Consultant Contract Implementation

Guidance to health service management on the implementation of Consultant Contract 2008

Volume IV, 14th October 2010

Purpose of guidance

Please note that this guidance is to health service management. This document is the fourth volume of such guidance. The document dated 25th July 2008 is referred to as 'Management Guidance, Volume I'. Management Guidance Volume II issued on 15th August 2008 and Management Guidance Volume III on 28th August 2008.

This document – together with Volumes I, II and III - is intended to clarify a range of issues associated with the implementation of Consultant Contract 2008.

This particular document focuses on the measurement of public and private practice. Further guidance issued since July 2008 regarding the measurement of public and private practice is detailed at Section 4.

Neither this document nor Volume I, II or III in any way supersede the terms and conditions of Consultant Contract 2008.

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1. Relevant sections of Consultant Contract 2008

Section 20 of the Consultant Contract 2008 deals with the regulation of private practice and the mechanisms for ensuring compliance with the 80:20 / 70:30 ratio of public to private practice.

It should be noted that ratios that differ from 80:20 public to private are held by Consultants in employment when Consultant Contract 2008 was offered in July 2008 and who remain in the post they occupied at that time. Such ratios are not available to any Consultant taking up post under Consultant Contract 2008 since that time.

Section 20 of the Contract provides that the volume of private practice may not exceed the specified ratio in any of the Consultant's clinical activities including inpatient, day-patient and outpatient.

The volume of practice refers to patient throughput adjusted for complexity through the casemix system. It does not include non-clinical activities, nor does it apply to time.

Where a particular activity is included in the measurement and calculation of public : private practice, both public and private work in this area must be included. Equally, where a particular activity is not counted, neither public nor private work may be included.

The Consultant will be advised on a timely basis if his or her practice is in excess of the 80:20 ratio of public to private practice in any of his or her clinical activities. An initial period of six months will be allowed to bring practice back into line but if within a further period of 3 months the appropriate ratio is not established (s)he will be required to remit private practice fees in excess of this ratio to the research and study fund under the control of the Clinical Director.

Section 20 of the Contract states that the Employer has full authority to take all necessary steps to ensure that for each element of a Consultant's practice, s(he) shall not exceed the agreed ratio.

Other relevant sections include Section 4 b), which states that

> "both the Consultant and the Employer shall co-operate in giving effect to such arrangements as are put into place to verify the delivery of the Consultant's contractual commitments"

and Section 12 l), which requires the Consultant

> "to participate in and facilitate production of all data/information required to validate delivery of duties and functions and inform planning and management of service delivery."

2. Implementation of measurement systems

Set out below are the measures required to implement the measurement of public private mix under Consultant Contract 2008. It should be noted that these apply to any Consultant – irrespective of specialty – holding Consultant Contract 2008 on a Type B, B* or C basis:

a) A monthly HIPE compliance report is to be run profiling each individual's performance in relation to their contact. The report covers a rolling three month period, 6 months in arrears.

b) The private practice of Consultants whose routine activity is not recorded on the HIPE e.g. radiology, pathology, must be monitored by using other hospital systems, such as Patient Administration or Laboratory systems.

c) Where a Consultant is shown as being in excess of their specified contract limit during the reporting period, either in respect of in-patient **or** day case activity, the issue must be raised with the Consultant by their Clinical Director.

d) The Consultant should immediately validate their data with the Clinical Director (or in their absence, the CEO/General Manager).

e) HIPE counts patients in a very particular way, adjusted for complexity. For example, a Consultant may indicate that they did not bill one patient in intensive care and so that one patient should be counted as public work. However, HIPE could class an intensive care patient as being 'worth' more, e.g. 40 'Case-mix adjusted units'. It is the HIPE figure of 40 that is moved to the public total, when re-calculating the public/private mix. This data is provided by HIPE reports.

f) If after validation there continues to be an excess of private practice, the Clinical Director and CEO/General Manager should review this and determine if there is a detrimental effect on the volume of public work. Each Consultant should be advised of the need to take positive action to reduce their level of private practice to the approved contractual ratio. While each Consultant is allowed a total of nine months for any one category (in-patients or day cases) to meet the requirements of the contract, the Consultant should be made aware of the extent to which they are compliant on a monthly basis. The period of adjustment is only allowed once for each category of patient.

g) If the 9 month period of adjustment has expired, the remittance clauses must be invoked in relation to excess private earnings.

h) Where the excess private practice is unavoidable and/or does not have a detrimental effect on public work, the clauses regarding remittance must still be invoked, where the period of adjustment has expired.

i) Where the excess private practice is detrimental to public service, the Clinical Director and CEO/General Manager must also take action to address this situation, up to and including a restriction on further private practice until compliance exists.

j) It is the duty of Consultant to validate their data and to provide information on income during a specified period. If this is not forthcoming, then the employer may estimate the amount of income and invoice accordingly.

k) All decisions, adjustments and actions taken must be carefully recorded so that documentation can be reviewed when the process is subjected to audit.

3. Evaluating whether a Consultant is compliant with the Contract

Set out below are number of processes which may be used when evaluating whether a Consultant has complied with his/her specified ratio of public to private practice. These processes should be used prior to remittance of private fees to the research and study fund.

a) Where the Consultant has not billed a patient categorised as a private patient that patient shall be counted as public only where satisfactory evidence has been provided by the Consultant that no fee resulted.

b) Where the patient public or private status has changed the patient should be counted

as private only for the period during which they were categorised as private and vice versa.

c) In the initial stages of contract implementation where the total patient volume in the three month period where the ratio is exceeded is 18 or less and the discounting of no more than 3 private patients would result in the Consultant complying with the ratio then the Clinical Director may authorise such discounting.

d) Where clinical activity is coded under HIPE for a Consultant or Consultants in a particular setting or specialty the employer should ensure that such activity is taken into account for each Consultant recorded as being involved in the care of the patient.

e) The formation and composition of Consultant teams are decided by the employer. A Consultant may only be a member of one team. Where the Consultant works as part of a team of Consultants the team ratio should be calculated by adding the ratios of the Consultants on the team together and dividing by the number of Consultants on the team. For example, a team of 7 Consultants where 5 have a ratio of 30% and 2 of 20% would have a team ratio of 27%. Type A Consultants should not form part of the calculation of the team ratio.

f) In the initial stages of contract implementation, at the discretion of the employer, Consultants working as part of a team may exceed the team ratio by no more than 5 percentage points and should not do so on a sustained basis. For example, where the team ratio is 27%, individual Consultants must not exceed a ratio of 32% - even if the team as a whole is compliant.

g) For those Consultants with joint appointments, with effect from 1st April 2010 for a period of 12 months only, data relating to the particular cohort of practice (inpatient, outpatient, daycase, diagnostic or other) from each of the sites to which the Consultant has a specified contractual commitment as set out in the Comhairle na nOspidéal / HSE letter approving the Consultant post may be aggregated. At the end of the 12 month period, satisfactory arrangements must be implemented to ensure that the requirement under the ratio is implemented in each site.

   To calculate the CMU value using data from two or more sites, use the following formula:

   a. (Site 1 CMU value multiplied by the no. of discharges / daycases) + (Site 2 CMU value multiplied no. of discharges / daycases)

   b. Add all the discharges / daycases from all sites together.

   c. Divide the answer to Step 1 by the answer to Step 2 to obtain the aggregate CMU value.

   Note that you cannot add inpatient to daycase data, daycase to outpatient or otherwise combine two different cohorts of practice.

h) For those Consultants where the service has been reconfigured to create a single department under single management across multiple sites data relating to work in the particular cohort of practice (inpatient, outpatient, daycase, diagnostic or other) from each of the sites to which the Consultant has a specified contractual commitment as set out in the Comhairle na nOspidéal / HSE letter approving the Consultant post may be aggregated. Such reconfigured services are limited to the following:

   a. Mid-West
   b. Drogheda, Dundalk, Navan
   c. Cavan Monaghan

Other locations may be added by the HSE at national level as reconfiguration progresses.

4. Further guidance on measurement of public and private practice

Set out below is a list of key documents relating to the measurement and organisation of Consultant public and private practice issued over the past two years:

- Department of Health and Children Circular No.1 of 1991 – recirculated in October 2008;
- Department of Health and Children Circular No.5 of 1991 - recirculated in October 2008;
- Sample Base ESRI template setting out 2006 private practice ratio, issued in August 2008
- HSE HiPE Casemix Unit – Guidance on Measurement of Public Private Mix – issued August 2008
- ESRI Information note on measurement of Inpatient & Daycase Activity – issued on 1st August 2008
- ESRI Explanatory Note on Individual Consultant Report – issued on 1st August 2008
- ESRI Guidance to Consultants on reporting of HIPE Data – issued on 1st September
- 2008
- Consultant Contract 2008 – Agreed Measurement systems for Public Private mix – 31st July 08,
- Consultant Contract 2008 – Management Guidance Vols I (25th July 2008), II (15th August 2008) and III (28th August 2008),
- Guidance on measurement of Outpatient and Diagnostic Activity – 29th September 08
- Template for monthly public private mix measurement report,

Each of these documents was circulated to Hospital Network Managers and other staff in 2008 / 2009 and may be obtained from same or from email: andrew.condon@hse.ie .

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