Appendix 2

Brighton & Hove HOSC November 2006

SOTC Question and Answers

1. Is the ISTC performing procedures at the rate specified in its contract (and has it been doing so since opening)?

At the current time (20 November 2006) the SOTC is performing approximately 50 operations a week in aggregate terms compared against a contract plan of approximately 100 operations.

1.1 What are the figures stipulated in the ISTC contract?

The GC-8 contract, which includes the provision of services at SOTC, is deliberately structured in such a way as to allow flexibility to referring PCTs in relation to the case-mix they refer. Accordingly, the contract is structured to allow full substitution within "Activity Groups" (which are clusters of similar types of operation). Instead of stating a number of procedures which a provider will be required to undertake, the contract specifies a value of activity which will be referred to Mercury Health within each Activity Group for each financial year. There is also some tolerance on over/under performance each month and between Activity Groups which can be used to smooth out contract performance.

The contracts are set-out like this to maximise efficiency within the ISTCs by creating a smooth and predicted referral flow both with regards to monthly volumes and with regards to the types of case. This presents a challenge to the referring PCTs and BSUH, however, with regards to getting the flow of referrals (volume and case-mix) right.

The table below shows the approximate activity volumes as identified in the contract.

Financial Year	No of HRGs or Operations*
2006/07 (10/12ths PYE)	4312
2007/08	5308
2008/09	5300
2009/10	5311
20010/11	5330
2011/12 (2/12ths PYE)	891

* BHCPCTs share of these volumes is approximately 40%.

1.2 If fewer procedures than planned have been performed, then how far is it lagging behind the contracted figures?

The answer to this is not straight forward. This is because activity may be counted against the value of the contract in advance of it being delivered. Cases are counted against the contract value when they are accepted by SOTC following referral and not when they are actually performed – should a case subsequently be rejected then the referral is obviously discounted. Since Mercury are given a maximum treatment window of 19 weeks to treat every case following acceptance the contract typically runs three months in arrear or on account. If, at the end of the five year contract, the PCTs decide to terminate the contract with Mercury then the PCTs would stop referring cases under this contract two to three months before termination in order to get full value out of the contract.

Consequently while Mercury Health has been performing fewer procedures per week than they are funded for they are not currently in breach of contract.

However Mercury Health recognises that the current situation requires urgent attention and productivity levels need to be significantly increased. At the end of October it was expected (but not contractually required) that SOTC would have treated approximately 1,700 patients. This was the agreed delivery plan against total funded activity between 1st June and 31st October of approximately 2,300 cases. By the end of October SOTC had treated approximately 600 patients (592 as at 28 October).

A revised delivery plan is therefore currently being developed and an update on this will be given at the HOSC.

1.3 If the ISTC is not yet up to speed, is it expected that it will be able to perform additional procedures in the remaining years of the contract so that the contracted number of procedures is attained?

SOTC is fully expected (and contractually obligated) to deliver the contract volumes in both this and subsequent years, on the proviso that sufficient cases are referred in to SOTC under the terms and conditions of the contract.

1.4 If the ISTC cannot perform extra procedures to make the numbers up, is this wholly for clinical reasons or because Mercury Health declines to do so?

There are a number of factors that explain why SOTC is not currently operating at full capacity. These include:

- Quality and timing of referrals into SOTC from BSUH with regards to patients on its existing waiting list
- Poor information provision that did not enable the teething problems to be easily detected and quantified in a timely way
- Booking and scheduling processes within SOTC that were not sufficiently robust
- Underestimating the impact of moving from a system of “waiting”, characterised by long waiting times and a large waiting list, to a

system of “booking” characterised by short waiting times and with queues comprising only of patients who are ready, fit and available for their operations and are readily contactable.

- The bedding down problems always associated with opening a new centre, with new people working around processes and systems that they may not be familiar with. Although Mercury provided an induction programme the BSUH seconded staff could not attend these in advance of opening because they were required to work full-time at BSUH in treating patients.
- National ISTC contracts that did not provide sufficient flexibility for a scheme of this size and nature in the opening few months. In terms of operational delivery they assume a very quick ramp-up of activity following opening.

Mercury accepts that it has a responsibility to make up the number of procedures (please see the answer to question 1.7 below) and the PCTs accept that they and BSUH have a responsibility to improve the quality of the referral information. Mercury Health is currently and will continue to use other local independent sector providers, at its own cost, to help make up these contracted volumes.

1.5 If the ISTC is not expected to perform the number of procedures contracted (and paid) for, was this something that was anticipated when the initial contract was drawn up?

The national contracts expect the provider to deliver the number of procedures, in each of the respective activity groups (defined by specific clusters of similar HRGs - Healthcare Resource Groups), that are paid for within the contract in accordance with the terms and conditions.

1.6 What (if any) leeway did the PCT have in negotiating the ISTC contract? (i.e.: to what degree is the PCT obliged to fill in the blanks on a standard Department of Health contract rather than devising a locally sensitive agreement?)

The PCT had only a limited influence on the content and nature of the national contracts. The PCT was not able to change the financial arrangements of the contracts nor the key terms and conditions. We can however now make amendments to the case-mix through an agreed contractual mechanism and we can negotiate improvements in waiting times, subject to affordability and capacity. However these changes must be agreed by all parties to the contract.

1.7 What steps are being taken (if necessary) to increase the number of procedures performed at the ISTC?

The PCT is currently developing a Deed of Variation with Mercury and the DOH which will require Mercury to make up the procedures it has not delivered thus far. It is expected that the backlog should be “recovered” by the end of March 2007. We will be able to provide additional information about

this at the HOSC meeting but at the time of writing this paper, the underpinning activity schedule for this Deed of Variation was still being developed and agreed. Mercury Health will be utilising other local independent sector providers, at its own cost, to help make up these contracted volumes.

From 2007/08 onwards SOTC is expected to deliver the weekly contracted volumes without having to use downstream providers.

2. Is the ISTC performing procedures safely?

The ISTC is performing procedures safely. The HOSC will be aware of initial concerns that were raised about patient safety but these were addressed in a timely way.

The PCT Board and Professional Executive Committee were both briefed about these concerns and agreed that a Peer Review (see Appendix 2) meeting should be convened in conjunction with clinicians working at the centre to identify whether the ISTC was operating safely and to examine the clinical governance processes with SOTC.

Appendix 1 sets out a statement agreed by all those who attended the Peer Review meeting held on 31st October 2006. This should be read in conjunction with Appendix 2.

2.1 Are standards as high as those for comparable elective surgery within the local NHS? (or as high as those of private providers traditionally used by the NHS to provide extra capacity?)

The standards that are required are at least as high as those required within the local NHS. The provider is subject to registration and inspection from the Health Care Commission and the contract is monitored in a more structured way than Service Level Agreements with NHS Trusts typically are, covering a comprehensive range of Key Performance Indicators.

2.2 Are some "teething problems" deemed acceptable when setting up a new ISTC, or is the intention that the unit should achieve safety targets from day one? If the former, how is an acceptable level of safety calculated? If the latter, why has the safety record been so poor (if it is poor)?

Any new centre is likely to experience some teething problems but patient safety is of paramount importance. In the first few weeks there were some reported incidents but these were rapidly dealt with. The media reporting of events post-dated the incidents concerned by at least four weeks (Hospital Doctor) and eight weeks (local press). By the time of the coverage all major incidents had been appropriately dealt with.

There is always an element of clinical risk associated in the delivery of health care. Clinical safety is a matter of managing clinical risk. No service can be

guaranteed as “safe” in all respects. The issue here is about the robustness of Mercury Health’s clinical governance systems and processes to manage this risk and ensure that standards are acceptable.

Problems were identified and addressed in a timely way – which is a good indication that the clinical governance processes and systems are in place and work. This was confirmed by external clinicians through the Peer Review process.

2.3 If there are concerns over safety, is it considered that recruitment practices have been a factor in this?

Recruitment practices are not considered to have impacted on safety. Mercury Health is required to maintain the same standards of recruitment as the NHS.

2.4 What steps are being taken to improve safety?

The management of clinical risk and patient safety is, essentially, an ongoing process in all organisations providing health care. Full risk management and clinical governance processes are in place at SOTC as they are within BSUH.

3. Is the ISTC receiving the expected level of referrals?

Yes. The number of referrals that have been made into the SOTC has been very encouraging and to date this has not been a problem.

3.1 If not, where is the system failing?

Not applicable.

3.2 What type of planning is in place to deal with low referral rates?

We are not experiencing any problems with regards to low referral rates.

3.3 Given the importance of Choice to the modern health service, what can be done to encourage referrals to the ISTC without restricting patient choice?

PCT’s will be developing a comprehensive range of primary care orthopaedic clinical assessment services to help manage this situation but also to enhance the patients experience of the assessment and diagnostic process. These will be multi-disciplinary teams (consultants, GPs with special interests and extended scope practitioners such as physiotherapists and podiatrists) located in community settings, such as Hove Polyclinic, and tasked with assessing and diagnosing patients referred by GPs prior to onward referral for surgery. Since these referrals remain within primary care they are not subject to the requirements of patient choice. Patients referred onwards for surgery

from the clinical assessment teams to secondary care would be offered their choice at that point in accordance with the requirements of national policy.

The formal offer of choice to patients is made at the point of referral from primary to secondary care. Since SOTC is not contracted to deliver the patients initial outpatient appointment, where the assessment and diagnosis of the patient is made, SOTC does not appear on the patient choice Directory of Services. Patients attending Royal Sussex County Hospital and Princess Royal Hospital for there initial outpatient services are effectively choosing to be treated at SOTC since that is where any surgery they require will be performed.

BSUH will shortly be placing its orthopaedic outpatient services onto GPs Choose and Book Directory of Services. The PCT is therefore working with the trust to make the choice offer more transparent to patients (the outpatient element will be entitled 'Central Sussex Orthopaedic Service' rather BSUH orthopaedics).

The PCT will also be making literature available within GP surgeries to explain how the overall pathway works. GPs will still make their referrals into a PCT assessment centre which will be responsible for discussing the offer of choice to patients and for securing a booked appointment with the secondary care provider they choose to be referred to. Once established every patient will be referred into a comprehensive range of orthopaedic Clinical Assessment Services and the PCT referral centre will then be tasked with managing onward referrals for surgery within the context of patient choice.

3.4 If the referral rates are disappointing, what work has been done to identify why this might be (for instance, do we know why some GPs may be reluctant to recommend the ISTC to their patients)?

Referral rates are not proving to be a problem. Local GPs are happy to refer patients through the pathway that results in the operation being undertaken at SOTC because this service is delivered by surgeons they know and trust.

3.5 Does the ISTC have comprehensive statistics on success rates of operations/individual surgeons available so as to allow people to make informed referral choices? If not, is it planned to publish this type of information?

Unfortunately there is no standard measure or baseline against which one provider can demonstrate whether their surgical outcomes in orthopaedics are better than another (either by organisation or surgeon). There is a much wider issue here about systematic audit of such measurement across the NHS.

The PCT and Mercury Health have agreed to undertake a clinical audit to measure outcomes at SOTC and to make this information publicly available. The design of the audit is currently in progress but data will only become

meaningful over time both with regards to volume and comparison. This outcomes audit is not required by the national contracts.

A list of the contract Key Performance Indicators, which are routinely monitored every quarter, is however attached as Appendix 3 – some of these do focus on important clinical output areas.

4. What has the impact of the ISTC been on NHS services in the region?

Although this is a very pertinent question this is not yet possible to assess as it is still early days.

4.1 Has the ISTC taken only "surplus" work? (I.e. have all the procedures undertaken by the ISTC been operations that the local NHS did not have the capacity to provide, or has the ISTC taken some operations that would otherwise have been performed in NHS settings?)

The SOTC was designed to deliver existing volumes of activity plus the forecast gap. The purpose of the SOTC contract is to deliver the vast majority of elective orthopaedic surgery to local people. The PCTs forecasting suggests that this contract will provide sufficient capacity to treat all Brighton & Hove residents whom require an orthopaedic procedure under the NHS.

4.2 What impact is the ISTC expected to have on the NHS's capacity to deliver complex orthopaedic (and other) care?

The BSUH surgeons that have seconded into the SOTC have typically had their job plans redefined. This means the consultants have less time to now work in outpatient clinics than was previously the case (this is because one session a week of outpatient time has been switched to deliver extra elective operating time). BSUH has put on additional clinics to ensure patients are still seen in outpatients and the PCTs will be looking to urgently develop Clinical Assessment Service clinics to manage GP referrals (these will be multi-disciplinary teams involving consultant input which will be able to see more patients).

BSUH believes it can deliver the underlying levels of complex cases. More detailed planning is being undertaken now that the centre is open, to assess the exact split of the complex cases that need to be delivered within BSUH (this needs to be analysed by surgeon and by case-mix). The assessment of the number of complex cases that SOTC would not be able to treat prior to the centre opening was in the order of 75 per month – the trust has aggregate surgeon capacity to manage this volume of complex cases assuming it is evenly distributed between its surgeons.

4.3 Can the NHS maintain surgical rotas for trauma and A&E care if routine procedures are being taken (or will be taken) by the ISTC?

BSUH has sufficient surgeon capacity to satisfactorily manage its trauma rotas and A&E care.

5. Training/staff retention: has the opening of the ISTC had a negative impact on the ability of the local NHS to train and retain staff?

There is no evidence of SOTC having a negative impact on recruitment and retention. This situation continues to be monitored by BSUH.

Are any such problems anticipated when the current guidelines for ISTC operation (e.g. those limiting the ability of ISTCs to recruit from the LHE) are relaxed?

There is absolutely no suggestion of any relaxation of this occurring. Indeed this is a matter which is taken very seriously by the DOH in their management of these contracts. Any breaches can result in financial penalties being levied upon the provider. Should a provider wish to appoint a clinician or nurse that has been employed within the NHS in the previous 6 month period than they have to make a formal request to do so and secure DOH and PCT agreement to proceed on a case-by-case basis.

This is another Key Performance Indicator that is closely monitored.

5.2 Is there confidence that the ISTC will be able to make a significant contribution to staff training in the long-term?

Mercury Health is keen to make such a contribution and the PCTs would welcome this.

The SOTC has been approved for the purposes of providing training by the Royal Colleges and Deanery.

6. Patient satisfaction: is patient satisfaction with the ISTC being monitored (and if not, why not)?

All patients are given an opportunity of completing a patient satisfaction survey. This is another Key Performance Indicator.

If so, do patients appear satisfied with the new service? What areas of the service have achieved the highest/lowest satisfaction rating?

Appendix 4 encloses the outcomes of the first quarter results from these. The overall feedback from these is very positive.

7. Travel: have there been problems reported with patients having to travel to the ISTC?

The PCT has not picked up on any concerns or issues relating to transport to the centre. The PCTs have a specific SLA in place with Sussex Ambulance Service for the provision of Patient Transport Service to support those SOTC patients with a clinical need for transport. In addition people on low incomes can claim reimbursement for their travel expenses. Patients using SOTC have exactly the same rights as other groups of patients attending NHS providers.

All elective orthopaedic surgery had been relocated to Princess Royal Hospital a year before SOTC opened. The extra capacity that the SOTC provides should ensure that local people have access to a relatively local service. Prior to SOTC opening some patients were travelling to Crowborough and Eastbourne for their surgery because there was insufficient capacity at BSUH to undertake their operations.

7.1 Is public transport/parking/signage/information about how to access the ISTC adequate?

There has been no evidence to suggest that public transport/ parking/signage/information about how to access SOTC is not adequate.

The NHS supports the 40x bus service which travels between RSCH and PRH sites.

8. Has the ISTC been fully integrated into the Local Health Economy?

The SOTC is very much integrated in to the local health economy and far more so than many ISTCs would be. However it is acknowledged that certain aspects of integration need more application.

What work has been done to ensure that the ISTC engages as smoothly as possible with other parts of the LHE?

A great deal of work has already been done to integrate SOTC in terms of clinical networks and clinical integration. The SOTC employs, through structured secondments, almost all the trust's consultant orthopaedic surgeons (and associate specialists, staff grades etc) as well as some of the trust's anaesthetists and nurses. The SOTC also holds SLAs with the trust for a range of clinical support services underpinned by clear funding arrangements.

What more could be done?

The LHE could increase the role that SOTC and Mercury Health plays with regards to their involvement in strategic planning (such as the “Settings of Care” agenda). The PCTs will consider and discuss with Mercury Health what an appropriate level of engagement in strategic planning might look like.

This involvement has not been addressed thus far as the operational issues and challenges following the opening of SOTC have taken priority.

9. Has the opening of the ISTC meant a reduction in waiting times for routine orthopaedic surgery?

The impact of the teething problems and managing the transitional period following opening have unfortunately resulted in a number of patients waiting longer for their operations than they should have.

However plans are being implemented to remedy this situation. Waiting times are now starting to come down. During November significant progress and improvement has been made. The rate of improvement will accelerate as capacity and activity levels increase month-on-month.

If so, are these in line with PCT projections?

Over the first 4 months (July, August, September and October) waiting times did deteriorate, in overall terms, and in this respect the PCTs delivery plans were not met. Both Mercury and the PCT are extremely disappointed that this happened and apologise for the situation occurring. These plans and trajectories are now being revised to correct this situation.

If waiting times have not been reduced in line with projections, why not?

There are a number of reasons that collectively account for this. These include:

- Quality and timing of referrals into SOTC from BSUH with regards to patients on its existing waiting list
- Poor information provision that did not enable the teething problems to be easily detected and quantified in a timely way
- Booking and scheduling processes within SOTC that were not sufficiently robust
- Underestimating the impact of moving from a system of “waiting”, characterised by long waiting times and a large waiting list, to a system of “booking” characterised by short waiting times and with queue’s comprising only of patients that are ready, fit and available for their operations and are readily contactable.
- The bedding down problems always associated with opening a new centre, with new people working around processes and systems that they may not be familiar with (although Mercury provided induction programme the trust seconded staff could not attend

these in advance of opening because they were required to work full-time at BSUH in treating patients)

- National ISTC contracts that did not provide sufficient flexibility for a scheme of this size and nature in the opening few months. In terms of operational delivery they assume a very quick ramp-up of activity following opening. In terms of PCT funding they require 100% of the monthly contract value from the outset.

Since the underlying problems were multi-factorial it has taken several months to start getting on top of the problems (and continuing to address them since some concern system and behavioural change which are always the hardest and longest to work through).

What difference will a fully functional ISTC make to waiting times?

Once the centre is operating at full capacity waiting times will come down and ensure national targets are delivered. Delivery of these improvements without the centre would have been very difficult to achieve and would have required the PCT to make significant investment in other local independent sector providers whose unit prices are more expensive.

The combination of the centre's capacity (5,300 operations p.a.) plus the "complex" cases that will continue to be provided by the trust (900 operations p.a.) will effectively increase the available funded capacity for local PCTs by 50% from previous levels. Prior to SOTC opening BSUH was able to deliver approximately 4,100 operations p.a.

What plans are there to (further) reduce waiting times for elective orthopaedic surgery?

The PCT is confident that by the Summer 2007 patients being treated at SOTC should be waiting no more than 20 weeks for their operation. The PCT is confident that SOTC will be able to further reduce the waiting time for an operation to 13-14 weeks by 2008 (measured from the point a patient is listed for surgery).

10. What effect has the ISTC had on the Princess Royal Hospital at Haywards Heath and the Royal Sussex County Hospital in Brighton?

The shift of this activity has presented BSUH with significant opportunities to change the configuration of its clinical services since the transfer of this elective orthopaedic activity has reduced the requirement for beds, theatres and staffing within the trust.

BSUH representatives will be able to discuss this in more detail at the HOSC meeting.

What future effects are predicted?

The future impact that SOTC has on both the Princess Royal Hospital and Royal Sussex County Hospital sites will be considered along with a number of other factors and services within the “Settings of Care” process. The Settings of Care process will be subject to public consultation.

11. Cancellations: Have there been instances of ISTC patients having operations cancelled or rescheduled at the last minute?

Some patients have had their operations cancelled. This is one of Key Performance Indicators that is monitored each quarter.

The first quarter’s performance was a 3.01% (8 cases) cancellation rate for non-clinical reasons and 0.75% (2 cases) for clinical reasons. The reasons for these cancellations depend upon the individual case concerned. The reasons experienced so far include failure to ensure required surgical kit and appliances are available on the day (6 cases), patients being identified as being unfit for surgery on the day, re-evaluation by the surgeon on the day of surgery about the type of procedure actually required.

11.1 If so, how does this compare with the cancellation rates for NHS elective orthopaedics (or for the private sector procedures that the NHS formerly bought in when it required more capacity)?

The PCT does not have ready access to national comparative data on operations that are cancelled on the day. However in 2005/06 the cancellation rate within BSUH was in 3.24% (119 cases out of 3,675) in overall terms. This comprised of 1.75% (64 cases) for clinical reasons and 1.49% (55 cases) for non-clinical reasons.

12. Communication: what measures are in place to ensure that there is ready access to patient records across organisations as patients are moved between NHS and Independent Sector facilities?

Patient notes and imaging (e.g.: x-rays) are made available to SOTC under a service level agreement between BSUH and Mercury. Mercury are required to provide immediate return on request on a 24/7 basis (in case the patient presents in A& E etc). There are systems in place across both organisations to track each set of medical records.

Have there been any problems in accessing patient records?

There have been problems in accessing some patient records. This might be because the patient also has an outpatient appointment in other specialities within the trust and the notes are required for that clinic appointment. The PCT, BSUH and Mercury are currently in the process of reviewing the current arrangements and looking to improve them.

13. Given the (often elderly) client-base for orthopaedic surgery, has the fact that the ISTC is unable to provide many aspects of routine medical care (i.e. care for problems unrelated to orthopaedic procedures) caused problems (e.g. with patients having to be transferred to NHS facilities at short notice?).

The ISTC is able to provide routine medical care for patients with existing medical conditions and does so regularly. There have not been an undue number of cases that have needed to be transferred to NHS facilities at short notice and this has not been a cause for concern.

Please also see the answer to question 17.

14. Length of stay: do patients at the ISTC receive comparable bed-days to patients undergoing similar elective surgery in NHS facilities?

Given the volume of cases that have thus far been undertaken this is difficult to assess but early indications show an average length of stay for hip and knee replacements just under the national average.

15. PALS and complaints procedures: which organisation is responsible for co-ordinating these?

Brighton & Hove City PCT is responsible for coordinating PALS and will liaise with the centre and other bodies as appropriate. A liaison meeting is to be set-up between the PCTs PALS officers, the local PPIFs and SOTC early in the New Year. This meeting will act as a vehicle for improving communication and to discuss overall themes that have emerged. It is envisaged that the liaison meeting will be held every six-months (this is not a contractual requirement but rather a local initiative to improve communication and provide feedback so as to improve the quality of the service).

Regarding complaints – information is provided to every patient and they can choose whether to use either the Mercury Health complaints procedure or the NHS one. Mercury's Health procedure is designed to mirror the NHS procedure closely.

15.1 How do patients access this system? (Is information readily available?)

Both SOTC and the trust inform patients that they should make contact with BHCPCT PALS service should they wish to do so. The contact information is made available on SOTC patient information and literature.

Information is provided to every patient about the complaints procedure within SOTC and they can choose whether to use either the Mercury Health

complaints procedure or the NHS one. Mercury's Health procedure is designed to mirror the NHS procedure closely.

16. Effective allocation of procedures: have there been instances where Mercury Health has had to refer patients initially allocated to the ISTC back to NHS (or private) services for their operations?

The technical term under the contract for this occurrence is "rejections". Some cases will be referred to SOTC by the PCTs but upon closer examination will be found to be clinically unsuitable for treatment at the ISTC. Such cases will be rejected. The rejection of cases usually happens either within one week of the referral being made or at the pre-operative assessment. Patients ordinarily attend pre-operative assessment approximately four to six week prior to being admitted for their operation.

Some patients initially referred to SOTC have been "rejected" back to the NHS to manage. Such cases are then treated at Princess Royal Hospital, often under the same surgeon. It is important to note that cases rejected by SOTC are returned prior to the patient's admission to SOTC.

The reason for the rejection of referrals back to BSUH is almost always about clinical risk and ensuring that patients are treated in the correct clinical setting. SOTC is able to treat the vast majority of patients who require an elective orthopaedic operation but it is not equipped or staffed to treat patients that have significant co-morbidities. Although each case must be assessed individually, broadly speaking any patient that has a predicted need for ITU care following surgery should not be admitted to SOTC. It should be noted that this is about anaesthetic complexity and clinical risk rather than about surgical complexity. In this respect SOTC is able to perform a full range of orthopaedic operations ranging from bilateral and revision surgery through to arthroscopies and excision of ganglions etc.

It is not always possible to identify whether a patient will meet the anaesthetic screening criteria at the point of referral to SOTC. Detailed clinical assessment of the patient takes place at the pre-operative assessment appointment. We believe the process and understanding is improving and that the number of rejected referrals back to BSUH is now decreasing.

This is a specific KPI that is monitored every quarter.

16.1 If so, how often has this happened, and why is it an issue (i.e. is it a problem of capacity or of over-complex cases being referred)?

Sixty seven cases were rejected by SOTC in the first quarter. This equated to 3.26% of all referrals made in this period.

There are a number of reasons that account for these cases being rejected. Initially there was some confusion amongst staff both at SOTC and BSUH about what level of complexity and case-mix the contract provided. This also resulted in some cases that would have been appropriate to refer into SOTC remaining within BSUH for treatment.

The level of understanding is now much improved. A rejection template and weekly rejection meeting between the SOTC, PCT and BSUH is to be held so as to create a clear and auditable system though which all returned cases will be processed.

17. Monitoring: how does the PCT monitor the effectiveness of the ISTC?

Appendices 2 and 3 set out the arrangements for performance management and monitoring of the contract. This process is overseen by the local PCTs and the Central Contracts Management Unit, within the DoH, together with Mercury Health.

17.1 Is any other body involved in monitoring the ISTC?

The following bodies are involved in the performance management of SOTC:

- Brighton & Hove City PCT
- West Sussex PCT
- East Sussex and Downs PCT
- Central Contract Management Unit (DOH)
- Mercury Health

The PCTs are then accountable to the SHA for performance of the provider.

Mercury is also subject to registration requirements and routine monitoring and inspections from the Health Care Commission.

17.2 Have arrangements been made to allow PPIFs/HOSC to monitor and scrutinise the ISTC?

The national contracts specify the following with regards to the relationship and role of local HOSCs (p.33-34 of the contract refers).

"The Provider shall upon receipt of reasonable notice and at its own cost:

(a) provide to any Health Service Body such reasonable information and assistance requested by such Health Service Body in connection with a request for information by, a question from, a recommendation or observation of, or consultation with, a Local Health Overview and Scrutiny Committee which is directly or indirectly connected to the services; and

(b) upon the reasonable request of a Health Service Body, arrange for an officer or employee of appropriate seniority to accompany

a representative of such Health Service Body to any meeting of a local Health Authority Overview and Scrutiny Committee at which matters directly or indirectly connected to the Services are likely to be raised"

17.3 If not, was the PCT in a position to request that such arrangements be made, and did it, in fact, attempt to negotiate for outside monitoring agreements to be instituted?

Prior to the PCT signing off the contract in December 2004 the PCT did not seek to change the contractual arrangements with regards to outside monitoring arrangements.

17.4 If the PCT made no such attempts, why not?

The PCT sees the primary role in monitoring this contract as the responsibility of the PCT and DOH. We would expect the HOSC to hold the PCT to account for this function but not to be involved directly in the performance management of this or other contracts that the PCT holds. We did not receive any indication from the HOSC to the contrary.

18. Does the ISTC perform any non-NHS procedures?

No.

18.1 If so, what is the ratio of private to NHS procedures?

SOTC is allowed to provide procedures to patients paying on a private basis (as are NHS Trusts who also have wards for private patients). However the contract requires Mercury Health to firstly deliver the contract values and to then obtain express permission from the PCTs that they are happy for SOTC to treat private patients.

The ISTC schemes were set-up to be able to deliver 130% of the specified contract volumes but the NHS/PCTs have the first call on capacity that can be delivered by the provider above the 100% contract ceiling.

To date SOTC has only treated NHS patients and has made no request to treat private patients.

19. What is the average cost of a procedure at the ISTC relative to the NHS tariff for such a procedure?

We can advise the HOSC of the following:

- The actual cost to the local PCTs is however equal to tariff assuming 100% utilisation of the contract value (based on total PCT expenditure divided by volume/case-mix).

- The contracts are not subject to Payment by Results. Therefore it is essential for the PCTs to make full use of the contract in order to get value for money.
- Mercury Health (and other ISTC providers) receives a total level of revenue which is greater than national tariff (i.e.: if one divides total revenue by the contract volumes and case-mix).
- The ISTC providers receive an additional payment via the PCTs from the DOH which is referred to as “dual tariff”.

The PCTs are not allowed to pass detailed information on to any third party with regards to the aggregate costs of the ISTC scheme since this would compromise the national procurement processes and Commercial in Confidence requirements. It could also expose the PCT to legal redress. In this respect the DOH has secured specific exemptions with regards to enquiries about this matter under the Freedom of Information Act. We are therefore not able to answer those questions regarding relative costs compared to NHS tariff.

19.1 Has the ISTC (to date) cost the NHS money or saved money? (i.e.: is more money going out of the LHE to pay for the ISTC than was formerly spent in providing NHS elective orthopaedics and buying surplus procedures from the private sector?)

Prior to SOTC opening the local PCTs were spending considerable amounts of money, in excess of national tariff prices, within the local independent sector for orthopaedic operations (approximately £5.5M in total in 2005/06 – 40% of which fell to BHCPCT).

If the PCT makes effective use of the contract then the ISTC will save the PCT money compared with previous arrangements where the PCT was making significant use of a number of providers who charged unit costs in excess of tariff.

What is the cost relative to tariff predictions over the length of the ISTCs contract?

The PCTs are not allowed to pass detailed information on to any third party with regards to the aggregate costs of the ISTC scheme since this would compromise the national procurement processes and the Commercial in Confidence status of the procurement. It could also expose the PCT to legal redress. In this respect the DOH has secured specific exemptions with regards to enquiries about this matter under the Freedom of Information Act.