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Planned Care: Elective Orthopaedic Centres (EOCs)

A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

JHOSC
17 May 2016

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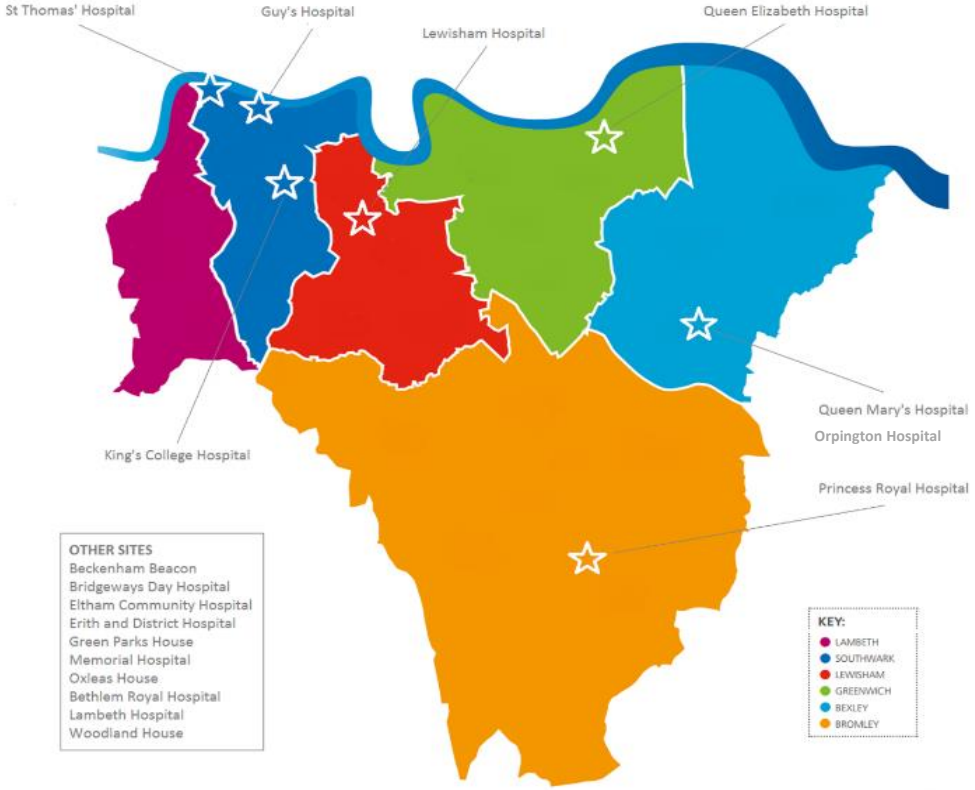
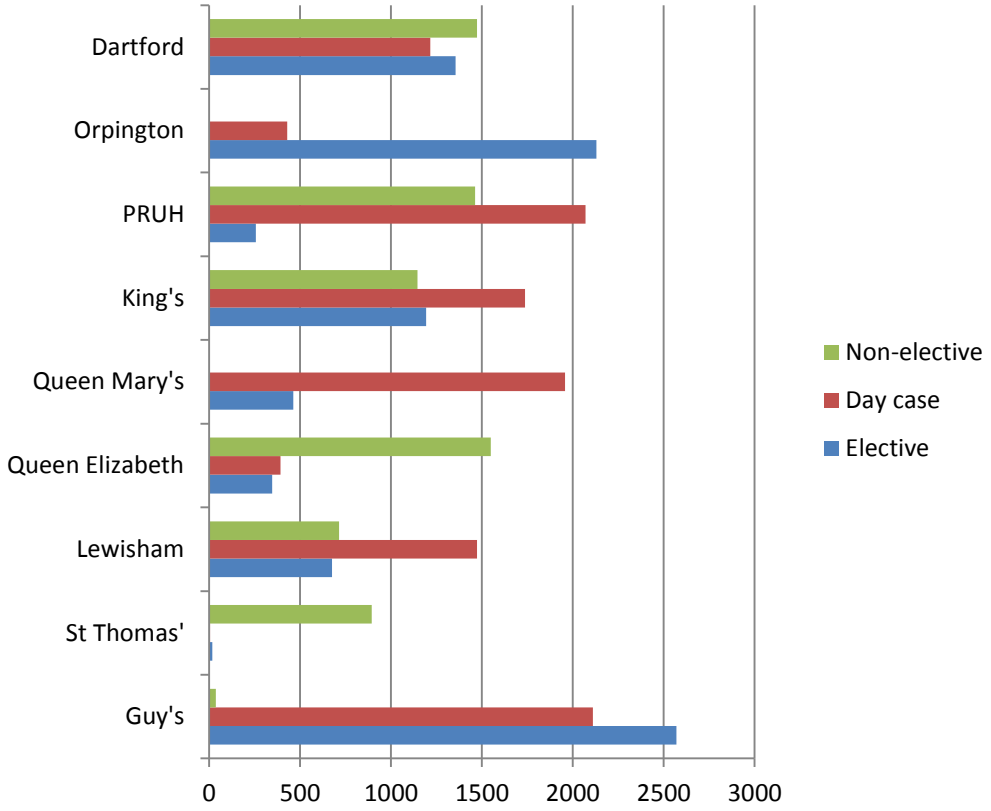
In south east London elective orthopaedic services are delivered across eight sites





Elective cases are inpatient waiting list case which can be planned in advance
Non-elective cases are emergencies
Day cases do not stay overnight

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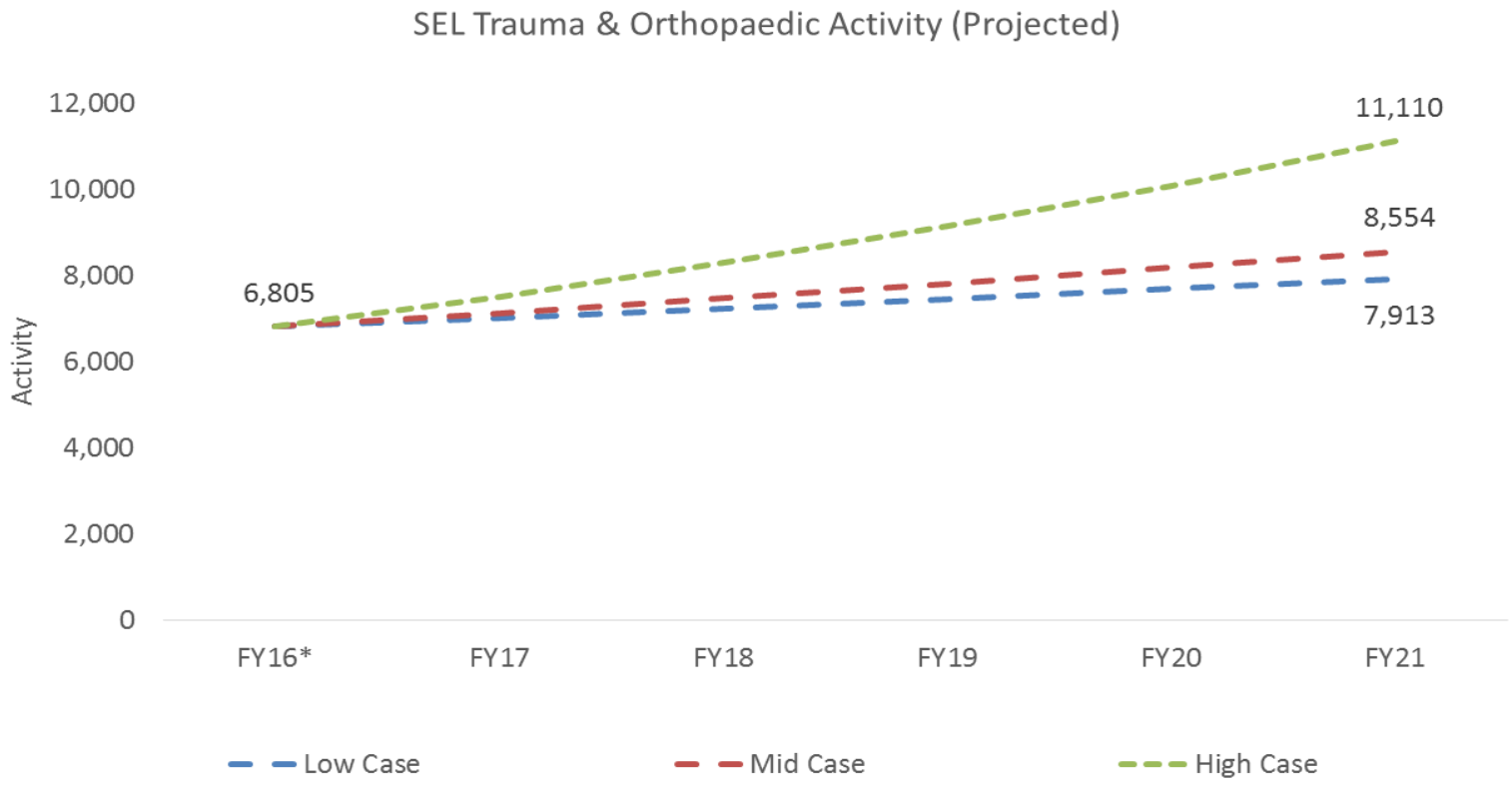
Demand for elective orthopaedic care is rapidly increasing



The green line shows the trend growth line. The blue line shows demographic growth. We are basing our planning on keeping growth to the red line through better management of out-of-hospital care.

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There is a compelling case for changing the way we deliver EOC

Meeting future demand	• Additional capacity will be needed to deliver elective orthopaedic care by 2021 based on demographic and non-demographic growth.
Patient experience	• Trusts are struggling to manage existing demand and keep to waiting time targets • Most beds are not ring fenced and so cancellations occur when hospitals are under pressure • While length of stay has improved it remains below the London average at most sites in south east London • Patient reported experience is variable across south east London
Quality, safety and outcomes	• Elective orthopaedics requires an environment in which the infection and complication risk is minimised • Evidence shows variability in hospital infection rates across south east London and trends over time in hospital infection rates show further improvements are required • Readmission rates are in line with the national average but there may be further opportunities to reduce further • Litigation costs are rising in the NHS and orthopaedic surgery account for about 14% of total claims • Surgeons undertaking low volumes of specialised activity results in less favourable outcomes as well as increased costs
Wider benefits	• There are opportunities to improve quality and costs through networking orthopaedic services

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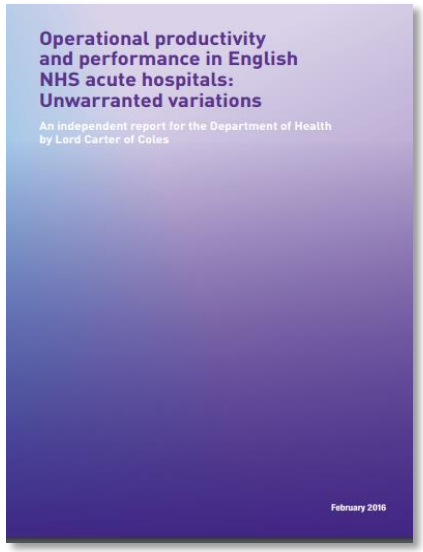
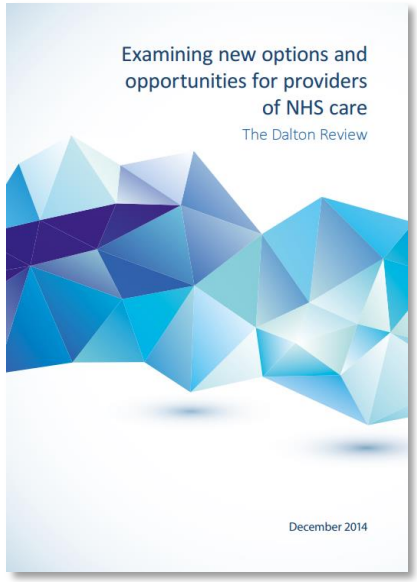
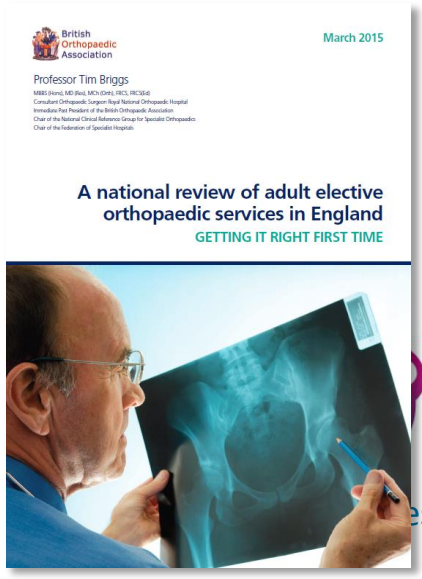
There are a number of national drivers supporting alternative models of delivering elective orthopaedics and encouraging consolidated services and partnership working

- Five Year Forward View – NHS England
- Getting it Right First Time – Professor Tim Briggs/British Orthopaedic Association
- Dalton review – Department of Health
- Carter review – Department of Health







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A series of provider and commissioner workshops held at the end of 2015/early 2016 agreed to devise a new model of service delivery to compare with the status quo

- Consolidation of elective inpatient services from the current eight sites to two sites; while retaining outpatient, day case and trauma services locally at base hospitals
- A higher quality and more efficient planned care pathway
- Exploring the case for consolidating specialist and complex cases
- Creating an orthopaedic network approach for procurement and service design
- A business model which ensure the financial benefits of consolidation benefits all providers rather than creating “winners and losers”
- This new model to be evaluated against the status quo / do minimum option

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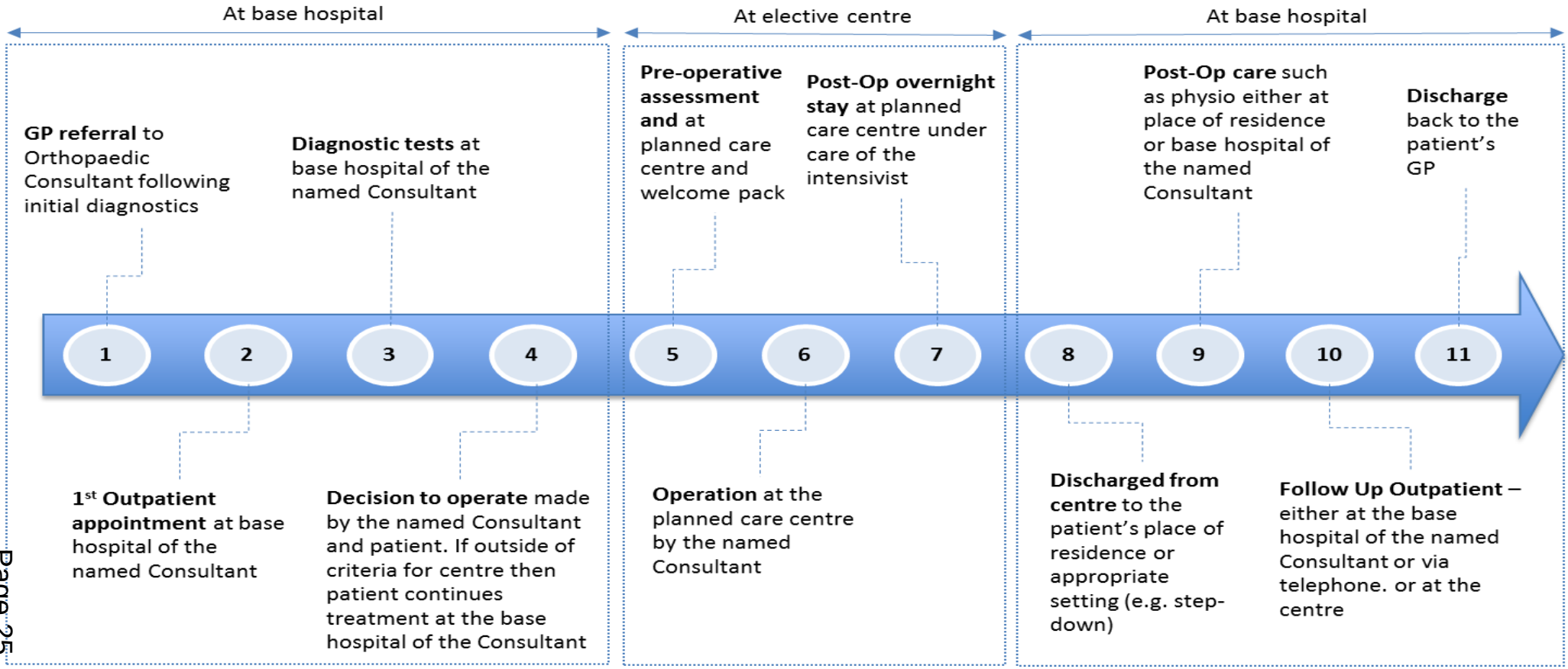
An outline 'pathway' has been developed

- Hosts would be expected to facilitate an optimised pathway so that elective orthopaedic care in south east London is as productive and safe as possible. Monitor[1] have set out 9 levers for improving productivity in elective care. These are summarised below:
- Standardising pathways and protocols
- Implementing effective performance management conditions
- Making visible leaders accountable for continuous improvement
- Using adaptive staff contracts
- Making efforts to engage patients and families in their own care
- The graphic below provides an example pathway on how elective centre(s) could work with base hospitals; and how patients will move between base hospitals and the elective centre for outpatients, treatment and rehabilitation. This is illustrative rather than prescribed but potential hosts are asked to describe how they will deliver this service.



1. Monitor (2015), Improving productivity in elective care

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Elective orthopaedic centre: outline model

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Summary
Elective orthopaedic care is delivered across two sites in south east London. **'**Local' or 'base' hospitals will continue to provide outpatient services, day case procedures, trauma and rehabilitation. This approach aims to improve efficiency to meet capacity and reduce variation in care.

Services
The full range of EOC services will be in-scope and include both routine and complex procedures. It is expected that providers will deliver these in a way that maximises throughput and efficiency.

Both sites will only focus on inpatient procedures. Trauma, day cases, outpatients and rehabilitation will be delivered at the base hospital. Some inpatient services may continue to be delivered where clinically appropriate to do so.

Depending on the final site some base hospital activities – such as outpatients – may also be delivered from the centre where it is a patient's local hospital.

Exclusions: Spinal surgery is currently out of scope and will be continued to be delivered as is.

Clinical dependencies and adjacencies
- Ring-fenced elective care beds and theatre services (cold site)
- Co-located with HDU and ICU
- Anaesthetics
- Routine diagnostic services (including radiology, pathology, pharmacy)
- Rehabilitation and occupational therapy services

Transport
Access is an important part of the model and is supported by the two-site option. Further work is required to identify an appropriate model.

Characteristics
Hosts should have all of the facilities and clinical adjacencies required to deliver the procedures in scope. These include:
- 'pre-hab' assessment and support as well as a defined team to manage ongoing patient care
- Access to musculoskeletal (MSK) radiology including CT and MRI
- Outpatient consultation rooms
- Access to critical care or high dependency unit when required
- Theatre inventory of equipment and implant components
- Ring-fenced beds/wards and theatres
- Links to other specialities including; vascular, plastic surgery, pathologist, radiotherapist and established multi-disciplinary team (MDT) network
- Access to step-down facilities
- Effective links with social care

Workforce
- Networked staff: staff will be drawn from across providers in south east London and will be supported by the appropriate contracting arrangements set out in the commercial model.
- Dedicated staff: the centre will directly employ some staff. This could include an orthopaedic team leader, nursing staff, anaesthetists, MSK radiologists, administrative and clerical staff, pathway co-ordinators

Volume and capacity
It is expected that each centre will need to accommodate around 4,500 procedures per year by 2021. This will require approximately 50 beds.

Commercial principles
It is expected that activity will be shared across hospitals with the EOC/s acting as a 'host' . It is therefore important, in order to mitigate the risk of 'winners and losers', that all providers accessing the centre/s agree to a shared set of commercial principles. Providers will be asked to submit their proposals on the commercial model based on the principle that base hospitals will retain ownership of activity undertaken by the EOC. This may take the form of a joint venture or profit share agreement or other model which remains true to the principle.

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The process to develop a new model of EOC will take place over a number of phases

Current phase: Present – September 2016

- Draft outline specification
- Site option identification
- Option appraisal
- Outline commercial (operating model) and management case (implementation route)
- Public engagement on the model and evaluation criteria
- Clinical and NHS England (NHSE) assurance
- Determine requirement for consultation

1: Strategic & Pre Consultation Case

September-November 2016

2: Consultation (if required)

- Run consultation (if required)

December 2016 – January 2017

3: Confirm preferred model

- Revise business case to reflect outputs from consultation
- Agree preferred model

January 2017 – Summer 2017

4: Outline business case

- Develop Outline Business case for each site (if required)
- Confirm detailed clinical model
- Confirm and agree detailed commercial model
- Alignment of business cases across sites
- Relevant clinical and regulatory assurance

From Summer 2017

5: Full Business Case / Implement

- Initiated preferred implementation route through agreed process
- Confirm plans for full business case (if required)
- Initiate any capital work

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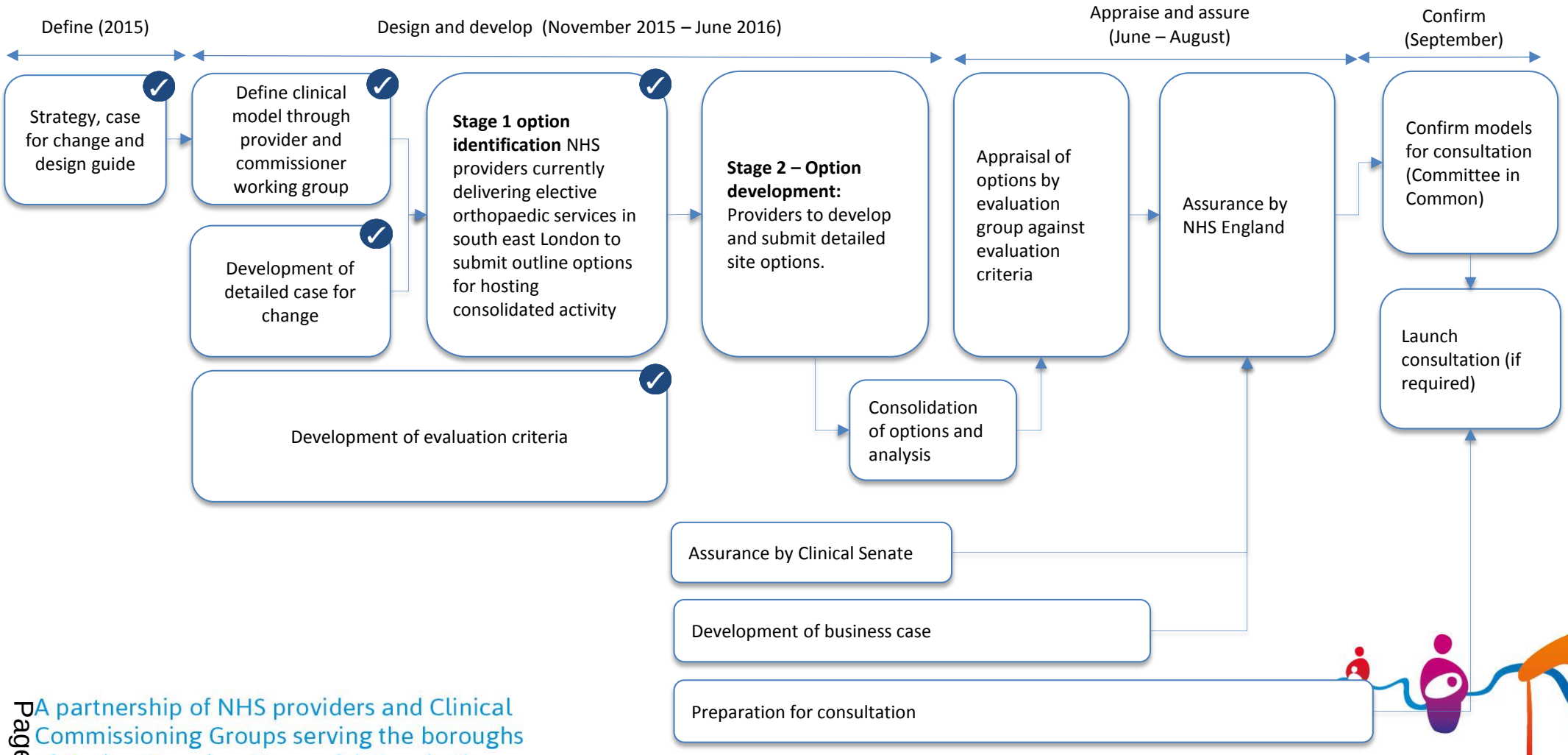
The current phase also has a number of important steps and includes the development and appraisal of options



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A number of groups will support the development of the clinical model

Group	Role	Membership	Frequency
Working group (clinical model and option development)	Develop the clinical model and business case: • Develop alternative clinical model • Build on clinical standards identified through workshop • Consider benefits and weaknesses of proposed clinical model • Confirm preferred clinical model to inform site option development	• Planned care delivery group Senior Responsible Officer (SRO), Director of Commissioning (DOC) and Director of Finance (DOF) • 2 Representatives from each acute trusts (via EOC network) • Supported by programme team	Fortnightly
Planned Care Stakeholder Reference Group	• Bring together stakeholders to consider and input into aspects of the programme • Suggested that this group meets 3 times throughout the process	• Equality groups/organisations most impacted • Healthwatch • Council for voluntary services or equivalent umbrella organisation • Current planned care service users	At key points in programme
Evaluation group	• Evaluates options against evaluation criteria based on additional analysis of options	• Commissioners – GP Leads and Directors • Patient and Public Voices • Local Authority representative • Clinical expert	3 times through process
Committee in Common	• Final decisions will be taken by the committee in common following recommendations form the evaluation group and other programme governance committees	• 3 members of each CCG (voting) • Lay members (non-voting)	As scheduled

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Planned Care Reference Group

As part of our public engagement work we established a reference group of interested members of the public to test our early thinking on the development of the new model. We have had two meetings with the group in January and March 2016.

Membership includes groups who are likely to be impacted by changes to planned orthopaedic services, such as older people, recent service users, Healthwatch, carers and people with a disability, campaign groups and voluntary and community group representatives.

Key feedback

- Overall, participants have said that their experiences matched the challenges facing local planned care services and reviewed the data/evidence behind them
- People would be prepared to travel if there was more certainty (procedures not being cancelled, higher quality services, more confidence in treatment given, better preparation and aftercare)
- When evaluating the options, quality should be prioritised over finances
- Careful consideration should be given to location of sites and transport/access links
- Further work needed to ensure that IT systems are compatible