Treasury Minutes on the Seventeenth and Twentieth Reports from the Committee of Public Accounts 2003-2004

17th Report: Hip replacements: an update

20th Report: Improving service delivery: the Veterans Agency

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THE SEVENTEENTH AND TWENTIETH REPORTS
FROM THE COMMITTEE OF PUBLIC ACCOUNTS,
SESSION 2003-2004

Seventeenth Report

Department of Health

Hip replacements: an update

PAC conclusion (i): Around 1 in 10 of consultants use hip prostheses for which there is inadequate evidence of effectiveness. Innovation can bring benefits for patients, but there need to be strict safeguards for new models with little or no track record. The NHS Purchasing & Supply Agency should issue a full list of prostheses which meet the NICE standard as soon as possible.

1. The Department agrees with this recommendation. In September 2000, NHS Purchasing & Supply Agency (NHS PASA) published a database on its intranet site containing the claims of manufacturers regarding their products and whether they met the National Institute for Clinical Effectiveness (NICE) benchmarks or not, therefore fulfilling its requirement under the NICE guidance. However, whilst much of the data supplied was satisfactory, problems were highlighted with the accuracy and validity of some of the data. As a consequence NHS PASA set up the Orthopaedic Data Evaluation Panel (ODEP) to give an independent view of manufacturers' claims regarding their products in relation to the NICE benchmarking standards. All manufacturers were asked to submit data for products meeting the 10 year benchmark to the ODEP for evaluation. The results were made available to the NHS via the NHSnet on 31 March 2004.

2. ODEP is now looking at manufacturers' claims on how their prostheses meet the NICE entry benchmark (three year benchmark). Manufacturers are currently collating data in support of this benchmark for submission to ODEP in September 2004. NHS PASA plan to publish the outcome of this evaluation in early 2005.

PAC conclusion (ii): To get the most value from the new National Joint Registry, it needs to be comprehensive. Currently only around half of NHS hip and knee replacement operations are recorded. The Department should identify the best means of encouraging wider participation, which might involve making data submission by NHS trusts mandatory, and implement it without delay.

3. The Department agrees that the National Joint Registry (NJR) should aim for full compliance. The Department has already issued guidance to the NHS in March 2003, and made it a condition of inspection for private hospitals to comply with the NJR. This has been effective as throughout the first year of its operation participation from trusts and surgeons has continued to grow. At 7 June 2004, 144 NHS trusts in England had entered data on the NJR. It is estimated that since the Committee looked at this area in November 2003 participation has increased from 50 per cent to around 70 per cent.

4. In its first year data on 60,000 hip and knee implant operations were entered. This growth in participation is demonstrated by the rise in the average rate data submitted from 460 in April/May 2003 to nearly 2,200 in March/April 2004.

5. The NJR Steering Committee already has a number of initiatives underway to increase compliance:

- Established a network of Regional Clinical Co-ordinators. These are respected orthopaedic surgeons who work with clinicians and trusts in their individual Strategic Health Authorities (SHAs) to promote the Registry.

- Established Regional Audit Co-ordinators (RACs) network. These RACs visit each trust providing advice and assistance on establishing processes to enter data and provide training courses where requested.

- Provision of a "bulk upload" facility, which will allow the data to be uploaded direct from a trusts central IT system. This will prevent the data having to be entered twice.

- Providing trusts with bar code readers to allow easy entry of implant numbers.

6. The Department will ask the NJR Steering Committee to provide a report on compliance rate after the Registry has been fully operational for two years and will consider the need for further action in the light of that information.

PAC conclusion (iii): Around 40% of trusts are offered incentives to introduce new prostheses, and around 1 in 10 of consultants had accepted incentives from hip prosthesis manufacturers. Departmental guidance sets out rules to ensure that incentives are transparent, properly authorised and do not impact adversely on patient care. Such incentives have the potential to distort clinical judgement and to prejudice the value for money of procurement decisions. The Department should explore with suppliers how these incentives might be phased out.

7. The Department reminded the NHS in October 2003 of its responsibilities of dealing with hospitality under HSG(93)5 *Standards of Business Conduct for NHS Staff and Commercial Sponsorship – Ethical Standards for the NHS* (November 2000) on how these should be handled. The Department agrees that orthopaedic services need to be treated in a way which is consistent with any other service in the NHS, and that the clinical governance committee in each trust should ensure that this guidance is applied equally, and that patients are not adversely affected.

8. Orthopaedic surgeons also have a professional responsibility to ensure that any prosthesis they use is both safe (ie CE marked, demonstrating compliance with Medical Devices Directive) and effective (ie the manufacturer has clinical data showing that it meets the NICE benchmark standard).

9. In addition, NHS PASA is currently helping trusts bring about greater transparency in their purchasing decisions. This includes identifying which benefits are a necessary part of the suppliers service i.e. training courses, and distinguishing them from activities that may be deemed an incentive.

PAC conclusion (iv): Patients should receive their hip replacement from a surgeon who has the experience and knowledge gained by carrying out the operation frequently. About half of consultants undertaking primary hip replacements do so less than the equivalent of once a week, and a significant proportion may gain insufficient experience to maximise their skills and knowledge. We recommend that the Department of Health considers as a matter of urgency advising patients as to the advantages of seeking a surgeon who regularly undertakes a number of operations a week.

10. We agree that patients should receive their hip replacement from a surgeon who is appropriately trained to carry out the procedure. The factors that need to be looked at when considering a surgeon's performance are multi-factorial. Surgeon volume alone may not ensure a quality outcome for patients and until the other factors, such as casemix, are understood more fully, it would be unhelpful to give patients only partial advice. Once the Department has considered surgeon volume and patient outcome, and looked at the strength of evidence on surgeon performance it will consider how patients should be advised.

PAC conclusion (v): The Department should obtain a good understanding of the relationship between numbers of operations carried out by individual surgeons and their outcomes. It should then set minimum annual numbers of primary and revision hip replacements to be undertaken by surgeons who work in the NHS.

11. The Department accepts that a better knowledge is needed about the number of hip replacements a surgeon performs and outcomes for patients. The National Orthopaedic Project and the Musculo-Skeletal Project are parallel work streams that are part of an integrated national strategy for orthopaedics. The Musculo-Skeletal project will encompass the work completed in orthopaedics within its remit but will also address the care of patients in primary care and referral to other secondary care services, for example rheumatology.

12. As part of the Musculo-Skeletal project the hip and knee benchmarking subgroup, which includes the British Orthopaedic Association (BOA), is looking at whether the number of hip replacements a surgeons does impacts on patient outcome. The intention is to examine the evidence around volumes of hip replacement to ensure the best possible outcome for patients. This work will examine the evidence available today but the NJR will be able to inform this debate in the future when we have a number of years data available.

PAC conclusion (vi): Too many referrals from General Practitioners for hip replacement turn out to be inappropriate. Trusts should give feedback to individual GPs on their referral patterns.

13. The Department agrees with the Committee's recommendation. The Musculo-Skeletal Strategy will address this issue specifically. This work will be illustrating the development of the role of primary care in helping focus the referral of appropriate patients into secondary care services including orthopaedics, encouraging the discussion of and the description of appropriate medical and surgical thresholds. As part of this learning there must be two-way communication and robust exchange of information between GPs and trusts to develop appropriate referral patterns, and ensure that lessons are learnt from inappropriate referrals.

PAC conclusion (vii): Primary hip replacements cost from £2,266 to £7,456. The Department should establish the reasons for the wide variation in costs, including whether costs are recorded accurately, and the scope for greater efficiencies.

14. Payment by Results, which is being gradually introduced over the next three years, will change the way hospital activity is funded. Locally negotiated pricing for hospital activity, including hip replacement, will be replaced by a standard national tariff, adjusted only for regional variation in wages and other costs of service delivery. The national tariff will be based on clinically meaningful groups of treatments and activities (Healthcare Resource Groups) and the price for the service will be based on NHS average prices, as reported by NHS organisations. The same process will apply across the whole English NHS.

15. NHS PASA is currently helping trusts identify the product cost element of the tariff and conducting price-benchmarking exercises so that trusts may ensure that they are getting value for money.

PAC conclusion (viii): The roll-out of Treatment Centres risks a mismatch between the need for and provision of additional capacity in the NHS. To mitigate that risk, the Department should take stock of the establishment of Treatment Centres to date, and apply the lessons in rolling out the next tranche.

16. The Department accepts that it should build on the lessons learnt from the current programmes. Where individual health economies wish to develop NHS Treatment Centres we will ensure that the learning and expertise from the NHS Treatment Centre (TC) Programme is shared with them. We do, however, intend to encourage commissioners to optimise the use of NHS Treatment Centres, particularly for orthopaedic procedures. We will also build on the first wave of the independent sector treatment centre (IS-TC) programme in securing sufficient capacity to deliver future waiting time targets.

17. We will mitigate any risk of a "mismatch between the need for and the provision of additional capacity" by asking primary care trusts (PCTs), led by SHAs, to develop robust capacity plans for 2008 to underpin future procurements. Guidance on capacity plans has just been issued to the NHS and PCTs have been asked to submit their requirements for additional capacity to their SHAs and the Department by 30 September 2004.

PAC conclusion (ix): Despite our predecessors' recommendation that standards should be set for follow up of hip patients after surgery, such standards are still not in place. The Department should implement that recommendation and agree standards with the British Orthopaedic Association without further delay.

18. The Department sees this as a local matter covered by clinical governance rules, and orthopaedic surgeons exercising good, informed professional judgement. The BOA published guidance on this issue in its publication *Total Hip Replacement: A Guide to Best Practice.* This advises orthopaedic surgeons that they should follow up patients at one year, five years and every five years after this. The Department supports this guidance and would expect orthopaedic surgeons to comply with the advice already provided by their professional body.

PAC conclusion (x): Although use of care pathways brings significant benefits for patients, only 50% of trusts use them for hip replacement cases. Use of care pathways by trusts, general practitioners and others involved in patient care should be universal for routine hip replacement work and pathways should be based on established templates to ensure consistency of good practice.

19. The Department agrees that the use of care pathways is an essential part of delivering the best possible managed care for patients. DH has been consistent in its emphasis and clear in its expectation to the NHS that the use of patient pathways is fundamental to ensuring good quality of care to patients.

20. The Modernisation Agency has promoted their use widely across the NHS through the Action-On and Collaborative Programmes in orthopaedics. Patient Choice will also require the use of patient pathways to ensure consistency in the offers of care to patients. To reinforce this the National Orthopaedic Project has patient pathways as one of the fundamental parts of the Clinical Systems Improvement process, and it expects to see these in the provision of orthopaedics services. It is also a key part of the diagnostic toolkit used as part of the orthopaedic project's tailored support programme for those trusts who need support in delivering orthopaedic services.

21. The Modernisation Agency has many examples of care pathways for orthopaedics on their website. These can be used by trusts and PCTs to develop ones that are suitable for their individual circumstances. However, it must be remembered that care pathways must never compromise the use of clinical judgement. Rather, they must support it. The opportunity to individualise care in the best interests of the patient must be built into the pathway.

Twentieth Report

Veterans Agency

Improving Service Delivery: the Veterans Agency

PAC conclusion (i): The Agency has estimated that the potential population of veterans and dependants is between four and five million, yet it has little idea of how many might reasonably be eligible for a pension or an award. .... The Agency needs to define better the target population within the wider body of ex-servicemen and women as a starting point to assess how many other potential beneficiaries there may be, in addition to the 271,000 already in receipt of assistance.

1. The War Pensions Scheme provides compensation for a very wide range of disablement arising from or aggravated by service and its provisions apply to any person who has served in the Armed Forces, including reservists. The Veterans Agency (VA) notes the committee's conclusion but wishes to point out that given the lack of any single, accessible source of data on those who have served over the last sixty-plus years, it would be extremely difficult to determine a defined target group within the wider veterans population which was more likely to have entitlement to a war pension but have not claimed. The VA, in partnership with the leading ex-Service charities, undertakes a variety of promotional activity, as outlined in the response to conclusion (iii), to ensure that those entitled to claim are aware of the War Pensions Scheme. Whilst these efforts continue to identify individuals who have a qualifying disablement but are unaware of the scheme, the numbers involved are limited and there is little, if any, evidence to suggest that ignorance of the scheme is widespread amongst veterans.

PAC conclusion (ii): The Agency should collate and analyse information about the composition of existing client and claimant groups to establish how representative they are of the wider population of ex-service personnel. .... The Agency needs to understand how representative existing claimants are to identify gaps in its promotional activities and take steps to raise the profile of its services among those who may otherwise remain unaware.

2. The VA has recently undertaken an analysis of claims to war pension received over the last four years and the extent to which the profile of those claiming reflected the known demographics of those leaving the armed forces in the same period. The outcome of this analysis suggests that those veterans claiming are proportionately representative of the wider ex-service population in terms of geographical location, branch of service, rank and gender. A new Armed Forces Compensation Scheme will be introduced in April 2005 and action is in hand to ensure that the processing systems put in place will facilitate more sophisticated analysis of claims received to allow ongoing monitoring and identification of any disparity between different groups of service personnel.

PAC conclusion (iii): Despite considerable efforts to raise awareness of its services, the Agency is unlikely to reach veterans who have not kept in touch with the ex-service community. .... The Agency needs to devise new and complimentary strategies to reach that wider body of ex-service men and women who do not have contact with the ex-service organisations. ....

3. The VA acknowledges that in the past its efforts to raise awareness of its services amongst veterans has been largely linked to events and publications related to the ex-Service organisations. As part of the Government's wider Veterans Initiative a Communications Action Team (CAT) has been established within the Veterans Forum. This is led by the VA and includes representatives of the main ex-Service organisations. The CAT has identified as a priority the need to

target information on services for veterans at those who do not have contact with the ex-Service organisations. A number of actions have already been taken in support of this aim. The VA has produced a Veterans Information Pack which will be widely distributed to individuals and agencies which are likely to come into contact with ex-Service personnel. Local Authorities and Citizens Advice Bureaux across the country have been provided with posters and leaflets advertising the VA and the Veterans Helpline. The VA will continue to work with the CAT in developing new communication products and strategies aimed at raising awareness of support available to veterans in all sections of the community. The VA will consider undertaking surveys across the wider community to try to determine the level of awareness of its services.

PAC conclusion (iv): It took the Agency an average of 131 days in 2001-02 to clear a first claim for a war disablement pension. .... The Ministry and the Agency should agree much more specific and demanding targets, particularly for first claims, to drive down lengthy waiting times for claimants.

4. Whilst the headline claims clearance target for the VA relates to the average time taken to process all claims, this is supported by internal targets for the various categories of work processed including first claims. Since 2001/02 the average time taken to clear first claims has been reduced from 131 to 118 days and the internal target for 2004/05 is to achieve a further reduction to 115 days. In addition to speed of clearance, targets set for the VA are intended to reflect other aspects of service delivery and wider strategic objectives. Whilst the targets set for 2004/05 do not anticipate significant reductions in clearance time, the VA has been set a demanding agenda to improve other aspects of quality and successfully implement the new Armed Forces Compensation Scheme from 2005. The longer term objective for achieving reductions in clearance times remains a priority.

PAC conclusion (v): Now the Ministry of Defence has responsibility for the Agency it should do more to improve communication and routinely provide service records within the agreed turnaround time. .... The Agency and the Ministry of Defence should identify the causes of the present delays, tackle any persistent hold-ups or bottlenecks, and take action to speed up the process generally so that agreed targets for the supply of service records are met.

5. In recognition of the difficulties encountered in this part of the claims process, a dedicated MOD liaison team has been established to closely monitor performance between the VA and the Ministry of Defence Disclosures section where requests are made for service records. As a result of this a re-defined process has been established for both actioning of work and the monitoring of performance of both parties involved against the priorities set. The VA is currently looking into the possibility of accessing service records electronically and if feasible this could result in quite significant savings in both processing times and man-hours. The liaison team is also monitoring the standard of requests in terms of content and address made by VA staff to prevent further delays as well as monitoring the number of delayed cases and taking immediate action to pursue those which are overdue.

PAC conclusion (vi): The Agency needs to focus on those hospitals which consistently fail to meet the ten day turnaround target agreed with the Department of Health for the provision of medical records from the National Health Service. ....

6. The provision of patient information by NHS Trusts to the VA is covered in the Health Service Circular HSC 1999/001 and stipulates an agreement with NHS Trusts that requests for information from VA should be met within 10 working days of receipt. Following the committee's recommendation, the VA has re-enforced amongst staff the need to follow up immediately non-receipt of Hospital Case Notes (HCN's). The VA keeps statistics on the number of hospitals that fail to meet the turnaround target which are then referred to a dedicated team set up to monitor and pursue these cases further. The VA also has established a contact with the

Office of the Chief Medical Advisor for the Department for Work and Pensions to report those hospitals that consistently fail to meet the target who in turn reminds the hospital of their duty to comply with the terms of the HSC 1999/001. It is anticipated that the introduction of the NHS Net will help to reduce waiting times by providing instant access to a number of required HCN's.

PAC conclusion (vii): As soon as the technology is available, the Agency should exploit the benefits offered by use of the NHS Net. ....

7. The VA accepts this recommendation and is working with the National Health Service Information Authority (NHSIA) towards establishing email connectivity to enable access to NHS Net. The expectation is that email access will have been agreed and established by September 2004.

PAC conclusion (viii): The Agency should develop indicators which cover the unit costs of processing claims and the productivity of staff dealing with them. ....

8. The necessary work to progress this recommendation is now well underway. An appropriate methodology involving work measurement study has been fully researched and initial preparatory work has taken place. It is anticipated that the results of the work study exercise will be available to the VA's management team during the financial year 2004/05 to enable consideration of costs and productivity of claims processing.

PAC conclusion (ix): The Agency currently has two computer systems which are unable to communicate with each other: one to access pensioners' details for its Welfare Service and the other to maintain records of its claims processing. As the Agency takes forward plans to replace these systems, it should take careful account of the findings of this Committee and the work of the Office of Government Commerce so that it does not repeat the failings which have been common to Government IT projects in recent years.

9. The VA accepts the committee's recommendation and will ensure that lessons from previous Government IT projects are carefully considered when developing any future plans to replace its existing systems.

PAC conclusion (x): The Agency should take steps to benchmark the efficiency and performance of its call centre. .... The Agency should familiarise itself with sources of good practise as a means to assess and improve its own performance.

10. Since the PAC hearing, the VA has commissioned an external examination of its Helpline designed to measure its performance against companies from a wide range of sectors. The survey, conducted in January 2004, concluded that the VA outperforms the average for public bodies sector but provided a wide range of recommendations for how service might be improved. The VA is now conducting a full review of its Helpline service and will ensure that the recommendations in the report 'Better public services through call centres' are fully taken into account.

PAC conclusion (xi): In the light of the long and distinguished service given by the Brigade of Gurkhas to the British Armed Forces, we urge the Agency and the Ministry of Defence to resolve promptly the uncertainty regarding eligibility of Gurkhas under the War Pensions Scheme. ....

11. The provisions of the War Pension Scheme apply only to members of the military forces who serve in units based in the United Kingdom. Prior to July 1997 the Brigade of Gurkhas was based in Hong Kong. Consequently, Gurkhas were not covered by the British war pensions scheme. Gurkhas disabled as result of service have access to the provisions of the Indian Army regulations, providing disablement and bereavement benefits. Following the hand over of Hong Kong to China in 1997, the Hong Kong garrison closed and the bulk of the Brigade was

established in the UK, bringing them within the scope of the War Pension Scheme. The VA has been working closely with the Adjutant General's staff to identify all those Gurkhas who have been medically discharged since 01.07.1997 and would be eligible to receive a War Pension paid at the same rates as any other person eligible under the Scheme. Gurkhas are being notified through the Chain of Command and steps are being taken in Nepal to raise awareness of the Scheme through the Gurkha Welfare Society.

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