‘Shaping your local health service’

The future of local orthopaedic services

Kent and East Sussex County Councils’ NHS Overview and Scrutiny Joint Select Committee response

April 2005

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Joint Select Committee response to the consultation relating to orthopaedic services within the South of West Kent Health Economy

1. Overview and Scrutiny of the NHS

1.1 The Health and Social Care Act 2001 makes statutory provision for local authorities with social services responsibilities to extend their overview and scrutiny functions to include health.

1.2 Kent County Council established a Pilot NHS Overview and Scrutiny Committee in November 2001, and East Sussex County Council in October 2002. These Committees became a legal entity when the Local Authority Overview and Scrutiny Committee's Health Scrutiny Functions Regulations 2003 were implemented on 1 January 2003.

1.3 In July 2003 the Department of Health issued guidance for the scrutiny of the National Health Service, and this guidance has been followed when undertaking this review.

2. The Joint Select Committee

2.1 Joint Select Committee membership

2.1.1 The Joint Select Committee consists of thirteen members:

Kent County Council Representatives:
- Dr Robinson (Chairman)
- Mr Davies
- Mr Fittock
- Mr Rowe
- Mr Simmonds
- Mrs Stockell
- Mr J Tolputt

East Sussex County Council Representative:
- Cllr Slack

Kent District/Borough Council Representative:
- Cllr Baker/ Cllr Gibson (Sevenoaks District Council/ Maidstone Borough Council)

East Sussex District/Borough Council Representatives
Cllr Bigg (Hastings Borough Council)
Cllr Phillips (Wealden District Council)

Patient and Public Involvement Forum (PPIF) representative:
Mr Reece

The inclusive nature of the Joint Select Committee's membership has enabled the process to encompass the various view points and perspectives of the Joint Select Committee's members.

2.2 Terms of Reference

2.2.1 The Terms of Reference for this topic review are outlined below:-

- To prepare a strategic response, on behalf of Kent County Council's and East Sussex County Council's NHS Overview and Scrutiny Committees (OSC), to the South of West Kent Health Economy consultation, "Shaping Your Local Health Service –Priority three". This relates to the reconfiguration of Women's and Children's Services and Trauma and Orthopaedic Services.
- To examine the proposals for Maidstone and Tunbridge Wells NHS Trust and to consider them in the wider Kent and East Sussex context.
- To take evidence from stakeholders, including relevant Acute Trust and Primary Care Trust (PCT) staff, partner organisations and community groups.
- To report the Committee's recommendations to both Kent County Council NHS OSC, East Sussex County Council NHS OSC, and to the South of West Kent Health Economy organisations.

2.2.2 The Joint Select Committee agreed this review would be undertaken in two phases. The first phase concentrated on the proposals for the redesign of services for women and children, and the Joint Select Committee report related to these services has already been published. This is the second phase, considering orthopaedic services. Consequently, this report is only concerned with orthopaedic services.

2.2.3 In constructing this report, the Joint Select Committee held five hearings and heard evidence from the Acute Trust and PCTs' Chief Executives, Consultant Orthopaedic Surgeons, transport representatives from both County Councils, Ambulance Trusts representatives, and Patient and Public Involvement Forum representatives. The Joint Select Committee also visited both prospective sites, which gave the opportunity to meet various members of staff. To account for the Consultants' busy schedules, the Joint Select Committee also made further visits to meet Consultant Orthopaedic Surgeons based in Maidstone. In addition to the verbal evidence the Joint Select Committee sought written evidence from various stakeholders, including Acute Trust staff; partner organisations, such as NHS Trusts in the surrounding areas, GPs' surgeries, etc; District/Borough and Parish Councils and MPs.

3. Strategic Context

In considering these proposals, it is important to acknowledge the drivers influencing changes to services nationally. Details of the main policy documents and initiatives influencing the redesign of orthopaedic services for the population of the South of West Kent Health Economy and those on the Sussex borders are set out below.

3.1 Achieving the 'NHS Improvement Plan: Putting people at the heart of public services'

3.1.1 The NHS Improvement Plan (June 2004) supports the progress of the NHS Plan (July 2000). It outlines the priorities for the NHS between now and 2008. The NHS Improvement Plan states that financial resources within the NHS have expanded from a budget of £33 billion to £67.4 billion, with the average annual spend per head of population growing from £680 to £1,345.

3.1.2 The document describes the next stage in the journey for improvement within the NHS as striving for responsive, convenient and personalised services across the whole of the NHS, for all patients. It emphasises the need to develop services to quickly treat those with curable illnesses but also to expand community services and support in the home.

3.1.3 The NHS Improvement Plan also sets out the approach for patient choice. From the end of 2005, patients will have the right to choose from four or five healthcare providers. This will be extended to choice of any healthcare provider by 2008 providing they meet a set criteria. To ensure that those with low income are not excluded from being able to exercise choice, eligible patients will be able to have their transport costs covered by the Hospital Travel Costs Scheme, as is currently available.

3.1.4 The NHS Improvement Plan cites financial incentives and performance management as a key driver for delivering these changes. Payment by Results, when it is fully implemented in 2008, will support patient choice, but will also create incentives for the efficient use of resources. Further details of this system are set out below.

3.1.5 The NHS Improvement Plan sets out to deliver a very different National Health Service for 2008, offering all patients the same access and the power to choose from a range of high quality services, based on clinical need and not ability to pay.

(Source: www.dh.gov.uk)

3.2 Payment by Results

3.2.1 Payments by Results is a mechanism used to determine the allocation of funds from the Department of Health (DoH) through Primary Care Trusts to Secondary Care Trusts. The foundation of this mechanism is to pay Secondary Care Trusts for the services they actually provide.

3.2.2 Payments by Results is based on using a Standard National Tariff (SNT) and Cost and Volume Commissioning. The Standards National Tariff will be a fixed price that PCTs will pay to the NHS Trust for providing a service. The costs will clearly differ between services. For example, the cost for cataract removal will cost much less than major heart surgery. Even with very similar services there may be differing cost implications, for example performing an elective orthopaedic operation on a relatively healthy patient will have different cost implications to conducting an orthopaedic operation on an individual with co-morbidity with another diagnosis, which may require extra monitoring or a longer length of stay. To account for the variances between very specific services, the NHS has created Health Resource Groups (HRGs) and each HRG will have a different fixed price.

3.2.3 HRGs are a case mix classification system that groups together patients who are clinically similar in terms of diagnosis and treatment and in their consumption of hospital resources, thus allowing comparisons of resource use across hospitals with varying mixes of patients. The HRGs will be classified by three-digit, alpha numeric code, for example:

H02	Primary Hip Replacement	SNT=£4,356
B02	Cataract Extension with lens implant	SNT=£~750

The HRGs will allow the funding to reflect changes in case mix and consequently will financially reward Trusts conducting more complex work.

3.2.4 Currently, most agreements between commissioners and providers are relatively crude, with commissioners paying a set amount for a block of activity, based on what has been provided in the past, i.e. commissioning based on historical budgets. Under Payments by Results, all service level agreements (SLA) will specify the exact amount of work to be done (based on HRGs) and the exact price to be paid (based on the standard national tariff). Consequently, the majority of the hospital budget will be a simple calculation:

Quantity x Price =Income

Payment by Results is currently being rolled out in a limited fashion, with full roll out predicted for 2008.

3.3 'Choose and Book'

3.3.1 If, at the GP practice, the decision is taken that the patient needs to see a specialist for elective care, this initiative will allow the patient to choose the hospital, date and time from a list of choices at the point of referral. This appointment will then be electronically booked whilst the patient is at the GP practice. The patient will also be given the option to book this appointment at a later date, either via the internet or over the telephone.

3.3.2 'Choose and Book' will interlink with Payments by Results as effectively the commissioning processes will be led by the patients' choice at the point of referral. The Secondary Care Trusts will be paid for the services they actually provide and this will be decided by where patients choose to have their secondary care. Consequently, PCTs' funds will follow the patient's choice into secondary care.

3.3.3 From August 2004 patients waiting for more than six months for elective surgery are offered faster treatment at an alternative hospital (including the private sector). For cataract and heart operations, patients are now offered a choice of hospital at the point of referral. This was introduced in January and April 2005, respectively.

3.3.4 By December 2005, all patients requiring an elective referral will be offered the choice of 4-5 providers of care. (Multiple-site providers will only be classed as one option).They will also be offered a choice of time and date for their booked appointment. From 2008, this will be expanded to encompass the right to choose from any healthcare provider, on condition that they meet NHS standards and are within a price range the NHS is willing to pay.

3.3.5 The range of services available to patients could be chosen from any of the following service providers:

- NHS Trusts
- Foundation Trusts
- NHS and Independent Sector Treatment Centres (ISTCs)
- Independent Sector Hospitals
- General Practitioners with a Special Interest (GPwSI)

3.3.6 The responsibility for developing the 'menu' of choices for patients lies with the PCTs. However, a full range of 4-5 choices may not be suitable for all patients, and there are exceptions, particularly where the urgency of diagnosis is essential. Hospitals that are unable to provide initial appointments within 13 weeks will be temporarily removed from the choice menu. Once appointments are available within the maximum waiting time, hospitals will be reinstated on the choice menu.

3.3.7 Patients will choose a provider for the whole of their elective care episode, including an initial outpatient appointment and any subsequent treatment. However, should a patient be unhappy with the standard of care, they will be able to return to their GP and discuss options, as is already standard practice.

3.3.8 Information will be available locally for patients, to inform their choice, and their GP or primary care professional will support them in making their decision. Patients can expect to be advised on information such as waiting times, patient experience and clinical quality, and may also be influenced by the location and convenience of the hospital. The NHS website www.nhs.uk will also be a source of information. PCTs will be expected to provide targeted packages of support to ensure choice is accessible to all and does not exclude hard-to-reach patients and communities.

3.3.9 The benefits for patients will include improved opportunities to influence the way they are treated, and to be provided with a more personalised health package. The freedom to choose appointment times will create more convenient appointments and a dramatically quicker referral process. The DoH argues that this will also lead to improvements for secondary care and will result in a reduction of 'Did Not Attends' (DNAs) and cancellation, as patients choose their own appointment times. They also suggest it will result in a reduction in the administrative burden of chasing hospital appointments on behalf of patients, and lead to a more consistent process for audits and referral letters.

3.4 Waiting List Targets

3.4.1 Nationally, waiting times for elective orthopaedic surgery have been lengthy and recognised as a problem area. NHS Trusts have been under pressure to reduce the maximum wait to 9 months by March 2005. This is to be reduced to 6 months at the end of this year.

3.4.2 This co-ordinates with the introduction of 'Choose and Book', which will not include those NHS Trusts with a waiting time in excess of 6 months on the provider menu. NHS Trusts are consequently under tremendous pressure to reduce waiting times.

3.4.3 The National Orthopaedic Programme (NOP) was established in January 2004 to support the delivery of an NHS 6 month wait target in Orthopaedics by December 2005. This involves four basic work streams:

- Increase the focus on orthopaedics
- Maximising the impact of existing initiatives
- Closer monitoring of performance
- A tailored support programme for highest risk Trusts

The tailored support programme has been developed by clinicians and managers from various national organisations, including the Department of Health, the Modernisation Agency, British Orthopaedic Association and the NHS. The tailored support programmes aim to develop an individual support package to Local Health Economies (LHE) with significant problems in orthopaedics. This aims to assist LHEs to develop realistic action plans to reduce waiting times, to implement and monitor plans and bring about sustained improvement.

3.4.4 Maidstone and Tunbridge Wells NHS Trust received a diagnostic visit by the NOP in November 2004. The key messages of the National Orthopaedic Programme report, as set out in the Acute Trust's public board minutes, are:

'Encouraging signs identified in the NOP report:

- The Orthopaedic Development Group is a good foundation on which to build for the development of a long term muscular-skeletal strategy, and is evidence of joint working between primary and secondary care.
- New Commissioner in post who will cover both the needs of Maidstone Weald PCT and South of West Kent PCT.

- Respected Extended Scope Practitioner (ESP) service working alongside consultants in outpatient clinics.
- Consultants committed to working with management as a unit, with a well regarded clinical lead.
- Ring fenced orthopaedic capacity at Maidstone.
- Foundations in place for LHE wide performance management frameworks and processes via the monthly Performance Improvement Plan meetings.

Key challenges and concerns identified in the NOP report

- Ineffective organisation and communications within Maidstone and Tunbridge Wells NHS Trust and across the LHE impacting on orthopaedics
- Lack of a robust and shared delivery plan to meet the 6 month target
- Lack of clarity about the priority of orthopaedics
- No evidence of a shared understanding of orthopaedic demand and capacity at sub-specialty level
- Lack of effective commissioning and active demand management
- Inconsistent and incomplete application of waiting list policy
- Poor data quality undermining the LHE's ability to plan and performance manage service improvement
- The LHE is not maximising current investment in staff and facilities

Key recommendations made by the NOP report:

- Use the action planning process as an opportunity to define, develop and demonstrate more mature LHE relationships
- Develop a robust delivery plan, owned and jointly developed by the LHE, which shows how the 6 month target at both March and December 2005 will be achieved
- Establish a project team to develop the delivery plan, reporting into the orthopaedic development group
- Dedicated resource should be released by all organisations in the LHE to develop the plan
- A joint LHE-wide modelling group should be established to work jointly on the NOP model for capacity and demand measurement
- Strengthen the remit and authority of the Orthopaedic Development Group to facilitate swift development and implementation of health economy patient pathways and operational protocols
- Ensure all boards are updated monthly on progress
- Take steps to maximise current investment in staff and facilities
- Address data quality issues to support better planning and performance management'

3.4.5 The Local Health Economy has recently agreed the action plan and the Acute Trust is currently implementing changes to ensure compliance with the maximum 6 month wait target by December 2005. The Acute Trust is now compliant with the 9 month wait target; however, this is partly as a result of a number of patients being offered choice at 6 months and being treated in the private sector at a cost of approximately £1.6 million in the last year.

3.4.6 Details of current waiting list figures, submitted to the Department of Health across Kent and East Sussex for orthopaedic procedures, are provided in appendix 1.

3.5 Infection control

3.5.1 Staphylococcus aureus is an extremely common cause of bacterial infection. Over 40% of the staphylococcus aureus causing blood stream infections are now resistant to methacillin and related antibiotics, i.e. Methicillin-Resistant Staphylococcus Aureus (MRSA). About 30% of the general population are colonised by Staphylococcus aureus; in hospital the percentage is much higher, and more likely to be MRSA, than in the general community. Densely populated communities, where people's immune systems are more susceptible, such as nursing homes and hospitals, in the main have higher rates of MRSA than the general population.

3.5.2 MRSA is one of the most well-publicised bacteria-causing infections and has become known as the 'super bug', due to its resistance to several antibiotics. There are still some antibiotics that can treat this type of infection, but much higher doses over longer periods are required.

3.5.3 MRSA can exist on many healthy people's skin without them even knowing it, but infections in wounds can lead to complications. Infection control is of particular importance with regard to orthopaedic surgery. Infection in replacement joints can lead to the destruction of the joint, and deep infections can cause severe problems for the patient, which may not immediately become apparent. Consequently, infection control measures in both orthopaedic surgery and wards need to be extremely comprehensive and of utmost importance.

3.5.4 Although probably the most well known, MRSA is not the only bacteria-causing infection. Due to the severity of problems associated with orthopaedic site infections, the Department of Health has instigated mandatory surveillance of orthopaedic Surgical Site Infection (SSI). This became mandatory in April 2004 but it is understood the Acute Trust had already taken part, prior to this, in the national voluntary SSI surveillance.

3.5.5 The mandatory surveillance of orthopaedic SSI requires that all NHS Trusts undertaking orthopaedic surgery must do surveillance in one or more of the orthopaedic categories; total hip replacement, hip hemiarthroplasty, knee replacement and open reduction in long bone fractures. In any financial year, surveillance must continue for a minimum of three consecutive months, commencing at the start of a calendar quarter.

3.6 Broomfield Hospital infection control example

3.6.1 Infection control measures, and the introduction of ring fenced beds (i.e. only those receiving elective orthopaedic surgery to be admitted) dramatically reduce the rates of infection. In the year prior to Broomfield Hospital in Essex introducing new infection control measures, 29 cases of MRSA were recorded in the

hospital's orthopaedic unit. In the following year (2000), no new MRSA cases occurred and there was a significant decrease in all post-operative infections. As a result of fewer complications, resulting in more predictable bed occupancy, the unit was able to treat 17% more patients without increasing operating lists.

3.6.2 At the Broomfield unit, all patients were swabbed for MRSA, prior to admission and those with positive results were put on a de-contamination regime in the community until they tested clear. The unit developed protocols to ensure stringent infection control measures were followed; all nursing staff wore disposable aprons and gloves for each interaction with a patient, and used alcohol hand rub before and after each consultation. Medical staff were required to leave jackets at the entrance to the ward and wear clean white coats, which were laundered daily. Visitors were not allowed to sit on the beds and the use of agency staff was minimised. This example shows that, through developing infection control measures, the risk of infection can dramatically be reduced.

3.7 European Working Time Directive

3.7.1 The implications of the European Working Time Directive (EWTD) were included in the previous Joint Select Committee consultation response. A copy of this information has been included in appendix 2.

4. The Discussion Phase

4.1 The public discussion

4.1.1 The Acute Trust and PCTs launched a public discussion on the future of trauma and orthopaedic services last year, from 4 October 2004 to 30 November 2004. The aim of this 8 week discussion period was to have an open public debate on the future of trauma and orthopaedic services which could inform firm proposals put forward in the consultation document. At this stage of the process, the preferred option was to centralise elective inpatient orthopaedic services at the Maidstone site, whilst centralising all orthopaedic trauma services at the Tunbridge Wells site. Tunbridge Wells was chosen for the centralisation of trauma services due its greater catchment population and historically higher number of trauma admissions, which, in the year 2003/04, amounted to 1736 at Kent and Sussex and 1483 at Maidstone Hospital.

4.1.2 It is understood this option was supported by 10 out of the 11 orthopaedic consultants across the two hospitals. It was felt that this offered the best solution, clinically, in terms of reducing cancelled operations, aiding infection control and greater opportunities to specialise. This would also aid the on-call arrangements, as centralisation, with the introduction of the European Working Time Directive, would reduce the pressure on the number of Junior Doctors required.

4.1.3 However, many of the general surgeons and other related specialities were extremely concerned by this proposal. Anxiety related to the consequences for patients needing other surgical interventions and the belief that it might lead to the loss of general surgical trauma at the Maidstone site. There was also extreme public concern related to the transfer times between Maidstone and Tunbridge Wells and the infrastructure linking the two towns. There is always some element of clinical risk when transferring patients from one site to another and Kent Ambulance Services has expressed its relief that the Acute Trust and PCTs are no longer proposing the transfer of trauma patients.

4.1.4 Understandably, public concern was extremely high and a public media campaign influenced the Acute Trust and PCTs to recognised the need to balance clinical issues with accessibility when developing the options for public consultation. The Acute Trust and PCTs consequently held an option appraisal day in January 2005 to discuss and reduce the 6 options proposed in the discussion period, resulting in 2 options being put forward as firm proposals.

4.2 The option appraisal day

4.2.1 The option appraisal day was attended by approximately 100 people, 78 actively participated, with the remaining acting as observers. The group was made up of members of the public, who had written to the Acute Trust and PCTs regarding the discussion phase, members of staff, including consultant orthopaedic staff and those opposing the discussion options, representatives of local health groups including patient and public involvement forums, local councillors and partner organisations.

4.2.2 The participants were asked to rank the evaluation criteria in order of importance, which was later used to evaluate each of the 6 options. The 10 criteria were ranked as follows:

1. Access to an orthopaedic bed in hospital in an emergency
2. Consistent with current best safe clinical practice in orthopaedics
3. Impact upon Acute Trust services and other health and social care organisations
4. Improve outcomes for the community
5. Impact on staff

6= Access to an orthopaedic bed in hospital for an elective operation
6= Reduction in chance of becoming infected with MRSA
8= Reduced likelihood of operations being cancelled
8= Affordability
8= Achievability

4.2.3 Participants were then asked to consider how well each of the options met the criteria. The participants were not informed of the outcome of the criteria ranking process in case it resulted in any bias in their appraisal. After weighting the options against the criteria, the options were ranked as follows:

1. Emergency orthopaedics at both Tunbridge Wells and Maidstone and elective at Tunbridge Wells

2. Emergency orthopaedics at both Tunbridge Wells and Maidstone and elective at Maidstone
3. To base emergency orthopaedics at Tunbridge Wells and elective orthopaedics at Maidstone
4. To base elective orthopaedics at Tunbridge Wells and emergency orthopaedics at Maidstone
5. Centralisation of all orthopaedic services at Tunbridge Wells
6. Centralisation of all orthopaedic services at Maidstone

4.3 The Joint Select Committee conclusion on the discussion phase

4.3.1 The Joint Select Committee commends the use of a discussion period to enable public debate and ensure options are developed within a true framework of patient and public involvement. The Joint Select Committee sympathises with the Acute Trust, PCTs and Consultant Orthopaedic Surgeons in deciding the options for public consultation. However, conversely, the Joint Select Committee feels the original discussion proposal should have been included in the consultation options. The Joint Select Committee recognises that this caused public anxiety; however, as this is considered the best clinical option in terms of orthopaedic services and was considered the third best option at the appraisal day, this should have been included as an option in the consultation period. Considering this option for open public debate would have allowed for further understanding of the implications and an opportunity to gain a balanced view.

5 Consultation Process

5.1 Consultation document

5.1.1 The Joint Select Committee feels the Acute Trust and PCTs have built on the experience of previous consultations and developed a comprehensive consultation document. Both staff and Patient and Public Involvement Forum representatives reported having the opportunity to comment on the document prior to its release. The Acute Trust distributed it to staff on wards prior to releasing it in the public domain. The consultation document was available on the website and on local wards and was sent to various GP practices. The Local Health Economy also placed a full-page advertisement in the local media, advertising the consultation and giving details of how to request a copy of the document.

5.2 Engagement of the public and stakeholder groups

5.2.1 The Acute Trust and PCTs decided against a traditional framework of Trust organised public meetings to communicate, discuss and receive feedback on the proposals for orthopaedic services.

5.2.2 Recognising that public meetings are often poorly attended, the Acute Trust and PCTs chose to repeat the methods adopted for the previous consultation, without the use of public meetings. Instead they developed the previously observed success of utilising localised public meetings. They presented the options at related community groups and meetings organised by Borough and District Councils and Patient and Public Involvement Forums and used this as an opportunity to discuss the options proposed. This was also extended to East Sussex, with the Patient and Public Involvement Forum for the PCT hosting a meeting to discuss the options.

5.2.3 In addition to these events, the Acute Trust hosted two public open evenings one at Maidstone hospital and a second at the Kent and Sussex hospital. These were intended to be opportunities for the public to find out more about the Acute Trust, and to update the community on methods used to combat infection control, learn about healthy living and what to do in emergency situations. It was also intended to provide a platform for involving the public in the orthopaedic public consultation.

5.3 Engagement of Acute Trust staff

5.3.1 As previously stated, the Acute Trust invited various members of staff to attend the option appraisal day. The Committee has heard a mixed perspective on the engagement of Acute Trust staff during the consultation period. Staff in Tunbridge Wells appeared informed, and reported having the opportunity to discuss the proposals. However, staff involvement appears to have been inconsistent on the Maidstone site. The Acute Trust management team report making attempts to engage with all staff affected by the proposals.

5.3.2 The Acute Trust communication plan illustrates various members of the Acute Trust management team attending staff meetings to discuss the proposals, including,

- monthly surgical care group meetings
- monthly theatre group meetings
- senior staff meetings
- holding open staff meetings for all staff to attend
- sister and matron meetings
- divisional meeting with the Orthopaedic Surgeons
- monthly visits to the relevant wards

5.4 Engagement of neighbouring Trusts

5.4.1 Medway NHS Trust, East Kent Hospitals NHS Trust, Kent Ambulance Trust and Sussex Ambulance Trust report being informed, and are supportive of the options being proposed. None of the Trusts believe either option will have a significant impact on their service provision; however, both East Kent Hospitals NHS Trust and Kent Ambulance NHS Trust are still in the process of confirming this hypothesis.

5.5 Joint Select Committee conclusions on the consultation process

5.5.1 The Committee is satisfied the Acute Trust has met its obligation to consult with staff and has involved those willing to be included at all stages of the development of the options. In terms of engagement with patients and the public, the Committee feels the Acute Trust and PCTs have made attempts to engage with relevant groups; however, the Committee is concerned that the PCTs decided against offering public meetings specifically to discuss the options. Consequently, the Committee recommends that the Acute Trust and PCTs fully evaluates the efficacy of public engagement arrangements for this consultation process prior to embarking on future public consultations.

6. The Proposals

The options

Option 1 Emergency orthopaedic care should be provided at both Tunbridge Wells and Maidstone with elective inpatient orthopaedics centralised at Kent & Sussex Hospital and then at the new PFI build at Pembury

Option 2 Emergency orthopaedic care should be provided at both Tunbridge Wells and Maidstone with elective inpatient orthopaedics centralised at Maidstone Hospital

Both hospitals would continue to provide full trauma services, outpatient appointments and day case surgery (more than 60% waiting list activity)

Current activity levels

1st April 2004 to 31st January 2005 activity data

Site	Numbers of Elective admissions		Numbers of Non Elective admissions
	Inpatient	Day cases	
Kent & Sussex	605	1076	1674
Maidstone	834	580	1214

A greater number of day case procedures are already conducted at the Kent and Sussex hospital, accounting for the variance between the two hospitals elective inpatient admission numbers. In addition, there were 222 procedures performed in the independent sector between April and end of January 2005 at a cost of 1.2 million, directly associated with a shortfall in Maidstone and Tunbridge Wells capacity. Another 100 patients were sent outside the Acute Trust as part of the GSUP initiative and 113 as part of the choice at 6 months initiative.

Day Case Activity

This refers to all day case activity and not just orthopaedics.

To cater for day case activity the Acute Trust intends to bring in a prefabricated unit to the Kent and Sussex site. This will be a mobile unit and will be in place in June 2005. This will allow time for the Acute Trust to transform the current ENT unit for day case activity. The Acute Trust intends to convert ward 14 as a day case recovery area by November 2005. The mobile unit will then be transferred to the Maidstone site.

The long term plan for the Maidstone site is to build an ISTC (Independent Sector Treatment Centre) for day case activity. This unit is planned to be built by October 2006.

Step down facilities

Reconfiguring services would allow for the introduction of step down facilities for orthopaedic patients requiring a longer length of stay and would enable greater throughput of patients. This would also allow more specialist care for those patients and would not impact on the capacity of the elective or trauma ward. The Acute Trust plans to develop a 17-bed ward at the Kent and Sussex as step down facilities. This model will also be developed at the Maidstone site, although the exact number of beds is still to be determined. The Chief Executive for the Acute Trust is proposing 10 beds for step down facilities at Maidstone Hospital.

Infection control measures

The options proposed by the Acute Trust will allow elective orthopaedic beds to be ring fenced and patients to be screened for MRSA prior to admittance, as is available currently at the Maidstone orthopaedic unit. The trauma and orthopaedic wards will be operated by staff solely dedicated to this unit, and the centralised elective theatre will be fitted with laminar flow (ultra clean air) facilities, which have been shown to dramatically reduce the risk of cross-infection.

Continuing investment in Maidstone Hospital

The Committee is satisfied that the Acute Trust is committed to Maidstone Hospital, as demonstrated by the huge investment into its services. Several services have moved to Maidstone as a result of previous consultations, including urology services, head and neck services, the development of the Breast Care centre and a substantial A&E development. The Acute Trust is also in the process of gaining approval for an Independent Sector Treatment Centre for day case activity at the Maidstone site. In addition, an outline business case for an intermediate care centre in Maidstone is currently being developed.

7. Geographical Context

7.1 Introduction

To appreciate the rationale for the preferred option of locating elective inpatient services at Tunbridge Wells, the Committee has considered the position of services in neighbouring Trusts across both Kent and East Sussex. On the following page, a map can be seen depicting the location of neighbouring hospital Trusts. Most relevant to this consultation are the location of services provided by Medway NHS Trust, East Kent Hospitals NHS Trust, Brighton and Sussex University Hospitals, East Sussex Hospitals NHS Trust and Surrey and Sussex Healthcare NHS Trust.

7.2 Services available across Kent

7.2.1 Medway NHS Trust provides trauma and orthopaedic services at the Medway Maritime Hospital. The Medway NHS Trust provides trauma, elective and day case surgery at this one site as well as outpatient appointments. East Kent Hospitals NHS Trust provide the full range of orthopaedic services at the Queen Elizabeth the Queen Mother Hospital at Margate and William Harvey Hospital at Ashford.

7.3 Services available across Sussex

7.3.1 Brighton and Sussex University Hospitals have recently undergone a similar consultation to Maidstone and Tunbridge Wells NHS Trust, the outcome of which is to provide orthopaedic trauma services at Brighton and to locate a new elective orthopaedic service at Haywards Heath. This is scheduled to be opened in June 2006. This will be a separate unit based on the current acute hospital site, and will be financed and run by the independent sector. Current capacity for this NHS Trust is 4500 elective operations, both inpatient and day cases. The Brighton and Hove PCT predicts this to increase to 5200 next year. The PCT has entered into a legal contract to commission 5500 operations per year from this new unit. Department of Health guidance requires independent sector units to have the capacity to expand by 30%. This would equate to full capacity in the region of 7000 elective procedures per year.

7.3.2 East Sussex Hospitals NHS Trust currently provides trauma and orthopaedic services at both the Conquest Hospital in Hastings and the Eastbourne District General Hospital. Surrey and Sussex Healthcare NHS Trust provides trauma services at East Surrey Hospital and an Independent Sector Treatment Centre provides elective orthopaedic provision.

7.3.3 The Horder Centre at Crowborough is an independent, charitable organisation offering joint replacement surgery. This is a free standing elective surgery centre, and not attached to a district general hospital. It is currently being used, along

MAP

with the Somerfield hospital in Maidstone by the PCTs and Acute Trust to bridge the capacity gap in its waiting lists and patients are offered this as an option as part of the choice at 6 months' initiative. Other private hospitals have been offered as part of choice and GSUP arrangements.

7.4 'Choose and Book'

7.4.1 It is extremely difficult to predict the impact the new 'Choose and Book' system will have on the commissioning patterns, as it is an unknown quantity. Patients will obviously have the choice of 4 or 5 providers, one of which will be from the independent sector. As PCTs are yet to finalise their menu choices, it is difficult to anticipate the impact and the choices patients will make.

7.4.2 As previously stated, it is felt patients will choose services based on waiting times, patient experience and clinical quality, and may also be influenced by the location and convenience of the hospital. It is also predicted that patients will be influenced by their GPs' perspective and preferences. The Acute Trust has spoken to GPs across its catchment area. These discussions have led the Acute Trust to believe local GPs would still recommend Maidstone and Tunbridge Wells NHS Trust to their patients. The Acute Trust feels the reconfiguration of services will enable it to excel in the criteria on which patients are likely to base their choice.

7.4.3 The Acute Trust has conducted retrospective postcode analysis of the number of patients with a postcode of over 40 minutes' drive from each hospital site by private motor car. For option 1, this would equate to 30 patients. This was a small number from north Kent, toward the Isle of Sheppey, and those north of the M20. The Acute Trust predicts these patients may choose Medway or Ashford. For option 2, those with a postcode of more than 40 minutes' travel equated to 120 patients. A large number were from East Sussex, and the Acute Trust considers these patients at risk of choosing Haywards Heath as an alternative option.

7.5 Geographical viability of services

7.5.1 To move elective inpatient orthopaedic services from Maidstone to Tunbridge Wells as opposed to centralising this service at Maidstone, is geographically the most viable option. The Acute Trust is concerned that, if this service were to be centralised at Maidstone, it would lead to those resident on the East Sussex borders to choose the new Haywards Heath development, and would result in a loss of income for the Acute Trust.

7.5.2 The Chief Executives for the South of West Kent Health Economy believe centralisation at Maidstone would equate to a loss of approximately 30% of the Acute Trust's patient base. The Chief Executives painted a potentially long-term picture of less viable services and, consequently, a reduction in services. Payment by Results and 'Choose and Book' are an unknown quantity but have the potential to have a huge impact on the viability of services. Therefore, to ensure sustainable services in the long term, nationally Acute Trusts are seeking to provide services with the greatest catchment area.

8. Current Pressures on Services

8.1 Current configuration of services

8.1.1 Maidstone Hospital currently boasts an elective orthopaedic, isolated, ring fenced unit. This is a temporary-build unit which has a laminar flow dedicated theatre within the unit and staff dedicated solely to the theatre and ward respectively. This unit has substantially reduced the number of post operative positive wound swabs, which now stands at 1.5%. All patients are screened prior to admittance to the unit and those with MRSA are not admitted until treated and clear of the infection. Of the 2543 patients entering the unit over the past 2 years only 2 have had a positive MRSA swab.

8.1.2 The Maidstone orthopaedic unit was constructed under a temporary 5 year planning permission. Discussions with planning officers indicate it is likely that this could be extended. However, the capacity of this unit is limited to 12 beds. In March 2005, 123 surgical procedures were planned; 15 were cancelled, so 108 surgical procedures were completed. However, only 89 were completed in the orthopaedic unit, 9 elective cases were treated in the main theatre, which poses a risk of infection, as this theatre lacks laminar flow (ultra clean air) facilities and is used by all specialities. A further 10 patients were from other wards. The unit also has a relatively high Average Length of Stay (ALOS) of 8 days. Consequently, although this unit is recognised as providing an excellent model of care, waiting lists are lengthy and capacity is a major issue.

8.1.3 Orthopaedic trauma services on the Maidstone site need to be further developed. Infection rates are high, as procedures are conducted in the main theatres and they were used by other specialities and lack the laminar flow (ultra clean air) facilities. Bed capacity also needs to be developed. This is currently limited to one 23-bed ward, which is not ring fenced. Recent figures display a large number of outliers (patients placed on the wrong type of ward), as a result of a lack of available beds on the ward.

8.1.4 Capacity at Tunbridge Wells equates to 48 beds for both elective and trauma patients and one laminar flow theatre, utilised for elective procedures. The orthopaedic services at Tunbridge Wells have yet to separate trauma and elective patients and have only recently introduced MRSA screening of elective inpatient patients prior to admission.

8.2 Rationale for Change

8.2.1 The Acute Trust and PCTs states that services are currently unsustainable and need to be upgraded at both sites; surveys have shown the public want local emergency access but are prepared to travel for elective surgery. The Acute Trust is struggling to meet demand, implement infection control measures, and suffers from high cancellation rates.

8.3 Infection control

8.3.1 The Acute Trust states that 47% of all elective and non elective patients admitted across all specialities during October and November 2004 were MRSA positive on admission. It is suspected this high number can be attributed in part to the number of patients entering hospital from nursing homes, where MRSA is higher than in the general population as a result of living in close proximity and the more elderly population having more vulnerable immune systems. Consequently, it is crucial that elective inpatients for orthopaedics are swabbed and treated, where necessary, prior to admission and receive care on isolated wards where the risk of cross-infection is significantly reduced.

8.3.2 Figures provided by the Acute Trust illustrate superficial wound infection rates for elective and trauma hip surgery across the two sites.

Superficial wound infection rates 2001-2004

	Maidstone	Tunbridge Wells
Elective total hip	3.3	2.8
Trauma Hip	10.9	1.7

It is important to note these figures include elective infection rates for Maidstone Hospital prior to the development of the isolated orthopaedic unit which has dramatically reduced the numbers of elective patients with a superficial wound infection.

The high rate at Maidstone in trauma hip surgery is exacerbated by the lack of a dedicated theatre.

The last surveillance of surgical site infection in orthopaedics figures submitted to the Department of Health were:

The percentage of surgical site infections per procedure July –September 2004

	Kent and Sussex Hospital	Maidstone Hospital
Total Hip replacement	1.4	0.0
Knee replacement	0.0	0.0
Hip hemiarthroplasty	7.9	10.0

8.3.3 Currently, orthopaedic infection control measures at Tunbridge Wells are in their infancy. All patients and visitors are requested to use alcohol gel on their hands; however, the site has only recently introduced screening of elective patients prior to admission. The greatest perceived risk relates to lack of ring fenced orthopaedic beds and separation of unscreened trauma patients. As described in section 3.4, infection control measures for orthopaedic patients are of paramount importance. Conversely, it was reported to the Committee that the Kent and Sussex Hospital compared favourably to the Horder Centre, which is purely an elective centre, in infection rates, but had less efficient throughput. However, implementation of more stringent processes will further reduce the risk of infection

8.3.4 Trauma services at Maidstone are also in need of updating. Currently, trauma theatre lists continue in the general theatres and there remains a problem of infection control and delays for surgery for emergency admissions.

8.3.5 The separation of elective and emergency trauma cases has been proven to substantially reduce the risk of cross infection. The reconfiguration of services would allow for the separation and ring fencing of orthopaedic theatres and wards.

8.4 Capacity and the choice agenda

8.4.1 The Acute Trust is under pressure to reduce its waiting time targets to under 6 months by the end of 2005. The choice agenda will add to this pressure; to be considered as an option on the electronic menu at GP surgeries, Acute Trusts need to have a wait of less than 6 months. By 2008, waiting times are to be reduced to 18 weeks from GP referral to operation. With the introduction of patient choice and the patients being ever more mobile, in order to keep services viable the Acute Trust would have to offer the best, most up to date and attractive services possible. The Acute Trust feels it is unable to provide this at present.

8.4.2 The Acute Trust is currently not meeting demand with a number of NHS patients being offered the Private Sector as an alternative option to waiting longer than 6 months. The Acute Trust needs to increase its capacity to reduce waiting times and reduce its reliance on the independent sector. Reconfiguring services would allow for the introduction of step down facilities for those requiring a longer length of stay and would enable greater throughput of patients. It would also allow more specialist care for those requiring a longer length of stay but would not impact on the capacity of the elective or trauma ward.

8.5 Cancellation rates

8.5.1 There are currently unacceptable delays to the provision of trauma care at both Acute Trust sites; 33-50% of elderly patients with hip fractures are currently deferred for more than 48 hours. Consequently trauma services need to be improved, regardless of the reconfiguration of elective care.

8.5.2 From October 2003 to August 2004, 16% of elective inpatients were cancelled for non-clinical reasons i.e. lack of theatre time or available beds, etc. This equates to 169 patients at the Maidstone site and 110 at the Kent and Sussex site.

8.5.3 The Acute Trust predicts that both options will allow reduce the number of cancelled operations. The option to move services to Tunbridge Wells would also allow for the further development of trauma services at both sites as it would make capacity available at the Maidstone site.

8.6 Investment in technology and sub specialisation

8.6.1 Centralising all inpatient elective orthopaedic services on one site would enable the consultants to develop sub-groups to enable them to specialise. This would allow further investment in the services and, therefore, more cost effective surgery.

8.6.2 Currently, consultants have special interests in specific areas, and, when cases are referred certain consultants specialise in some areas of work. The Acute Trust aims to make this a more formal arrangement. For example, it is currently exploring the promotion of hand surgery as a specialised service. If elective services were to centralise then 2 or 3 consultants with a special interest could develop this as a specialist service and sub-specialise. This sub specialism could then be promoted in terms of marketing and referrals. Without centralisation, this service cannot be covered if the one specialist consultant is unavailable.

8.6.3 Centralising consultants would also aid bids for investment in specialist technology. Through having a critical mass of consultants, the Acute Trust potentially would be more willing to invest where the technology will be utilised by a greater number of consultants.

8.7 European Working Time Directive

8.7.1 The Acute Trust is under pressure to reduce the reliance on Junior Doctors. Junior Doctors' hours have been reduced to 56 hours per week. In 2008 this will further be reduced to 48 hours per week. Doctors' training time has been reduced and surgeons are emerging from training after 5 years instead of 8 years and so they would be less experienced than existing colleagues. Consequently services are moving to be more consultant led.

8.7.2 Centralising elective inpatient services would create less pressure for on call arrangements and would also enable Junior Doctors to rotate and gain experience between separate trauma and elective services. As the Acute Trust becomes able to develop more specialist services it would also become a more attractive environment for those in training.

8.8 Conclusions on the rationale for change

8.8.1 Both options proposed by the Acute Trust and PCTs would allow the separation of trauma and elective services and both options would:

- Aid reductions in waiting lists
- Increase capacity
- Promote infection control
- Provide the foundations for increased specialisation/investment in technology
- Reduce the number of cancellations

The Committee agrees that due to the current pressures on services that services in their current form are unacceptable and improvements are necessary to ensure all patients receive a service in the best possible environment.

9. Impact on Social Services

9.1 Introduction

9.1.1 In Kent there are two Social Services teams providing services for patients treated by Maidstone and Tunbridge Wells NHS Trust. Since the Acute Trust merged in 2000, the two units have successfully worked closely together to provide a seamless service. The team also liaises with East Sussex County Council Social Services department, as many Sussex residents receive treatment at the Kent and Sussex Hospital.

9.1.2 Although Kent Social Services have a good working relationship with East Sussex County Council, each authority's system of assessment is different. A Kent hospital discharging a Sussex patient would carry out an assessment for that patient but could not put in place any care package for them. However, both departments report successful partnership working.

9.2 Current issues affecting Social Services

9.2.1 Social Services arranges appropriate home care packages for those requiring Social Services intervention, such as home carers for patients leaving hospital after elective orthopaedic surgery. It was explained to the Joint Select Committee that cancellations disrupt this process and arrangements, causing care packages to be rearranged and different carers engaged.

9.2.2 Hospital acquired infection affects the prompt discharge of post-operative patients. If a patient was to be discharged into their own home or care home carrying an infection, the potential for their own delayed recovery and the spread of an infection to other elderly, vulnerable people was a concern. To allow recovery from infection, and to be sure that they were being discharged clear of risk, it was occasionally necessary to keep a patient in hospital longer than initially intended. This inevitably had resource implications for the Acute Trust.

9.3 Impact of the proposals on Social Services

9.3.1 The centralising of elective surgery at Tunbridge Wells would generate an increase in workload for the West Kent Area Team, as they would have to cater for those previously going to Maidstone Hospital, covered by Mid Kent Social Services. However, the working relationship between the two social work areas was reported to be extremely good. An agreement had been reached between the two on how services would be organised to maintain the fastest possible

discharge service and it is intended that more staff would be allocated to cover the increased workload.

9.3.2 An elective surgery workload was more predictable, and so easier to work with. The likely needs of a patient returning home after a hip operation, for example, were familiar and reasonably predictable, and teams are often able to meet patients before admission to allow the planning of their discharge care package well in advance. With decreased cancellations and more stringent infection control measure this would enable this process to run more smoothly.

9.3.3 If option 1 was accepted, Maidstone residents that choose not to travel to Tunbridge Wells Hospital for elective surgery may choose instead to attend Medway Hospital. When liaising with Medway Hospital, Kent Social Services teams would rely on assessments made by Medway Hospital Social Work team. These teams worked in the same way as Kent, which reduced complications.

9.3.4 Occupational Therapy requirements for discharged elective surgery patients were delivered by a joint Health and Social Services team. It has been confirmed to the Joint Select Committee that this arrangement would also be able to cope with the increased workload caused by elective surgery being moved to Tunbridge Wells.

9.4 Conclusion

9.4.1 Both Social Services departments agree that option 1 would pose no significant problems to providing their existing services. For East Sussex, services would continue as they do at present, with little impact. East Sussex County Council Social Services department, perceived that acceptance of option 2 would result in a number of patients choosing not to travel to Maidstone.

9.4.2 The Kent Social Services representative concluded that the centralising of elective orthopaedic surgery would mean services would be easier to plan, and cancellations kept to a minimum, provided services were run separately from trauma services. The Kent Social Services representative also confirmed that travel had not shown up as a major worry amongst the patients he had encountered in his work and through his involvement thus far with the present consultation.

9.4.3 The Joint Select Committee is satisfied that these options will not have a detrimental effect on Social Services provision in either county.

10. Transport Implications

10.1 Assessing the need

10.1.1 The Acute Trust and PCTs are in the process of conducting a travel survey to assess exactly how visitors and patients using orthopaedic services travel to the

hospital sites. Early indications reveal the vast majority of this patient group travel by private car for elective orthopaedic care.

10.1.2 The Joint Select Committee recognises that relatively few patients will need to travel to the alternative site for elective care. Outpatient appointments and day case surgery will be provided at both sites. As medical advances are made, a greater number of procedures will be conducted as day cases and the average length of stay for inpatients is substantially reducing. However, for those required to travel to the alternative site, it is important transport issues are not a barrier to seeking treatment or receiving visitors.

10.2 Patient Transport Services

10.2.1 The Maidstone and Tunbridge Wells NHS Trust operates two central booking offices that jointly provide all non emergency Patient Transport Services (PTS). These services include a hospital care service (volunteer drivers), two Ambulance services (Kent Ambulance and Sussex Ambulance), a central collation and 'gate keeping' service and an information and advice service.

10.2.2 All NHS non-emergency patient transport requests are processed through the central booking office and only those with a medical need will be considered for hospital transport. Medical needs have to be agreed by a doctor before being accepted, in accordance with Department of Health guidance, although the Acute Trust accepts referrals from Midwives and Dentists to the service. The criteria may potentially change in the future and the Acute Trust has had discussions with the local PCTs regarding this matter.

10.2.3 The PTS provides services across the Acute Trust catchment area and so provides services in Kent, Sussex, parts of Surrey and South East London. However, the majority of the PTS is concentrated around a 15 mile radius of each hospital site. This service can be required to travel across the whole of the UK where repatriations and specialist care can occur. The logistics department of the Maidstone and Tunbridge Wells NHS Trust is not concerned that this reconfiguration will place extra demand on the PTS services. They feel that, provided the access criteria remains the same, they have the capacity to cope with any increase in demand. There is no charge to the patients for using the services provided by PTS.

10.3 Volunteer drivers

10.3.1 Patient transport services are in the process of strengthening their links with local volunteer bureau that provide volunteer driver services for patients. Regular meetings are taking place with those in and around Maidstone, and the Acute Trust is hoping to expand this to encompass volunteer organisations across South West Kent and East Sussex.

10.3.2 The Joint Select Committee is reassured that the Acute Trust has taken the initiative to understand the services that are available across the community. These services are extremely valuable for those not meeting the PTS criteria.

There are a number of organisations offering services for driving patients to hospital appointments; however, the Joint Select Committee is concerned that those most in need of these services are unaware of how to access this information. Consequently, the Joint Select Committee recommends that the Acute Trust provides information on transportation choices and when sending to access these with appointment details to patients.

10.4 Hospital Travel Costs Scheme

10.4.1 Patients in receipt of certain benefits are entitled to a refund on travel to hospital appointments via the Hospital Travel Costs Scheme (HTCS). HTCS is aimed at people who do not have a medical need for NHS Patient Transport, but cannot meet the cost of travel to hospital. Patients can reclaim travel costs for journeys to and from hospital for NHS treatment, and a patients escort if it is medically necessary.

10.4.2 As with PTS, this scheme will encompass any choice patients wish to make from the provider menu. Consequently, those on low incomes will not be restricted from exercising choice. As previously stated, PCTs are in the process of developing support packages to prevent communities for being excluded from exercising choice.

10.5 Road infrastructure

10.5.1 The supporting road infrastructure between Maidstone and Tunbridge Wells is of paramount importance to support access to the new hospital development at Pembury. The Committee acknowledges that at present, there are problems areas, including the A21 and Colts Hill.

10.5.2 The two A21 schemes between Tonbridge and Pembury and Kippings Cross and Lamberhurst are in the Government's Targeted Programme of Improvements (TPI). However, following the 2004 spending review, these two schemes have slipped and will not be built until 2008/2009 at the earliest. This creates potential issues for the Acute Trusts PFI development at Pembury. The Highways Agency directed Tunbridge Wells Borough council to impose developer agreements when granting planning permission. The planning condition for the new hospital at Pembury states that no more than 32 beds or 38 consulting rooms shall be occupied for use until either (a) the construction of the A21 Tonbridge to Pembury scheme has commenced or (b) completion of suitable mitigation measures at the A21 junctions with Longfield Road and A264. It is understood all relevant partners are in discussions to establish a way forward. However the Committee recommends Kent County Council and relevant District and Borough Council colleagues continue to urge Government to ensure this scheme is underway in time to support the new hospital development at Pembury in 2010/11.

10.5.3 Colts Hill Strategic Link has been submitted for funding twice through the Local Transport Plan Annual Progress Report (July 2003 and 2004). On both occasions the Government accepted that Kent County Council had demonstrated a need for

the scheme but that “it does not present sufficient priority for approval at this time”. The scheme is likely to be a high priority in Kent County Council’s new Local Transport Plan 2006-2011, which will be submitted to the Government in July 2005. However the long term prospects for the bypass, in terms of central Government funding are uncertain. Consequently the Joint Select Committee recommends Kent County Council and relevant District and Borough Council colleagues continue to lobby Government to secure funding for the Colts Hill Strategic Link.

10.6 Committee conclusions on transport

10.6.1 The first stage of the Joint Select Committee’s report concerning women’s and children’s services involved investigating solutions sought in other areas. The Joint Select Committee recommended the extension of the East Kent integrated transport model, if on evaluation this proved to be successful. (An extract from the previous Joint Select Committee consultation response relating to the East Kent model can be found in appendix 3, with the response from the joint decision making board). The Acute Trust is currently exploring this and is keen to extend it as a model to West Kent and into East Sussex. In the interim period, the Joint Select Committee is keen for comprehensive information on travel choices to be available for those patients and visitors accessing hospital services

11. The Joint Select Committee’s Analysis of the Proposals

11.1 Influential factors

11.1.1 All the Consultant Orthopaedic Surgeons and nursing staff the Joint Select Committee has spoken to are in agreement that elective orthopaedic services should be centralised and provided at the new Pembury development. This will allow the services to be developed to optimal configuration, but will also allow greater sub-specialisation. However, the consultants differ in opinion on where the services should be provided in the intermediate period, prior to the new development at Pembury.

11.1.2 Extending the existing orthopaedics centre at the Maidstone site would cost £2m-3m, and to remove the temporary buildings and build a permanent theatre and beds would cost approximately £6.5m. The Acute Trust estimates the cost of upgrading theatres and wards at the Kent and Sussex hospital, to support centralised elective services to cost to be approximately £1m.

11.1.3 For any capital scheme over £1m, it is necessary to seek strategic capital through the business case process with the Strategic Health Authority. This process would take approximately 12 months. A tendering process would then ensue, prior to any build commencing. Consequently, this could take 2 to 3 years before option 2 could be implemented. Due to the sums involved, a similar time frame could be expected for any extension of the temporary unit at Maidstone.

The Kent and Sussex Hospital could upgrade existing facilities to expand capacity. As services are moving from the Kent and Sussex Hospital, theatre space will become available.

11.1.4 The Acute Trust has stated it will be able to dedicate the Culverden theatre suite for all orthopaedic requirements and upgrade the second theatre to laminar flow. For the Joint Select Committee to support this option, this theatre must be upgraded prior to any movement of services. The Acute Trust has committed to ring fencing the elective ward and providing a 17 bed step down ward. Consequently provision at the Kent and Sussex will amount to 65 beds:

24 bedded unit for trauma services
24 bedded unit for elective inpatient services
17 bedded unit for step down facilities

For the Joint Select Committee to support this option the Acute Trust must ensure the step down facilities for orthopaedic patients requiring a longer length of stay are in place and fully staffed, including physiotherapy requirements, and be in close proximity to the orthopaedic wards.

11.1.5 The Joint Select Committee is extremely supportive of increased numbers of day case procedures as opposed to inpatient stays. This will also be provided locally, so will reduce the number of patients travelling to the alternative site increase the capacity of the elective unit and increase the throughput of patients. The Committee urges the Acute Trust to embed the day case model at both sites as soon as possible, to aid the increase in capacity for the elective inpatient services.

11.1.6 Option 2, centralising elective orthopaedic services at Maidstone long term is not supported by the Orthopaedic Consultants, who are keen for elective orthopaedic services to be developed at the new Pembury development. To centralise orthopaedic services for the immediate period would require a new build at Maidstone, potentially a lengthy process. This would also reduce the Acute Trust's catchment area. Moving services to Maidstone would restrict the extension of orthopaedic trauma services for the Maidstone site as there is limited capacity for expansion within the constraints of existing facilities.

11.1.7 The Joint Select Committee also considered the alternative of retaining services in their current format until the opening of the new development. To do this would leave the Acute Trust severely under capacity and would not allow for the upgrading of services in Tunbridge Wells in regard to infection control or enable greater capacity for orthopaedic trauma services at Maidstone Hospital. To separate out elective and trauma patients at Tunbridge Wells a critical mass of patients is needed. At present, the Acute Trust only has the capacity for 12 elective beds and 2 wards of 24 beds. To enable the Acute Trust to separate out elective patients it needs to be able to utilise 24 elective beds and have the staff to support these. This alternative would also not allow for the benefits of consolidating resources, in regard to specialisation and greater investment in technology. In addition, neither site would have the benefit of step down facilities.

11.1.8 The Orthopaedic Surgeons at Maidstone are extremely keen that any move from the current elective unit at Maidstone will not result in a lesser service for their

patients, and are keen for the success of the current unit to be replicated at Kent and Sussex. They are insistent that, to reduce the risk of infection, the elective theatre is not used by other specialists for out of hour emergencies. The Joint Select Committee has been reassured by the Acute Trust Chief Executive that this would also be extended to the orthopaedic trauma theatre. Consequently, the Joint Select Committee recommends that the two theatre suites at the Culverden suite should be used purely for orthopaedic surgery (1 for elective and 1 for trauma). Any future change to this model should be brought to the attention of the respective NHS Overview and Scrutiny Committees (OSCs).

11.1.9 The Acute Trust has also reassured the Joint Select Committee that option 1 will allow for the development of trauma services at Maidstone Hospital, providing planning permission for the temporary built unit can be extended. The Acute Trust Chief Executive is proposing the development of the current elective unit for orthopaedic services, which will enable trauma patients to be treated in the theatre equipped with laminar flow facilities. It will also allow the development of step down facilities on the current orthopaedic trauma ward. The Joint Select Committee therefore recommends that any movement of services must result in an improvement of orthopaedic trauma services at Maidstone and the development of step down facilities.

11.1.10Consultants will generally continue working at their current sites, with trauma and day case surgery at their respective sites. Consequently Maidstone consultants will need to travel to the Kent and Sussex Hospital for their elective sessions and associated ward rounds. It is proposed that the consultants work in a ‘buddying’ system, with consultants paired from Maidstone and Kent and Sussex Hospital. This would aid continuity for patients’ follow up care in hospital, as the patient would be seen by their consultant or their ‘buddy’. All outpatient appointments will continue at the patient’s closest site (Kent and Sussex Hospital or Maidstone Hospital) and will normally be seen by the consultant who undertook the operation or their ‘buddy’ in time of leave. This system also offers opportunity for sub-specialisation and improved specialist cross cover arrangements during annual leave.

11.2 Committee concerns

11.2.1 The Joint Select Committee is concerned regarding the development of service provision for paediatric orthopaedic services. Elective paediatrics will be retained at Maidstone, with patients being treated in the current elective unit and then transferred to the children’s ward. Paediatric orthopaedic trauma would be treated at either of the two sites. If a child was treated at the Kent and Sussex Hospital, after surgery they would be transferred to the Ambulatory care centre. If the child needs further monitoring after this time they would be transferred to the children’s ward at Pembury. The Joint Select Committee has heard conflicting evidence regarding the proposals for paediatric orthopaedic care and concerns have been expressed by the lead consultant for paediatric orthopaedic services. Further information is required by the Joint Select Committee on the model for paediatric orthopaedic care. The plans for this service appear to be fluid and there does not appear to be a consensus, between clinicians. Consequently, the

Joint Select Committee requests that a written update be brought to the attention of the OSC in 3 months time.

11.2.2 The Joint Select Committee is apprehensive regarding the intermediate plans prior to the implementation of either option. The Kent and Sussex Hospital has only recently introduced MRSA screening of patients prior to admission, and the extent to which this is embedded in the admission process is not clear. The Joint Select Committee is extremely concerned that these beds are not ring fenced. Orthopaedic trauma patients and pre-screened elective patients are also mixed on the same ward, which poses an infection control risk. The Joint Select Committee acknowledges that the Acute Trust is struggling with balancing capacity issues with separating male and female patients, however, the mixing of screened and unscreened patients is not acceptable. It is unacceptable for the same quality standards implemented at the Maidstone site not to be extended to the Kent and Sussex Hospital. The Joint Select Committee urges the Acute Trust to ring fence the 24 elective orthopaedic beds and implement stringent infection control measures at the Kent and Sussex Hospital orthopaedic wards. This is to occur on the upgrading of the second laminar flow theatre, to ensure these infection control processes are embedded into the culture of the wards prior to any reconfiguration of services from the successful elective orthopaedic centre at Maidstone.

11.2.3 The Joint Select Committee is also concerned regarding the reputation and fabric of the Kent and Sussex Hospital. Particularly with the introduction of 'Choose and Book'. The Joint Select Committee has concerns regarding the extent to which patients would choose to receive their elective orthopaedic care at the Kent and Sussex Hospital. The Acute Trust has already begun to address concerns and is hosting a general open evening at both hospitals for the public to visit and see the facilities for themselves. As the fate of the Kent and Sussex Hospital has been unknown for some time, the Joint Select Committee is concerned that it has been subjected to substantial under investment for a number of years. The Acute Trust's Chief Executive has reassured the Joint Select Committee that a re-painting programme is in operation. However, the Joint Select Committee feels that the patient and visitor entrance and signage also needs to be addressed. The Joint Select Committee recommends that the Acute Trust develop plans to upgrade the Kent and Sussex Hospital in terms of re-decoration, balancing the need to refresh the building with demonstrating value for money for a building with a limited lifespan. The Joint Select Committee also encourages the Acute Trust to recognise public concerns regarding the reputation of the Kent and Sussex Hospital and to develop a strategy to address and disperse public anxiety regarding cleanliness and infection control.

11.2.4 The Joint Select Committee is anxious that to reconfigure services to the suggested format at the Tunbridge Wells site necessitates 17 major moves to free the capacity of the wards and theatres. The Joint Select Committee has sought reassurance from the project lead, estates director and Chief Executive that this is feasible in the timeframe proposed, and that implementation will be in place for October 2006. Although the Joint Select Committee was reassured by the Acute Trust, the Joint Select Committee will continue to monitor the pace of the implementation in regard to this matter.

11.2.5 The Joint Select Committee is also concerned to learn that the Acute Trust is significantly under resourced with regard to consultant staff for orthopaedic services for the population it serves. It was reported to the Joint Select Committee that the Acute Trust was in the bottom 10 nationally for its numbers of surgeons per head of the population. At present, the Acute Trust has an Orthopaedic Surgeons to population ratio of 1:45k. In 2003, nationally, the ratio was 1:37k. The Joint Select Committee acknowledges the Trust is in the process of recruiting 2 further consultant staff.

11.3 Committee's conclusions

11.3.1 The acceptance of option 1 and the centralisation of orthopaedic services at Tunbridge Wells will allow the issues in the rationale for change to be addressed. It will allow for the separation of elective and trauma services and the replication of Maidstone Hospital's isolated elective ward, without the capacity issues. It will also provide the foundation for greater sub specialisation. The extension of day case care will result in fewer inpatient admissions. These currently represent over 60% of the Acute Trust's waiting lists.

11.3.2 All orthopaedic consultants are keen for elective orthopaedic services to be centralised at the new Pembury development as this will allow for greater sub-specialisation and accordingly they are not keen for elective care to permanently remain at the Maidstone site. The Tunbridge Wells option will enable existing facilities to be refurbished and can be implemented relatively quickly.

11.3.3 The movement of elective services to Tunbridge Wells will allow for the expansion of orthopaedic trauma services and the upgrading of current facilities at both sites. It will increase consultant integration and provide the foundation for developing a level 2 trauma centre. Currently the closest centres are in London and Brighton. The release of capacity at Maidstone site will allow for the development of step down facilities for patients across the two sites.

11.3.4 Option 1 will also allow the Acute Trust a greater population catchment area, and with the introduction of 'Choose and Book' this will become increasingly important for Trusts. It will enable the Acute Trust to modernise services in a move towards meeting the factors that are thought to influence patient choice.

12. Conclusion

12.1 During the evidence gathering process the Committee has often heard conflicting evidence; however it is undeniable that services in their current format are not acceptable. Due to the serious nature of orthopaedic infections, the isolation and strict infection control measures must be enforced and in the current configuration of services this is not achievable for all. The Acute Trust's struggle with capacity issues needs to be addressed, and with the introduction of Payment by Results and 'Choose and Book', the loss of income due to lack of capacity could lead to services becoming unviable.

12.2 The new Pembury development will offer the opportunity for the Acute Trust to develop orthopaedic services to optimal configuration, a move that is supported by all Consultant Orthopaedic Surgeons, and will allow for the development of more specialist services and potentially a level 2 trauma centre. Although supporting such a move will result in the loss of a successful orthopaedic unit at Maidstone, this unit has severely limited capacity and the orthopaedic trauma services at this site are in need of upgrading. The movement of the unit will allow for the modernising of trauma services and more stringent infection control measures. Furthermore, a critical mass of patients is needed to develop services to a comparable level for those utilising the Kent and Sussex Hospital in Tunbridge Wells.

12.3 The impact of the reconfiguration on passenger transport services is thought to be minimal, and the Joint Select Committee has recommended the Acute Trust develop mechanisms to ensure that those not eligible but requiring transport support are assisted to access volunteer services. Both County Council Social Services directorates are supportive of the preferred option and believe the impact on their services to be deliverable.

12.4 Over the last three months, the Joint Select Committee has gathered extensive evidence from a number of diverse sources. On balance, after careful consideration of this evidence, the Committee supports the movement of elective orthopaedic services to the Kent and Sussex Hospital and then to the new Pembury development in 2011, provided the Committees recommendations are met. This has been a difficult decision, however the Joint Select Committee is satisfied that this reconfiguration is in the best interest of the community that the Maidstone and Tunbridge Wells NHS Trust serves.

Recommendations

The Joint Select Committee support option 1, the movement of elective orthopaedic services to Tunbridge Wells, **provided the following recommendations are met in full**.

- The second theatre in the Culverden Suite at Tunbridge Wells must be upgraded to laminar flow prior to any changes being implemented.
- The Joint Select Committee urges the Acute Trust to ring fence the 24 elective orthopaedic beds and implement stringent infection control measures at the Kent and Sussex Hospital orthopaedic ward. This is to occur on the upgrading of the second laminar flow theatre, to ensure these infection control processes are embedded into the culture of the wards prior to any reconfiguration of services.
- The two theatre suites at the Culverden suite must be utilised purely for orthopaedic surgery (1 for elective and 1 for trauma). Any change to this model in the future should be brought to the attention of the respective NHS Overview and Scrutiny Committees (OSCs).
- The two step down facilities, 17 beds at Tunbridge Wells and 10 beds at Maidstone, for orthopaedic patients requiring a longer length of stay, must be in place and fully staffed, including physiotherapy requirements, and be in close proximity to the orthopaedic wards.
- The Committee urges the Acute Trust to embed the day case model at both sites as soon as possible, to aid the increase in capacity for the elective inpatient services.
- Any movement of services must result in an improvement of orthopaedic trauma services at Maidstone.
- Further information to be provided on the model for paediatric orthopaedic care. The plans for this service appear to be fluid and there does not appear to be a consensus between clinicians. Consequently the NHS OSC requests a written update to be brought to the attention of the OSC in 3 months time.
- The Acute Trust develops plans to upgrade the Kent and Sussex Hospital in terms of redecoration, balancing the need to refresh the building with demonstrating value for money for a building with a limited lifespan.
- The Acute Trust recognises public concerns regarding the reputation of the Kent and Sussex Hospital and develops a strategy to address and disperse public anxiety regarding cleanliness and infection control.
- The Acute Trust and PCTs fully evaluate the efficacy of public engagement arrangements for this consultation process prior to embarking on future public consultations.
- The Acute Trust provides information as to transportation choices and how to access these with appointment details sent to patients.
- Kent County Council and relevant District and Borough Council colleagues continue to urge Government to ensure the A21 schemes are underway in time to support the new hospital development at Pembury in 2010/11.
- Kent County Council and relevant District and Borough Council colleagues continue to lobby Government to secure funding for the Colts Hill Strategic Link.

The NHS Overview and Scrutiny Committees will continue to closely monitor developments and the implementation of these plans if the proposals are accepted. The NHS Overview and Scrutiny Committees will continue to hold the Acute Trust and PCTs to account with regard to these proposals.

Appendix 1

Trauma and Orthopaedic Waiting lists Quarter 3 2004/05 From the Department of Health

Ordinary admissions and Day case

	Total Number of patients waiting for admissions	Less than 1 month	1 to <2 months	2 to <3 months	3 to <4 months	4 to <5 months	5 to <6 months	6 to <7 months	7 to <8 months	8 to <9 months	9<10 months
Dartford and Gravesham NHS Trust	933	178	223	115	148	74	93	50	28	24	-
East Kent Hospitals NHS Trust	3477	489	671	558	525	381	347	292	173	41	-
Maidstone and Tunbridge Wells NHS Trust	2332	290	454	355	273	215	199	249	186	110	-
Medway NHS Trust	2062	174	287	289	297	284	271	230	155	68	-
Brighton and Sussex University Hospitals NHS Trust	2971	310	525	422	404	356	339	313	231	69	2
East Sussex Hospitals NHS Trust	1956	350	417	282	277	193	192	130	91	24	-
Surrey and Sussex Healthcare NHS Trust	1396	170	315	275	190	175	131	76	46	18	-

Ordinary admissions

	Total Number of patients waiting for admissions	Less than 1 month	1 to <2 months	2 to <3 months	3 to <4 months	4 to <5 months	5 to <6 months	6 to <7 months	7 to <8 months	8 to <9 months	9<10 months
Dartford and Gravesham NHS Trust	339	47	75	36	56	38	45	22	11	9	-
East Kent Hospitals NHS Trust	2064	231	326	297	312	253	248	214	148	35	-
Maidstone and Tunbridge Wells NHS Trust	1101	100	200	146	137	106	101	140	113	58	-
Medway NHS Trust	1018	69	139	140	165	126	131	109	92	47	-
Brighton and Sussex University Hospitals NHS Trust	1811	172	304	239	245	232	211	207	147	53	1
East Sussex Hospitals NHS Trust	1224	184	232	157	167	145	140	106	72	21	-
Surrey and Sussex Healthcare NHS Trust	646	50	106	113	94	102	82	46	40	13	-

Daycases

	Total Number of patients waiting for admissions	Less than 1 month	1 to <2 months	2 to <3 months	3 to <4 months	4 to <5 months	5 to <6 months	6 to <7 months	7 to <8 months	8 to <9 months	9<10 months
Dartford and Gravesham NHS Trust	594	131	148	79	92	36	48	28	17	15	-
East Kent Hospitals NHS Trust	1413	253	345	261	213	128	99	78	25	6	-
Maidstone and Tunbridge Wells NHS Trust	1231	190	254	209	136	109	98	109	73	52	-
Medway NHS Trust	1044	105	148	156	132	158	140	121	63	21	-
Brighton and Sussex University Hospitals NHS Trust	1160	138	221	183	159	124	128	106	84	16	1
East Sussex Hospitals NHS Trust	732	166	185	125	110	48	52	24	19	3	-
Surrey and Sussex Healthcare NHS Trust	750	120	209	162	96	73	49	30	6	5	-

Patients waiting over 6 months

Trust	Total Number of patients waiting for admissions over 6 months
Dartford and Gravesham NHS Trust	102
East Kent Hospitals NHS Trust	506
Maidstone and Tunbridge Wells NHS Trust	546
Medway NHS Trust	453
Brighton and Sussex University Hospitals NHS Trust	615
East Sussex Hospitals NHS Trust	128
Surrey and Sussex Healthcare NHS Trust	140

Appendix 2

Introduction of the European Working Time Directive

The European Working Time Directive (EWTD) already applies to UK employees; however, Doctors in training were previously exempt but have now been included. By 1st August 2004, NHS organisations were legally required to ensure all staff are compliant.

The main points of the EWTD are that employees should have:

- 11 hours' rest in every 24 hours (includes junior doctors as of August 2004)
- A minimum 20 minute break when a shift exceeds 6 hours
- 24 hours' rest in every 7 days as a minimum, or 48 hours' rest in every 14 days
- A minimum of four weeks' annual leave
- A maximum of eight hours work in every 24 hours for night workers
- By August 2004 a general reduction in junior doctor working hours to 56 hours per week and a further reduction to 48 hours by 2009 or by exception 2012.

(Modernisation Agency Survey of Models of Maternity Care June 2004)

This reduction in the availability of junior doctors has created huge new challenges to the NHS. Despite PCTs providing funding for Acute Trusts to employ more junior doctors, this reduction and the further reduction expected in 2008 has necessitated new, innovative ways of working and the redesign of hospital services.

Appendix 3

Solutions implemented in other areas

Although there are often many modes of transport available, awareness of these is can be low. Within Hertfordshire a number of partners across local authorities, the NHS and other local transport schemes rallied together to derive a solution. These bodies set up a partnership 'Herts Transport Direct'. The aim of this was to set up one point of contact –a hot line for residents on all the transport services in Hertfordshire and make bookings where possible. To do this the project team examined the wealth of transport from buses taxis, trains, dial a ride and volunteer car schemes to non emergency ambulances and social services transport. It considered how effectively these were meeting the needs of everyday people, whether to do their shopping or making hospital appointments. Through assessing what was available the project team could develop a means of a one point of access phone line where information would be available identifying the most appropriate mode transport for the callers needs.

Within East Kent a project board has recently met to consider transport issues. A joint post between the NHS and Kent Social Services has been appointed to move the project forward and map the availability of transport across East Kent. This will encompass the private, public and voluntary sectors and it will also be necessary to examine the planning, resources and budgetary procedures adopted by health and social services departments. This will help in estimating the scale of the operation and will give the board a suitable basis for consideration of an integrated project. It is possible this will be extended to encompass West Kent. The Joint Select Committee recommends extending the East Kent Integrated Transport model, if it is proved to be successful on evaluation, to include West Kent with the involvement of appropriate bodies in East Sussex.

Summary of response given by the Joint Board on 23 February 2005

Work would continue with the local authorities and others to address the transportation challenges. The trust will continue to explore the East Kent Integrated Transport model

Glossary

Acute:	Used to describe a disorder or symptom that comes on suddenly and needs urgent treatment. It is not necessarily severe and is often of short duration. Acute is also used to describe hospitals where treatment for such conditions is available.
Acute Trust:	Refers to Maidstone and Tunbridge Wells NHS Trust.
Consultation Process:	Legally it is the PCTs' responsibility to consult with the public regarding major service change. However, on this occasion the PCTs have chosen to conduct the process in partnership with the Acute Trust.
Committee:	Refers to the Joint Select Committee.
Community care:	Health or social care and treatment outside of hospital. It can take place in clinics, non-acute hospitals or in people's homes.
Consultant:	A senior doctor who takes full responsibility for the clinical care of patients. Most head a team of junior doctors.
GSUP:	General Supplementary. General Supplement to achieve activity waiting list targets in orthopaedics. This is provided from government funding to Strategic Health Authorities to target the worst waiting lists and make alternative provision, in the private sector.
Elective:	Used to describe operations, procedures or treatments that are planned rather than carried out in an emergency.
Laminar flow theatres:	Ultra clean air conditioning facility.
PCTs:	Primary Care Trusts, locally managed free-standing NHS organisations responsible for improving health, plus commissioning and delivering health care for local residents. In regard to this consultation this refers to Maidstone and Weald Primary Care Trust, South West Kent Primary Care Trust, Sussex Downs and Weald Primary Care Trust.

Trauma centre levels:

Level 1	Major Acute Hospital	Neurosurgery, cardiothoracic, plastics etc

Level 2	Acute General Hospital	24hr consultant led trauma service 24hr Xray,CT. Dedicated trauma theatres
Level 3	Acute General Hospital	Majority of injured patients Maidstone, Kent & Sussex

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Choose & Book - patient's choice of hospital and booked appointment Policy framework for choice and booking at point of referral 2004

Public Private Partnerships in the National Health Service: The Private Finance Initiative

Trust Documents

Consensus paper on the Proposed New Elective Orthopaedic Unit

Report of the Trust Trauma Committee on the Future Provision of Trauma Care

Acute Trust board minutes

Websites

www.chooseandbook.nhs.uk

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