Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Joint Committee on Health

Meeting

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Opening Statement

By

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HSE

Introduction

Good morning Chairman and members of the Committee and thank you for the invitation to attend this meeting to discuss the Hospital Consultant Contract. I am joined by my colleagues Ms Colette Cowan, CEO, University of Limerick Hospital Group and Ms Angela Fitzgerald, Deputy Director, Acute Division.

The recent Primetime (PT) Programme examined the issue of private practice in the public hospital system and identified a number of unnamed individuals who were allegedly not meeting their contractual obligations. The issues raised are concerning for our patients, their relatives and the wider public.

Our hospital level data shows that, with a small number of exceptions individual hospitals are compliant with public private mix requirements and in fact the proportion of public patients treated is higher than the required level. This would suggest that the issues raised in end programme are about individual practice rather than whole system non-compliance issues.

However the recent PT programme raises a number of fundamental issues that we will seek to address with you today.

1 . The requirement for individual consultants to fulfil their contractual commitments in terms of commitment to public hospital
2 The requirement for individual consultants to fully comply with agreed private practice limits
3 . Issues relating to off -site practice outside of agreed contractual arrangements
4 . Potential displacement of public patients arising from excess private practice

1. Fulfilling public commitments under the Contract

Consultant duties in a hospital encompass three distinct elements- healthcare provision, education and research. Consultants are responsible for all patients under their care and for all the actions of their team. They are also responsible for education and research as part of the development of healthcare in Ireland. All consultants are required to have a work practice plan agreed with the Hospital CEO/Clinical Director. These practice plans set out clearly the daily commitments for consultants in accordance with the three core duties. They specify tasks such as outpatient and surgical sessions, teaching sessions and make provision for frequency of on-call arrangements. For joint appointments, there is a requirement for separate work practice plans to oversee the hours worked in each institution.

The practice plans are submitted in support of the employer's application for the consultant post and where there is a change of contract type. Under the 2008 contract, the review and oversight of these schedules is the function of the local Clinical Director. Hospital management and the Clinical Director are responsible for ensuring that all consultants fulfil their contracted commitments. There is also an obligation on the employer to ensure that he/she meets their obligations under the individual contracts including the provision of theatre and outpatient facilities and the total number of hours worked. Where consultants exceed the agreed hours, there is provision for additional payment in respect of such hours. The rates of payment are specified within the contract.

There are a number of ways in which hospital managers and clinical directors measure compliance with public hours worked. These include activity levels by consultant, waiting lists by consultant, daily and weekend discharges. The measurement of EWTD compliance levels for junior doctors also provides an opportunity for review of hours worked by consultants. We know from our monthly review of such data that for many disciplines particularly surgery, doctors exceed their contracted hours on a regular basis.

We have asked all Groups to review their existing arrangements with their Clinical Directors for overseeing work practice plans with specific reference to fulfilling their public commitments and addressing operational issues such as discharge planning, theatre access and outpatient sessions. We fully recognise the employer's obligations in this matter as well as the compliance requirements in relation to hours worked . In particular the development of the new structures within the HSE will bring a strengthened focus on operational efficiency and driving value within the public system.

2. Complying with private practice limits.

Consultants are employed under a number of different employment contracts. The most recent of these contracts being the 2008 Consultant Contract. All new consultants appointed since 2008 are employed under this contract. The 2008 contract provides for the following:

- Type A contract- these contract holders can treat public patients only.
- Type B contract holders – these doctors can treat private patients within public hospitals up to an agreed limit which may not exceed 30%
- Type B* - these doctors were employed pre-2008 and transferred to the new contract. They are allowed to have off –site practice
- Type C- these doctors are allowed to have off site practice and their private practice limits within a public hospital are also prescribed.

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Nationally within the acute hospitals

- 6% (169) of consultants hold Type A contracts, this contract does not allow for any private practice.
- 66% (1,789) hold Type B contracts which allow for limited on-site inpatient private practice and the remainder
- 28% (748) hold Type B*, Type C, or pre 2008 contract under which allow for onsite and offsite inpatient private practice. In relation to pre 2008 contract holders, the determination of private practice limits is by reference to the proportion of beds designated for private use in accordance with the provisions of the Health (Amendment) Act, 1991. We will discuss this further below**.**

2.1 Oversight arrangements for private practice.

Seven hospital groups were established in 2014 following the appointment of seven Group CEOs. The responsibility for reporting of individual consultant compliance with the contract, including adherence to public/private ratios, was formally delegated to the Hospital Groups in 2014 as part of the evolving hospital group development. Within the context of the overall delegation of responsibilities to Group CEOs, this oversight of consultant contract compliance was delegated for a number of reasons, including:

- Ensuring accountability and responsibility was devolved to Hospital Groups for all operational matters pertaining to their hospitals
- Recognition of joint appointments/cross hospital work arrangements and the effect on private work could only be assessed locally
- Guidance regarding detailed calculation of compliance, as per the contract, could only be applied locally

Part of the rationale for this approach related to the fact that the management guidance issued to support the contract provides for specific measures to address small volume / national specialist services and also provides guidance in relation to joint appointments and measurement arrangements. Also, in light of the complexities in relation to income generation and the requirement for regular review of work plans, it was felt that the reporting – alongside monitoring and management - must be exercised at the hospital level with oversight from Groups.

The HSE nationally does not coordinate the data as it was recognised that this data cannot be used in the absence of context, for example it did not allow for aggregation where consultants had commitments to more than one public hospital, it also did not provide details for the non- admitting specialities such as anaesthesia.

Monitoring of the public/private mix is complex and needs to account for Hospital Group services being differentiated between hospitals, with certain larger hospitals providing the bulk of emergency and complex care while the smaller hospitals concentrate on less complex emergency, day case and elective care. As Consultants may work across a number of hospitals in the hospital group the Public/Private mix must be considered in that context.

Within the context of the HSE performance accountability framework, there is a monthly performance meeting between the hospital groups and their individual hospitals. Given the devolved authority for overseeing private practice, there is a clear expectation that Hospital Groups review public /private mix and consultant contract compliance as part of their monthly engagements with hospitals.

Compliance is also a standing item in our monthly meetings with the Groups. In this context Groups are asked to assure the National Director that they are reviewing compliance issues as part of their regular monthly performance meetings and addressing issues of non -compliance with them.

2.2 Current Compliance with Private Practice Limits

The HSE collects and reports information from HIPE monthly, in arrears, in relation to the percentage of public and private work being undertaken at each Hospital on an elective in-patient basis and on a day-case basis. Latest data from September 2017 shows public private mix at a system level stands at 82% public for elective in-patient work and over 85.8% for day-case work. National performance has been consistent at this level. The Public/Private mix for inpatient and day cases has remained consistent over the past few years and has not been influenced by recent changes to legislation. 82% of all inpatients discharges are emergencies and individual consultants cannot control the level of private work arising through ED admissions.

For those sites where there is higher than 30% private practice, there are relevant factors to be considered on an individual basis including historical bed designation absence of private facilities in the area or service (e.g. paediatrics, maternity services) and supra regional or national specialist services (e.g. cancer services).

2.3 Interventions in areas of non –compliance

The HSE performance management process has highlighted issues or areas of potential non -compliance and has where it is deemed appropriate intervened to examine and address such non-compliance through independent review or internal audit processes. Two examples of such review processes are UL and St Vincent's Hospital Group. The findings from such review processes serve to inform improvements in internal controls or oversight arrangements including review of practice plans and total hours worked but they have also highlighted some structural challenges in relation to the operation of the contracts.

2.4 Structural Challenges in relation to overseeing compliance

With specific reference to the 2008 Contract , a key issue has been the fact that the development of the contract was predicated on the principle of co-location with associated benefits in terms of additional investment in capacity and facilities and equipment which would benefit public and private patients and removal of the requirement for off- site practice Due to the downturn in the economy ,no co-located sites were developed and as a result the full operation of the provisions of the contract were compromised. During that same period, the expectation that hospitals would seek to maximise income posed an additional challenge

From our on-going review of public private mix compliance with hospitals and groups and our broader review of financial performance through the accountability framework a number of issues have been identified that pose key challenges in terms of groups exercising their oversight function.

- The decision by way of legislation to effectively de-designate private beds (2013 legislation) was aimed at optimising private income and supporting the delivery of accelerated income targets. The Comptroller & Auditor General's Report of 2010 was a driver for the 2013 legislative changes. These designations which were historic do not correlate in all cases with the 80/20 split prescribed in the 2008 limit. In a number of cases they allowed for higher levels of on-site practice. The change in law exacerbated the challenges in this area as it meant that the mechanism in the then existing consultant contract (pre 2008) was redundant. It has been agreed there is merit in issuing specific guidance on this matter. This will support improved oversight of private practice across all consultants.

- There is no mechanism to allow HSE to determine if consultants have billed and been paid for all of the patients recorded as private on hospital systems.
- None of the consultant contracts make provision for monitoring offsite private practice and the HSE currently has no access to information in relation to offsite activity. The HSE is in discussion with the Department about appropriate additional measures to be implemented to enable effective oversight of this issue. We are evaluating the potential to implement an annual compliance statement.
- Private patient income accounts for 12% of acute hospital funding. Hospitals have a statutory requirement to collect private accommodation charges from patients who elect to be treated as private patients in public hospitals. This income is required to fund patient care.

3. Potential displacement of public patients

Public patients should not be displaced by private practice levels at individual or hospital level. Improving elective access is a core requirement for the HSE and this is evidenced in the on-going initiatives and efforts in relation to waiting lists. In 2017 the HSE , working in collaboration with the NTPF has achieved the targets set by the Minister for inpatient, day case and outpatient waiting lists . For the fourth month in a row, we have seen a reduction in the numbers waiting over 15 months for Inpatient and Day case procedures. We fully accept that waiting 15 months for an outpatient or inpatient procedure is too long and for this reason we are progressing with plans to effect further sustained improvements in overall waiting list with a particular focus on long waiters and on patients who have been deemed clinically urgent. We are very conscious of the impact of delays in specialties such as orthopaedics and ophthalmology on quality of life and independence of patients and for this reason we are prioritising these specialties within the context of the funding being made available in 2018. We expect to make significant improvements in access times for these specialties.

With specific reference to concerns raised about compliance with the consultant contract provisions in relation to waiting list management it may be helpful for the committee to clarify the HSE position on this matter. The Consultant's Contract 2008 and guidance from the National Director of Acute Hospitals in September 2009 refer to a common waiting list for treatment, diagnostic investigations, tests and procedures on an out-patient basis in public hospitals. Currently, out-patient waiting lists relate to a patient's first consultation with a consultant, which may or may not involve a diagnostic test. In regard to these first consultations at consultant-led clinics, the HSE does not permit the attendance of private outpatients at public outpatient sessions. Private patients are to be seen in separate clinics outside of the public commitment. Hence, for operational purposes, there is one public hospital waiting list for outpatient services, with all patients electing to be seen as public patients.

As previously stated the public private mix at national level stands at 82% public for elective in-patient work and over 85.8% for day-case work. It should also be noted that 82% of discharges are accessing care through the emergency department and there. Notwithstanding this consistent performance at national level, the HSE will ensure that the additional measures being undertaken in relation to oversight of consultant contract compliance address any issues at individual consultant level in relation high levels of private elective work .

Finally in terms of tackling elective access on a consistent basis, hospitals face recognised challenges in the context of other competing demands or capacity challenges:

- 5% growth in emergency attendances in 2015 into 2016 and 2016 into 2017.
- Increase in the >75 years of age cohort of 5% year on year and the associated challenges in terms of resource use. Specifically the propensity to admit in this age cohort is 50 % compared with an average of 26%; their length of stay is twice as long as the average patient
- Bed days lost to Delayed Discharges- typically we have 550 beds occupied by patients who are medically fit for discharge but require further supports
- Beds closed due to staffing shortages or infection control reasons– at any one time we can have up to 170 beds closed

- Consultant manpower shortages- by comparison with OECD and other international norms, Ireland has insufficient consultants per head of population> This shortage is compounded by increasing challenges in terms of attracting and retaining doctors

The activity data at hospital and national level does not suggest that private patients treated in public hospitals are seen out of sequence or ahead of a public patient that had greater clinical need. Finally it should be noted that the waiting lists held by public hospitals may patients who have private health insurance but who have elected to be seen as public patients for either reasons of personal choice or due to the complexity of their condition eg cancer.

In conclusion, the HSE fully acknowledges the imperative to ensure that it has appropriate measures in place at all levels to ensure robust oversight of contract compliance with particular reference to public commitment and private practice and it is taking a number of additional actions in conjunction with the Department to strengthen existing controls in this area. Furthermore in relation to access for public patients, the HSE is working with the Department and the NTPF on a comprehensive set of measures aimed at delivering sustained improvements in access to outpatient and scheduled care.

I trust this information is of assistance and my colleagues and I will endeavour to answer questions the Committee may have or provide any further information required.

This concludes my opening statement.

Thank you.