2014 private patient costing exercise.

R14 Enhance the 'income dashboard' by inclusion of cumulative figures on 'year to date' income against budget.

R15 In line with development of HSSD's Integrated Report, enhance Key Performance Indicators on how private patient finances are managed, to enable HSSD to demonstrate compliance with its stated policies and relevant objectives, including recovery rates.

R16 Routinely prepare a memorandum income and expenditure account for private patient activity and use it to monitor the performance of the private patient business.

Longer term planning for private patient income

8.1 Private patient activity is an integral part of the business model for the General Hospital. Effective long-term planning for private patient income, linked to other long-term planning, is therefore important, particularly in light of the 'Future Hospital' project.

8.2 Work to develop longer term planning for HSSD's private patient business as part of the 'Future Hospital' project is at an early stage. At the end of 2014 HSSD engaged a management consultancy to review opportunities and deliver an options appraisal.

8.3 Planning for HSSD's private patient business is part of development of the Acute Service Strategy and the 'Future Hospital' project. HSSD is developing Individual Service Plans for each acute service to define the overall capacity needed along the specialty pathways. HSSD management has explained that each plan will consider both the opportunities for private patient activity and the delivery of public activity.

8.4 HSSD has recently made two appointments that are significant to private patient business planning - a Private Patient Manager and a Head of Income, Risk Management and Compliance. The job descriptions for both of these posts show they are key to longer-term planning and risk management for HSSD's private patient business.

Recommendation

R17 Produce a longer-term plan for the private patient business that is fully integrated with other planning including the 'Future Hospital' project, workforce planning and risk management.

Monitoring compliance

9.1 Simply establishing and implementing appropriate policies and procedures is not sufficient. Robust arrangements for monitoring implementation and compliance are essential to ensure that the private patient business is operating economically, efficiently and effectively in the context of its policy objectives.

9.2 Various arrangements for the governance of private patient activity are included as part of a number of documents, including *The Financial Scheme of Delegation*; consultant contracts; and role descriptions for divisional leads. However these arrangements are not clearly mapped out in one place to show necessary linkages and ensure they are comprehensive and consistent. Although there is a Private Patient Committee intended to bring together clinical, financial and operational governance, attendance has been difficult to secure and there has been a lack of action between meetings. HSSD is re-assessing the Terms of Reference and membership of this Committee in order to better meet governance needs.

9.3 One key area for effective monitoring is compliance by consultants with relevant policies and procedures for private patient work.

9.4 The requirement for transparency in the private patient work undertaken by clinicians - 'where, when and what' - is clearly documented in HSSD's operational and procedural paperwork. The *Terms and Conditions of Service* and *A Code of Conduct for Private Practice* both require that consultant Job Plans, which set out each consultant's work schedule, should include private patient commitments as well as public. In addition, consultants' contracts are clear that public work commitments must be fulfilled to allow private patient work to be undertaken. However:

- there is no documented approach to monitoring how consultants undertake their private patient work alongside public work;

- a high level of 'custom and practice' has grown up around delivering private patient work and this has created confusion around the 'rules' for managing it. Job Plans have until recently only had to include 10 Programmed Activities, including operating theatre sessions. As most operating theatre sessions routinely include a mix of public and private patients, in practice Job Plans did not clearly identify the extent of private patient work being undertaken;

- work recently to clarify arrangements means that consultants undertaking private patient work at the hospital are now required to have Job Plans which include additional, unpaid Programmed Activities scheduled in the normal working week to 'compensate' HSSD for the time consultants spend on private patient work within their 10 public Programmed Activities. However, this approach is

not yet set out in any formalised procedure document and there is no monitoring of its implementation;

- these 'compensatory' Programmed Activities are based on an estimate of the amount of private patient work likely to be undertaken by each consultant. Management has explained that this is considered as part of each consultant's appraisal when 'log books' of clinical work undertaken are reviewed. However, there is currently no formal reporting of the volume of private patient activity within public sessions undertaken by consultants. HSSD is developing a 'medical staffing dashboard' as part of its evolving Integrated Report. HSSD intends that one of the KPIs will assess compliance with medical staff Job Plans and report the extent to which clinical consultants are delivering 10 Programmed Activities of public work;

- management information on how operating theatre time is used for public and private patient procedures is under-developed. The current approach considers only numbers of public and private patients in each theatre session rather than the proportion of theatre time used. As theatre lists typically include procedures which take different amounts of time – necessary to make best use of a fixed-length theatre session – then numbers alone do not provide sufficient detail for monitoring use; and

- currently, HSSD calculates use of theatre resources for private patients for all theatres together, rather than by consultant or by specialty, masking any variation within the data. The lack of detail by consultant also means practice cannot be compared with individual Job Plans. Not monitoring in detail what resources are committed to delivering private patient work also means HSSD cannot assess what resources are needed to meet the demands of public work - or work out where there is room for efficiencies.

Recommendations

R18 Document and implement robust overall governance arrangements for private patient activity.

R19 Monitor the effectiveness of the restructured Private Patient Committee and make further changes if necessary.

R20 Clearly document the approach to monitoring how consultants undertake their private work alongside their public work.

R21 Clarify the requirements for quantifying and reflecting private patient work within Job Plans and monitor their implementation.

Conclusion

10.1 Private patient income is an integral part of the business model for the General Hospital. Clear policy objectives, appropriate procedures and monitoring of compliance with those procedures can ensure that private patient activity does not detract from public provision.

10.2 There is good practice in the way HSSD sets and manages its private patient budget and arrangements for securing recovery of private patient income are robust.

10.3 But current arrangements do not secure effective management of private patient income:

- policy is not clearly articulated;
- there are weaknesses in the development of the private patient tariff;
- procedures for identifying all private patient activity accurately are time consuming and potentially ineffective;
- financial monitoring of private patient activity is not fully developed;
- longer-term planning of private patient activity, integrated with other planning, has not been completed;
- there are weaknesses in the overall governance of private patient activity; and
- monitoring of the volume of private patient work by consultants is informal.

10.4 Steps have been taken or are in train in key areas: improving the arrangements for preparing the private patient tariff, making key appointments to develop the private patient function and restructuring the Private Patient Committee. But more needs to be done to secure effective governance and management of private patient activity.

10.5 More widely, the weaknesses in policies and procedures to secure and use high quality information echo those in our report on management information in operating theatres. Good information is needed for good decision-making and securing the quality of information is a priority for HSSD.

Appendix 1: Recommendations

R1 Develop an overarching private patient policy that defines in one place the objectives of; operational and financial principles for; and standards on conducting private patient business.

R2 Reconsider the appropriateness of current policies for charging for private patient activity.

R3 Review, update and close current gaps in the coverage of procedural documents, ensuring these are aligned with a revised private patient policy to provide clear, consistent and comprehensive guidance to support decision-making.

R4 Adopt and document compliance with relevant elements of a recognised approach to costing, such as that published by the Healthcare Financial Management Association.

R5 Adopt and implement documentation standards for tariff construction.

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R9 Adopt and implement proportionate audit procedures of both cost and activity information used to inform the tariff.

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R11 Take steps to improve the accuracy and completeness of:

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R14 Enhance the ‘income dashboard’ by inclusion of cumulative figures on ‘year to date’ income against budget.

R15 In line with development of HSSD’s Integrated Report, enhance Key Performance Indicators on how private patient finances are managed, to enable HSSD to demonstrate compliance with its stated policies and relevant objectives, including recovery rates.

R16 Routinely prepare a memorandum income and expenditure account for private patient activity and use it to monitor the performance of the private patient business.

R17 Produce a longer-term plan for the private patient business that is fully integrated with other planning including the ‘Future Hospital’ project, workforce planning and risk management.

R18 Document and implement robust overall governance arrangements for private patient activity.

R19 Monitor the effectiveness of the restructured Private Patient Committee and make further changes if necessary.

R20 Clearly document the approach to monitoring how consultants undertake their private work alongside their public work.

R21 Clarify the requirements for quantifying and reflecting private patient work within Job Plans and monitor their implementation.

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