London Clinical Senate

Advice on proposals for elective orthopaedic care in South East London

June 2016

V1.0

Independent advice on proposals for elective orthopaedic care in South East London

Prepared for:	**Mark Easton, Programme Director, Our Healthier South East London and Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups.**
Approved by:	**London Clinical Senate Council Chair**
Date:	**20 June 2016**

AIMS OF THE REPORT: To provide the following advice:

1. Whether the clinical case for change and proposed model for elective orthopaedic care are underpinned by a clear clinical evidence base (where this exists)

2. Whether the proposed clinical model is considered to be clinically safe and has the potential to improve safety of care compared to the current model, in particular:

    a. Whether the proposed model of care poses any risks to the continuation of a clinically robust trauma system in South East London
    b. The potential of the proposed model of care to enable standardisation through the adoption of best practice and to improve the management of complex cases

3. The potential of the proposed clinical model to improve the quality of elective orthopaedic care.

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1. Executive summary

The London Clinical Senate has been asked by the six Clinical Commissioning Groups in south east London to provide advice on proposals to improve elective orthopaedic care. These form part of *Our Healthier South East London* (OHSEL), a five-year commissioning strategy to improve health, reduce inequalities and deliver high-quality, sustainable health services for people in that area of London. This report sets out our findings, advice and recommendations.

Work to date in south east London has concluded that orthopaedic services are generally safe and high quality, but under considerable pressure, which will intensify with population changes increasing demand and NHS financial pressures. Waiting time standards are regularly breached and late cancellation of operations is not uncommon, impacting significantly on patients, families and carers. Capacity constraints and demands on emergency care are seen as contributing factors.

These issues are not unique to south east London. A national work programme initiated by the report "*Getting it Right First Time*" (GIRFT)[2] has explored the delivery of planned orthopaedic care across England and identified many opportunities for improvement. This has informed the case for change to improve elective orthopaedic care in south east London and the proposed model of care in which elective orthopaedic inpatient care currently carried out at eight hospital sites would be consolidated into two high volume elective orthopaedic centres. Orthopaedic trauma care, day cases and outpatients would continue to be provided locally at all current sites.

The Clinical Senate has been asked to provide advice on three issues:

1. Whether the case for change and proposed model of care have a clear evidence base
2. Whether the proposed model of care would be clinically safe, with particular regard to maintaining a robust system of trauma care and care of patients with complex needs
3. The potential of the proposed model to improve the quality of elective orthopaedic care

We set up an independent review team, which I chaired, to formulate the advice. This included clinical members with expertise in orthopaedic care, in key services that support delivery of orthopaedic care and members who represented the patient and public voice. Collectively, the team brought substantial knowledge and experience to advise on the proposals presented to us and I am very grateful to them all for the time they committed and for the thoughtful and constructive way in which they considered the many points we debated.

The core part of the review involved a series of discussions over one and a half days with clinicians and representatives of patients and the public in southeast London who have been involved in developing the proposals and/or could be affected by them. I am grateful to everyone who took time to meet or speak with us and for the openness with which they shared their views. This allowed us to explore issues, opportunities and concerns about the case for change and the proposed mode of care in some depth and to triangulate what we heard with supporting documentation we received. I would also like to thank the OHSEL Programme Team for their support in organising the not insignificant logistics of these sessions.

Overall, the case for change indicates that there are opportunities to improve elective orthopaedic care in south east London. Work to date has concentrated on the peri-operative part of the pathway, which is the main focus of GIRFT. The review team felt very strongly that the case for change should be developed further to explicitly consider the whole elective orthopaedic care pathway. We also noted the case for change currently lacked evidence of being informed by an equalities impact assessment.

Clinical stakeholders we spoke with were generally supportive of the proposal to consolidate elective orthopaedic inpatient care into two centres with more capacity to meet forecast demand, as the lack of ring-fenced beds is seen as a significant factor in the challenges currently experienced. Many felt a two-centre model could be workable. Clinical engagement to date has mainly involved orthopaedic surgeons from the acute providers and now needs to be broadened to involve clinicians across the pathway, including interdependent services and primary care.

Representatives of patients and the public whom we met agreed with the need to address current challenges, however views on the proposed model were mixed and they would like clearer information about aspects of the proposals, how improvements would be achieved and the process for considering options. We were impressed with the approach to engaging with patients and public and believe there is an opportunity to develop this further into one based more on co-production.

Providing as much care as possible as locally as possible is important and the proposal to maintain orthopaedic trauma care, day care and outpatients locally is essential and widely supported. As with the case for change the model of care needs to cover the whole pathway, including community services and primary care. Achieving the full range of benefits envisaged will require this approach. For example, variation in availability and provision of community services' is a concern, which risks inequalities in pathways to and from proposed elective orthopaedic centres.

The proposed model of care is described in outline only currently, so lacks operational detail and we identified several other important issues that need to be considered. There would be significant implications for the provision of orthopaedic trauma care which will have to be looked at very carefully to ensure robust local trauma services could be maintained. Key issues include ensuring sufficient and skilled staff at local hospitals, potential impact on rotas, training and capacity. Many other workforce issues which a future workforce model would need to address, across the whole pathway, were raised during our discussions, for example in relation to education and training; staff mobility, continuity and oncall arrangements and skills and experience. Clear and agreed pathways would be needed to support patients with complex needs, patients who deteriorate in an elective orthopaedic centre and patients who need to be readmitted following surgery. Travel and transport implications for patients, carers and families and the impact on equalities are important factors in considering how the model could be delivered and options for doing so; we identified several areas where there could be a risk of inequalities increasing. We recognise we have been asked to give advice at a point in time in this process and that work is ongoing. Consequently, some of our recommendations may already be planned, though we do not think this is the case for all of them.

Due to variations in community and secondary care there was not unanimity within the review team that the centralisation approach was necessary to yield the opportunities outlined. Some felt a comparison with the option of no site change but improved joint working alone still needed to be made both financially and from the impact on staff and patients' equalities. That opportunities exist to improve elective orthopaedic care in south east London is not in doubt, however. A commitment to address current challenges, the collaborative approach being taken and the existence of good practice that can be shared are real strengths to build on. We hope our advice and recommendations assist this work as it moves forward.

Professor Geoff Bellingan
Review Team Chair and Member of the London Clinical Senate Council
On behalf of the Review Team

2. Background

Our Healthier South East London (OHSEL) is a five year commissioning strategy which aims to improve health, reduce health inequalities and ensure all health services in south east London meet safety and quality standards consistently whilst being sustainable in the longer term. An integrated whole system model has been developed through six clinical leadership groups which each focus on different parts of the health system. One group is focused on planned care. Within this, one workstream is exploring the potential to improve planned orthopaedic care.

OHSEL programme reports that orthopaedic services in south east London are generally safe and high quality and that over the last ten years waiting times have come down considerably and there has been substantial investment in these services. Despite this, services are reported to be under considerable pressure and this is expected to intensify as demand increases (driven by an increasingly aged population and population growth) and the pressures on NHS finances increases. OHSEL identifies the challenge as how to improve the quality of care and meet waiting times standards for elective orthopaedic care in the face of a growing population and constrained finances.

OHSEL has considered how to improve orthopaedic care in south east London (SEL) by drawing on *Getting it Right First Time, A national review of adult elective orthopaedic services in England (March 2015)*. A series of workshops have been held involving clinicians, managers and patient representatives to explore the issues and consider possible solutions. Through these workshops, the planned care group confirmed a case for change in the way that elective orthopaedic care is delivered to achieve improvements. The group proposed that the case for consolidating elective orthopaedic procedures within SEL to provide standardised pathways of care should be developed and evaluated and have identified a range benefits that such a change has the potential to deliver.

Several options have been developed for consolidating elective orthopaedic care. The emerging model is to consolidate elective inpatient services from the current eight sites to two sites whilst retaining outpatient, day case and trauma services at all hospital sites as currently configured. OHSEL has produced an outline specification for an elective orthopaedic centre and providers of elective orthopaedic care in south east London have been invited to submit responses to these. An evaluation group has developed evaluation criteria and work is taking place to identify and evaluate specific options.

The Committee in Common (CiC) has been established to enable the six clinical commissioning groups (CCGs) in south east London to come together for the purpose of strategic decision making, with particular reference to *Our Healthier South East London* or any successor strategy as agreed by the CCGs. Meetings of the CiC are essentially simultaneous meetings of the six CCGs. The CiC met for the first time in March 2016 and agreed that there was a sufficient case for making a change in how elective orthopaedic services are provided and that these proposals should progress towards an options appraisal. The CiC also approved the elective orthopaedic care case for change and outline model, the outline specification for an elective orthopaedic centre and the evaluation criteria.

3. Scope of advice requested

The Clinical Senate has been asked to give advice on three issues:

1. Whether the clinical case for change and proposed model for elective orthopaedic care are underpinned by a clear clinical evidence base (where this exists)

2. Whether the proposed clinical model is considered to be clinically safe and has the potential to improve safety of care compared to the current model, in particular:

    a. Whether the proposed model of care poses any risks to the continuation of a clinically robust trauma system in South East London
    b. The potential of the proposed model of care to enable standardisation through the adoption of best practice and to improve the management of complex cases

3. The potential of the proposed clinical model to improve the quality of elective orthopaedic care.

4. Formulation of Advice

4.1 Review Process

The Clinical Senate Council established an independent review team to consider the case for change and the proposed model of care and formulate the advice requested. Professor Geoff Bellingan, a Clinical Senate Council member, chaired this, Overall membership (see section 8) included clinicians with expertise in orthopaedics, rehabilitation, general practice, older people's care, paediatric care, critical care and anaesthesia, trauma and emergency care and two members from the Clinical Senate's Patient and Public Voice Group. Clinical membership was multi-professional, including medical, nursing and allied health professional expertise. To ensure independence members of the review team have not had any involvement in developing the proposals considered and live and/or work in other areas of London or outside of London. All members were asked to formally declare interests and no conflicts were identified.

The review team considered a range of documentation provided by the OHSEL Programme Team (see section 7.1). The team then held a meeting/teleconference to share and discuss views and findings from the information and evidence provided. From this, members identified a number of issues that they felt needed to be explored further. The review team also agreed a broad framework of issues that members identified as important to consider in formulating the advice requested.

The central part of the review process involved the review team having the opportunity to discuss the case for change and proposed model of care directly with a range of stakeholders in south east London who have been involved in developing the proposals and/or who could be affected by them. The review team asked to meet with patients and carers representatives involved in the process and with specific groups of clinicians involved in delivering elective orthopaedic and trauma services and services with which they interface. The review chair also extended an invitation, through the OHSEL programme team, for any other clinicians who wished to share their views to 'drop-in' to one of two discussions sessions and some took up this offer. Discussions took place over one and half days (see section 7.2). A whole day

session on 20 May 2016 involved the full review team. A half-day session was held on 19 May 2016 so that anyone unable to attend the main session had another opportunity to speak with members of the review team. The chair and four other members were involved in this session. One further session was organised with two patient and carer representatives who wished to participate in the review but were not able to attend either day. A teleconference was held on 25 May 2016 with the review team's patient and public voice members and one clinical member.

This report presents the review team's findings, conclusions and advice drawing from the overall process. The advice provided is the unanimous view of all members

4.2 Limitations

The OHSEL programme team provided a large amount of information to inform this review. The review team's advice is based on the information seen and discussions held with stakeholders from South East London as noted above. Wherever possible the review team has strived to triangulate the two. The information provided was necessarily lacking in some respects at this stage in the process. The financial case for change has not been completed and a transport impact analysis has not been undertaken as potential site options for proposed elective orthopaedic centres, which form a key part if the proposed model of care, have not yet been specified.

The advice from this review provides a clinical and service user perspective on the case for change and the proposed model for elective orthopaedic care in south east London. The proposed model of care includes concentrating planned orthopaedic inpatient care in two centres. The future location of services is beyond the scope of this review and the review team has not considered this. Advice provided by the Review Team may inform the options evaluation process.

5. Review findings

Introduction

The emphasis of the work carried out to date by OHSEL to improve elective orthopaedic care in south east London has focused on the inpatient part of the pathway. For people who choose surgery, certainty about the process, surgery carried out by an experienced surgeon and team in an appropriate environment, as short a stay in hospital as possible and support to recover are key factors in achieving a positive overall care experience. We know this is not always the case currently. Therefore, taking action to improve orthopaedic inpatient care is important. This is likely to improve efficiency and productivity though a detailed financial case has not been presented yet.

The review team believes however that in seeking to make these improvements, the whole planned care pathway needs to be considered. We should seek to empower patients, improving people's knowledge of surgery and alternative treatments so they feel informed about both benefits and possible harms, have realistic expectations of outcomes and are supported to make the right decision for them. For people on a surgical pathway, what happens before and after surgery can be equally important in achieving the best possible outcome. This view has underpinned our consideration of the case for change and the proposed model of care and our advice. Hence, equity across the sector is important for access to high quality and efficient elective and trauma services, for planned and emergency admissions (and any readmissions). This should also apply both to access and to the discharge process from provider sites to the community and home.

Musculoskeletal disorders (back and neck pain, osteoarthritis and rheumatoid arthritis) account for about a quarter of the years lived with disability in England and the majority of patient episodes take place in the community. It is important that any future plans continue to support this community based activity.

Orthopaedics and Trauma is a high volume, high turnover specialty which undertakes about one third of all surgical procedures in the NHS today. Approximately one third of all Orthopaedics and Trauma activities are emergency admissions usually with a fracture, the vast majority of which are treated well locally. Very few patients require management in a major trauma centre. Without well-functioning local hospitals, major trauma centres would quickly become swamped by the referral of hip, ankle and wrist fractures.

A further third of Orthopaedics and Trauma patients have surgery as planned day case procedures, operated on by surgeons who specialise in the various anatomical areas (foot and ankle, knees, hips, spine, upper limb and hands as well as paediatric problems). Unless access is very easy, it is illogical to have large numbers of patients travelling before and after surgery to a centre when the surgeon could perform the procedures locally in a dedicated day care facility.

The final third of orthopaedic procedures are surgeries which require a planned inpatient stay of which approximately half (circa one sixth of the total orthopaedic activity) are major joint replacements. These high volume complex procedures are carefully monitored for success nationally. Individually they are not particularly expensive compared to other treatments offered by the NHS however they are the most common (and amongst the most successful) major surgical procedures carried out today. These are typically the focus for most planned centralisation of care.

It is important that the transfer of the technical operation of arthroplasty[1] to a separate geographically detached care centre does not destabilise the provision of emergency and day care delivered locally. The vast majority of patient episodes take place through outpatients and should be delivered locally by the team who may eventually operate on the patient and ensure their safe transfer back into the community.

The evidence base

A number of recently published reports[2,3,4]underpin the work taking place in south east London. These are credible sources and indicate significant opportunities to improve patient experience and outcomes in the provision of orthopaedic care and surgery. They also highlight that changes to improve the quality of care, can also lead to significant cost savings, an important consideration given the substantial financial challenges facing the NHS. The British Orthopaedic Association's 2015 report1, which builds on the original research by Professor Tim Briggs[5], is probably the most significant, drawing on analysis of national datasets and insights from orthopaedic services across England and further afield.

Musculoskeletal injuries and disorders can be a cause of significant discomfort and disability, which can have a huge impact on people's lives and those of their families and carers[6]. There is evidence that the incidence is increasing, particularly as the population ages. Orthopaedic surgery already accounts for a high volume of NHS workload and resources, as noted above, and with demand predicted to increase this will increase pressure on NHS resources. Evidence also shows that variation exists in both care processes and clinical outcomes and therefore opportunities exist to improve quality and effectiveness of orthopaedic care. Musculoskeletal care is an area where there is a large amount of data compared with other service areas though still there are gaps, mainly relating to community services.

5.1 The case for change

The case for changing the way in which orthopaedic care is delivered in south east London draws heavily on GIRFT. The review team considers using evidence within GIRFT as the basis for reviewing current arrangements and identifying opportunities to improve orthopaedic care is a sensible approach. In applying the evidence however, it is essential to consider the local context, and whether any particular factors have a bearing on current services, experiences and outcomes and the best way in which improvements could be achieved. Recognising where evidence shows good practice to exist, so learning can be shared and built on, is as important as identifying where evidence indicates opportunities for improvements can be made. It is also relevant that the data is more focused on secondary care with a relative paucity of community and primary care information. Analysis of referral variation would be interesting (at a practice and even GP level) and may result in a different emphasis to provision going forward.
The case for change presented to the review team highlights four main drivers for change:

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[1] Arthroplasty is a surgical procedure to restore the function of a joint e.g. a hip or knee.

[2] A national review of adult elective orthopaedic services in England: Getting it Right First Time (British Orthopaedic Association, March 2015)

[3] Helping NHS providers improve productivity in elective care (Monitor, October 2015)

[4] Operational productivity and performance in English NHS acute hospitals: Unwarranted variations (An independent report for the Department of Health by Lord Carter of Coles (February 2016)

[5] Getting it Right First Time: Improving the Quality of Orthopaedic Care within the National Health Service in England (Professor Timothy W R Briggs, September 2012)

[6] Carers can include roles such as mental health support workers

- Increasing demand for elective orthopaedic care based on predicted demographic and non-demographic growth and the need for additional capacity to meet this;
- Improving patient experience – reported experience is variable across the health economy and there are current capacity challenges and a lack of ring-fenced elective orthopaedic beds, impacting on waiting times and causing cancellations and there are opportunities to reduce the length of hospital stays;
- Improving other aspects of quality (including patient safety and outcomes) – ensuring surgery is carried out in the optimal environment to reduce infection rates, achieving further reductions in post-operative readmission rates and reducing litigation claims;
- The potential to achieve wider benefits by networking and increasing collaboration between orthopaedic services to improve productivity and achieve efficiencies in procurement.

Demand for elective orthopaedic care is undoubtedly rising. The 2015 GIRFT highlights upward trends in referrals, hospital admissions and in the number of joint replacements carried out nationally. Data in the case for change indicates an upward trend in elective orthopaedic activity in south east London and the expectation that this will continue is a reasonable one. The case for change highlights three different scenarios of predicted demand over the next five years to 2020/21 ranging from 16% to 63%, and proposes the mid-range scenario of a predicted 26% growth as the basis for planning assumptions. The high case scenario highlighted growth rates for orthopaedic activity at south east London providers of 11% a year between 2011/12 and 2014/15, though this figure is noted to include non-elective as well as elective activity. Some stakeholders we met queried the figures provided and felt that they were modelled on activity and not on a robust enough understanding of future demand.

Reducing health inequalities is one of the aims of the *Our Healthier South East London* strategy alongside improving health and ensuring all health services in south east London meet safety and quality standards consistently whilst being sustainable in the longer term. We did not see any evidence that an equalities assessment has informed the case for change, including through the modelling of demographic growth and forecasts of future demand. Overall, we felt that equalities information provided for this review was weak. Transport and travel times and the impact on both patients, and carers/families were raised on a number of occasions by patient and carer representatives we met, and acknowledged by clinicians and the programme as an issue. We are aware that work has taken place to consider equalities for the OHSEL programme overall[7] and this identified carers and people who are socially deprived as key groups to consider alongside groups with protected characteristics and considers the potential impact for all groups on a range of service areas including planned care. It is not clear how this has been applied to the elective orthopaedic care programme, including how it has influenced the outline specification developed for proposed elective orthopaedic centres.

All of the stakeholders we met identified opportunities to improve orthopaedic care and shared many examples of current challenges along the pathway. These echoed issues identified in the case for change, with long waiting times and operations cancelled at short notice, often followed by delays in timely rescheduling for surgery, were raised most often. The impact of cancellations on families and carers is significant. The particular impact on people with a learning disability,

[7] Our Healthier South East London Equalities Analysis (July 2015) (www.ourhealthiersel.nhs.uk Accessed 05 May 2016)

who have an increased incidence of musculoskeletal disorders, and need longer preparation time and support through the overall care process, was raised several times.

The need to admit emergency cases was said to be a frequent reason for planned operations being cancelled and there was strong support for the concept of ring-fencing elective orthopaedic beds. Despite the clinical advantages highlighted in GIRFT for ring-fenced elective beds this is not uniformly available in providers across the sector at present. Conversely, instances of emergency admissions not being able to move rapidly to a ward because of capacity constraints were also raised, supporting the case for increasing overall inpatient capacity in the system.

In addition to evidence from national work[8] the review team heard about local examples within south east London where action had already been taken, or is being taken, to separate elective and emergency orthopaedic pathways and consolidate planned inpatient care with dedicated facilities. These models appear to operate effectively, from what we were told and data provided in the case for change[9] indicates that challenges identified can be addressed in practice. This is an important source of learning for the health economy. We were told that:

- Within Guy's and St Thomas NHS Foundation Trust, elective orthopaedic care has been concentrated at Guy's Hospital for over 20 years; this model was reported to have improved outcomes and the larger volume of activity was felt to be a key factor
- Within King's College Hospital NHS Foundation Trust, elective orthopaedic inpatient care previously provided the Denmark Hill site is now carried out at Orpington Hospital[10], which focuses on planned care. Improvements in patient experience, length of stay and standardisation of care processes were described in this model
- Lewisham and Greenwich NHS Trust has moved towards this model and is developing additional capacity to concentrate the Trust's elective orthopaedic surgery at Lewisham Hospital[11]
- The South London Health Innovation Network's[12] programme includes improving musculoskeletal care and provides an important vehicle for supporting implementation and spread of good practice.

Many stakeholders we spoke to identified significant existing challenges in other areas of the overall pathway for elective orthopaedic care, pre-and post-surgery across south east London. As noted earlier, the overarching case for change focuses on improving quality by consolidating elective orthopaedic surgery and, whilst the case for change acknowledges that this cannot happen in isolation[13] it does not currently address these wider pathways issues. Some stakeholders felt this to be a significant gap and the review team shares this view. The main issues identified were:

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[8] A national review of adult elective orthopaedic services in England: Getting it Right First Time (British Orthopaedic Association, March 2015)

[9] Ref LOS page 13 – check others

[10] The Princess Royal University Hospital and Orpington Hospital became part of Kings College Hospital NHS Foundation Trust in October 2013

[11] Lewisham Healthcare NHS Trust merged with Queen Elizabeth Hospital in Greenwich to form Lewisham and Greenwich NHS Trust in October 2013

[12] The Health Innovation Network is the Academic Health Science Network (AHSN) for South London, one of 15 AHSNs across England. AHSN's connect academics, NHS commissioners and providers, local authorities, patients and patient groups, and industry in order to accelerate the spread and adoption of innovations and best practice, using evidence-based research (http://www.hin-southlondon.org/clinical-areas/musculoskeletal website accessed 2 June 2016)

[13] Elective Orthopaedic Care: Case for change and outline model, March 2016 Draft v1.0, page 24)

- Differences and variability in community services e.g. processes, protocols, services provided and in discharge procedures between CCGs/ boroughs impact on the ability to effectively discharge people following surgery; whilst some pathways do exist we heard they are not always followed. Provision of community social care packages was highlighted as a particular concern and models of equipment provision, especially in meeting short notice requirements, and links with reablement pathways were stressed as important. Also highlighted, was the fact that consolidation to two elective orthopaedic centres would expose that patients from different boroughs would have different support in the community, thus risks driving a postcode discharge problem. We heard some excellent examples of what good support looked like, especially the Lewisham home care package on discharge. Learning from such good practice will be important in improving the overall pathway of care and mitigating the risk of inequalities increasing.

- At the front of the pathway the quality of referrals to musculoskeletal services is reported to be mixed; there is a need for greater education and support for GPs to facilitate a more standardised approach, whilst recognising capacity challenges that also exist within general practice. In a number of neighbouring CCGs there have been successful initiatives (led by the Academic Health Science Network) to reduce the musculoskeletal workload on the local community, GP services, physiotherapy services and secondary care services by the assessment and treatment of patients in the community utilising physiotherapy practitioners and community sports facilities for knee problems and, elsewhere (Lanarkshire, Scotland) for back problems, reducing demand on physiotherapy treatments and GP consultations. It would be important to learn from and embed these initiatives during any reorganisation of delivery to improve the overall pathway of care.

- Care leading up to surgery needs careful planning to reduce medical complications, last minute cancellations and support prompt discharge. Variability in the quality of pre-operative assessment and in pre-assessment processes was highlighted, including limited capacity within some care of the elderly teams who unusually, but successfully triage elderly high-risk patients at Guy's and St Thomas' to optimise patients' before surgery; however, this system has failed to be achieved in the Orpington service at King's in that this model did not translate across to the Orpington site. Access to an anaesthetic review, to a protocol, prior to surgery was again variable as was the presence of a protocol. Patient access to education and the approach to joint schools can lead to lower lengths of stay, especially for patients who have comorbidities and people who experience social deprivation; again some examples of good practice were noted though not universal.

- Several stakeholders identified difficulties in being able to repatriate people to local hospitals and discharge into community services. The review did not explore in any detail the issues that would surround patients with complex medical needs such as those requiring renal replacement services, sickle services, chronic pain support or any other complex physical or mental health support. This will require planning so the home medical team is able to input into the care plans with a sector-wide delivery package put in place. This will also need to encompass discharge planning so that there is a seamless transition to these services if ongoing medical problems exist.

- Provision of timely pro-active rehabilitation, reablement, including specialist rehabilitation in the community; this impacts particularly on elderly people being discharged from hospital, who are also affected by a lack of intermediate care. Again, although there were examples of good practice this was not universal or mentioned in the plans.

- The review was not presented with detailed work including job-planning approaches to allow an assessment of the degree to which elective care at a specialised centre and trauma care at a local hospital could be effectively provided. This is important to convincingly ensure: that both local care and elective care institutions can be staffed and retain the skills needed; that this pertains not just to orthopaedic surgeons but to other co-dependencies within the wider team including nursing staff, anaesthetists, theatre staff, allied health professionals, care of the elderly etc.; and also that readmissions can be dealt with safely and efficiently wherever they present.

- Changes impacting on primary care (and their feasibility) were not specified, for example any changes in volume of post-operative wound care or dressings that might arise from the fact that post discharge travel arrangements could make this more attractive.

Clinical involvement to date has mostly involved orthopaedic surgeons across south east London. The surgeons we met supported the case for change, in particular the effect of current capacity challenges and agreed with the overarching aims and expected benefits of consolidating elective orthopaedic care, whilst noting that much of the detail had yet to be worked through. Other clinicians we met have had very little involvement in the work so far and whilst agreeing with the case for addressing current pressures, and the principles of consolidation, they felt there were other areas of the pathway (noted above) that would need to be addressed alongside any changes to inpatient care in order to achieve the full range of benefits envisaged.

Patients and carers representatives are involved in this work through a Planned Care Reference Group (PCRG). The review team discussed the case for change and proposed model of care with the independent PCRG Chair and six other members. The Chair explained that the purpose of the PCRG is to advise the OHSEL programme on issues that will need to be addressed if the programme wishes to consult publically on the proposals. Members identified waiting lists, cancellations and capacity as important issues to address, however felt that overall the case for change and proposed care model did not present sufficient evidence about current challenges and the benefits that improvements would achieve or provide information on wider impact and risks associated with the proposals. Over the course of the two meetings held to date PCRG members felt attempts had been made to respond to issues they raised but some issues were outstanding. Particular concerns related to the lack of reference to local services in the community including links to social care and primary care. It was reported that the selection criteria for the appraisal of potential elective orthopaedic centres had been changed to reflect the PCRGs views on the importance of services at other sites continuing to be viable.

Some PCRG members we spoke with are also involved in other workstreams within the overall OHSEL programme. For example, we heard about the development of local care networks, which the overarching OHSEL strategy proposes as the key vehicles for developing and integrating care in the community, however stakeholders were unclear how the different workstreams interface to ensure overall coherence.

The case for change notes that orthopaedic services in south east London are generally safe and high quality. None of the stakeholders we spoke to identified any concerns about the quality of surgery. Some of the clinicians we met identified specific aspects of care which could be improved for example, we heard that not all patients with fractures have the rehabilitation support they need in hospital and require greater input from nurses, physiotherapists and occupational therapists to enable discharge; enhanced recovery needs to be more firmly embedded. Some of the more unusual procedures[14] are carried out in low numbers in all units which is not regarded as safe practice. GIRFT makes a number of recommendations about rehabilitation though this is not referenced in the case for change. As noted above not all centres were able to provide ring-fenced elective orthopaedic beds. GIRFT also highlights the benefits of networking to surgical practice; this includes mentoring and peer support to encourage adoption of best practice, and to challenge colleagues where this is not the case, as well as gaining benefits of standardising use of equipment and prosthesis.

The South West London Elective Orthopaedic Centre (SWLEOC) is frequently referenced as an example of how a consolidated approach in south east London could function and the benefits that could accrue. This service has been established for a number of years, is identified as a good practice model in GIRFT and is geographically close to south east London therefore it is sensible to learn from this experience. That should not limit learning from elsewhere, however, including examples of changes delivered with SEL. Some stakeholders highlighted the need to be mindful of demographic differences between south west and south east London, with higher levels of deprivation in the latter and wide ethnic diversity, and potentially a need for greater support, including from social services. A further note of caution related to the time required following the establishment of SWLEOC before benefits were realised.

Data shows that the volume of some surgical procedures is low in some services and it would be sensible for surgeons to review their practice in relation to complex cases. Consolidation and networking could offer an opportunity to do this. Orthopaedic surgeons we met discussed the potential to standardise the choice of implants which could achieve cost savings through a more collaborative approach to procurement and appeared committed to explore this, though acknowledged it would be a difficult thing to do. There is further good practice to follow in this area however, with evidence of standardisation of implants being introduced at Guy's and St Thomas' several years ago and of increased standardisation being introduced more recently at Lewisham and Greenwich. Recognising issues involved in changing practice, this should be commended.

Conclusion

Overall, we agree that there is a case for improving the delivery of elective orthopaedic care in south east London and the GIRFT report provides a robust evidence base for assessing the potential to do this although the impact of primary care referral practices are probably lacking and could add an important richness to this. Pressures clearly exist within current services and are likely to increase as demand rises if no action is taken. Capacity constraints affecting waiting times and cancelled operations appear to be the key issues. NHS Constitutional standards are regularly breached.

[14] For example, revision surgery of all types, ankle elbow and shoulder replacements and partial knee replacements.

Based on the evidence we saw, equalities issues have not been sufficiently explored in the case for change. These include general issues such as travel times and costs (and any socioeconomic impact for specific population groups), disease specific issues such as complex medical care, readmissions etc and patient population issues such as such as mental health, learning disabilities, vulnerable groups and age. There is limited information about any current inequalities in relation to elective orthopaedic care or the implications of future demographic changes, particularly at a borough level where there is likely to be greater variance than for south east London as a whole.

There is a clear commitment to involving patients, carers and their representatives in this work. We felt the PCRG with an independent chair is a good model, with a clear remit. PCRG members welcomed their involvement and agreed with some of the current challenges that need to be addressed however told us they would like more feedback about how comments and advice provided by the PCRG are taken on board.

There has been strong clinical leadership and engagement in this though this now needs expand to expand to include staff who work across the pathway, home to home[15].

The case for change presents information at a relatively high level and some stakeholders, particularly the PCRG, would like to see stronger evidence, with more detail about current challenges and opportunities for improvement, including how these could be addressed within the current model.

We heard strong support for the principle of separating elective and emergency pathways and ring-fencing planned care beds. The review team heard about good examples within the health economy, which largely precede the GIRFT work, which offer significant opportunities to share and build on learning. However, not all services have ring fenced orthopaedic beds currently.

Everyone we spoke to discussed the importance of considering the whole pathway for elective orthopaedic care however collective ownership was not evident. Although there clearly are challenges within the pathway in addition to those identified in the peri-operative stage, the case for change has not yet considered them. Tackling the current variation in approaches, protocols and processes for elective orthopaedic care, particularly within community services across south east London, is a key area. The case for change does acknowledge this[16], although it is not clear how it will be taken forward. Failure to do this risks limiting benefits realised from improvements to the inpatient part of the pathway, or creating greater inequality in access and provision of care. Increasing standardisation will need a collaborative approach and should seek to maximise benefit from the many examples of good practice that already exist.

[15] Home refers to a person's usual place of residence

[16] Case for change p24

5.2 The model of care

The key features of the model of care developed in response to the case for change are:

- Consolidating routine and complex/specialist elective orthopaedic inpatient care from the current eight sites to two centres, with two potential options in terms activity carried out at the centres:
    - Routine and complex care would be undertaken at both centres
    - Routine care would be undertaken at both centres and complex/specialist care would be undertaken at only one centre
- Orthopaedic trauma care, day cases, outpatient care and rehabilitation would continue to be provided at all current sites (defined as “base hospitals”)
- Orthopaedic care for children and young people will continue as now; the review team was advised that the minimum age of admission to an elective orthopaedic centre would be 18 years.
- The model of care would be underpinned by a shared set of commercial principles through which base hospitals will retain ownership of activity undertaken in an elective centre.

Many stakeholders we spoke to supported the principle of the two-centre model as the basis for consolidation and felt this would be workable for elective inpatient orthopaedic care. However, the model is described in outline only at this stage and consequently there is a lack of detail about how the networking it will require and arrangements for supporting people through the overall pathway would operate in practice. Many of the issues that stakeholders raised related to this.

As with the case for change, the model does not currently cover the whole pathway of care. The majority of stakeholders felt it was essential that it does in order to address current challenges in community provision noted earlier. Without considering the overall pathway, there is a risk that key elements of the model will be missing. A number of important issues emerged through our conversations:

- There was a strong sense of the need to create an approach which “pulls” people through the pathway to return to home as soon as possible with necessary support. This requires attention at the front of the pathway, before surgery, as well as follow-up care;
- A more consolidated model of inpatient care would increase the number of interfaces between different services and would need to be supported by standardised protocols and processes across the whole pathway to address current variation, including variation in community services, whilst ensuring care was tailored to individual needs, particularly for people with complex and social care requirements. This would facilitate the “pull” approach;
- A lack of standardisation would be likely to create inefficiencies and inequalities, as patients admitted to the same centre for the same procedure could be following different protocols and/or have different levels and types of community support. This would impede the “pull” approach;
- If constraints elsewhere in the pathway are not addressed, improvements in the effectiveness and efficiency of inpatient care (increasing the flow of patients through proposed centres and reducing length of stay) may not be achieved.

A specification has been developed as the basis for providers interested in hosting an elective centre to submit an expression on interest. The model includes an outline, example, pathway, which illustrates how elective centres could work with base hospitals and how patients will move between base hospitals and elective centres for outpatients, treatment and rehabilitation. Guidance[17] expects that hosts would *"facilitate an optimised pathway so that elective orthopaedic care in SEL is as productive as possible"*. This would need to take a collaborative, whole systems approach.

Some stakeholders expressed support for a two-centre model and described the need for an inner and outer south east London balance to ensure access. The review was clear it was not tasked with looking at relative merits of which sites and indeed had not been provided with sufficient information to allow this. Information received by the review team summarised the current (2015/16) level of activity for routine and complex[18] elective orthopaedic procedures as a combined total of 24,431 beddays requiring 79 beds (assuming 85% occupancy). The forecast activity levels for 2020/21, which is based on the mid-range of three scenarios, is a combined total of 30,786 beddays requiring 99 beds (at 85% occupancy). The review team felt that the evidence it received about the proposed model of care lacked detail and would be strengthened if the rationale underpinning the case for a two-centre option were more clearly set out, including evidence about the population base/travel and transport. There would also need to be a financial and capital case for change that demonstrated the GIRFT assumptions did hold up.

The review team understands that the proposed two site model options will be considered against the current model which will act as a base case. PCRG members expressed the view that an enhancement of the current model, which explored the extent to which GIRFT benefits could be delivered, should be one of the alternative options examined. The review team felt that the rationale for including or discounting options was not explicit in the information we received.

Although work on definition and modelling has been carried out through the working group, we detected some uncertainty about the scope of procedures that would be undertaken in the proposed elective orthopaedic centres, for example, whether post trauma reconstructive surgery, which is planned care, would be included and whether all day cases were excluded. It was suggested that surgeons needed to define what should be done as a day case and what should be included in planned care e.g. should it include trauma care which could be undertaken in a planned fashion following initial treatment for an injury?

Many issues were identified during our discussions where a more standardised and networked approach would be needed to ensure a consolidated model, and associated pathways, functioned optimally. Many of the clinicians we spoke with described differences in clinical approaches by different teams. While some standardisation has taken place e.g. a broadly uniform approach to joint prosthesis at Guy's Hospital, and increased standardisation at Lewisham Hospital, differences were identified across the pathway in pre-assessment, in exercise and pre-operative work-up, in consent processes and approach and in post-operative planning and care. Although it is certainly achievable, greater standardisation would require significant work. Some clinicians we met discussed the need to identify and spread the best practice which currently exists within south east London and this would be a sensible approach as clearly there are many good examples to build on.

[17] Elective Orthopaedic Care: Case for change and outline model, p31

[18] The case for change notes that the categorise used reflect the GIRFT work and that complex procedures have been defined by GIRFT and the draft specification for specialised orthopaedics developed by NHS England's Specialised Orthopaedic Clinical Reference Group and were described in the draft outline specification for an elective orthopaedic centre

Achieving greater consistency in the approaches and care provision across the six boroughs will be challenging and be influenced by many factors. Developing the model of care across the whole pathway would be a useful way of beginning to agree some common principles about how this could be done and to reach agreement on the key areas where standardisation matters most. We heard one example where procurement of local musculoskeletal services was currently out to tender, which appeared to be disconnected from this process.

In addition to points raised above, discussions identified a range of other issues that would need to be addressed to enable a consolidated model to work effectively. Many of these related to workforce issues, including job planning and education and training. The importance of information sharing and flow across the whole pathway was another key issue as the number of interfaces between different services would increase significantly in a consolidated elective inpatient care model. Some examples of integrated IT systems exist and span hospital/community teams and GPs, though tend to be localised within boroughs. Some stakeholders also felt the opportunity to look innovatively at an improved model for rehabilitation within the overall model of care was not being taken. GIRFT includes recommendations to improve hospital, community and outpatient rehabilitation[19] including characteristics of a model of care associated with better outcomes and reduced length of stay.

The review team considered whether the proposed model of consolidation would be deliverable. It would require significant collaboration across south east London, for both providers, at a service, social care and organisation level, and commissioners, and was described as the first "test" of whether the current system can collectively achieve strategic change in south east London across care boundaries. We noted several examples of cross sector working that have successfully introduced significant change and improvements in south east London, for example, the trauma network and changes in vascular services. We also heard evidence of approaches being shared across the area, for example, in care of the elderly services and in discharge arrangements in Lewisham. We felt there was a general commitment from clinicians we met to work together to deliver improvements and, in the main, a realistic view of what that would involve. Understandably, given their involvement to date, the orthopaedic teams were far further down the journey than any other clinical groups and any patient groups.

Conclusion

Whilst many stakeholders indicated support for a two-centre model for elective orthopaedic inpatients, patients and carers representatives have mixed views and would like to see stronger evidence, including the potential to deliver benefits through the current model or an enhancement of it.

We felt that the assumptions behind the two-centre model, for example relating to critical mass, could be explained in more detail. The information we received did not include evidence in relation to the changing population base, travel and transport times or capital expenditure, which will have a bearing. The rationale for continuing to explore or discount specific options was not explicit in the documentation we received.

[19] GIRFT chapter 11. Stocktake of rehabilitation services in England for elective and trauma surgery (in collaboration with the Chartered Society of Physiotherapy)

Robust networking and collaboration will be essential to build the relationships and trust required for the proposed model to operate effectively, in particular standardising clinical approaches and processes and establishing effective relationships with the range of services needed to support the proposed model. There are good examples to draw on where this has been achieved in south east London.

The model of care is described in outline only at this stage. Consequently, there is a lack of detail about how the arrangements would operate in practice. It also mainly relates to the proposed elective orthopaedic centres. As some of the benefits envisaged would be dependent on other parts of the pathway, and in view of the breadth of issues identified by stakeholders, the model of care should be developed further to encompass the whole pathway. Whilst it will not be feasible to address all issues at this stage, agreement around common principles e.g. scope, operating principles to facilitate standardisation, 7 day services, the workforce model, should be pursued. The workforce model is a key issue considered further in the next section (see 5.7).

Achieving greater consistency in community services across the six CCGs and boroughs seems critical to such a model working effectively and is likely to be challenging, however limiting these to this specific patient group may prove helpful in the long-term development of these issues. Developing the model further to encompass the whole pathway of care would help to address this, including the model of rehabilitation.

There is a real opportunity to build on arrangements established through the PCRG by involving members more in co-designing the pathway, together with wider clinical involvement, including GPs, as the work moves forward.

Impact and clinical safety

The review team has not seen any evidence that an impact assessment has been carried out on the proposed model of elective orthopaedic care to identify any potential risks and unintended consequences that it could have, including for interdependent services and the wider system.

The draft hurdle[20] criteria for evaluating potential options for implementing the model include safety and sustainably criteria (focusing on the impact on emergency departments and trauma care and location within south east London) however information that the review team received did not include any detail on how this would be assessed. We would emphasise that the assessment of impact on trauma care needs to be especially on local trauma care for the large amount of orthopaedic trauma that does not need to be carried out in a major trauma centre.

We have considered what impact the proposed model could have and explored this with all of the stakeholders whom we met. Key findings from this are summarised below.

[20] The approach to appraising options for elective orthopaedic centres involves two stages. The first is an assessment against "hurdle" criteria which are essential criteria that any potential option must meet to warrant further consideration

5.3 The overall elective orthopaedic pathway

A range of issues would need to be addressed in other parts of the pathway to implement inpatient model of care effectively and achieve overall improvements. These have been highlighted in earlier sections of this report. There would be two main risks if these are not addressed:

- Improvements to the inpatient part of the pathway creates new pressures and challenges elsewhere in the pathway, including the risk that inequalities could increase
- The benefits envisaged are not achieved because the wider pathway changes needed to support them do not take place

Tackling the current variation in approaches, processes and availability of community services across south east London is a key area to address to enhance the pre and post-operative stages of the pathway. Particular issues include the need for greater standardisation; difficulties in repatriating patients to local hospitals and discharge into community services; provision of timely, pro-active rehabilitation, including specialist rehabilitation in the community and ensuring effective integration with primary care and social care.

5.4 Impact on patients, carers and families

The review team heard that particular populations in south east London had a clear preference for treatment to take place locally and would not wish to have care provided in an elective orthopaedic centre elsewhere in south east London. It was not clear to the review team how patient choice would be reflected in the proposed model of care.

Overall, PCRG members felt that people would be prepared to travel further for planned surgery if there was certainty about their care and the benefits envisaged were delivered. Notwithstanding this, the impact in terms of travelling to an EOC if it was not local was a concern. Many people who require orthopaedic surgery are elderly and / or may have limitations in their mobility and may need to be accompanied by a relative, friend or carer. Family and friends may also be elderly and concerns were expressed about visitors not being able to travel to an EOC. Travel issues relate to both practicalities and cost.

The proposal that the model of care would include a taxi service for collecting patients for admission and taking them home following discharge, which operates at SWLEOC, would help to mitigate this concern. Proposed arrangements need to take account of the location of pre-assessment and joint schools if held centrally and consider the concern about visitors.

We noted that the draft evaluation criteria include a travel time analysis and will assess the impact on total transport times for populations potentially affected by different options for hosting proposed EOCs.

The draft evaluation criteria also include an equalities impact assessment that will examine the extent to which an option promotes equality and minimises disadvantage to protected groups. The review team understands that this will also explore the impact on carers and people who are socially deprived. We understand that an equalities steering group has been established to advise and oversee this work.

5.5 Trauma care

The proposed model of care for elective orthopaedic inpatient care functions would have significant implications for the provision of trauma care (this includes trauma care for adults and children and young people). In particular, there were concerns for patients with trauma that did not trigger the threshold for treatment on a major trauma pathway. This includes the very large number of patients with fragility fractures (for example hip fractures), patients with isolated limb fractures and some complex injuries such as peri-prosthetic fractures[21]. Maintaining skills and expertise in local hospitals would be essential.

The review team understands that the major trauma network has only recently been engaged in this work therefore has not had the opportunity to fully consider the implications. Nevertheless, the review team has identified several issues that would need to be addressed if the model of care was implemented.

A view was expressed to the review team that separating planned and trauma/emergency orthopaedic pathways has the potential to deliver improvements in trauma care as well as for elective care by freeing up capacity and improving flow through acute trusts, benefiting trauma pathway and emergency departments. This assumes that local orthopaedic trauma units benefit from at least some of the capacity that would be released in base hospitals by the creation of elective orthopaedic centres. The review team identified the risk that the opposite could occur i.e. the trauma overflow would lose its release valve of using cancelled elective capacity and so trauma patients could be disadvantaged in the proposed new system.

Major trauma services already operate on a networked basis, with common standards, protocols and processes, which a planned orthopaedic care network could learn from in terms of both the approach to their development and overall network governance.

The review team did not identify any significant impact or concerns in relation to major trauma and noted there are established mechanisms in place to audit and monitor quality. The greater risk would relate to the management of other trauma such as hip and lower limb fractures, fractured wrists, hands, elbows and shoulders and the impact on trauma units in base hospitals. Key risks identified were:

- The establishment of elective orthopaedic centres (EOCs) could denude acute sites of staff and expertise (surgeons and the wider team). The approach to staffing EOCs would need to mitigate this risk so that appropriate staff and skill mix are always available in base hospitals to provide trauma care. Options for doing this were discussed with stakeholders. A visiting surgeon model would enable a surgeon to operate at an EOC and provide trauma services at a base hospital, as well as clinics and day surgery (this is the approach at SWLEOC). A model of surgeons working solely in an EOC(s) risks surgeons becoming isolated. Maintaining links, and clinics, at a base hospital is important. Site based working in which teams could rotate between the EOC and base hospitals on a planned basis would be dependent on sufficient numbers and organisation of staff to be able to allocate block times at both sites.

[21] These are fractures around joint replacement prosthetics or implants. They can occur during surgery or postoperatively.

- Trauma pathways can involve patients being scheduled for planned surgery following initial treatment. A large proportion of “non-major” trauma can be done on a scheduled basis within one to two weeks of initial injury, and sometimes as a daycase procedure. This surgery that could be carried out in an EOC or in the base hospital would need to be considered, taking account of the appropriateness of the environment (e.g. patients with open wounds should not be admitted to an EOC because this risks introducing infection) and patients’ needs, and reflected in the scope and capacity plan.

- Increased working across sites could result in delayed discharges or increased length of stay for trauma admissions, if for example the surgeon/team who operated on a trauma case was scheduled to be at the EOC and unable to see a patient as part of the discharge process; an approach in which surgeons give and accept responsibility for seeing each other’s patients was discussed as a way to mitigate this risk, though options would need much more consideration and careful planning across sites;

- A reduction of experienced staff at smaller trauma units could lead to more activity being transferred to the major trauma centre. This could then have consequences for major trauma care by increasing demand on resources there;

- A reduction in elective activity and staff at smaller trauma units has the potential to affect the sustainability of the unit;

- There may be an impact on training, for example, if the proposed changes diluted junior doctors’ and other trainees’ involvement in trauma care; proactive planning on appropriate training arrangements, as part of the wider workforce planning, would be needed to mitigate this;

- Spilt site working between an elective centre and the major trauma unit was felt to be difficult as clinicians coming into the centre may not have enough experience and the approach could impact on infrastructure and relationships; split working between general trauma and EOCs would be feasible, indeed desirable, provided issues identified above are addressed.

5.6 Children and young people’s orthopaedic care

The proposed elective orthopaedic model of care for south east London does not include any changes to the arrangements for children and young people’s orthopaedic care. Currently, some elective care is provided by district general hospitals and more complex work is referred to the Evelina London Children’s Hospital, the tertiary centre at Guy’s and St Thomas’ Hospital NHS Foundation Trust. Children and young people’s trauma care is considered in section 5.5.

The proposed model is for adult elective orthopaedic care i.e. for people from18 years of age onwards, the outline specification highlights the need for proposed EOCs to have formal links with paediatric services.

There is often a cross over between children and young people’s services and adult services in the management of young people aged 16 and 17, some of whom may wish to be treated within adult services. Some young people with long-term conditions require a lot of orthopaedic care, often provided under paediatric community teams into their early 20’s. Future models of care should enable young people’s choices to be supported.

If any young people under the age of 18 were treated in the proposed EOCs, staffing arrangements would need to demonstrate compliance with extant requirements for children and young people's health services, including appropriate safeguarding and resuscitation training. Arrangements would need to be put in place to ensure relevant guidance and training was kept up to date.

The review team's discussions identified young people with cerebral palsy as a particularly vulnerable group. There is no consistency currently in arrangements for these young people in their transition to adult services and no clear pathway to follow. It was recognised that improving the quality and consistency of transition involving an appropriate, individualised assessment with clear information, would support these young people to choose the right pathway for them. This is a general issue and not specific to orthopaedic care. However, achieving improvements in transition for elective orthopaedic care could offer wider benefits and learning. This programme would offer an opportunity to do this.

5.7 Workforce issues

A range of issues would need to be considered in developing the workforce model to support the proposed model of care. The outline specification for an EOC expects host organisations to adopt the SWLEOC model of staffing which is reported to comprise a core team, including nursing, anaesthetic and therapy staff, at the EOC to support the needs of orthopaedic surgeons from the base hospitals which the EOC serves. The specification notes that depending on the range of services provided there may be a need to provide specialist teams to deliver the appropriate standard of care and these could be employed by the centre or drawn from base hospitals. The aim is to limit the need for teams and individuals to work across more than three sites as this could have a detrimental impact on patient and staff experience.

We recognise discussions about workforce are at an early stage however, unsurprisingly, this was a key area of discussion with the majority of stakeholders we met. Workforce arrangements, and involvement, would be critical to effective delivery of this model. It would have challenges, however would offer opportunities as well and, as noted in other sections, existing examples of consolidated care, multi-skilled staffing models and integrated working between health and social care are important sources of learning. Key issues that emerged from our discussions were:

<u>The overall workforce model</u>

The model put in place must be attractive to staff and at the same time mitigate the risk of denuding staff from base hospitals. The workforce model would need to clearly set out how staffing arrangements at base hospitals would ensure robust cover arrangements for orthopaedic trauma care, and also day cases and outpatient, as well as how staffing capacity would be aligned across the whole elective care pathway to facilitate improvements overall. This would apply to doctors, nurses and allied health professionals. Recent experience at Orpington Hospital is reported to show benefits of centralised skills (physiotherapists, occupational therapists, nurses and doctors); length of stay is reported to have fallen and patient and staff satisfaction are reported to be high; the unit appears attractive to staff, with no recruitment difficulties and good retention rates reported; the fact that much of the workforce is local, was felt to add to the stability. We were not party to any impact on other providers in the sector and whether recruitment and retention differs across south east London. The approach to 7-day provision needs to be thought through, especially to ensure provision of timely rehabilitation, which is key to improving outcomes.

Education and training

Training arrangements, for all staff, need to be considered as an integral part of the process; this was emphasised by many people we met including the PCRG. Some stakeholders emphasised that staff (therapists and nurses particularly) want to work, and gain experience, in both elective and trauma care; examples of rotations exist that facilitate this currently. There should be greater focus on developing staff skills and experience to embed the enhanced recovery approach. Trainees from all specialities are rotating more frequently and ensuring adequate training opportunities and supervision within the model would need careful consideration and planning.

The case that consistency and volume improves quality by developing skills and expertise applies to other members of the team in addition to surgeons e.g. therapists, theatre/ anaesthesia teams and nursing teams and this needs to be taken into account. Education models for staff across the pathway, including GPs, should be considered as part of these arrangements.

Staff mobility, continuity and oncall arrangements

Continuity in terms of relationships with the team caring for them is important to patients and their families/carers and the workforce model should aim to achieve this; for example, it would be important for surgeons who operate at an EOC to hold clinics at base hospitals and to have wider interaction across south east London; the merits of teams rotating, not just surgeons should be explored. Arrangements should facilitate both discharge and follow-up from EOCs and readmissions to local centres. There would potentially need to be a model of surgeons taking responsibility for each other's patients e.g. to ensure a timely response and avoid delays in discharge. The impact on and implications for training and supervision would also need to be considered within such an approach.

Skills and experience

There is a shortage of geriatricians in some hospitals which will worsen over the next few years e.g. there is a current gap of 3-4 WTE consultants in Lewisham. Given the forecast rise in the number of older people requiring orthopaedic care the workforce model may need to consider innovative ways to address this, perhaps through jobs shared across sites that have no problems with recruitment, or using other clinicians.

5.8 Complex patients with co-morbidities and patients who deteriorate

Early and robust pre-assessment is essential for patients who require orthopaedic care and have poor physical health, which may involve more than one health condition (co-morbidities). Pre- assessment can be challenging for patients who fall within the ASA3 and 4[22] categories and the model of care needs to be unequivocal about the management of these patients as part of the overall pathway. Currently, difficulties can arise in scheduling assessments far enough in advance, which should ideally be a minimum of six weeks before surgery, to ensure appropriate preparation and work-up. Pre-assessment should take place at the base hospital and a system to flag needs and risks, ideally digital, should be in place as part of information sharing arrangements across trusts. IT challenges may need to be addressed to enable this. Demographic changes indicate that the number of people with complex needs and multi-morbidities will increase in future years, therefore ensuring services are planned to be able to meet these patients' needs is an important consideration.

[22] The ASA physical status classification system is a system for assessing the fitness of patients before surgery. ASA3 is a patient with severe systemic disease and ASA4 is a patient with severe systemic disease that is a constant threat to life.

We were told that up to 30% of patients seen in the EOC at Guy's Hospital are ASA3 therefore there is experience of looking after these patients in a planned care environment in the sector (we are not aware of the data for Orpington or Lewisham). Some ASA3 and almost all ASA4 patients' surgery would still need to be scheduled at an elective centre with access to full support (critical care, medical support etc). Typically, this would be envisaged at an acute hospital because of the support required or at a non-acute site with designated facilities, appropriately experienced staff and clear policies for escalation and transfer to an acute site if necessary.

The outline specification for an EOC does not specifically mention management of patients with co-morbidities though does set out the facilities and clinical adjacencies that providers hosting an EOC should have. For peri-operative care this includes "*access to critical care or high dependency care when required*" and an "*appropriate anaesthetist*". The workforce model, as noted earlier, expects adoption of the SWLEOC model, which includes the requirement for "*experienced anaesthetists – consultant anaesthetists, junior grade anaesthetists, potentially further anaesthetists to cover anaesthetic issues*". Interdependencies with other services are also noted and state "*orthopaedics services must have formal links with the following specialities in order to provide a comprehensive service – the schedule includes transfusion services, vascular services, anaesthetics and intensive care*".

The outline specification would be significantly strengthened if the requirements for these adjacencies and interdependencies and workforce expertise and skill mix were explicitly defined e.g. co-located, accessible within a defined timeframe, supported by jointly developed protocols etc. This would also benefit from clarity on the coordination of the assessment centre so discussion of high risk patients is focused and planning is robust and communication with the teams, including the discharge planning, is explicit. This would set out expectations of quality and mitigate risk in the option appraisal process. For patients whose clinical status deteriorates but not to a level requiring critical care, there needs to be physician oversight of management. An example of this model currently exists provided by geriatrician's at Guy's and St Thomas'.

Arrangements for managing a patient who deteriorates whilst in an EOC would need to be clearly described covering initial management and transfer to an acute hospital / environment as required to meet their ongoing needs. Pathways must be unambiguous and would need to be agreed in advance. Capacity planning would need to be determined so there would be the ability for any such patients to be accepted at the appropriate acute provider if required.

We also considered patients who require emergency readmission following planned care and discharge from an EOC and identified a number of considerations in these circumstances. Patients would be admitted to an acute (base) hospital which, in the proposed model, may not be where the initial surgery was carried out. Clear processes would need to be in place to ensure timely access to a patients' records. Responsibilities for patient assessment, management and follow-up, including reviewing, updating and sharing the original care plan need to be agreed in the event that the original operating surgeon and team members were not available.

5.9 Care of older people

It is important that clinicians in orthopaedic services and clinicians with expertise in the care of older people maintain a close relationship. A significant proportion of orthopaedic workload involves this sector of the population and demographic changes means this proportion is growing. Older people with complex needs, often require significant support through their care pathway and to maximise their opportunity to get the best possible outcome. This is also the case for older people who are frail. The geriatricians we spoke with emphasised the importance of a collaborative approach in pre-operative assessment, care in hospital and in discharge planning, all of which may involve significant preparation. A collaborative approach is also important in supporting an older person, and their family or carer, in making the right choice about surgery or an alternative treatment.

Existing collaboration and networking of geriatricians across south east London is a strength that should be built on, for example by base teams linking to an ortho-geriatrician within the proposed elective centres. Key requirements for an effective pathway include a generic referral form to enable pathways to be planned; more effective pre-operative assessment to optimise patient outcomes and recovery, which is not working as well as it could be currently e.g. we noted potential benefits of using a frailty index, currently being piloted in Leeds, to assist in identifying people's needs and help to target older people's expertise as affectively as possible. The model proposed would also require increased working with social services, including a need to build relationships across all six boroughs; clear guidance would also need to be agreed about repatriating patients from the proposed elective centres to local hospitals in a timely way with a local bed base to enable this.

An increasing shortage of geriatricians will also need to be tackled at a time when demand for this expertise is rising. Current service issues include a lack of capacity within the existing model at Orpington to enable complex geriatric assessments to be followed through. This is important for good care. The outline specification does not currently mention formal links with older people's services.

The model in place at Guy's and St Thomas' provides support for the whole care pathway, though only for the local population. It could provide the model for standardising the pathway across the whole of south east London but would need to involve all stakeholders i.e. community and local authority services, as well as those in the hospital.

5.10 Conclusion

The proposed model of care for elective orthopaedic inpatient services would have implications for other areas of orthopaedic care and for other services with which orthopaedics has an interdependence or an interface. Some of these implications have the potential to increase risk.

A comprehensive impact assessment should be carried out on the proposed model of care to enable all risks and unintended consequences to be identified and evaluated so that ways of mitigating any potentially adverse impacts can be explored. This would enhance the overall model and give assurance to stakeholders on issues that concern them. This also offers an opportunity to address some of the service challenges that exist now and improve these for the future. Relevant insights from this assessment, including mitigating actions, should be reflected in the outline specification and taken into account in any options appraisal.

Broadening clinical engagement will be important in taking this work forward and we identified a real willingness amongst stakeholders to do this. PCRG involvement is equally important and as indicated earlier there is an opportunity to build on the very positive PCRG model to deliver an approach based more on co-production.

The potential implications for trauma services suggests that there is a case for reaffirming the model for trauma care and re-affirming or refining pathways alongside the proposed model for elective orthopaedic inpatient care.

The review team recognises that some of the detail in relation to operational implications of the model of care, could only be addressed after an options appraisal process had been completed and a decision made about location(s). That is beyond the scope of this review, however we believe that key principles about operational interfaces are very important considerations at this stage.

Potential to improve the quality of elective orthopaedic care

Overall we believe there is a significant potential to improve elective orthopaedic care across south east London through the collaborative approach that has been adopted.

The greatest shortfalls in quality currently relate to the length of waiting times and the number of scheduled admissions that are cancelled prior to surgery. Both of these factors can have a significant impact on patient experience, delaying treatment of patients affected and disrupting their lives and those of their families and/or carers. Providing more protected capacity (ring-fenced beds, theatres and supporting infrastructure) would increase certainty in scheduling and offer the potential to deliver marked improvements.

However, we reiterate again the importance of considering the whole elective care pathway; the peri-operative stage of the pathway cannot be considered in isolation. For example, the model of care does have the potential to reduce length of stay for an elective admission, however the quality and effectiveness of pre and post-operative care are as important in achieving the best overall experience and outcome for patients. The full benefits that the case for change is seeking may not be achieved without taking this approach.

There are examples of services within south east London, both longstanding and more recent developments, as well as examples elsewhere, which indicate that consolidation can be achieved and has the potential to deliver the improvements in quality envisaged. We identified the potential to improve quality, care processes and training. There are also potential opportunities to enhance research. The South London Health Innovation Network's (HIN)[12] musculoskeletal programme aims to work with stakeholders across South London to improve clinical models in place for common MSK conditions, for example, the ESCAPE-pain[23] programme. This is an important resource that should be drawn on to support improvements in the elective orthopaedic pathway.

In addition to examples of models of consolidation, there are clearly other very good examples of practice to draw on and share within south east London in other areas of the pathway which offer the potential to improve quality.

[23] ESCAPE-pain is a NICE-endorsed rehabilitation programme for people with chronic joint pain which integrates self-management and coping strategies with an exercise regimen individualised for each participant. The programme received a 2016 Best Practice Award in the Rheumatology and Musculoskeletal Health category by the British Society of Rheumatology.

Our discussions also revealed a number of other, specific issues that this work provides an opportunity to address to drive improvements e.g.:

- Improving GPs' with effective MSK education programmes to improve the quality of referrals
- Embedding an enhanced recovery approach within the elective pathway
- Developing a local approach that gives an equivalent focus on areas such as ankle and wrist fractures as there is on hip fractures, which has a national database and uses transparency of published data to drive improvements, applying learning from this.

Separating elective and trauma care has the potential to improve trauma care by releasing capacity and increasing the focus on trauma in base hospitals. For example, King's College Hospital identified opportunities to improve the fractured neck of femur pathway if current space constraints were addressed and particularly if a dedicated ward was available.

Learning from the trauma network could also assist in developing and applying cross organisation standards and operating procedures and managing patient flows, for example a commitment to accept patients who would need to be transferred from EOCs.

A strong commitment to improve orthopaedic care, and to do this through collaboration, was very evident amongst the clinicians we met. There appeared to be a genuine willingness to network and make changes, whilst acknowledging further work would be needed to make this happen and being realistic about some of the challenges that would be confronted.

Work to deliver some of the improvement opportunities identified in GIRFT are not necessarily dependent on the establishment of an EOC and could begin now. For example, networking across current services to begin introducing greater standardisation across the pathway. Making progress in advance, especially in achieving greater consistency within community services and strengthening education programmes for GPs, could facilitate transition to the proposed model of care if established and deliver earlier gains.

Evaluating the impact of any changes introduced is an essential part of any change process and often overlooked. The approach to doing this should be agreed up front and co-produced with patients and staff, particularly in identifying key measures of success, and built into the change process as it is taken forward.

The review team considered the most recent CQC quality reports for provider trusts in south east London. These identified some issues relevant to surgical services, highlighting good practice as well as opportunities to improve. As this work is taken forward, it would be appropriate to ensure that issues relevant to orthopaedic care are taken into account.

The next section highlights key areas where we identified particular opportunities to improve or mitigate risk to quality.

Potential to improve the standardisation of care

We identified several areas where greater standardisation would be needed to ensure that a consolidated model for inpatient elective orthopaedics achieves the full range of benefits envisaged.

- Addressing current differences in processes, approaches and services available within community services is a key area. If not tackled, this could contribute to inequalities. If tackled, it should enable better outcomes, experience (for patients and staff) and training. We believe introducing more standardised pathways offers a significant opportunity. It is important that everyone is working to the same standards and pathway design, involving patients and carers in co-production, would be a good way to enable this.

- Ensuring access to high quality, consistent patient information and improving patient education approaches tailored to the needs of different communities.

- Data indicates that some surgeons are undertaking low volumes of some procedures. A more standardised approach offers the potential to increase critical mass for low volume and complex cases. This is highlighted in the case for change and we heard a willingness to explore it though consideration of the approach to increasing specialisation between surgeons seems to be an at early stage. It would be enabled by introducing a more formalised networking approach, building on the collaboration that already exists. A network would also be a vehicle for standardising operational processes and procedures.

- Savings through standardisation of prosthesis is a further opportunity with some examples of this already being achieved in south east London, as noted earlier.

- A sector wide opportunity for a collaborative approach to improvement and education should be jointly developed integrating both primary and secondary care. This is essential, as demand management is mostly within the gift of primary care.

- A sector wide approach to examine procedures of limited value which could be agreed by all resulting in a standardised approach would be invaluable to contain demand (which is often professionally generated) for example for arthroscopies[24] and menisectomies[25]. Although such procedures have dramatically decreased, they are still undertaken in circumstances where benefit is doubtful. Pathways and procedures should be reviewed to ensure that they have proven benefit.

Potential to improve the management of complex cases

- This links to the point above; there is support for the idea of a body of surgeons able to do complex work, building up critical mass.

- This work provides a real opportunity to look collaboratively at the model of care and tailor services for people with complex needs, across the whole pathway, including pre and post assessment, and involving interdependent services to support patients with complex needs to achieve the best possible outcomes.

[24] An arthroscopy is a minimally invasive surgical procedure on a joint in which an examination and sometimes treatment of damage is performed using an arthroscope, an instrument that is inserted into the joint through a small incision

[25] A menisectomy is the surgical removal of all or part of a torn meniscus, a thin fibrous cartilage between the surfaces of some joints, e.g. the knee.

Potential to improve the quality of elective orthopaedic care

A range of potential opportunities exist right across the pathway. We would emphasise again that taking an end to end pathway approach will be necessary to fully realise them. Key ones we would highlight are:

- Access to ring-fenced beds for elective orthopaedic inpatient care should enable improvements by providing certainty in capacity and should lead towards achieving waiting time standards and eliminating late cancellations
- Outcomes could be improved by increasing standardisation/reducing variation; introducing greater consistency in processes and approaches based on agreement about best practice and by addressing ALL aspects of the pathway including pre and post-operative care
- There is an opportunity for larger teams and networking which have the potential to improve practice, training and education across the pathway and all care settings
- Potential to improve staff experience and satisfaction; the NHS Staff Survey indicates this to be typically lower than average in orthopaedic services. There is a recognised association between positive staff experience and positive patient experience and outcomes
- Consolidation of elective inpatient care, or the approach to implementation, also have the potential to increase risk and affect quality in a negative way e.g. risks to trauma care in local hospitals if not planned carefully and informed by a thorough risk assessment.

Potential to improve patient experience

- Increasing certainty in the overall pathway, improving waiting times, reducing cancellations, improved pre and post-operative care, better information and education for patients and carers/families would improve experience. However, it would be important to ensure that need that this was not offset by challenges in access and poor interfaces between proposed EOCs and local services, including links with primary care, community services and information sharing/ communication between services.
- Patients value building a relationship with clinicians and teams and this could be reduced with a more mobile workforce, working across a greater number of sites. Ways of mitigating this risk would need to be considered in any staffing model. A patient navigator role providing a single point of contact to enable smooth pathways and “pull” through the system was one idea that emerged from discussions.

5.11 Measures of success

We explored with all stakeholders we met what they would consider as key measures of success if the proposed model of care was implemented. Common measures identified by almost everyone were shorter lengths of wait, fewer cancelled operations and hospital stays that were as short as possible. The importance of measuring clinical outcomes was highlighted, though specific measures were not discussed.

It was acknowledged that setting some goals can lead to perverse behaviours, or a focus on some improvements to the detriment of others, so the approach needs to be carefully considered. Key measures should also be developed through a process that involves patients and carers and staff.

A combination of clinical, functional recovery e.g. through patient reported outcome measures (PROMs) and process related outcomes were suggested, covering the whole pathway and interdependent services where necessary. Improvement goals should be articulated as clearly as possible and demonstrate clear alignment with the current shortfalls that the case for change is aiming to address.

We noted earlier that musculoskeletal services have rich data sources which should assist in measuring the impact of any changes, however there are also gaps, particularly in community services. Any new data collection should be carefully considered to ensure that it would add real insight and value on measures identified as important and that resources and processes would be available to collect it without adding significant additional burden.

It is equally important to monitor risk and the effectiveness of any mitigating action.

6. Summary of advice and recommendations

The Review Team's advice on the three areas requested [shown in the boxes] is summarised below. Recommendations are provided at the end of each section.

Whether the clinical case for change and proposed model for elective orthopaedic care are underpinned by a clear clinical evidence base (where this exists)

The case for change

1. The case for changing the way that elective orthopaedic care is delivered in south east London draws significantly on the work of GIRFT, which makes a strong case that taking action in several areas e.g. networking across services, tackling variation in practice, increasing critical mass, having dedicated facilities, making better use of available data, will improve the quality of care and make better use of resources.

2. The south east London case for change highlights capacity constraints affecting waiting times, with NHS Constitutional Standards regularly breached, and causing operations to be cancelled at short notice, as key issues. Patients affected have a poor experience of care, which can also impact on their families and carers. Rising demand and financial pressures within the NHS are predicted to compound this over coming years. The case for change also identifies the potential to reduce length of hospital stay for some people admitted for some surgical procedures; to increase specialisation with a view to improving outcomes where surgeons undertake low volumes of some procedures and the potential to make further reductions in rates of infection and in readmission following surgery.

3. Overall, the case for change presented indicates that there are opportunities to improve elective orthopaedic care in south east London in the areas identified. However, it currently concentrates on the peri-operative period, which is the main focus of GIRFT. Although the case for change acknowledges the importance of considering the whole patient pathway, it does not yet reflect this. Variation between community services and processes across the six CCG's/boroughs is a current challenge. We heard a need to improve the quality of GP referrals, address variation in pre-operative assessment and approaches to optimising patients for surgery, and to improve discharge arrangements and follow-up. We also heard several examples of existing good practice in these areas.

4. Due to variations in community and secondary care, there was not unanimity within the review team that the centralisation approach was necessary to yield the opportunities outlined. Some members felt a comparison with the option of no site change but improved joint working alone still needed to be made both financially and from the impact on staff and patients' equalities.

5. There is evidence that patients and carers representatives are involved in this work. We felt the PCRG model is a good one. Members seemed to agree on the case for addressing waiting times and cancellations particularly. Views were mixed on some issues however. Some PCRG members felt the evidence in the case for change was limited and that not all of their questions have been answered.

6. There is evidence of clinical engagement and broad clinical support for the case for change although engagement to date has mainly involved leads in orthopaedic surgery from the main acute providers. Other clinicians we met were generally supportive, particularly of the need for ring fenced beds, although they were clearly far less involved. They also placed more emphasis on tackling challenges elsewhere in the pathway. There remains the potential for unforeseen issues to arise as engagement deepens, this applies in particular to general practice where we had little evidence of wide involvement.

7. We saw little evidence that the case for change has been informed by a consideration of equalities. It is important that any current inequalities in relation to orthopaedic care, and the implications of future demographic changes, are understood so that future recommendations can seek to address these, and to mitigate the risk of compounding inequalities further.

8. Whilst we have focused on clinical evidence, both the GIRFT work and the south east London case for change aim to deliver financial benefits as well as quality improvements and this is acknowledged as a driver for change. The case for change included little information about this though surgeons we met identified the potential to make changes and efficiencies, for example relating to choice and procurement of prosthesis.

Recommendations

9. The case for change should now be extended to encompass the pre-referral, pre-operative and post-operative phases so that it covers the whole end to end pathway from home to home. Some of the benefits which the current case for change aims to deliver will not be achieved without doing this. It would also ensure that proposals for the model of care take account of all key issues. There would need to be collective ownership of this approach.

10. Exploring current good practice across south east London could make an important contribution to the evidence for the case for change.

11. The case for change would be strengthened by explicitly considering equalities in relation to elective orthopaedic care and by providing further detail to demonstrate the nature of current shortfalls or challenges described.

12. Clinical engagement needs to be expanded to encompass clinicians involved across the pathway, including general practice.

13. A comparison with the option of no site change but improved joint working alone needs to be made both financially and from the impact on staff and patients' equalities.

14. Though PCRG members acknowledged efforts made to respond to information they have requested, it seems more evidence is needed that their views and issues they raise have been listened to. Patient and carers involvement could be strengthened further by developing the current engagement model into one of co-production.

15. Modelling of forecast demand may need further work to address concerns that this is based more on activity than demand.

The model of care

16. Clinical stakeholders generally seemed supportive of consolidating elective inpatient care and the lack of ring-fenced beds was a seen as a significant factor in the operational challenges currently experienced. Many felt that a two-centre model could be workable. Providing as much care as possible as locally as possible is important. The proposal to maintain outpatients, day care and trauma care locally is sensible and is widely supported by stakeholders.

17. We felt that the assumptions behind the two-centre model, for example relating to critical mass, could be explained in more detail and the rationale for continuing to explore or discount specific options was not explicit in the documentation we received. These issues were of particular concern to some PCRG members, who also felt the potential to achieve benefits within the current model, or an enhancement of it, had not been explored enough.

18. The model of care is described in outline only at this stage. Consequently, there is a lack of detail about how the arrangements would operate in practice and we have identified many significant issues that have yet to be considered, or considered in sufficient depth. These relate to how the proposed model of care impacts on the wider orthopaedic and trauma pathway and how it impacts on services with which elective orthopaedic inpatient care has an interdependency or an interface e.g. paediatrics, critical care. We know that the OHSEL programme is mindful of many, though perhaps not all of these. Key issues include:

    a. The need to define a proposed model of care for the end to end pathway, including consideration of the implications for primary care and general practice;
    b. The need to articulate how the proposed model would achieve the improvements envisaged including with reference to good practice already happening in south east London;
    c. Ensuring consolidation of elective inpatient care does not denude local hospitals of skills and resources to maintain robust, high quality local services, including defining the overall workforce model for the whole pathway; implications for local orthopaedic trauma care is a key risk;
    d. A model of care which consolidates planned inpatient orthopaedic care would increase the number of interfaces across different services and organisational boundaries. Standardisation of processes and protocols and greater consistency across all services, including community services across the six CCGs and boroughs, would be essential in ensuring such a model worked effectively;
    e. Robust pathways would be needed for managing complex patients and patients who deteriorate beyond the capacity of an EOC to treat and care for them;
    f. Pathways for readmissions need to be defined and ensure people have access to the quality of care needed at any relevant point of re-entry into the system and can be transferred if necessary in a timely fashion.

19. Travel and transport implications of the proposed model of care, particularly the consolidation of inpatient activity, are a significant concern for the PCRG, which has flagged implications for carers and visitors as well as patients.

20. More work has been carried out to date on the proposed EOCs than other parts of the model of care, including an outline specification. Developing the model of care for the overall pathway would inform further development of the specification and ensure that critical interdependencies and interfaces are clearly defined. This is not the case currently.

21. Robust networking and collaboration would be essential to build the relationships and trust required for the proposed model to operate effectively, in particular standardising clinical approaches and processes. There are examples to learn from and draw on where this has been achieved in south east London. Currently, however, the model of care has little detail on the proposed networking approach.

22. During this review we heard that two CCGs are in the process of tendering, or are about to tender for, musculoskeletal (MSK) services specifically or wider community services which include MSK services. It was not clear how related areas would adopt the proposed model of care that we were considering and stakeholders we spoke with did not know. This is a potential risk to developing the overall coherent and coordinated approach to elective orthopaedic care which the model of care is seeking.

Recommendations

23. As with the case for change, the model of care should be further developed and defined to encompass the whole pathway of care. Particular attention needs to be given to the pre-referral, pre-operative and post-operative phases including readmissions. Key interfaces and requirements to ensure a robust and effective model overall should be reflected in specifications developed e.g. for all parts of the pathway including community based musculoskeletal treatment and care.

24. Building further involvement with patents and carers representatives through an approach based more on co-production would enable implications and opportunities of the proposed model of care to be jointly explored and potential solutions to be jointly developed e.g. transport issues and assessment, pathways and processes.

25. Developing engagement with staff would similarly support development of the overall model of care, including exploring workforce implications and developing recommendations. We identified a significant range of workforce issues that would need to be addressed across the whole pathway, including education and training.

26. The option identification and appraisal process should be as explicit and transparent as possible in setting out the rationale for inclusion or exclusion of specific options.

27. Criteria for appraising options to determine the location of proposed elective orthopaedic centres reference impact on trauma, inequalities impact and travel and transport implications, but lack the level of detail about specific criteria that would be used or how those assessments would be carried (i.e. who has responsibility). This should be explicit.

28. An impact assessment should be carried out on the whole model of care to ensure all potential risks and unintended consequences are identified and taken into account, including necessary mitigating action. This should take into account any impact of staff groups movements to centres either planned or potentially unplanned. This should inform specifications developed e.g. in relation to interdependencies and the options appraisal process. This would test the sustainability and deliverability of the proposed model. Pending further work to develop the whole model of care this should start with the proposed model for elective orthopaedic centres and base hospitals.

29. The timeline for the proposed model of care indicates that implementation could start from summer 2017, subject to the outcome of consultation (if required) and business cases. It is not clear when benefits could start to be realised. The opportunity to achieve earlier benefits through a networking approach, for example through greater standardisation, including procurement of prosthesis, should be explored.

Whether the proposed clinical model is considered to be clinically safe and has the potential to improve safety of care compared to the current model, in particular:

a. Whether the proposed model of care poses any risks to the continuation of a clinically robust trauma system in South East London
b. The potential of the proposed model of care to enable standardisation through the adoption of best practice and to improve the management of complex cases

Trauma system

30. We believe that the proposed model of elective orthopaedic inpatient care functions would have significant implications for the provision of trauma care (this includes trauma care for adults and children and young people). In particular, there are concerns for patients with trauma that would not trigger the threshold for treatment on a major trauma pathway. This includes the very large number of patients with fragility fractures (for example hip fractures), patients with isolated limb fractures and some complex injuries such as peri-prosthetic fractures as well as patients who could have planned surgery following initial treatment for an injury as part of the pathway for their emergency trauma.

31. We did not identify any significant impact or concerns in relation to major trauma and there are established mechanisms in place to audit and monitor quality. The greater risk would relate to the management of other trauma such as hip and lower limb fractures, fractured wrists, hands, shoulders and elbows and the impact on trauma units in local “base” hospitals. This includes the risk that if effective local trauma care is not maintained, this could then impact on the major trauma centre by increasing non-major trauma workload transferred there.

32. Key risks include the establishment of elective orthopaedic centres denuding staff (or some specialist groups of staff) from “base” hospitals, impacting on the timely availability of staff, potential destabilisation of rotas especially for junior doctors but also for the wider team (excellent care is delivered by the whole team, not only by surgeons).

33. Concerns also relate to capacity for general trauma care and that the demand for trauma care would lose the current "release valve" of utilising cancelled elective capacity, meaning the proposed model could, potentially disadvantage trauma patients. A further consideration is the approach to managing trauma patients who may have scheduled surgery following treatment for the initial injury.

Recommendations

34. The implications for orthopaedic trauma care should form part of the proposed model of care impact assessment. Mitigation required to address key risks or unintended consequences identified should be agreed and built into the options appraisal process i.e. this should consider the implications for a site potentially being selected or not selected as an elective orthopaedic centre.

35. Standards have been agreed for trauma care in England[26]. Any proposals for change need to ensure that the required service specification can continue to be met for all Trauma Units as well as the Major Trauma Centre.

36. The Director of the South East London, Kent and Medway Trauma Network should be involved in an advisory capacity in assessing the implications of the proposed model of elective orthopaedic care for trauma care, and in the appraisal of options. For added scrutiny and independence, we recommend that the assessment and conclusions are discussed with the London Trauma Operational Delivery Networks Steering Group and that the Steering Group is asked to confirm its support.

Standardisation and complex cases

37. The proposed model of care does have potential to enable standardisation though there is limited information available at this stage on how, or the extent to which, this could be achieved. We noted previously that standardisation would be critical to enable the proposed model of care to work effectively and to facilitate seamless patient pathways. This was generally recognised and there seems to be a commitment to do this whilst acknowledging the challenges. Some standardisation on use of prosthesis has taken place at two trusts, one many years ago and one more recently, which provides experience to build on and shows that changes of this sort have been achieved. Achieving standardisation in processes and across pathways more broadly, including community services is also essential, as we have emphasised, and will also require a substantial amount of work.

38. Opportunities to improve the management of complex cases are also indicated. The case for change highlights that some of the more unusual planned orthopaedic procedures are carried out in low numbers in all units in south east London which is not regarded as safe practice. At this stage, how this would be addressed is not clear.

39. Securing optimal outcomes for people with complex needs also requires excellent pre-operative assessment to optimise patients for surgery and to follow this through the pathway. We identified examples of where this does and does not work well currently.

[26] D15/S/a The NHS standard contract for Major Trauma Services (all ages), Schedule 2 – the Service Specification

Recommendations

40. Work should begin to identify where standardisation offers the greatest opportunities to deliver improvements (quality and cost). Given its importance to the overall model of care proposed, and because of wider benefits and learning that would accrue, we would recommend an early focus on community services, including pre-referral and pre-operative assessment and post-operative care which could be for a defined group of patients initially e.g. older people with comorbidities.

41. Work should also be started to explore opportunities for increasing standardisation in the use of prosthesis.

42. Approaches to increasing critical mass of low volume surgery should begin to be explored so that the potential implications e.g. for surgeons and teams, and possible options to do this can begin to be explored.

The potential of the proposed clinical model to improve the quality of elective orthopaedic care

43. The case for change states that patients and carers representatives have emphasised the importance of being clear about how the proposed changes would improve care and have expressed a view that if there was more certainty about care e.g. procedures not being cancelled; early discharges; higher quality services; more confidence in treatment given; better preparation and aftercare – then patients would be prepared to travel. Articulating the intended improvements, how they would be achieved and how they would be measured as clearly as possible is therefore very important.

44. Orthopaedic care is supported by robust data sources, though there are gaps, e.g. in community services. GIRFT identifies a range of potential areas for improvement with supporting data sources.

45. As stated earlier, some of the proposed improvements that the proposed model of care for elective inpatient orthopaedics seeks to deliver would not be fully achieved without wider changes within the pathway, hence, the need to consider a model of care for the end to end pathway overall. Consequently, improvement goals should be identified along the pathway, with interdependencies clear.

46. We identified several examples of good practice in the delivery of MSK services across south east London where changes and improvements were reported to have been achieved. All providers have something to share. We also heard a general commitment to identify and spread the best as part of the overall improvement approach. There needs to be greater emphasis on doing this.

47. The proposed changes have the potential to increase risk as well as benefits. Impact monitoring needs to encompass both.

48. Opportunities also exist to improve research and development across the spectrum of the pathway.

Recommendations

49. Patients and carers and staff should be involved in identifying and agreeing measures of success. Goals and measures covering the whole pathway should be articulated as clearly as possible and be widely shared. They need to be owned by the whole system.

50. Risks and unintended consequences e.g. on local orthopaedic trauma services, local community based assessment programmes, should also be monitored to test the effectiveness of mitigating action and to enable early identification of additional risks that could arise.

51. Improvement objectives should be realistic and cover the short medium and longer term and include a combination of clinical, functional recovery and process goals.

52. Research and development opportunities should be highlighted.

53. The process of reporting against agreed improvements, and risks, should be transparent and visible.

54. Changes implemented should be subject to objective evaluation and learning should be widely shared.

7. Supporting information

7.1 Information submitted to the review

The following documentation informed the review

1. Elective Orthopaedic Care: Case for Change and outline model
   (Draft v1.0, March 2016)

2. Our Healthier South East London Outline specification for an elective orthopaedic centre
   (Draft v8, March 2016)

3. Planned Care: Elective Orthopaedic Centre Drfaft Evaluation Criteria
   (v9, March 2016)

4. Equality Analysis guidance and template and Equality Analysis Screening
   South London Commissioning Support Unit, Version 1.0, 08.05.2014)

5. Report to the Partnership Executive on the Planned Care Elective Orthopaedic Workshop (28 January 2016)

6. Our Healthier South East London Consolidated Strategy
   (Draft v2.0, August 2015)

7. List of attendees at three elective orthopaedic care clinical workshops held on 13 November 2015, 27 November 2015 and 8 January 2016 and a meeting with Professor Tm Briggs held on 16 March 2016

8. Our Healthier South East London Planned Care Reference Group
   a. Report from the first meeting (25th January 2016)
   b. Report from the second meeting (16th March 2016)

9. Planned Care Reference Group database (anonymised)

10. TARN (the Trauma Audit & Research Network) for the South East London, Kent and Medway Trauma Network Clinical Reports (July 2015 and April 2016)

11. National Peer Review Report: Major Trauma 2015 – An overview of the findings from the 2015 National Peer Review of Trauma Networks, Centres and Units in England (NHS England, 29 September 2015)

12. National Peer Review Visit Report for the South East London, Kent and Medway Trauma Network (28th January 2015)

13. D15/S/a The NHS standard contract for Major Trauma Services (all ages), Schedule 2 – the Service Specification

14. The Review Team also considered:

    - A national review of adult elective orthopaedic services in England: Getting it Right First Time (British Orthopaedic Association, March 2015)
    - BOA Professional Guidance to Implementing Getting it Right First Time in England (British Orthopaedic Association, February 2016)

- Helping NHS providers improve productivity in elective care (Monitor, October 2015)
- Getting it Right First Time National Professional Pilot Report for Guy's and St Thomas' NHS Foundation Trust (June 2014)
- Getting it Right First Time National Professional Pilot Draft Report for King's College Hospital NHS Foundation Trust (June 2014)
- National Hip Fracture Database annual report 20i5
- National Hip Fracture Database annual report 20i5 supplement (An analysis of 30-day mortality in 2014)
- National Hip Fracture Database Dashboards 2015 for hospitals within:
    - Lewisham Hospital
    - Queen Elizabeth Hospital
    - King's College Hospital
    - The Princess Royal Hospital
    - St Thomas Hospital
- Care Quality Commission Quality Report for Lewisham and Greenwich NHS Trust (Date of Publication: 13/05/14)
- Care Quality Commission Quality Report for Guy's and St Thomas' NHS Foundation Trust (Date of Publication: 24/03/16)
- Care Quality Commission Quality Report for Guy's and St Thomas' NHS Foundation Trust Community health inpatient services (Date of Publication: 24/03/16)
- Care Quality Commission Quality Report for King's College Hospital NHS Foundation Trust (Date of Publication: 30/09/15)

7.2 Review team enquiry sessions

ENQUIRY SESSION PROGRAMME – 19 May 2016

Time	Activity	Purpose/notes
14.00	Review Team preparatory session	• Finalise areas of enquiry • Finalise format / review team areas of inquiry
14.15-15.00	**Dr Malcolm Tunnicliff ,** Clinical Director and Consultant in Emergency Medicine, King's College Hospital NHS Foundation Trust and Deputy Director, South East London, Kent and Medway Trauma Network	• Explore Implications for emergency medicine alongside wider trauma management and system issues
15.00-15.45	**Mr Arfan M Malhi,** Consultant Orthopaedic Surgeon and Clinical Lead for Orthopaedics, University Hospital Lewisham, Lewisham and Greenwich NHS Trust **Dan Gibbs**, Divisional Manager for Orthopaedics, King's College Hospitals NHS Foundation Trust **Mr Yathish Shenava,** Consultant Orthopaedic Surgeon, Lewisham and Greenwich NHS Trust	• Explore views on the case for change, proposed model of care across the whole pathway, evidence and quality goals, impact on wider orthopaedic care, trauma care and the wider system, workforce, risks, measures of success
15.45-16.15	Drop in session: **Dee Parker**, Theatres Strategy Lead, Lewisham and Greenwich NHS Trust **Laura Bradly**, Divisional General Manager, Lewisham and Greenwich NHS Trust **Mr Peter Earnshaw**, Clinical Director for Orthopaedics, Guy's and St Thomas' Hospital NHS Foundation Trust **Imogen Head**, General Manager, Surgery, Guy's and St Thomas' Hospital NHS Foundation Trust	• The attendees have expressed interest in meeting members of the review team to discuss the proposals being considered and/or were unable to attend session on Friday 20 May 2016
16.15-17.00*	**Mr Ajeet Kumar**, Consultant Orthopaedic Surgeon and Clinical Lead for Orthopaedics, Queen Elizabeth Hospital, Lewisham and Greenwich NHS Trust	• As for the 15.00-15.45 session, (Mr Kumar was not able to attend at that time).
16.15-17.00*	**Dr Jonty Heaversage**, GP, Chair of NHS Southwark Clinical Commissioning Group, member of the Evaluation Group and of the Committee in Common	• Explore the proposals from the perspective of a GP provider as well as commissioner
17.00-17.15	Review Team discussion time	• Take stock of key points to share on Friday

Review Team members involved in this session: Professor Geoff Bellingan (Chair); Professor Colin Howie; Jude Monteath, Christiana Ozoemelam and Anna Swift.

*Review Team members split for these parallel sessions.

ENQUIRY SESSION PROGRAMME – 20 May 2016

Time	Activity	Purpose/notes
8.45-9.00	Review Team preparatory session	• Finalise areas of enquiry • Share key issues from 19 May session • Finalise format for the session
09.00 - 10.00	**Peter Gluckman**, Independent Chair Planned Care Reference Group (PCRG) **John King**, PPAG Chair, PCRG Member **Wendy Horler**, Keep Our NHS Public, PCRG Member **Eileen Smith**, Keep Our NHS Public, PCRG Member **Olivia O'Sullivan**, Save Lewisham Hospital, PCRG Member	• Opportunity to discuss the case for change and model of care across the whole pathway with representatives of patients, carers and members of the public involved in the process
10.00-10.45*	**Dr Mick Jennings**, Consultant Anaesthetist - Critical Care, Lewisham and Greenwich NHS Trust	• Purpose as for 13.15-14.00 session (unable to attend the later session)
10.00 – 10.45*	**Sally Sampson**, Occupational Therapy lead, Guy's and St Thomas' NHS Foundation Trust **Jacky Jones**, Physiotherapy Lead, Guy's and St Thomas' NHS Foundation Trust **Jane Sykes**, Lead Physiotherapist, King's College Hospital NHS Foundation Trust **Lucy Carter**, Head of Therapies, Health and Social Care, Lewisham and Greenwich NHS Trust	• Opportunity to discuss the case for change and model of care with allied health professionals involved in the delivery of elective orthopaedic care and across the overall pathway including the interface with community care
10.45 – 11.00	**Susan Davis**, Head of Nursing, Surgery, Guy's and St Thomas' NHS Foundation Trust **Janice Allen**, Head of Nursing, Surgery, King's College Hospital NHS Foundation Trust **Nicky Smith**, Orthopaedic CNS/Team Leader, Lewisham and Greenwich NHS Trust Ian MacLennan, Head of Nursing, Lewisham and Greenwich NHS Trust [unable to join the discussion]	• Opportunity to discuss the case for change and model of care with senior nursing involved in the delivery of elective orthopaedic and considering the overall pathway including the interface with community care
11-30-12.15	**Mark Easton**, Programme Director **Professor Jules Wendon**, Medical Director, King's College Hospital NHS Foundation Trust (member of the Clinical Executive Group) **Dr Ian Abbs**, Medical Director, Guy's and St Thomas' NHS Foundation Trust (member of the Clinical Executive Group)	• Opportunity to discuss the case for change, model of care and process with the person who requested advice (on behalf of the six CCGs) and those with leadership roles in the overall Our Healthier South East London programme including how the Review Team's advice will be used
12.15-12.45	**Dr Tina Sajjanhar,** Our Healthier South East London Paediatric Lead and Consultant Paediatrician, Lewisham and Greenwich NHS Trust	• Opportunity to consider the interface with and any implications for children and young people who require orthopaedic care and how these are being addressed within the overall model of care
12.45 - 13.15	Lunch break	• Take stock of progress - review/reaffirm areas of enquiry for the afternoon session

*Review Team members split for these parallel sessions

Time	Activity	Purpose/notes
13.15-14.00*	**Dr Anuj Chaturveti**, Planned Care Lead, NHS Greenwich Clinical Commissioning Group	• Propose Gary plus other members (tbc) meet Anuj
13.15 – 14.00	**Dr Simon Cottam**, Critical Care Clinical Director, King's College Hospital NHS Foundation Trust **Dr Eoin Sherry**, Consultant Anaesthetist and Head of the Department of Anaesthesia, Guy's and St Thomas' NHS Foundation Trust [unable to attend] **Dr Jonathan Watkiss**, Anaesthetic Lead, Guy's and St Thomas' NHS Foundation Trust [unable to attend]	• Explore the implications and impact of the proposals and model of care for anaesthetic and critical care services and in the context of overall orthopaedic and trauma care • Also to explore the approach to managing deteriorating patients within the model of care
14.00 - 15.00*	**Mr Adel Tavakkolizadeth**, Major Trauma Centre Lead at King's College Hospital and CCG Trauma & Orthopaedic Lead for the Trauma Network, Consultant Upper Limb & Orthopaedic Surgeon King's College Hospital NHS Foundation Trust **Mr Peter Earnshaw**, Clinical Director for Orthopaedics, Guy's and St Thomas' Hospital NHS Foundation Trust **Mr Patrick Li**, Elective Orthopaedic Clinical Lead, King's College Hospital NHS Foundation Trust **Mr Joydeep Sinha**, Clinical Director for Orthopaedics, King's College Hospital NHS Foundation Trust **Mr Marcus Bankes**, Consultant Orthopaedic Surgeon, Guy's and St Thomas' Hospital NHS Foundation Trust **Miss Diane Back**, Consultant Trauma and Orthopaedic Surgeon, Guy's and St Thomas' Hospital NHS Foundation Trust and Training Programme Director for South East London	• Explore views on the case for change, proposed model of care across the whole pathway, evidence and quality goals, impact on wider orthopaedic care, trauma care and the wider system, workforce, risks, measures of success
15.00– 15.45	**Dr Jugdeep Dhesi**, POPS (proactive care of older people going to have surgery) Team Clinical Lead, Guy's and St Thomas' NHS Foundation Trust **Dr Dan Bailey**, Clinical Lead, Care of the Elderly, King's College Hospital NHS Trust **Dr Liz Aitken**, Consultant Geriatrician, Lewisham and Greenwich NHS Trust	• Explore the implications and impact of the proposals and model of care on the care of older people across the whole pathway • Also to explore the approach to managing deteriorating patients within the model of care
16.00 – 17.00	Review Team discussion time	• Debate findings and conclusions from discussions over the two days
17.00	Session ends	

*The Review Team split for these parallel sessions

8. Review Team members

Professor Geoff Bellingan (Chair)

Geoff Bellingan is professor of critical care medicine at University College London and medical director for surgery and cancer at University College London Hospitals NHS Foundation Trust (UCL). He is a critical care consultant with an active research interest in acute lung injury and is currently leading two international clinical trials on novel therapies for acute lung injury. He has been Medical Director for surgery and cancer at UCLH for the last six and a half years. As chair of the NCL/NEL cancer unification board he oversaw the successful service moves of a number of complex cancers across North Central and East London and West Essex. He is senior responsible officer for delivering Proton Beam Therapy at UCLH. He is a member of the London Clinical Senate Council.

Professor Colin R Howie

Colin is an Honorary Professor at the University of Edinburgh and Consultant Orthopaedic Surgeon at the Royal Infirmary of Edinburgh, Lothian University Hospitals NHS Trust. Colin is a Past President of the British Orthopaedic Association and the British Hip Society. He is the Orthopaedic advisor to Chief Medical Officer for Scotland and Clinical Lead for the Getting ir Right First Time (GIRFT) Access Report Scotland. Colin is a member of the Interventional Procedures Committee at the National Institute for Health and Care Excellence.

Mr Tahir Khan

Tahir is a consultant orthopaedic surgeon currently working at the Royal National Orthopaedic Hospital in Stanmore in the Young Adult Hip Unit. He was appointed as a consultant orthopaedic surgeon at Central Manchester University Hospitals in October 2002, where he established a high quality lower limb and childrens' orthopaedic surgery practice before relocating to Stanmore in May 2013. Tahir trained in the north-west of England (Sheffield, Birmingham and Manchester) and undertook specialist fellowship training in the USA, Toronto, Canada, and Mainz, Germany.

Tahir's experience and interests include children's orthopaedics, hip and knee surgery (hip and knee arthroscopy, realignment osteotomies, primary total hip replacement) and in particular hip pain in children, adolescents and young adults. Tahir is particularly interested in hip preservation surgery and offers arthroscopic hip surgery and osteotomies around the hip joint.

Tahir has always enjoyed the interaction with patients and takes time to discuss all treatment options, looking at alternatives and explaining things clearly.

Dr Susan J La Brooy

A Consultant Physician in Acute Medicine and Care of the Elderly in a medium-sized District General Hospital in London throughout her career, Susan has managed a portfolio career over this time, which has always been driven by a commitment to improving care for patients.

Susan has had experience in developing Care of the Elderly Services within her own Trust and Health Community but also contributed to the National Service Framework for Older People nationally and helped other Trusts to develop their services through the Modernisation Agency.

As Trust Medical Director Susan took a lead for clinical governance and service improvement and this role and this was extended to the North West London sector, when she became one of the Medical Director for *Shaping a Healthier Future* (a programme to transform the way healthcare is delivered for people in in this part of London). Susan continues in this latter role at present with Clinical Lead responsibility for the transition of paediatric services and the delivery of the seven day service priorities, for which North West London is one of the areas in the first phase of implementation in England).

Susan has also held a London role in Postgraduate Medical Education as an Associate Dean at the then London Deanery and lead for pan London Trust Liaison.

She continues to support development of learning by acting as coach and mentor to health professionals

Dr Gary Marlowe

Gary trained at St Bartholomew's Medical school and has worked as a GP in City and Hackney for the last twenty years. He is a member of City and Hackney Clinical Commissioning Group's (CCGs) Governing Body. Gary is an executive member of the British Medical Association (BMA) and actively campaigns for the NHS that holds true to its founding principles. He is clinical lead for the CCG's Planned Care Programme Board and ultimately believes joint patient and professional development of pathways across primary and secondary care will deliver the best and most cost effective care.

Mr Iain McFadyen

Iain is experienced consultant in Trauma and Orthopaedics with a full-time trauma practice. He has a special interest in complex upper and lower limb fractures, non-union, bone infection and deformity correction. Whilst undertaking internal fixation of all types of fractures, he is also an expert in the use of circular fixators including Ilizarov and Taylor Spatial frames.

Iain was previously Chief of Trauma in Brighton where he helped lead the establishment of major trauma systems on the South East Coast. He is National Director of Clinical Audit for the UK's Trauma Audit and Research Network (TARN) and co-chairman of the Fracture Guidelines Development Group for the National Institute for Health and Care Excellence (NICE).

Iain is a keen educator and teaches on instructional courses for healthcare professionals locally and internationally. He is the current Chair of the AO UK Current Concepts in Trauma Management Course, the AO Europe Masters Course in Intramedullary Nailing and the AO Europe Masters Course in Bone Reconstruction.

Iain has published scientific papers in trauma in peer-reviewed professional journals and has authored orthopaedic textbook chapters. He assists with editorial reviews for *The Journal of Bone and Joint Surgery, The Journal of Orthopedic Trauma, and Injury*

Jude Monteath

Jude is a Consultant Physiotherapist and has been working as a Clinical Chartered Physiotherapist for most of her career, progressing to Consultant Physiotherapist latterly. During that time her clinical speciality has always been MSK and Orthopaedics and currently she is a Consultant Physiotherapist in the Orthopaedic Shoulder Clinic at Barnet Hospital, which is part of the Royal Free Hospital. She continues to develop her clinical skills in her extended role at every opportunity including recently becoming an independent prescriber. During this time she has also had Senior Management roles and worked as Head of Therapies, General Manager, Assistant Director of Ops for Pharmacy and Therapies and been on the Trust Board.

She has worked with her professional body (The Chartered Society of Physiotherapy) on many developments and in an advisory capacity. As part of her clinical development role she has been involved in MSK developments of all descriptions for this Trust and its predecessor organisations, including being on the Better Care for Orthopaedics and involved in numerous Modernisation Agency strategies for Orthopaedics.

She is holder of the Health Foundation Leadership Award and is a Fellow of the Modernisation Agency. Main interests now are in clinical work and her Consultant role and in designing and taking forward service developments in the MSK field.

Jacqueline Sealey

Jacqueline is a retired Lead Inspector for the Adult Learning Inspectorate and is also a trained Ofsted Inspector. During the course of her career in Education, Jacqueline has held several other senior roles, including Director of Post Schools Education in an Inner London borough; Vice-Principal at a College of Further Education; Associate Professor of Warwick University re. Women and Gender; Team member re. BA/MA courses in Multicultural Education and Senior Lecturer in the English as a Foreign Language Department at Surrey University, and Head of a school for pupils with emotional and behavioral difficulties in Surrey. Amongst other roles, Jacqueline has been a member of the Cabinet Office's Public Appointments Committee; the BBC's former General Advisory Council and Performing Arts Fund.

She was Non-Executive Director of Brent and Harrow Health Commissioning Agency, with responsibility as Lay Chair for Medical Physics, oversight of the St. Mary's Hospitals NHS Foundation Trust and Equal Opportunities, then elected Chair.

Jacqueline is closely involved in Hillingdon Clinical Commissioning Group (CCG) and is a member of Healthwatch Hillingdon, her practice Patient Participation Group, is Lay Member of the Board of Directors of "Metro Health" Providers, comprising 16 GP practices and a member of the CCG's Procurement Team for Community Chronic Pain Services.

Jacqueline has been a member of the Clinical Senate's Patient and Public Voice Group since its inception in 2013 through which she has provided advice to the London Health Commission and to inform the Strategic Commissioning Framework for Primary Care Transformation in London. She is a member of the London Diabetes Strategic Clinical Network and has spoken about diabetes at the Clinical Senate Forum.

Anna Swift

Anna qualified as a registered nurse in 1999 and has worked in the acute setting ever since gaining experience in the Emergency Department, maxillofacial inpatients and finally as a Matron for Surgical Specialities including trauma and orthopaedics.

Anna has been involved in several strategic projects including reorganising existing services and managing transition locally.

Christiana Ozoemelam

Christiana is a member of the London Clinical Senate Patient and Public Voice Advisory Group. She is passionate about improving the quality of healthcare service provision, empowering people and reducing inequality. She has a wealth of experience in patient and public engagement, quality improvement and capacity building in the voluntary, public and private sector.

Dr Adrian Wong

Adrian is a consultant in intensive care medicine and anaesthesia at Oxford University Hospitals NHS Foundation Trust. He has an interest in clinical governance, medical education and point-of-care ultrasound.

He is past chair of the Intensive Care Society Trainee Committee and current member of the European Society of Intensive Care Medicine NEXT Committee. Adrian is passionate about the use of technology and new media to improve medical education and patient care.

9. Declarations of interests

The London Clinical Senate provides independent and impartial advice. The Review Team did not include anyone who has been involved in the development of the proposals on which we are giving advice or who has been involved in, or is likely to be involved in, any part of NHS England's assurance process for these proposals. All Review Team members formally declared their interests and no conflicts exist.

The review process involved discussions with a range of stakeholders in south east London. This included Dr Ian Abbs, Medical Director for Guy's and St Thomas' NHS Foundation Trust, who is a member of the London Clinical Senate Council. Dr Abbs has had no other involvement in this review process.

The Senate Council includes four other members associated with south east London. These members have also had no involvement in the review process.

10. Review terms of reference

INDEPENDENT CLINICAL REVIEW: TERMS OF REFERENCE

Title: Advice on proposals for elective orthopaedic care in South East London

Sponsoring Organisation: Our Healthier South East London, a collaboration of the 6 Clinical Commissioning Groups (CCGs) in South East London (Bexley CCG, Bromley CCG Greenwich CCG, Lambeth CCG, Lewisham CCG and Southwark CCG).

Clinical Senate: London

NHS England regional or team: NHS England (London)

Terms of reference agreed by:

Professor Geoff Bellingan, Clinical Senate Council member and Review Chair

on behalf the London Clinical Senate and

Mark Easton, Programme Director, Our Healthier South East London

on behalf of Bromley, Bexley, Greenwich, Lambeth, Lewisham and Southwark CCGs

Date: 29 March 2016

Aims and objectives of the clinical review

Our Healthier South East London, a collaboration of the six CCGs in South East London, has asked the Clinical Senate to provide independent clinical advice on proposals for elective orthopaedic care. The proposals centre on opportunities to improve quality and outcomes by consolidating elective inpatient orthopaedic care and reflecting networked solutions championed in the report *Getting it Right First Time, A national review of adult elective orthopaedic services in England* by Professor Tim Briggs, published in March 2015.

The Clinical Senate has been asked to provide the following advice:

1. Whether the clinical case for change and proposed model for elective orthopaedic care are underpinned by a clear clinical evidence base (where this exists)

2. Whether the proposed clinical model is considered to be clinically safe and has the potential to improve safety of care compared to the current model, in particular:

    a. Whether the proposed model of care poses any risks to the continuation of a clinically robust trauma system in South East London
    b. The potential of the proposed model of care to enable standardisation through the adoption of best practice and to improve the management of complex cases

3. The potential of the proposed clinical model to improve the quality of elective orthopaedic care.

Background

Our Healthier South East London (OHSEL) is a five year commission strategy which aims to improve health, reduce health inequalities and ensure all health services in south east London (SEL) meet safety and quality standards consistently whilst being sustainable in the longer term. An integrated whole system model has been developed through six clinical leadership groups which each focus on different parts of the health system.

OHSEL reports that orthopaedic services in SEL are generally safe and high quality and that over the last ten years waiting times have come down considerably and there has been substantial investment in the service. However, services are under considerable pressure and this expected to intensify as demand increases and the pressures on NHS finances increases. OHSEL identifies the challenge as how to improve the quality of care and meet waiting times standards for elective orthopaedic care in the face of a growing population and constrained finances.

OHSEL has considered elective orthopaedic care in SEL drawing on *Getting it Right First Time, A national review of adult elective orthopaedic services in England* (March 2015). Through a series of workshops involving clinicians, managers and patient representatives, the planned care group confirmed a case for change and proposed that the case for consolidating elective orthopaedic procedures within SEL to provide standardised pathways of care should be developed and evaluated. A range of expected benefits have been identified.

Several options for consolidating elective orthopaedic care have been developed. The emerging model of care is to consolidate elective inpatient services from the current eightsites to two sites whilst retaining outpatient, day case and trauma services locally as currently configured.

Draft evaluation criteria have been developed and work is taking place to identify and evaluate specific options. If required, public consultation on specific proposal for service change would take place in the autumn.

Scope of the review

This review relates to the proposed model for elective orthopaedic inpatient care. The interface with other orthopaedic care and services and interdependencies with other clinical services will need to be considered in order to provide the advice requested.

The advice relates to the model of care only. Options evaluation is outside the scope of this review. Advice provided by the Review Team may inform the evaluation process.

Review team members

The Review Team will be chaired by **Professor Geoff Bellingan**, a member of the Clinical Senate Council, Medical Director, Surgery and Cancer Board and Consultant in Critical Care, University College London Hospitals NHS Foundation Trust and Professor in Intensive Care Medicine, University College London.

Overall membership of the Review Team will include clinicians with expertise in **orthopaedics, critical care, paediatric care, older people's care, anaesthesia, trauma/ emergency care, rehabilitation and general practice** and will be multi-professional, including medical, nursing and allied health professional expertise. There will be two members from the Clinical Senate's **Patient and Public Voice Group.** Membership will include external expertise, independent of London, as well as expertise from areas within London unrelated to the changes proposed. Advice on membership will be sought from the London Clinical Senate Council and Forum members with relevant expertise, relevant clinical networks and professional bodies. The Review Team will seek advice from other independent experts on specific issues if indicated.

The Review Team will not include anyone who has been involved in the development of the south east London proposals or who has been involved, or is likely to be involved, in any other part of NHS England's assurance process for these proposals. All Review Team members will be required to formally declare any interests and to sign a confidentiality agreement.

Methodology

The Review follows current guidance[27] on the role of clinical senates in providing clinical advice to inform NHS England's service change assurance process. It will involve the following key steps:

Step 1: **Establish the Review Team**

Step 2: **Brief the Review Team** and circulate key documentation for desk-top assessment (the proposed schedule of documentation is considered on page 4)

Step 3: Hold a **Review Team meeting/teleconference** to:

a. agree the overall methodology that will be applied to formulate the advice
b. share desk-top assessment findings
c. identify issues that need to be explored, clarified or validated to assist in formulating the advice
d. agree any further information/documentation that Review Team members agree to be required to inform the review (and advise the OHSEL Programme Team)

Step 4: Hold **Review Team "enquiry sessions"** (over 2 days) in South East London to undertake the following:

a. Meet and discuss the proposals with stakeholders involved in their development to explore key lines of enquiry
b. Provide an opportunity for other clinical stakeholders impacted by the proposals to share views with the Review Team
c. Debate findings within the Review Team and finalise conclusions
d. Identify any outstanding issues and agree the process for following up (and further Review Team discussion as agreed necessary).

Step 5: **Prepare a report** setting out overall findings, conclusions, advice and any recommendations; circulate to the Review Team
Hold a meeting/teleconference with the Review Team to discuss the draft report content and agree any amendments

Step 6: Once agreed by the Review Team**, share the report with the Clinical Senate Council** which will:

- Ensure terms of reference have been met
- Comment on any specific issues where identified by the Review Team
- Agree that the report can be issued.

Subject to the schedule of Council meetings the Senate Council Chair may undertake this on the Council's behalf.

Step 7: **Issue the report and advice**.

In determining the review approach and formulating advice the Clinical Senate Council and Review Team will draw on the following, which include guidance on testing an evidence base:

- Clinical Senate Review Process: Guidance Notes, NHS England, August 2014
- NHS England's Service Change Toolkit
- Planning, assuring and delivering service change for patients, NHS England, November 2015

[27] Clinical Senate Review Process: Guidance Notes (NHS England) August 2014

The Clinical Senate Council has also agreed a set of principles which it believes are essential to improving quality of care and outcomes. The Council will seek evidence of, and promote, these principles in the issues it considers and the advice that it provides. They are:

- Ensuring a **seamless patient journey**
- Being **patient-centred** (this includes patient experience, tackling inequalities – in
- access and outcomes – and being responsive to the diversity within London's population)
- **Supporting self-care**
- **Improving standards** ⎫ (these include use of evidence and research, application of
- **Improves outcomes** ⎭ national guidance, best practice and innovation)
- Ensuring **value** (this includes issues such as long term sustainability, implications for the clinical workforce, consideration of unintended consequences)

Documentation required

In formulating advice the Review Team will draw on previous work undertaken and documentation that has informed and been developed by the OHSEL programme. The OHSEL Team will make relevant documentation available to the Review Team together and, if necessary, an overarching "navigator" paper which will guide Review Team members through the programme's history and the significance of documentation provided, including pointers to relevant sections/pages of documents where the whole document is not relevant.

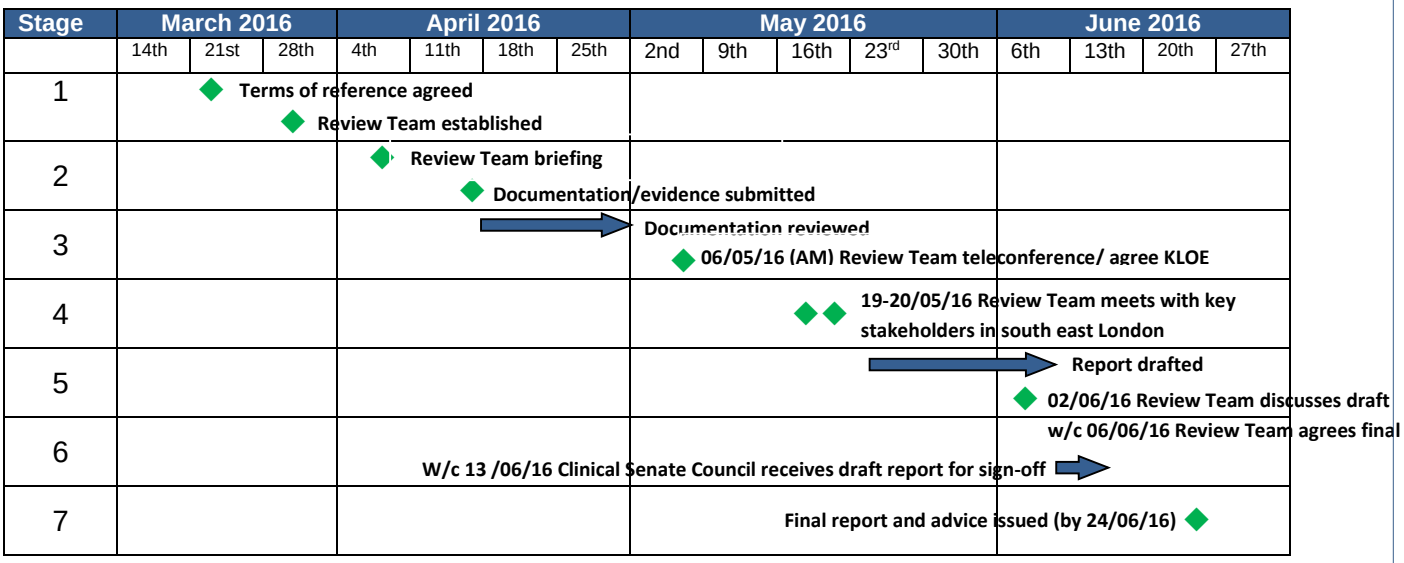
The documentation that will inform this review is anticipated as follows. Excluding those marked with an asterisk*, documents will be provided by OHSEL. Further requirements may be confirmed following establishment of the Review Team.

- A national review of adult elective orthopaedic services in England, Getting it Right First Time (March 2015)*
- Getting it Right First Time, Improving the Quality of Orthopaedic Care within the National Health Service in England (September 2012)*
- The case for change (rationale for the proposed change and evidence base)
- Proposed clinical model (description, rationale and evidence base)
- Supporting activity and workforce data and modelling, patient flows and pathways, performance against key quality indicators benchmarking data/patient experience data/ PROMS – available information should be provided initially and any further specific requests will be discussed with the OHSEL team
- Latest National Trauma Peer Review reports and the Trauma Audit and Research Network data
- Criteria to evaluate options for delivering the proposed model of care and approach
- Schedule of evidence and best practice that have informed the proposals
- CQC inspection reports (planned care services)* - to be accessed via www.cqc.org.uk
- Equality Delivery System (EDS2) report(s)
- Draft strategic and transformation plans (relevant extracts)
- Other relevant/local strategies/service reviews on orthopaedic / interdependent services
- Process used to develop the proposals including staff, service user and public involvement
- Programme risk log

The Review Team will formulate advice requested based on consideration and triangulation of documentation provided, discussion with key stakeholders and members' knowledge and experience. The advice will be provided as a written report.

Timeline

OHSEL has requested that the advice is available before the end of June 2016. NHS England's assurance process commences in July 2016.



Risks

It is essential that the processes through which the Clinical Senate formulates advice are robust and the approach outlined is designed to do this. Recruiting appropriately experienced Review Team members who are available on the key dates set for the review and ensuring adequate time to prepare for key activities are the most critical elements and pose the greatest risk. Every effort will be made to mitigate this risk.

Reporting arrangements

The Review Team will report to the Clinical Senate Council which will agree the report and be accountable for the advice contained in the final report.

The Clinical Senate Council will submit the report to the sponsoring organisation and this clinical advice will be considered as part of the NHS England assurance process for service change proposals.

Report

A final draft report setting out the advice will be shared with the sponsoring organisation to provide an opportunity for checking factual accuracies prior to completion. Comments/correction must be received within 3 working days.

The final report will be submitted to the sponsoring organisation by 24 June 2016.

Communication and media handling

Our Healthier South East London will be responsible for publication and dissemination of the report. The expectation is that it will be made publicly available as soon as possible following completion. The Clinical Senate will post the report on its website at a time agreed with the sponsoring organisation.

Communication about the clinical review and all media enquiries will be dealt with by the sponsoring organisation.

If helpful, the Clinical Senate will support the sponsoring organisation in presenting the review's findings and explaining the rationale for the advice provided e.g. at a key stakeholder meeting subject to discussion and availability of Review Team members.

Disclosure under the Freedom of Information Act 2000

The London Clinical Senate is hosted by NHS England and operates under its policies, procedures and legislative framework as a public authority. All the written material held by the Clinical Senate, including any correspondence sent to us, may be considered for release following a request to us under the Freedom of Information Act 2000 unless the information is exempt.

Resources

The Clinical Senate will recruit Review Team members and cover members' reasonable expenses. It will also provide management support to the Review Team, including coordinating all communication relating to the review, documentation sharing, meeting organisation and report production.

The sponsoring organisation will identify a named contact to coordinate the provision of documentation and any other information requested and to assist in coordinating stakeholders' participation in the review at a local level, including organising accommodation for meetings.

If during the course of the review the Review Team identifies any additional requirements to formulate the advice requested, the Review Chair or Clinical Senate Programme Lead will, if necessary, discuss these with the sponsoring organisation and may seek resources for this.

Accountability and Governance

The Review Team is part of the London Clinical Senate accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the review report and its advice on the proposals for elective orthopaedic care to the sponsoring organisation. The sponsoring organisation remains accountable for decision making. The review report may draw attention to specific issues, including any risks, which the Clinical Senate believes the sponsoring organisation should consider or address.

If the Clinical Senate identifies any significant concerns through its work which indicate risk to patients it will raise these immediately with relevant senior staff in the organisation(s) involved. Please note that depending on the nature of the issues identified the Clinical Senate Council may be obliged to raise these with the relevant regulatory body(ies). Should this situation occur, the Clinical Senate Council Chair will advise the Chief Executives, Clinical Leads and Chief Officers of the provider and commissioning organisations involved.

Functions, responsibilities and roles

The **sponsoring organisation** will

i. provide the Review Team with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance and other documentation requested. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and commissioning intentions). The sponsoring organisation will provide any other additional background information requested by the Review Team (see page 4).
ii. respond within the agreed timescale to the draft report on matters of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical senate council and the sponsoring organisation will

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate Council will

ii. appoint a Review Team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
iii. endorse the terms of reference, timetable and methodology for the review
iv. consider the review recommendations and report (and may wish to make further recommendations)
v. provide suitable support to the team and
vi. submit the final report to the sponsoring organisation

Review team will

i. undertake its review in line with the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to the clinical senate council for comment, consider any such comments made and incorporate relevant amendments to the report. The team will subsequently submit a final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Review team members will undertake to

i. commit fully to the review and attend/join all briefings, meetings, interviews, panels etc. that are part of the review (as defined in the methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it.
v. declare, to the chair and the clinical senate manager, any conflict of interest prior to the start of the review and /or any that materialise during the review.

Contact details of key personnel coordinating the review process

For the London Clinical Senate:

Sue Dutch
Clinical Senate Programme Lead
Email: sue.dutch@nhs.net

Jaimie Cross
Clinical Senate Development Manager
Email: jaimie.cross@nhs.net

For Our Healthier South East London:

Tom Henderson
Project Lead for Planned Care
Email: tomhenderson@nhs.net