Dr David Bennett  
Monitor  
Fair Playing Field Review  
4 Matthew Park Street  
London SW1H 9NP

Dear Dr Bennett

I am writing on behalf of: 

The British Orthopaedic Association's Patient Liaison Group.

In line with the British Orthopaedic Association's commitment to encourage its Patient Liaison Group to participate in and comment on current developments and research we are happy to submit our comments and concerns on your Fair Playing Field Review. We wish, however, to point out that there has been no editorial influence by the BOA in the drafting of the contents of this document.

Viz: The BOA recommends that commissioners commission quality and enshrine this in good contracts that promote partnership working between providers so that a fair playing field is generated which keeps the quality of outcome at the centre of all contracts.

The Patient Liaison Group is happy to submit a stand alone paper, outlining specific issues that concern this patient representation group, as part of a comprehensive BOA response to the consultation.

To start we would like to point out that we have published a list of papers outlining Orthopaedic Patients’ expectations and responsibilities in a number surgical circumstances - http://www.boa.ac.uk/PI/Pages/plg.aspx. These are regarded as benchmark standards by the British Orthopaedic Association, and any provider that cannot meet these expectations risks failing to provide an adequate service. The expansion of legitimate service providers without the insistence that they acknowledge such standards not only puts the NHS at a disadvantage but also compromises patient safety.

It seems to the Group that the consultation draft is, on the whole, comprehensive. However there are some issues that we would like to bring to your attention:

1) We are concerned that the higher payments made to ISTCs, creates an imbalance between the said providers and NHS Trusts.

2) We are concerned that paying the ISTCs a guaranteed fee irrespective of the number of procedures they carry out is prejudicial, and has the effect of causing an imbalance in the whole cash-flow process.
3) There is a tendency to commission surgical procedures without adequate post-operative reviews... e.g.: Long term follow up for arthroplasty as per BOA guidelines (X-rays at 1, 5, 10 yrs). We feel this is short-sighted & should be addressed. Full and comprehensive consultant-led follow up for all surgical procedures is not only necessary, but critical in identifying those patients who might need further interventions...

4) We are uncomfortable with an increase of providers - some of whom will per se 'cherry pick' the more lucrative/simple cases - leaving the higher risk more complex ones to the NHS. In effect this means that NHS Units will not be able to balance the cost of the more complex procedures against the cost less complex: with a potential of driving the NHS Unit into debt. There is also a fear that Orthopaedic Units that are deprived of a cross section of procedures will not be able to adequately train the up & coming surgeons - thereby diminishing the pool of consultants-in-waiting.

5) We are also concerned that if wholesale Musco-Skeletal services are commissioned into the private sector, many well-proven NHS clinical pathways will be lost and this may possibly destabilise local services. “Local” services are overwhelmingly the choice of patients, and anything that puts these 'at risk' endangers the level playing field.

6) Additionally we are concerned that some of these providers will not have sufficient back up in case of the unexpected. We strongly advocate the management of all orthopaedic procedures under the aegis of a multi-disciplinary team based in a fully equipped Orthopaedic Unit. The commissioning of services that fall short of this jeopardise the safety of the patient and increase the risk of a poor outcome.

**EXAMPLE: Commissioning of bunion surgery:**
While the BOA PLG does not question the core competence of many of the Podiatric Surgeons who perform this procedure there are only approximately 47 working under the aegis of a multi-disciplinary NHS network, and therefore who fall within the recommendations of this Group - as recorded in our “Expectations of Foot and Ankle Surgery patients” available from our web pages at: [http://www.boa.ac.uk/PI/Pages/plg.aspx](http://www.boa.ac.uk/PI/Pages/plg.aspx) - The referral to other Podiatric Surgeons who have no multi-disciplinary network back-up potentially puts the patient at risk and should be discouraged. This philosophy can be applied across the commissioning field - Only Units that can prove that their Clinicians not only have a core competence, but can demonstrate that they have the full support of a comprehensive multi-disciplinary network should be commissioned to carry out any surgical procedure.

7) It is particularly concerning that some independent suppliers might be bringing in clinicians from other Countries, who have no knowledge of the NHS support-web that should be made available to themselves and their patients. In discussing the levelness of the playing field it is essential that the NHS Orthopaedic Units are supported, and paid in a manner that allows them to compete with other suppliers, and that independent suppliers should only be allowed to function if they can prove they comply with CQC and DH mandates that ensure any patient that is treated in their UNIT has the same high quality resources available to them as they would in a Multi-disciplinary Orthopaedic Network.

8) Our final concern relates to the fine imposed on Trusts when a patient exceeds the Referral To Treatment Time (RTTT). The fine (approximately £250) – irrespective of the number of days by which the 18 weeks is exceeded has created an atmosphere within the Trusts where the need to
launder the figures, to avoid the fines, over-rides the need to treat the patients. We believe this manipulation has come to be known as “Gaming”.

**EXAMPLE: I quote a colleague of mine from West Yorkshire:**

“We have a reasonable referral to first appointment time but the processing through the pre-operative pathway is intensely variable, usually but not exclusively, due to lack of Anaesthetist assessment and tests such as echocardiograms. It has come to my attention that a number of 18 week breach patients have been put in a holding "basket" in the waiting list office, awaiting approval from a "manager" irrespective of clinical priority and probably enduring increasing pain and distress. This is in my view disgraceful as simple uncomplicated patients are admitted ahead of this queue. I think if clinicians behaved in this way we would, quite rightly be disciplined.”

Clearly these practices create a far from level playing field – instead they create an atmosphere of distrust in a Trust and prejudice the care of patients.

In conclusion:

All patients should be given the opportunity to understand and participate in their diagnosis and treatment.

All centres commissioned to treat patients must meet minimum standards of care, including being part of a multi-disciplinary network, and clinicians who work in the units should not only meet Royal College standards, but also have full access to, and understanding of, the relevant networks. The NHS and any ISTC, and their administrators, should remember that planned admissions are cost effective and the opposite of emergency admissions which are proving very expensive. The more emergency cases that can be prevented or converted to planned the better and cheaper the health service!

Prepared for and behalf of the British Orthopaedic Association Patient Liaison Group by:

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