# Appendix 1

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| **Report to**: | Brighton & Hove Health Overview and Scrutiny Committee |
| **Regarding:** | Sussex Orthopaedic Treatment Centre (SOTC) |
| **Date:** | 5th November 2008 |

## 1. Background

1.1 The HOSC first reviewed the Sussex Orthopaedic Treatment Centre in 2006, shortly after it opened. At the time the HOSC requested a further review of the SOTC and its contracting and commissioning arrangements after the service had time to establish itself.

1.2 The HOSC has asked a number of questions about the current performance of the organisation which are detailed below.

## 2. About the SOTC

2.1 The SOTC provides day care and inpatient orthopaedic elective (planned) surgery. This includes hip and knee replacements or revisions and minor hand and foot procedures.

2.2 The service is commissioned by Brighton & Hove PCT; East Sussex Downs and Weald PCT and West Sussex PCT for the people living in these areas.

2.3 In May 2007 the original provider, Mercury Health was taken over by Care UK, an established independent provider of health and social care services.

2.4 By the end of October 2008 it is anticipated that the contract with Care UK will be transferred from the Department of Health to South East Coast Strategic Health Authority, where it will be hosted by Brighton & Hove PCT on behalf of the local NHS.

2.5 Approximately 60% of patients are referred to SOTC from Brighton and Sussex University Hospitals Trust (BSUHT) both the Royal Sussex County Hospital and the Princes Royal Hospital. The remainder come from the Victoria Hospital Lewes, Brighton and Hove Integrated Community Assessment Team and the Vale Clinic. At the time of onward referral it is intended that the vast majority of patients will have been diagnosed and placed on a pathway for surgery.

2.6 The SOTC is registered with the Healthcare Commission (HCC) which is responsible for monitoring performance against HCC standards and national regulations.

2.7 A few months after SOTC opened it became apparent that there were a large number of patients waiting to be treated and at risk of breaching NHS maximum permitted waiting times. A management plan to deal with this was

agreed and given contractual force under a Deed of Variation (DoV) to the Project Agreement (main contract).

2.8 Late in 2007, Care UK brought to the PCTs' attention that although these patients had been treated (or rejected either for clinical reasons or at patient request) under the DoV, a further large backlog of newer referrals had built up. A formal plan to tackle this backlog was negotiated by PCTs and Care UK. PCTs also required assurance that the SOTC would be able to provide services as part of an 18 week patient pathway by the national NHS target date of December 2008. It should be noted that there was no contractual obligation upon Care UK to accept this as the Project Agreement, which allows for a longer pathway, pre-dates the introduction of the 18 week Referral to Treatment policy.

2.9 Recognising that it is imperative to the successful future of the SOTC that it can comply with the 18 week commitment, Care UK has committed to a Turnaround Plan that addresses both clearing the backlog of untreated patients and achieving its part in attaining the 18 week standard by the end of November 2008. The period from March 2008 to December 2008 is referred to as the Turnaround Period.

2.10 The intention is for the Turnaround Plan to be formally incorporated into the Project Agreement by a second Deed of Variation. The Plan requires that a larger number of patients than usual MMT (Monthly Minimum Take or the contacted value/volume of activity) are treated by Care UK with numbers in excess of MMT treated either within SOTC or by onward referral to other independent providers ('outsourcing'): the cost being met by Care UK.

2.11 Success of the Plan is measured by a target number of patients being treated by the end of the Turnaround Period and a 'steady-state' waiting list achieved i.e. the calculated waiting list size will allow an 18 week treatment pathway for the great majority of all patients to be maintained.

2.12 It should be noted that the reality of delivering 18 weeks Referral to Treatment will depend on close and sustained cooperation between the Provider and all NHS parties. The parties have also acknowledged the need to agree a transition protocol for a return to main contract and will endeavour to do so by mid-November 2008.

## 3. HOSC questions

The HOSC have asked a number of questions under the following headings:

1 Performance
2 Reasons for underperformance
3 Contract details
4 Clinical safety
5 Referral to the SOTC
6 Patient Choice and transparency
7 Impact on NHS Trusts
8 Treatment at the SOTC and BSUHT
9 Integration with the local; health economy
10 Patient access
11 Waiting times

12 Cancellation rates
13 Patient records
14 Length of stay
15 “Rejection” of patients from the SOTC
16 Value for money
17 Training

HOSC questions and background information provided by the HOSC are in italics.

**3.1 Performance**

*The last time the HOSC asked Qs of SOTC/PCT, the Committee was told that the SOTC was expected to perform:*

- *4312 procedures in 06/07 (contract running for only 10 months within this financial year);*
- *5308 procedures in 07/08;*
- *5300 procedures in 08/09.*

***a) Were the actual figures for 06/07 and 07/08 in line with this projection?***

The actual figures cannot be disclosed as this is commercially sensitive information.

Actual referrals for 06/07 and 07/08 were in line with the projection, though a number of patients were subsequently rejected for clinical, social or personal reasons, which resulted in the number of treated patients being less than the projection.

***b) Is the activity currently predicted in 08/09 in line with this projection?***

Yes, and is predicated on the successful achievement of the Turnaround Plan

***c) <u>If</u> performance/current prediction of performance is lower than anticipated, is this due to capacity problems at SOTC or to some other reason (lack of referrals etc)?***

Does not apply if b) above holds true.

***d) If there was a shortfall in any of the completed years of the contract/there is an anticipated shortfall in any of the contract’s remaining years, how will this be reflected in terms of payments, remedial activity etc?***

The PCTs and SOTC have implemented the Turnaround Plan to clear the backlog of untreated patients and to ensure the required number of patients is treated going forward. Both the Provider and PCTs accept this Turnaround

Plan as setting out the method of remedying any alleged breaches of the Agreement prior to 26 March 2008.

***e) When HOSC looked at this issue in 2006, members were told that BH PCT was in the process of drawing up a "Deed of Variation" with Mercury Health (the former owners of the SOTC) which would have obliged Mercury Health to clear its shortfall by March 2007 (where necessary by "spot-purchasing" capacity from other local providers). Can the PCT confirm whether this took place as anticipated?***

It appears that all of the original DoV patients were dealt with either by SOTC or by outsourcing (purchasing of capacity from other independent providers), however, another backlog of new referrals built up i.e. referrals made during the months in which the original backlog was being cleared.

**3.2 Reasons for Underperformance.**

*When HOSC last examined this issue, members were told that the SOTC's underperformance (at that time) was due to a number of factors including:*

***a) To what degree have all these issues now been addressed (please provide details for each bullet point)?***

- ***ineffective referral from BSUH***
- ***poor information provision which made it hard to identify and remedy teething problems within the unit;***
- ***ineffective booking processes within SOTC***
- ***underestimation of the difficulties of moving from a "long wait" to a "no wait" system;***
- ***bedding-in problems (including problems associated with the induction of seconded BSUH clinicians);***
- ***inflexible national contracts for Independent Sector Treatment Centres (ISTCs) which assumed an unrealistically quick ramp-up of services in the months after opening.***

***Ineffective referral from BSUH.***

Referrals were not 'ineffective' rather that more work needed to be done to ensure that the right patients were referred to the SOTC in a timely fashion.

Considerable work has been undertaken by all parties to ensure that necessary information is provided. The PCTs have introduced an inter-provider template to ensure that the correct data/information is available to the health professionals to establish whether the patient is on the right pathway for treatment and whether this should take place at the SOTC or BSUHT. Incomplete data is monitored to ensure high quality.

Early health screening has also been introduced to minimise the chances of referring across patients that may need more care post-operatively than SOTC is able to provide.

There is also a very helpful weekly meeting so that staff from BSUHT, the Booking Office and SOTC can review any patients for whom there are questions and/or queries.

Work is currently being undertaken to further improve the referral process as the move to the shorter, 18-week patient pathway means that there is less time to ensure that patients are both fit for surgery and willing to make themselves available for treatment.

Considerable work has taken place with the Brighton & Hove Health User Bank (patient group) to ensure that the PCT and BSUHT explanation of the 18 week patient pathway is fully understood. The patient group has produced, and is piloting a new leaflet for patients.

***Poor information provision which made it hard to identify and remedy teething problems within the unit.***

Currently both PCTs and Providers are reviewing the pathway for treatment from GP referral to SOTC to improve patient experience and increase service efficiencies. As noted above, a new referral template has been recently developed to improve information flows between professionals and organisations.

***Ineffective booking processes within SOTC.***

The SOTC has significantly improved its booking processes since the last report. Effective arrangements are in place for scheduling staff to liaise with consultants leading to increased throughput in the Centre. Additionally much greater cooperation is now achieved between the Booking Office and the Centre leading to an improved flow of patient referrals and better information to improve the efficiency of bookings.

***Underestimation of the difficulties of moving from a "long wait" to a "no wait" system.***

Significant progress has been achieved through the introduction of the Orthopaedic Booking Office which is responsible for the management and reporting of the Forward Order Book (Waiting list). They have adopted Clinical Criteria to ensure that suitable patients are 'fit' for the purpose of treatment at the SOTC. They have also introduced across the care pathway an Access policy to ensure patients are ready and available for their operations. This policy replicates that of BSUHT.

***Bedding-in problems (including problems associated with the induction of seconded BSUH clinicians).***

SOTC has adopted a robust mechanism for inducting all new staff into the organisation's structures processes and systems. This includes mandatory training programmes in key areas of safety for all permanent and temporary staff associated with the unit - which has been approved by the HCC (the Healthcare Commission)

***Inflexible national contracts for Independent Sector Treatment Centres (ISTCs) which assumed an unrealistically quick ramp-up of services in the months after opening.***

Ramp-up profiles were determined by whatever the participating parties thought were achievable. In the case of SOTC the difficulties associated with both split pathways and the transfer of services and staff from BSUHT were probably underestimated by all parties, something seen in other ISTCs operating in similar circumstances.

***b) Are all parties now confident that the SOTC is operating a high quality service which is effectively integrated into the Local Health Economy?***

SOTC has seen improvements to the quality of services being offered over the past year, which has been monitored by HCC and reflected in the subsequent HCC reports over the past 12 months. The centre is fully compliant with all relevant regulations. These improvements have also been reflected in the reduction of numbers of complaints raised.

The service has become more integrated into the wider pathways and there have been improvements in partnership working with other providers which will be fully seen under 18 weeks.

**3.3 Contract Details**

*When HOSC previously examined this subject, members were told that BH PCT had limited room for manoeuvre in negotiating a contract for the SOTC (as ISTC contracts were essentially centrally negotiated by the Department of Health). However, members were also informed that there was some scope for re-negotiating elements of the contract in light of experience of actually running the service. (Any such re-negotiation would have to be agreed by all parties to the contract.)*

***Has the PCT sought/ is it planning to seek to re-negotiate any elements of the SOTC contract?***

The Project Agreement includes a formal change process mechanism under which subject to all parties agreeing elements of the contract can be changed. Some changes are most unlikely to occur i.e. to the fundamental contractual and financial bases; furthermore no changes can be approved that undermine H.M.Treasury's original value for money conditions.

However, it was always acknowledged that the original case-mix would change because of changes in the pattern of demand, introduction of new surgical procedures/techniques etc. A case-mix change is currently under discussion, which if agreed which will reflect forecast demand and permit greater flexibility of referrals. Another change which has been agreed and will be finalised by Care UK within the next months is the adoption of a protocol

for prosthesis usage. Pass-through charges from SOTC to PCT for the excess cost of high-value prostheses will be greatly reduced once this has been implemented.

**3.4** ***Clinical Safety.***

*When HOSC previously scrutinised this matter, members were told that clinical safety at the SOTC was of a high standard, at least as high as at comparable NHS and independent sector units (there had been some concerns about clinical safety in the very early days of the SOTC's operation, but these had been swiftly addressed).*

***a) Can the PCT confirm that the SOTC is still operating safely?***

Despite an adverse report earlier in the year the Healthcare Commission, PCTs and Department of Health are confident that the SOTC is now operating safely. A great deal of work has been done in the Centre over the last six months to ensure that SOTC complies with standards of best practice. The unit has high quality staff, systems and processes.

The SOTC has robust clinical governance processes in place. Data is collected and information shared at monthly clinical governance meetings. Reviews of Key Performance Indicators, incidents and complaints are routinely undertaken. In addition the results of audits are reviewed and lessons learned put into practice. Policies are reviewed and approved and changes to practice critically reviewed prior to their adoption.

To strengthen the internal governance arrangements SOTC and PCTs will be developing a clinical audit schedule e.g. looking at infection control compliance with standards of best practice across the clinical pathways. These will be regularly reviewed at the Clinical Advisory Group –and where necessary flagged at the Joint Services Review (a formal review of performance standards carried out quarterly).

PCTs have been in touch with the HCC to try to find comparative data on outcomes. This is remarkably difficult – given case-mix, and non-uniform recording of complications and outcomes. SOTC routinely collects Patient Reported Outcome Measures (PROMS) on hip and knee replacements, as part of a national process. This provides valuable information for clinicians and managers about what the patient thinks about his or her improvement in for example pain and mobility following surgery. This will provide very useful comparative data**.**

***b) When HOSC scrutinised this issue in 2006, members were informed that the PCT and Mercury Health were jointly undertaking a clinical audit of the SOTC, the results of which would be made publicly available. Have these results been made available, and is a regular (published) clinical audit a feature of the PCT's agreement with Care UK?***

The audit of patient outcomes was in the planning stages in 2006 and the PCT has not requested that Care UK continues the work agreed with Mercury Health. However, as noted above data from patient-reported outcomes has

been collected from the middle of 2008 and this will be made available to the PCTs and the public. Additionally Care UK reports its infection control and prevention data to the Health Protection Agency and MRSA data to the Department of Health and NHS Choices web site.

***c) Does the PCT have other information on the clinical performance of the SOTC (i.e. performance against national/regional averages/comparator units)?***

All transfers of patients to BSUH are discussed individually at the monthly Clinical Reference Group meeting held at the SOTC that is chaired by one of the senior surgeons. A recent audit of the transfers showed that they had been adequately pre-assessed and that the patients had had their surgery at the SOTC appropriately.

There is a robust clinical governance process with a comprehensive monthly report and performance is closely monitored. There are regular audit projects (e.g. wound site infection monitoring) and the SOTC is part of the Royal College of Surgeons' Patient Reported Outcome Measurements hip and knee replacement audit.

### *3.5 Referral into SOTC.*

*In 2006, the HOSC heard that the level of referral into the SOTC had met or exceeded expectations.*

***a) Is the level of referral into the SOTC equivalent to 2006 levels?***

Yes, see data under b) below.

***b) How many patients have been referred to the SOTC for each year from 2006-2008?***

May 2006 – March 2007 6924 templates received

April 2007 – March 2008 6576

April 2008 - Sept 2008 3408 (full year forecast 6800)

Please note that the above are gross referrals to the Booking Office prior to Booking Office returning any referrals that are clinically unsuitable or inappropriate.

### *3.6 Patient Choice/Transparency.*

*When HOSC last examined this issue, members learnt that patients did not necessarily "choose" to be treated at the SOTC; people who opted to receive elective orthopaedic care at the Princess Royal or Royal Sussex County Hospitals were effectively, but not explicitly, choosing to use the SOTC. It was noted that this situation was not entirely satisfactory, and that a degree of greater transparency was required and was in the process of development.*

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 patient's 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 who have already chosen to attend Royal Sussex County Hospital or Princess Royal Hospital for their initial outpatient services are effectively choosing to be treated at SOTC since that is where any surgery they require will be performed, unless issues of clinical complexity indicate otherwise.

BSUH will shortly be placing its orthopaedic outpatient services on to the GPs' Choose and Book Directory of Services. PCTs are therefore working with BSUHT to make the choice offer more transparent to patients.

PCTs 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 that will be responsible for discussing the offer of choice to patients and for securing a booked appointment with the secondary care provider they choose. 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.

In addition PCTs are developing a comprehensive range of primary care orthopaedic clinical assessment services to enhance the patient's experience of the assessment and diagnostic process. This work is in development and awaiting decision on procurement route and model to be made by PCT. 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.

***a) Has a system now been developed which makes the choices on offer to Brighton & Hove patients more transparent?***

No, it has not. There is no national requirement to do so.

***b) If such a system has been developed, are prospective patients told, at the time when they "Choose & Book" services, that the SOTC provides NHS services, but is owned and managed by a "for-profit" independent sector company?***

No, it has not. There is no national requirement to do so.

***c) What advice regarding Choose & Book of the SOTC (and other independent providers of NHS services) does the PCT give local GPs?***

Choice and choose & book is offered at the point of referral and therefore a patient needs to be assessed for surgery in outpatient before choice is offered. The Integrated Community Assessment Team service model will inform how and where choice is offer to a patient.

### *3.7 Impact upon NHS Trusts.*

*A commonly voiced worry at the time when the ISTC programme was first rolled out was that ISTCs might impact upon existing NHS providers (e.g. by effectively "cherry-picking" relatively straightforward procedures and leaving NHS providers to pick up more complex procedures which generally have a higher risk of exceeding tariff). In 2006, HOSC was told that there was insufficient information to make an assessment of the SOTC's impact upon the Local Health Economy in this context.*

***a) Are we now in a position to ascertain the general impact of the SOTC on the Local Health Economy?***

The concern around cherry-picking may be an issue in other health economies but the set up is very different in this local health economy. Any patient choosing to be referred to the orthopaedic department at BSUH will either have their surgery at PRH or the SOTC and it is the level of care and treatment required by the patient that is the determining factor. There is no cherry-picking.

Review of the case mix which is sent to SOTC is underway. This is being done in conjunction with all effected providers to ensure that there is no treat of destabilisation of the local health economy. The separation of HRG codes and tariffs may be insufficient to always reflect the true costs of providing a service.

***b) In what ways has the SOTC impacted upon the performance of BSUH? (perspective from BSUH as well as/rather than the PCT)***

BSUH perspective - the NHS tariff through which we derive our income is relatively crude and uses an average case mix. The analysis we have completed indicates that the income we derive from our more complex orthopaedic work does not match the expenditure incurred by BSUH.

It has also made planning for the delivery of a maximum 18 week wait from referral to treatment for our patients more complex. The referral process requires two additional steps that would not normally be part of the pathway:

- Formal referral from a booking office run by West Sussex PCT
- Formal acceptance or rejection of the patient by the SOTC

This in turn minimises the time available for the treatment of patients on an 18 week pathway.

The separation of Health Resource Group codes (HRGs are used as a means of determining and equitable reimbursement for care services, they consist of 'units of currency' which support standardised healthcare commissioning across the service) and tariffs may be insufficient to always reflect the true costs of providing a service. The local health economy will need to find a way of ensuring that it can ensure financial viability of a service providing a different case mix which is consistent with the developing strategic direction of developing Trauma, Teaching & Tertiary Centre (3Ts) at BSUHT.

### *3.8 Treatment at SOTC/BSUH.*

*In 2006 the HOSC was told that it was estimated that SOTC would be unable to treat approximately 75 referred cases per month (e.g. because patients had co-morbidities/complications which meant that they were best treated in a generalist hospital with ready access to other clinical specialities). The assumption was that the majority of these cases would be handled by BSUH.*

***a) How accurate has this 2006 estimate proved (i.e. how many cases per month, on average, are managed at BSUH facilities rather than at the SOTC)?***

This assumption was correct, although BSUHT is doing more work currently in the run up to December to ensure that any patient who has already waited more than 18 weeks is treated promptly.

***b) Does the volume of specialist/complex elective orthopaedic work it is obliged to pick up cause problems for BSUH? (perspective from BSUH as well as/rather than the PCT)***

BSUHT - It is not so much the volume of work rather than the need to divide r work and the time of our consultants across several operating sites. BSUHT consultants have trauma commitments at the Royal Sussex County site and their operative commitments in two hospital settings, along with clinic commitments on other hospital sites, in line with 'Best Care, Best Place'.

This makes it more difficult for BSUHT to make best use of consultant time and also means that BSUHT have double the number of 'queues' for inpatient surgery which in turn slows down throughput.

### *3.9 Integration with the Local Health Economy.*

*In 2006, HOSC members heard that the SOTC had been well integrated into the Local Health Economy (more so than many ISTCs), but that more could be done to involve the SOTC's managers in strategic planning.*

***How has the further integration of the SOTC into the Local Health Economy been taken forward, particularly with regard to strategic planning?***

Greater integration is being seen between providers through:

- Case mix review – changing case mix to reflect changes in demand.
- Pathway development - Link with 18 weeks sub-group demonstrate commitment to overall pathway and partnership working to put the patients needs at the centre of the pathway and irrespective of organisations or any conflicting contracting measures.
- Improved transfer - Provider to provider meeting to resolve specific issues of patient transfers between BSUH and SOTC. Development

of template to ensure referrals as streamline and arrive with sufficient information in a timely manner.

### *3.10 Patient Access.*

*In 2006, HOSC members were told that significant problems with patient access had not been identified: i.e. patients appeared to have no particular problem in travelling to and from the SOTC. (For B&H based patients, the SOTC replaced NHS-provided orthopaedics at the Princess Royal Hospital rather than at a city site, so B&H patients already had to travel to Haywards Heath for treatment.)*

***a) Is it still the case that patients seem generally content with the accessibility of the SOTC?***

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

The NHS partly funds the 40x bus service that which travels between RSCH and PRH sites.

The situation with regard to the accessibility of the SOTC for patients is as previously reported; patients seem content in overall terms with accessibility. Neither the PCT nor SOTC have received complaints from patients in respect of accessibility. The referral process is more or less as described in the response given to the HOSC in November 2006. Patients are referred by their GP into outpatient services provided at NHS facilities and these hospitals have their orthopaedic surgery provided by Care UK's SOTC facility.

As noted previously, Choice is given at the point of referral in primary care. The results of a recent patient experience survey conducted by Care UK of patients using the SOTC indicate that only 14% of the respondents felt that they were given no choice of hospital but would have liked a choice.

***b) What is the typical experience of a Brighton & Hove patient who uses the SOTC (i.e. where do they access initial consultations, outpatient's appointments, physiotherapy etc)?***

The patient pathway for Brighton and Hove patients is typically referral for an orthopaedic out patient appointment, which is undertaken at BSUHT. Any diagnostic tests that are required to assist diagnosis and care planning are also undertaken at BSUHT. If a decision is taken by both surgeon and patient that surgery is the treatment of choice, a template referral for surgery is raised and forwarded to the Orthopaedic Booking Office.

The Booking Office determines the patient's appropriateness for surgery at the SOTC with reference to the agreed referral criteria e.g. no referrals to the SOTC for patients under the age of 16 years and the agreed case mix. If the patient meets these criteria the referral template is passed to the SOTC. Other referrals are forwarded to BSUH for surgery.

The SOTC undertakes a paper based review of referrals and determines whether the patient will have a telephone pre-assessment usually only

suitable for patients whose referral information indicates they are fit and are referred for day case surgery only. All other patients will be invited to the Centre for a nurse led pre-assessment and possibly anaesthetic assessment to determine the patient's fitness for surgery. This enables the Centre to commence planning for the patient's admission.

Post-operative physiotherapy is community-based.

***c) What work has the PCT undertaken to gauge patient satisfaction with the SOTC?***

The PCT requires that the SOTC undertakes regular surveys of in and day patients to measure patients' experience and satisfaction with the service they receive. The survey is a validated questionnaire, very similar to the one in use at NHS facilities allowing comparison between the SOTC and other NHS providers. The results from the most recent survey indicate that 95% patients rated their care as excellent or very good.

The PCT regularly looks at complaints and Patient Advice and Liaison Service (PALS) data regarding all providers of health services commissioned by the Trust.

**3.11 Waiting Times.**

*In 2006, HOSC members were told that the SOTC's teething problems had meant that waiting times for elective orthopaedic procedures had not been reduced as anticipated, but that a reduction in waiting times was expected imminently. The PCT predicted that waiting times should be down to 13-14 weeks by 2008.*

**a) Is it the case that waiting times for elective orthopaedic procedures have reduced significantly since the SOTC has been in operation?**

Average time from decision to treat to admission in SOTC suggesting a significant improvement is now being seen

2006 – 17.88 weeks

2007 – 23.25 weeks

2008 - 16.64 weeks

***b) What is the current local waiting time for these procedures and how does this compare against national targets etc?***

The national target is 18 weeks Referral To Treatment (RTT) for all patients. The above suggests that SOTC has made significant progress towards this target.

***c) How do the current waiting times for complex elective orthopaedic procedures (e.g. procedures performed by BSUH rather than at the SOTC) compare with waiting times for these procedures prior to the establishment of the SOTC?***

BSUHT is currently treating some additional patients so it can ensure delivery of the 18-week target from referral to treatment.

***3.12 Cancellation rates.***

***In 2006 HOSC members were told that the cancellation rate for procedures at the SOTC was broadly comparable with the BSUH cancellation rate (approximately 3% of operations in both cases).***

***a) What is the current cancellation rate at the SOTC?***

The results from the last quarter, reported at the recent Joint Service Review (a joint meeting between PCTs and Care UK) show non-clinical cancellations of 1.68%.

Of the 27 non-clinical cancellations, by far the largest number -19 are accounted for by patients changing their minds on the day of surgery and deciding not to proceed with their operations.

Clinical cancellations were 2.31% of total procedures. Of the 29 clinical cancellations, 12 were patients that were diagnosed with previously unknown co-morbidities (the presence of one or more disorders (or diseases) in addition to a primary disease or disorder or the effect of such additional disorders or diseases) on the day. 10 patients had unrelated infections such as colds.

***b) To what degree are these cancellations avoidable?***

The SOTC has been reviewing cancellation data on a monthly basis with a view to taking action to bring the number of cancellations down to the lowest level. The majority of the cancellations are now unavoidable as can be seen from the response above. The remaining small numbers of organisational cancellations are always investigated and changes to procedures put in place to ensure the lowest possible incidence.

**3.3 *Patient Records.***

*In 2006 HOSC was told that there had been some problems in instituting an effective system for sharing patient records across SOTC, BSUH etc, and that an improved system was being devised*.

***Are there still problems associated with sharing patient records?***

Patient notes and imaging (e.g. x-rays) are made available to SOTC under a service level agreement with BSUHT. Care UK is 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.

BSUHT has a dedicated member of staff, funded by the PCT, whose job it is to ensure the timely transfer of records to SOTC. Our audit record indicates that 78% of records reach the SOTC within 48 hours of the request, the balance as soon as possible thereafter.

In order to improve the arrangements still further BSUHT is planning to send the notes to the SOTC 'in anticipation' of the referral from 1 December – this means that should minimise down-time at BSUHT whilst the second stage checking period gets underway.

**3.4** ***Length of Stay.***

*In 2006, HOSC members were told that the average length of stay at the SOTC was a little under the national average.*

***What is the current average length of stay at the SOTC?***

It is difficult and possibly misleading to give and average length of stay at the SOTC as this is dependent on the referred case mix at any point in time. The current rate of day case procedures undertaken at the Centre is 65% of all procedures. The average length of stay for a primary hip replacement is 4.24 days and for a primary knee replacement 4.71 days.

This compares to an average length of stay at Care UK's two other orthopaedic centres of 5.83 and 4.96 for a primary hip replacement and 4.86 and 4.85 for a primary knee replacement.

***3.4 "Rejection" of patients from SOTC.***

*In 2006, HOSC members were informed that a number of patients were referred to the SOTC but subsequently "rejected" for treatment, generally because they had significant co-morbidities requiring care from a General Hospital rather than a specialist treatment centre. Members were told that it was never intended that the SOTC should be in a position to accept patients with very complex co-morbidities. However, it should be possible to significantly reduce the rate of "rejection" by ensuring that referral was as accurate as possible (i.e. possible problems were identified at an early stage and patients referred to BSUH services accordingly).*

***Has the rate of "rejection" from the SOTC fallen as the PCT predicted it should?***

The Booking Office and SOTC have developed a process to actively manage patients that are referred to SOTC but are later deemed unsuitable for treatment at the Centre.

A group of clinicians from the Booking Office (BO) and SOTC meet to discuss and agree why the patient cannot be treated there safely. The BO will

accept the rejection based on whether or not the patient is clinically unsuitable (patients' conditions can change) or whether it is because they are not available for treatment. The detail obtained from these weekly meetings is then used to further refine the triage of referrals to SOTC. This should ensure the process is more robust and the time from referral to treatment is reduced.

### *3.16 Value for Money.*

*In 2006 the HOSC asked questions relating to the "value for money" of the SOTC. At this time, BH PCT was unable to provide detailed information about the cost per procedure at the SOTC versus the NHS tariff cost, as these details were subject to commercial confidentiality (and specifically exempted from Freedom of Information requests). However, members were informed that the SOTC did not replace a system via which all elective orthopaedic procedures were provided at tariff, but rather a system with significant NHS under-capacity, ameliorated by a considerable amount of "spot-purchasing" from independent providers (often at costs very significantly above tariff).*

*Therefore, even though it was unable to discuss elements of the SOTC's performance against national NHS tariff levels, Brighton & Hove PCT was confident that a fully operational SOTC would offer considerably better value for money than the system it replaced.*

#### *Does the SOTC still offer value for money?*

Rules of commercial confidentiality still apply. Initial H.M. Treasury assessment established a position on value for money. No change may be made to the contract that worsens that position; however, a change that improves it may be made subject to all parties agreeing.

Further work needs to be undertaken following the completion of the VFM work and the case mix review.

### *3.17 Training.*

*In 2006, HOSC members were told that the SOTC was not yet engaged in the formal training of clinical staff, but that Mercury Health was fully committed to providing both under and post graduate training opportunities at the SOTC in the near future.*

#### *What is Care UK's stance on training at the SOTC?*

#### *Is under and post graduate training currently taking place at the SOTC?*

Since Care UK acquired Mercury Health in the spring of last year, some constructive steps have taken place locally. The local Deanery visited the centre along with senior management from Care UK and senior clinicians from Brighton NHS University Trust in November 2007 and the outcomes were very positive regarding the training of junior doctors in both Anaesthetic and Orthopaedic specialties.

Care UK is pleased to confirm that a number of Registrars are able to access the facilities as part of their rotational work plan under the supervision of the seconded consultants who work in the Centre.

Discussions are being planned regarding Anaesthetics and nurses (graduate and undergraduate) with the relevant Higher Education Institutes in line with the formal processes agreed with the Department of Health and local stakeholders.