

Comptroller and Auditor General

**Private Patient Income: Health and Social Services Department
Follow-up**

09 February 2017



JERSEY AUDIT OFFICE

R.17/2017

Private Patient Income: Health and Social Services Department

Follow-up

Introduction

- 1.1 Clinical consultants working in the Health and Social Services Department (HSSD) are permitted to undertake work for privately funded patients if 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 by private medical insurers. In 2016 private patient income amounted to approximately £7.6million, equivalent to 5.5% of HSSD's 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.
- 1.5 In 2015 I reviewed how HSSD manages private patient activity and income, and reported on 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.

1.6 My report:

- set out the good practice I found in how HSSD recovers private patient income after issuing an invoice, through robust systems and appropriate debt collection procedures; but also
- made recommendations for improvement in managing private patient activity and income, some of which can be more widely applied across HSSD.

Objectives and scope

1.7 In following-up the 2015 review, I have assessed:

- the adequacy of the arrangements HSSD has put in place to manage and monitor the implementation of the recommendations made and for evaluating the impact of implementation;
- the extent to which actions HSSD has identified against each recommendation address the improvement areas identified in my report; and
- the progress HSSD has made in implementing agreed recommendations;

I have not evaluated the details of proposals to establish a Trading Operation for private patient activity.

1.8 In addition to **recommendations** this report contains **areas for continuing management action** relating to more detailed aspects of implementation.

Arrangements to manage, monitor and evaluate the implementation of recommendations

- 2.1 HSSD has established good arrangements to manage the implementation of my recommendations. In June 2015 HSSD submitted an action plan to the Public Accounts Committee (PAC) which set out the specific actions to be taken, who was responsible for implementation and when they would be delivered. HSSD updated this action plan in September 2015 and re-submitted it to the PAC.
- 2.2 The action plan has since been used as the basis for recording progress made. Implementation is overseen by the Hospital Managing Director and the Director of Finance.

The operational aspects of the action plan are chiefly managed through arrangements put in place in late 2014 and early 2015:

- Since November 2014, Private Patient Business has been managed by the Divisional Lead for Operational Support Services. With a background in private healthcare and consultant liaison, the Divisional Lead takes a strategic view, identifying opportunities and promoting clinical and commercial development of HSSD's Private Patient Business.
 - HSSD appointed a full time Private Patient Business Manager (PPBM) in September 2014. The PPBM is now established as the operational lead and business development manager for private patient work. The PPBM actively manages progress on key recommendations to do with policy development, operational practice and the overall governance of private patient activity.
 - A significant mechanism for the implementation of recommendations is HSSD's Private Patient Management Committee (PPMC), which was relaunched with updated Terms of Reference in March 2015. Progress against the action plan from my report is a standing item on the agenda for the PPMC which meets bi-monthly to:
 - discuss and resolve emerging issues;
 - identify opportunities for service and quality improvement; and
 - oversee HSSD's relationship with self-funding patients and health insurance companies.
- 2.3 The Costing Working Group (CWG), comprising key clinical and financial staff and initially established in 2014 to oversee tariff generation, drives further developments in HSSD's approach to costing and has managed the implementation of my recommendations on costing and charging.

2.4 Key strengths in HSSD's arrangements for implementing my recommendations are:

- they build on the improvement work which was already underway during my review;
- the action plan identifies priorities;
- the plan focuses on a small number of key workstreams which underpin most recommendations;
- core actions are aligned with departmental objectives and HSSD's developing over-arching strategic plan; and
- there has been sustained and increased strategic, operational and senior clinical involvement.

2.5 However:

- early progress in some areas has not resulted in rapid implementation of change; and
- plans to evaluate the impact and contribution of specific actions, once implemented, are relatively undeveloped.

I expand on these points later in my report.

Ensuring actions address the identified area of improvement

2.6 The programme of work as set out in the action plan is, in the main, aligned with the improvement needs identified in my report. This is straightforward where the recommendations are quite prescriptive, in particular in relation to tariff generation and income management. However, HSSD cannot yet demonstrate or be confident that all the risks and opportunities identified in my report have been, or will be, adequately responded to. It has not:

- ensured that all the areas requiring improvement have been explicitly considered and captured in actions. In particular, my 2015 report identified that HSSD had not set any guidance for consultants about undertaking private patient work when on sick leave from public duties. In the draft documentation I initially reviewed for this report, this issue had still not been addressed; or
- developed Key Performance Indicators (KPIs) with baseline and targets or tolerances to allow assessment of whether the actions taken have resolved the key underlying issues. I understand that the Divisional Lead for Operational Support Services plans to identify KPIs to monitor compliance with the Policy on Private Patients, and to evaluate the difference this makes to service operation and to outcomes. I have identified this as an area in need of concerted management action later in this report.

Recommendation

R1 Improve arrangements for considering issues identified in audit and other external reports so that:

- all areas requiring improvement are explicitly considered and addressed; and
- KPIs are used to assess the effectiveness of actions in addressing underlying issues.

Progress in implementing agreed recommendations

Private patient policy and procedural documents

- 3.1 Effective management of private patient activity, including to avoid any conflicts between private patient work and public work commitments, requires clearly articulated policy and appropriate operational standards and guidance.
- 3.2 I previously reported that HSSD had a range of relevant policy and procedural documents on operational and financial aspects of private patient business that had been developed over several years. But HSSD did not have one overarching private patient policy that set out clearly, and in one place:
 - its aims and objectives in undertaking private patient business; and
 - the principles that guide how this business is to be conducted.
- 3.3 The various existing documents lacked:
 - a clear description of what HSSD wants to achieve with its private patient business, and why. None made 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 ten public 'Programmed Activities' would be assured.
- 3.4 I also reported 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 of 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.
- 3.5 I identified scope for improvement in these areas and made three recommendations. In Exhibit 1, I evaluate the steps taken and planned in response to these recommendations.

Exhibit 1: Private Patient Policy and procedural documents

Recommendation	Update	Status	Evaluation
<p>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.</p>	<p>An overarching Policy on Private Patients has been agreed by HSSD’s Corporate Directors but has yet to be ratified by HSSD’s Policy and Procedures Committee that is due to consider it in January 2017. The Policy incorporates in one place relevant operational and financial principles. It includes:</p> <ul style="list-style-type: none"> • the role of private patient activity in supporting HSSD’s objectives and resilience, in particular in attracting consultants to the Island and improving overall capacity; • the approach to developing the tariff; and • how consultants should manage private patient work alongside their public contracted hours. The draft Policy states that consultants: <ul style="list-style-type: none"> ○ are required to satisfy their public commitments as outlined in their contract; ○ outside of this requirement, have no restriction on the amount of private patient activity which can be undertaken; and ○ must follow the standards and, if they do not, privileges may be withdrawn by the Hospital Managing Director. <p>The developing Policy has been routinely reviewed by the PPMC and tested widely, including with Clinical Directors and Divisional Leads.</p>	<p>Content agreed but not yet ratified or implemented.</p> <p>Delayed - originally due July 2016.</p>	<p>Although HSSD’s action plan stated that the Policy would in place by July 2016, no timetable setting out milestones and deliverables was established. In particular, the time required to ensure wide ranging consultation – rightly undertaken to promote ownership - had not been planned for.</p> <p>The Policy as drafted:</p> <ul style="list-style-type: none"> • is comprehensive, based on good practice; • reflects active involvement from relevant disciplines: operational; financial; and clinical; • has been consulted on: changes proposed can be tracked through evaluation to Policy amendments; • provides a good basis for holding practitioners to account; and • includes a review date.

Recommendation	Update	Status	Evaluation
	<p>The Hospital Managing Director and Director of Operations have actively supported its progress.</p>		<p>HSSD has not though explicitly set out how it will make sure the Policy's newly agreed standards and expectations mitigate specific risks identified in my 2015 report.</p>
<p>R2: Reconsider the appropriateness of current policies for charging for private patient activity.</p>	<p>HSSD's Private Patient Business Unit Strategy, dated January 2015, includes an action to review the trading structure during Q2-Q4 2015 to enable profit making. Based on externally commissioned reviews of patient experience and market opportunities, in March 2016 HSSD developed a Business Case to establish a Trading Operation.</p> <p>This included that, while the Future Hospital will provide a modern building from which to operate private patient services, HSSD cannot wait until it is built to begin to make the changes required.</p> <p>HSSD has completed work required as the basis of a proposal for a Trading Operation for discussion at the Council of Ministers. If the Council of Ministers supports the proposal, the Minister for Treasury and Resources would make a Proposition to the States Assembly.</p> <p>HSSD is planning for the Trading Operation to be established in 2017.</p> <p>HSSD is seeking to market its Private Patient Services with 'all in' bundled prices for some procedures, to produce a fixed package price covering all fees, including consultants' charges. This is aimed at self-paying private patients,</p>	<p>Partially implemented.</p>	<p>HSSD is reconsidering its Policy on charging for private patient activity. Discussions with Treasury and Resources about the proposal are proceeding but a final decision is yet to be made.</p> <p>The Business Case examines a number of scenarios to establish the potential benefits and risks of moving to a Trading Operation.</p>

Recommendation	Update	Status	Evaluation
	<p>starting with cosmetic procedures, to eliminate the difficulties patients currently experience seeking the best Island price, and to improve transparency. HSSD hopes that this will help Jersey retain private patients who currently go to UK providers, whose fixed package prices are well advertised.</p>		
<p>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.</p>	<p>The draft Policy on Private Patients incorporates procedural guidance. This includes:</p> <ul style="list-style-type: none"> • that a private inpatient has the right to change to public status if there is a significant change in medical or social circumstances; a Change of Status (Private to Public) form must be completed with a copy held on their medical notes and TrakCare (the patient management system) updated; • that all private activity undertaken within HSSD facilities is chargeable and all HSSD staff must undertake reasonable measures (examples are given) to identify private patients and recover income; • that consultants are responsible for ensuring copies of clinic, operating, anaesthetic and other information relating to care at the hospital is appropriately filed with the patient's public medical records; and • that for inpatient and day cases, the Elective Surgical Admissions Policy must be followed, with particular attention to compilation and closure of the Operating Theatre list one week prior to the list occurring. 	<p>Content agreed but not implemented.</p> <p>Originally due by July 2016.</p>	<p>In line with development of the Policy, the procedural guidance within it demonstrates an inclusive approach. Ownership across the hospital has been supported through active involvement of the PPMC members in gathering and representing colleagues' views. This increases the likelihood that guidance will be implemented.</p>

Recommendation	Update	Status	Evaluation
	The draft guidance I initially reviewed did not address all recommendations made in my 2015 report. It did not clearly set out that consultants should not undertake private patient work when on sick leave from public duties; however, officers subsequently amended the draft to include such a provision.		

Recommendations

- R2** Ensure implementation of the Policy on Private Patients addresses relevant risks and opportunities as identified in my report.
- R3** Establish a schedule of KPIs to evaluate the contribution and impact of key aspects of the Policy and associated procedural guidance, to provide management information on the extent to which each achieves its planned outcomes.
- R4** If proposals for a Trading Operation for private patient income are taken forward, develop and implement robust arrangements for the governance, oversight and management of the Trading Operation.

Establishing charges for private patient business

- 3.6 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.
- 3.7 My 2015 review assessed the process HSSD had adopted to develop its tariff for private patient procedures. I compared HSSD's approach with the good practice issued by the Healthcare Financial Management Association (HFMA) in Clinical Costing Standards. I found some areas of good practice but some areas in need of significant improvement. In particular:
 - the quality of key data items at patient level was potentially unreliable:
 - there were significant unexplained variations in the average theatre times for procedures from the 2009 and 2010 data, the averages of which were used in the 2011 costing exercise; and
 - there were underlying weaknesses in the quality, particularly completeness, of clinical coding.
 - the overall strategy and approach to costing for private patient business was not brought together in a strategic document. The costing methodology was difficult to follow, and there were some unexplained differences in costing calculations and figures used; and

- the spirit of the Clinical Costing Standards had been applied to the private patient costing methodology but there were significant inaccuracies that had not been resolved through audit.

3.8 From this comparison with good practice I made six recommendations for improvement.

3.9 In 2015 HSSD engaged In-Form Solutions, a UK based specialist consultancy, to review the costing methodology ‘as a proportionate interpretation of best practice in costing’ and to:

- provide an opinion on whether the tariffs recover full costs;
- benchmark prices against market expectations;
- provide an opinion of the commerciality of the Private Patient Service; and
- advise on the structure of the tariff to:
 - make it simpler for hospital staff to instruct Finance that billable events have occurred; and
 - improve partnership working with customers.

3.10 In Exhibit 2, I evaluate progress against my six recommendations.

Exhibit 2: Establishing charges for private patient business

Recommendation	Update	Status	Evaluation
R4 Adopt and document compliance with relevant elements of a recognised approach to costing, such as that published by the Healthcare Financial Management	<p>NHS Costing Guidance was the basis for the 2015 tariff development. The standards adopted are set out in HSSD’s <i>Private Patient Tariff 2015: Technical Document</i>.</p> <p>HSSD established the Costing Working Group (CWG) to identify and prioritise improvements. The group includes financial, costing and operational senior managers as well as clinicians.</p> <p>Using the HFMA’s six costing steps, HSSD has used a top down approach to calculate the individual costs of procedures based on theatres data for 2013 and 2014</p>	Implemented.	<p>HSSD has formalised and documented standards used in its approach to costing private patient services. It has used its experience of the 2015 tariff setting to identify and prioritise improvements needed in the future.</p> <p>The CWG has identified further actions needed to improve</p>

Recommendation	Update	Status	Evaluation
Association (HFMA).	<p>exported from the Patients Administration System (PAS), cost information taken from the general ledger and information from the pharmacy system. HSSD has taken into account inflation and any other known cost and activity effects to inform the 2015 tariff.</p> <p>To support a joined-up approach, HSSD undertook the costing project concurrently with production of:</p> <ul style="list-style-type: none"> • the <i>Acute Services Strategy Model</i>; and • an <i>Income and Expenditure Statement</i> for private patient services. <p>HSSD adopted agreed standards across the workstreams.</p>		compliance with costing standards. These are set out in relevant sections later in this report.
R5 Adopt and implement documentation standards for tariff construction.	<p>HSSD adopted a documentation scheme for the 2015 tariff costing project and set this out in the <i>Private Patient Tariff 2015: Technical Document</i>.</p> <p>HSSD stores all documents relating to costing electronically in a defined file directory structure and agreed format.</p> <p>The file structure includes the specific models, assumptions and source data used to calculate different elements of patient costs.</p> <p>Hard copies are available in a structured audit folder.</p>	Implemented.	The documentation standards implemented enable those not involved in tariff construction to follow the process. The file structure clearly marks final versions and archives older documents for reference. Meeting papers, notes and correspondence are also stored to support how the tariff has been constructed.
R6 Adopt and implement quality control procedures to ensure internal consistency of	<p>Quality control processes undertaken in the 2015 tariff construction are included in the draft Policy on Private Patients. The tariff was checked for reasonableness:</p> <ul style="list-style-type: none"> • with consultants, including Clinical Directors; • with other private providers; and 	Implemented.	In construction of the tariff, the CWG has focused on improving documentation and communications of the costing process between key

Recommendation	Update	Status	Evaluation
<p>tariff derivation prior to finalisation.</p>	<ul style="list-style-type: none"> • through some external benchmarking. <p>Where a new service or a new approach to service delivery is introduced and there is little or no historical data, HSSD undertakes ‘bottom up’ costing: for example, if clinicians move a service to an outpatient setting when previously it had only been undertaken in an operating theatre, the new costs of staff time, accommodation and consumables, plus overheads, are assessed.</p> <p>Concurrent development of the <i>Acute Services Strategy Model</i> and <i>Income and Expenditure Statement for Private Patient Services</i> supports consistency in:</p> <ul style="list-style-type: none"> • the input data used; • categorisation of costs; • model design; and • assumptions. 		<p>stakeholders.</p> <p>The use of ‘bottom-up’ costing supports changes in practice and enables HSSD to demonstrate that it is complying with the States’ Financial Direction 4.1.</p> <p>In-Form Solutions identified opportunities for the further development of quality control procedures. These are considered below.</p>
<p>R7 In deriving the tariff and additional private patient charges, calculate and apply appropriate on-costs for high value consumables, equipment and drugs.</p>	<p>The <i>Private Patient Tariff 2015: Technical Document</i> sets out the basis for charges for consumables, equipment and drugs. It lists:</p> <ul style="list-style-type: none"> • general consumables factored into all procedures, for example sutures; • specialty specific consumables factored into procedures for that specialty; • high cost consumables charged to a specific patient: <ul style="list-style-type: none"> ○ prosthetics (joints, lenses) or fixations; ○ single use instruments / consumables over £15; ○ equipment hired for a specific procedure; and 	<p>Implemented</p>	<p>HSSD has defined its approach to recovering the cost of consumables, equipment and drugs in tariff setting and in making additional charges.</p> <p>It has adopted a standard uplift to cover overheads and applied this to high cost consumables, equipment and drugs.</p> <p>In-Form Solutions suggested that HSSD might be under-recovering the cost of general</p>

Recommendation	Update	Status	Evaluation
	<ul style="list-style-type: none"> high cost drugs defined by the NHS Enhanced Tariff Option and updated annually. <p>High cost drugs and consumables are charged with a 25% mark up to cover procurement, distribution, administration and other overheads. This is based on the standard calculation of overheads, which for 2015 is 23%, adjusted for estimated disputes.</p>		<p>consumables, as 'private patient work can have above average consumable costs per minute in theatre due to the type of elective procedure that patients often choose to have privately'. HSSD has plans to explore this further as part of its quality control procedures, set out below.</p>
<p>R8 Adopt and implement quality control procedures for patient level information used in tariff development.</p>	<p>Improvement in quality control procedures is being driven through implementation of HSSD's Informatics Strategy.</p> <p>A key objective of the strategy is to improve the 'ownership' of data quality across all divisions. Service managers are increasingly responsible for the quality of the data. HSSD's informatics function supports this by:</p> <ul style="list-style-type: none"> reviewing and enforcing data definitions and standards; and exception reports, data quality monitoring and auditing. <p>However, the <i>Private Patient Tariff 2015: Technical Document</i> notes issues with data quality and the consequent need to use 'assumptions' where there are data limitations. In particular, it sets out data quality risks in activity in the Endoscopy Suite: for data used in tariff construction, procedure duration fields were incomplete for 30% of all endoscopy patient records. HSSD used the average duration of the valid procedures to populate the empty fields.</p>	<p>Partially implemented – the Informatics Strategy action plan covers period to Q2 2017.</p>	<p>HSSD's Informatics Strategy is established and making progress. There have though been recruitment difficulties which have impacted on achievement so far.</p> <p>The PPMC does not consider the relevant outputs from the TIG and has not, for example, considered implications of poor data for costing Endoscopy procedures.</p>

Recommendation	Update	Status	Evaluation
	<p>The Hospital's Theatre Information Group (TIG), which covers public and private activity, considers progress against the Informatics Strategy action plan. 'Improving data quality' is a standing item.</p> <p>HSSD has started work to implement a 'Person¹ Level Information and Costing System', or PLICS, in line with best practice identified in the NHS and other healthcare systems. The intention is that this will use all HSSD activity – from outpatients, community and acute services, to social care – and map how resources are used across pathways of care.</p>		
<p>R9 Adopt and implement proportionate audit procedures of both cost and activity information used to inform the tariff.</p>	<p>There have been two specific reports focusing on the information which underpins the 2015 tariff construction:</p> <ul style="list-style-type: none"> • consultants EY, in a review of HSSD's planned acute service delivery, advised about activity modelling; and • In-Form Solutions, in assessing at a high level whether the tariff recovers costs, concluded 'that broadly it does, but there are opportunities to improve on its accuracy.' <p>HSSD has stated that: 'in addition, HSSD will engage a periodic independent review of the tariff' but there are no further details.</p>	<p>Not implemented.</p>	<p>While the work HSSD has commissioned has identified ways to secure improved data accuracy, neither of these reviews constituted:</p> <ul style="list-style-type: none"> • audit of the figures provided; or • validation of information from source. <p>There is as yet no forward looking audit plan for cost and activity information.</p> <p>HSSD's plans to implement PLICS will require that the quality of activity and cost</p>

¹ HSSD has ambitions to use this system across health and social care services, and so is not using the more usual term 'Patient Level Information and Costing System' which applies only to health services.

Recommendation	Update	Status	Evaluation
			information is routinely assured for all its services.

Recommendation

R5 Plan and implement a proportionate programme of audit of both cost and activity information to support future enhancements to costing across HSSD.

Area for management action

A1 Ensure that the PPMC considers and takes action on relevant outputs from TIG.

Identifying private patient activity and billing for it

3.11 Robust arrangements are required to:

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

3.12 My report noted risks in all three of these areas:

- that Patients Administration System (PAS) records are incomplete and do not identify all private patient activity;
- that not all high cost consumables are billed for; and
- that manual transfer of information used to generate invoices increases the likelihood of error.

3.13 In 2015, I noted that:

- work to support front line staff in understanding and complying with private patient management processes had not been delivered as planned; but

- HSSD management intended to include the coding of private patient activity as part of the work of its clinical coding department in 2015.

3.14 Based on my assessment, I made three recommendations (see Exhibit 3).

Exhibit 3: Identifying private patient activity and billing for it

Recommendation	Update	Status	Evaluation
<p>R10 Provide clear and unambiguous guidance to and support for frontline staff for all parts of the process for identifying private patient work.</p>	<p>Three developments are relevant in this area:</p> <ul style="list-style-type: none"> • the draft Policy on Private Patients is designed to provide guidance, and clarify responsibilities, for all HSSD staff on managing private patient business; • the PPBM has reviewed and reissued key documents used to levy private patient charges, with support from the Patient Finance Team and service managers. The aim is to achieve greater consistency and improve capture of chargeable patients. This includes roll out of a common Consultant Admission form to be used by all private medical secretaries in submitting elective private patient’s details to the hospital. The information is used to log patients on the PAS which must be completed before a patient can be admitted; and • the Head of Income and Costing is reviewing the governance of processes to record, collate and manage private patient billing information, including increasing responsibilities and ownership within Divisions. 	<p>Partially implemented.</p>	<p>The Policy on Private Patients is not yet implemented. Key procedural documents from the Policy have though been rolled out.</p> <p>No process is yet finally agreed or in place to evaluate the impact of the new forms, or other aspects of the Policy on Private Patients, in improving capture of private patient work.</p>
<p>R11 Take steps to improve the accuracy and completeness of:</p> <ul style="list-style-type: none"> • the coding of 	<p>For patients referred for private inpatient or day case treatment, the Consultant Admission form now includes:</p> <ul style="list-style-type: none"> • the intended procedure code; • an estimated length of stay; • the expected admission ward; and 	<p>Partially implemented.</p>	<p>HSSD has taken significant steps to identify how to improve the quality of clinical coding and data on consumables used in</p>

Recommendation	Update	Status	Evaluation
<p>private patient procedures in operating theatres; and</p> <ul style="list-style-type: none"> information on the consumables used in operating theatre procedures. 	<ul style="list-style-type: none"> any high cost consumables, prosthetics, loan sets or drugs to be used. <p>Work to understand how best to improve the coding of procedures undertaken in operating theatres has focused on evaluating the cost and benefits of two approaches:</p> <ol style="list-style-type: none"> direct input from a clinical coding supervisor in the theatre, to help clinicians assign codes; and just providing updated coding sheets for each specialty. <p>Analysis showed unacceptable variation – from a quality and cost perspective - in accuracy and completeness of codes when entered by theatre staff following written guidance.</p> <p>Pilots are underway in three specialties to improve the way theatre stock is managed:</p> <ul style="list-style-type: none"> bar coded consumables are scanned at the point of use; information is recorded against a named patient; and the income team automatically receives billing information for patients identified as privately funded. <p>Subject to evaluation of the pilots, it is intended this approach will be used for all specialties.</p> <p>HSSD has submitted an Investment Request to enable it to appoint a clinical coder to be present in theatre and code private patient theatre activity.</p>		<p>operating theatres. As well as improving patient safety, extending and maintaining these improvements should support the accuracy and completeness of:</p> <ul style="list-style-type: none"> costing information for all theatre procedures; and billing of private patient procedures.
<p>R12 Using 'lean' principles, review current processes and arrangements for</p>	<p>HSSD has undertaken a review of arrangements to manage outpatient private patient activity, including billing and debt recovery procedures. This indicated a need to:</p> <ul style="list-style-type: none"> streamline processes, including using on-line forms; and 	<p>Partially implemented</p>	<p>HSSD has identified the key issues with billing for outpatient procedures and how to reduce the risk of</p>

Recommendation	Update	Status	Evaluation
<p>billing for outpatient private patient procedures with the aim of reducing the risk of error and maximising efficiency.</p>	<ul style="list-style-type: none"> • identify dedicated capacity to capture and bill for outpatient activity. <p>Further work is now underway to research options for on-line forms, including:</p> <ul style="list-style-type: none"> • seeking good practice in the UK and elsewhere; and • assessing the benefits of various dedicated systems. <p>In addition, the Head of Income and Costing is revising internal structures to ensure that:</p> <ul style="list-style-type: none"> • tasks and roles are appropriately allocated in line with the Policy on Private Patients and respective income targets across HSSD's Divisions; and • processes support efficient and effective capture of all patient services provided within HSSD and charges are raised accordingly. <p>As part of the review of processes and arrangements for billing, the resourcing and team structure of the Patient Finance Team are being revised. The aim is to develop a culture of 'ownership' of financial issues across Divisions, by using incentives to encourage supportive relationships and working practices.</p> <p>Progress includes identification of the need, as a pre-cursor to any move to a Trading Operation, to:</p> <ul style="list-style-type: none"> • transfer some duties previously assumed by the Patient Finance Team - such as identifying activity, pulling PAS reports and collating charges – to Divisions involved with private patient activity; 		<p>error.</p> <p>Implementation is underway but has been delayed due to resourcing issues and other priorities.</p>

Recommendation	Update	Status	Evaluation
	<ul style="list-style-type: none"> • make HSSD's Operational Support Services Division responsible for initiating billing for all private patient activity, including for outpatients; and • transfer all debt recovery responsibilities to Treasury and Resources with a planned implementation date of February 2017. 		

Area for management action

A2 Ensure that the evaluation and documentation of the benefits of the clinical coding and theatre stock management workstreams include a focus on private patient management and income.

Budgeting and budget monitoring

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

3.16 In my original report, I noted 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 monthly, 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 is 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 PPMC receives an 'income dashboard' that includes income from sources other than private patients, for example overseas patients.

3.17 However, I also noted:

- accountability and responsibility for monitoring and managing the reports generated from the private patient income and expenditure account were 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;
- the 'income dashboard' did not include cumulative income figures; and
- while income is set out, the associated expenditure was not as clearly reported.

3.18 I made four recommendations in this area (see Exhibit 4).

Exhibit 4: Budgeting and budget monitoring

Recommendation	Update	Status	Evaluation
<p>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.</p>	<p>HSSD's <i>Private Patient Tariff 2015 - Technical Document</i> describes overhead apportionment methodologies used.</p> <p>In developing the tariff, the CWG acknowledged the need to agree an overhead apportionment framework applicable to all costing exercises, including those supporting the Medium Term Financial Plan.</p>	<p>Implemented.</p>	<p>I welcome the recognition of the need to agree a framework to ensure consistency across costing exercises.</p>
<p>R14 Enhance the 'income dashboard' by inclusion of cumulative figures on 'year to date' income against budget.</p>	<p>HSSD publishes an income dashboard monthly to management groups. This includes a graph showing cumulative performance against income targets and expenditure budgets.</p>	<p>Implemented.</p>	<p>The PPMC actively uses the information on cumulative income against budget. PPMC members discuss reasons for any variance.</p>

Recommendation	Update	Status	Evaluation
<p>R15 In line with development of HSSD's Integrated Report, enhance Key Performance Indicators (KPIs) on how private patient finances are managed, to enable HSSD to demonstrate compliance with its stated policies and relevant objectives, including recovery rates.</p>	<p>A 'patient income' set of graphs is incorporated into HSSD's monthly integrated report. These graphs include:</p> <ul style="list-style-type: none"> • income variance against budget; • income forecast; and • monthly income by service. <p>However, few KPIs (with targets and tolerances) have been defined. I understand that the PPBM is working with the Head of Informatics on additional KPIs.</p>	<p>Partially implemented.</p>	<p>There is relatively rich financial data but this does not yet provide an 'at a glance' dashboard of performance against targets.</p> <p>KPIs clearly linking performance to business objectives - with targets and tolerances - remain underdeveloped.</p>
<p>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.</p>	<p>Shadow income and expenditure statements are presented quarterly to PPMC.</p> <p>These show year to date over- or under-recovery of the private patient budget and forecast the full year out-turn.</p>	<p>Implemented.</p>	<p>The PPMC uses the income and expenditure statement and discusses:</p> <ul style="list-style-type: none"> • reasons for variation; and • opportunities presented; or • remedial actions required.

Recommendations

- R6** Agree an overhead apportionment framework applicable to all costing exercises including those supporting Private Patient Income, the Medium Term Financial Plan and the annual budget.
- R7** Establish and regularly report financial KPIs which clearly demonstrate the link between current performance and business objectives in a way which enables 'at a glance' understanding of the position.

Longer term planning for private patient income

3.19 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. In line with this, in 2015 I made one recommendation (see Exhibit 5).

Exhibit 5: Longer term planning for private patient income

Recommendation	Update	Status	Evaluation
<p>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.</p>	<p>In late 2014, consultants EY reviewed:</p> <ul style="list-style-type: none"> • options available to Jersey for the future of private patient provision; and • relative risks and benefits of each. <p>The May 2015 report established potential growth in the private patient market and a range of possible actions to increase HSSD’s market share. These were ranked by risk, complexity, investment needed and impact.</p> <p>In January 2015, HSSD developed its ‘Business Unit Strategy’ for private patient services, based on EY’s findings. This informs HSSD’s:</p> <ul style="list-style-type: none"> • Acute Services Strategy 2015-2024; and • development of a workforce plan, currently underway. <p>The Acute Services Strategy and workforce plan underpin service design and</p>	<p>Partially implemented</p>	<p>HSSD has concluded that its approach to private patient activity will be to seek to do ‘more of the same’ rather than significantly change its service offering.</p> <p>Consistent with this, there have been important developments in:</p> <ul style="list-style-type: none"> • HSSD’s understanding of the potential market; • identifying and implementing a prioritised and resourced workplan aimed at increasing market share; and • a business case to move to a Trading Operation. <p>However, there is as yet no detailed plan to ensure the Future Hospital project is fully informed by a realistic assessment of private patient business opportunities over the medium and longer-term.</p> <p>Although HSSD’s Acute Services Strategy 2015-2024 includes a need to develop a ‘Clear private practice strategy to maximise</p>

Recommendation	Update	Status	Evaluation
	resourcing decisions for the Future Hospital project.		opportunities for the island to enhance income to the benefit of the public system', this is not yet in place.

Recommendation

R8 Produce a longer-term plan for private patient business that is fully integrated with other planning including the 'Future Hospital' project, workforce planning and risk management.

Monitoring compliance

3.20 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.

3.21 In my 2015 review I found that:

- although information about the governance of private patient activity was included in various documents, arrangements were not clearly set out in one place;
- HSSD could not demonstrate that arrangements were comprehensive and consistent;
- there was room for improvement in the effectiveness of the PPMC; and
- whereas the need for transparency in what private patient work is undertaken by clinicians was stated in documentation, there was:
 - no agreed approach to monitoring how consultants undertake their private patient work alongside public work;
 - a high level of 'custom and practice' around delivering private patient work, creating confusion around the 'rules' for managing it;
 - inconsistency in how consultant Job Plans demonstrate how HSSD is 'compensated' for the time consultants spend on private patient work within their 10 public 'Programmed Activities'; and
 - more to do to monitor and report on use of operating theatres for private work by speciality and by consultant.

3.22 In my 2015 report these findings led to four recommendations, set out in Exhibit 6.

Exhibit 6: Monitoring compliance

Recommendation	Update	Status	Evaluation
<p>R18 Document and implement robust overall governance arrangements for private patient activity.</p>	<p>HSSD has set out governance arrangements within the Policy on Private Patients along with relevant operational procedures. It establishes the roles and responsibilities of:</p> <ul style="list-style-type: none"> • the Hospital Managing Director; • Private Patient Services managers; • the PPMC; • consultants and non-consultant staff; • administrators and secretaries; • hospital departments; and • finance officers. <p>However, there are no plans in place to ensure these are complied with and are robust.</p> <p>The PPMC Terms of Reference (ToRs) include a responsibility for ‘reviewing corporate governance surrounding the management of Private Patient Services as required’.</p>	<p>Content agreed but not yet ratified or implemented.</p> <p>Delayed - originally due by July 2016.</p>	<p>The Policy on Private Patients has been considered and agreed by HSSD’s Integrated Governance Committee.</p> <p>HSSD goes some way to recognising the need to manage Policy rollout. It sets out how the document will be distributed and that ‘managers should ensure that all staff are made aware of the Policy and its content’.</p> <p>However, this is not sufficient to ensure the Policy is implemented as intended. HSSD’s approach to improving its management of private patient business so far lacks a clear focus on how it will assure itself that governance arrangements are robust and effective.</p>
<p>R19 Monitor the effectiveness of the restructured Private Patient Committee and</p>	<p>In March 2015, the PPMC ToRs were revised to clarify roles and responsibilities, including how actions would be recorded and monitored.</p> <p>HSSD has formalised arrangements for producing meeting minutes, and for managing agendas and papers to provide</p>	<p>Implemented.</p>	<p>PPMC administration is significantly improved: its activities can be clearly followed and understood by reading papers and minutes.</p>

Recommendation	Update	Status	Evaluation
<p>make further changes if necessary.</p>	<p>a clear record of the work of the PPMC.</p> <p>Through work to develop the draft Policy on Private Patients, the PPMC has revised its membership to ensure good representation of colleagues' views. This has resulted in recruiting an anaesthetist as a formal member of the PPMC.</p> <p>In September 2016 the PPMC revised the ToRs to reflect this change. At the same time the PPMC began considering how well its ToRs meet current and future business needs. HSSD plans to reconsider PPMC's ToRs when a decision on implementation of a Trading Operation is clear.</p>		<p>There is evidence that the PPMC routinely considers how to improve its effectiveness, for example by extending membership to improve representation and communication.</p> <p>However, the PPMC has not yet established a framework against which to monitor its achievement, as part of evaluating compliance with the Policy on Private Patients, once implemented.</p>
<p>R20 Clearly document the approach to monitoring how consultants undertake their private work alongside their public work.</p>	<p>The draft Policy on Private Patients sets standards for managing private work alongside public work, and that these will be monitored through ensuring that:</p> <ul style="list-style-type: none"> • consultants are able to provide evidence they are delivering ten 'Programmed Activities' of public contracted hours; and • where a consultant's public waiting times exceed 12 weeks to outpatient or inpatient, the Clinical Director and Divisional Lead will review all activity within that specialty and report to the Hospital Managing Director if it is determined that private patient activity is causing delays to public patient access. <p>The mechanisms by which these are expected to be routinely managed for all consultants are respectively:</p> <ul style="list-style-type: none"> • consultants' annual appraisals, which include a review 	<p>Partially implemented</p>	<p>In 2015 I noted HSSD's intention to:</p> <ul style="list-style-type: none"> • develop a 'medical staffing dashboard' as part of its evolving Integrated Report; • include a KPI to assess compliance with medical staff Job Plans; and • report on the extent to which clinical consultants are delivering ten Programmed Activities of public work. <p>Whilst HSSD still plans these initiatives, there is no timetable for</p>

Recommendation	Update	Status	Evaluation
	<p>of delivery of 'Programmed Activities'; and</p> <ul style="list-style-type: none"> the Waiting List Group, which meets weekly to identify issues with waiting lists and times. <p>How performance will be analysed and reported is not documented.</p>		implementation.
<p>R21 Clarify the requirements for quantifying and reflecting private patient work within Job Plans and monitor their implementation.</p>	<p>The draft Policy on Private Patients states:</p> <ul style="list-style-type: none"> Scheduling of work and timetabling: regular private commitments must be noted in a consultant's timetable; and Outpatients: consultants should agree with their Divisional Lead how private outpatient lists are to be managed. <p>Clinical Directors review consultant job plans at least annually, but there is no established mechanism for assuring this process includes these requirements.</p>	<p>Not implemented.</p>	<p>There are no documented arrangements in place to monitor that these practices are undertaken in all Divisions.</p> <p>Additionally, performance against these requirements is not assessed or reported.</p>

Recommendations

- R9** Establish arrangements, including KPIs, analysis and reporting mechanisms, to assess compliance with roles and responsibilities as set out in the Policy on Private Patients.
- R10** Establish a framework to evaluate the effectiveness of the PPMC.
- R11** Document and implement arrangements to enable HSSD to monitor compliance with standards for managing private work alongside public work, including against Job Plans.

Conclusion

- 4.1 My work can serve as an effective driver for improvement. However, whilst I can provide analysis and insight and make recommendations, it is management that is responsible for implementation. Effective consideration of audit reports driving action is therefore essential.
- 4.2 I welcome the action that management has taken in many of the areas that I highlighted and the changes that have been secured as a result. HSSD has adopted a structured approach to implementing recommendation, focussing on key weaknesses and aligned with departmental objectives. I particularly welcome the steps that have been taken to improve the administration of the PPMC and arrangements for charging private patients. But I also recognise that there are areas where further work has been slower:
- the development of policies and procedures;
 - the arrangements for identifying private patient activity and billing for it;
 - development of KPIs to allow effective and timely monitoring of performance by management; and
 - monitoring of compliance with policies.
- 4.3 Some of the areas for further development I have identified relate to HSSD's informatics function. As this impinges not just on private patient activity but the whole of HSSD's activities, I am planning a separate review of this area.
- 4.4 HSSD is seeking a move of its private patient activity to a Trading Operation status. Effective delivery in such an environment is not only about policies, procedures and systems but also about culture and behaviour so that the importance of effective governance and compliance is embedded.
- 4.5 Looking more broadly, my review also identified that there is scope to improve arrangements for securing the best value from my and other external reports. This involves looking beyond implementation of specific recommendations to ensuring that all action areas are identified and addressed and that a robust approach is adopted to monitoring the effectiveness of the actions implemented.

Appendix 1: Summary of Recommendations and Management Actions

Arrangements to manage, monitor and evaluate the implementation of recommendations

- R1** Improve arrangements for considering issues identified in audit and other external reports so that:
- all areas requiring improvement are explicitly considered and addressed; and
 - KPIs are used to assess the effectiveness of actions in addressing underlying issues.

Progress in implementing agreed recommendations

Recommendations

- R2** Ensure implementation of the Policy on Private Patients addresses relevant risks and opportunities as identified in my report.
- R3** Establish a schedule of KPIs to evaluate the contribution and impact of key aspects of the Policy and associated procedural guidance, to provide management information on the extent to which each achieves its planned outcomes.
- R4** If proposals for a Trading Operation for private patient income are taken forward, develop and implement robust arrangements for the governance, oversight and management of the Trading Operation.
- R5** Plan and implement a proportionate programme of audit of both cost and activity information to support future enhancements to costing across HSSD.
- R6** Agree an overhead apportionment framework applicable to all costing exercises including those supporting Private Patient Income, the Medium Term Financial Plan and the annual budget.
- R7** Establish and regularly report financial KPIs which clearly demonstrate the link between current performance and business objectives in a way which enables 'at a glance' understanding of the position.
- R8** Produce a longer-term plan for private patient business that is fully integrated with other planning including the 'Future Hospital' project, workforce planning and risk management.
- R9** Establish arrangements, including KPIs, analysis and reporting mechanisms, to assess compliance with roles and responsibilities as set out in the Policy on Private Patients.

R10 Establish a framework to evaluate the effectiveness of the PPMC.

R11 Document and implement arrangements to enable HSSD to monitor compliance with standards for managing private work alongside public work, including against Job Plans.

Areas for management action

A1 Ensure that the PPMC considers and takes action on relevant outputs from TIG.

A2 Ensure that the evaluation and documentation of the benefits of the clinical coding and theatre stock management workstreams include a focus on private patient management and income.



JERSEY AUDIT OFFICE

KAREN McCONNELL
COMPTROLLER and AUDITOR GENERAL

JERSEY AUDIT OFFICE, LINCOLN CHAMBERS (1ST FLOOR), 31 BROAD STREET, ST HELIER, JE2 3RR
T: 00 44 1534 716800 E: enquiries@jerseyauditoffice.je W: www.jerseyauditoffice.je