DRAFT consultation document

Improving planned orthopaedic care in south east London

Supporting information

This document provides further information and data to support the information in the Improving planned orthopaedic care in south east London – consultation document. Each section and numbers relate to the relevant section within the consultation document. Links are included where there is further reading, programme reports, and external information that is also relevant.

[NB: all relevant information will be published on our consultation website]

Contents

Contents

Supporting information to section 1 – Introduction

We outlined briefly our wider plans for local services in our introduction to our consultation document. This section gives more details on how our proposals fit in with plans for local health and care.

Sustainability and Transformation Plan

Our consultation document sets out the case for introducing a new model of care for planned adult inpatient orthopaedic surgery in south east London. The proposals we are considering are the result of many discussions and several years of planning by the local NHS; however, they sit within a wider strategic piece of work, called the Sustainability and Transformation Plan (STP), which looks at many services and outcomes for the population of south east London.

The plan describes how local health and social care organisations will work together to ensure financial and clinical sustainability in the future.

Our proposals to improve orthopaedic services are among a number of initiatives being explored to help integrate services better and improve provision out of hospital, closer to people's homes.

We aim to improve mental and physical health and integrated care across south east London in several priority areas:

- Community based care
- Maternity
- Children and young people
- Cancer
- Planned care
- Urgent and emergency care
- Mental health

Each of these areas of work has been shaped over several years by a clinical leadership group, which includes clinicians, commissioners, social care leads and other experts, Healthwatch representatives and other patients and members of the public from across south east London.

The proposals outlined in this document for orthopaedic services fall within the 'planned care' workstream.

A key aspect of the plan is to develop a strong foundation of community-based care to support people to live healthier lives and avoid admission to hospital. This includes developing stronger links between social, primary and community care and working towards consistent standards of support in the community for patients both before and after surgery.

The STP process is important because it requires health and social care organisations to plan together to make sure services and resources are coordinated to deliver the best possible care now and in years to come.

The south east London STP is being jointly developed by clinical commissioning groups (CCGs), hospitals, community health services and mental health trusts, with the support of local councils and members of the public.

In addition to integrated and community based care, other key features of the south east London STP include:

NHS provider productivity and quality
Through the STP, the six provider NHS trusts in south east London are working together to improve care and strengthen the financial sustainability of the local NHS. This programme is crucial as it will ensure that trusts offer the best possible services in the most cost-effective way in the future.

Optimising specialised services
NHS England is leading a review of specialised services for people living in south London and those coming into the area for specialist care (a third of all specialised activity is from the South of England). There is potential for achieving quality improvement and better value for money in many specialist areas.

The Sustainability and Transformation Plan aims to achieve much better outcomes by:

- Supporting people to be more in control of their health and have a greater say in their own care

- Helping people to live independently and know what to do when things go wrong

- Helping communities to support one another

- Making sure primary care services are consistently excellent and with an increased focus on prevention

- Reducing variation in healthcare outcomes and addressing inequalities by raising the standards in our health services to match the best

- Developing joined up care so that people receive the support they need when they need it

- Delivering services that meet the same high quality standards whenever and wherever care is provided

- Spending our money wisely, to deliver better outcomes and avoid waste

Read more about these plans on our website: www.ourhealthiersel.nhs.uk

Supporting information to section 5 – Case for change

There are a number of issues that need to be addressed to make sure that everyone in south east London has access to the best orthopaedic services, in a way that is sustainable for the NHS in the future. This section gives further information on the case for change and includes additional data that was used in our analysis.

5.1 Meeting future demand

We have projected the number of adult patients in south east London who may need to have a planned inpatient orthopaedic procedure in the future under three scenarios:

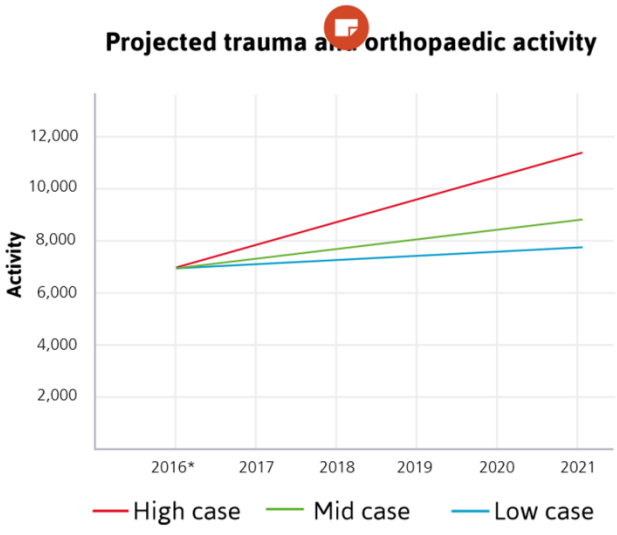
- Low case: This represents the minimum amount of demand we could experience in the future
- Mid case: This represents the middle amount of demand we could experience in the future
- High case: This represents the maximum amount of demand we could experience in the future

We have used the mid case scenario for most of our planning, and these figures are quoted in our consultation document. The mid case indicates that demand for planned adult inpatient orthopaedic surgery will increase by 25% by 2021 – from 6805 procedures to 8554 per year (Table 1 and Fig. 1).

Table 1: Projected increases in activity 2015 - 2021

Case	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Low	6805	7015	7232	7454	7681	7913
Mid	6805	7125	7461	7811	8175	8554
High	6805	7507	8283	9137	10076	11110

Figure 2: Projected increases in activity 2015 - 2021



There are a number of reasons for this, but increasing levels of obesity and an ageing population are the most significant factors. The NHS is introducing preventative initiatives to support people to stay fit and healthy, and therefore help reduce demand in the future, but, even taking this into account, numbers are expected to increase substantially.

Our mid-case projection assumes that the impact of NHS prevention and out of hospital care initiatives will slow the rate of increase. The high-case projection, which indicates demand of more than 11,000 procedures per year by 2021, will be reached if we are unable to slow the current trend.

This is not an issue affecting south east London alone. Nationally, referral rates are increasing by 7-8% per year. Since 2010, there has been an increase of 4% each year for hip replacements and 10% for other joint replacements.

If we don't take any action to change the way we provide these services then, using the mid-case scenario, we estimate that by 2021 south east London hospitals will need an additional 20 inpatient beds and seven operating theatres to accommodate growth in orthopaedic surgery.

Existing services won't be able to cope with this increase without expanding and becoming more productive and efficient. Providers have described the individual plans they could put in place for meeting this rising demand, however pressures continue to exist and it is a struggle to meet current patient demand.

We need to find a way to offer orthopaedic surgery to many more people than we can at the moment – and in a way that is cost effective – while offering patients the very best services and experience.

5.2 Quality, safety and outcomes

National evidence shows that there are opportunities to make orthopaedic services safer by reducing infection rates and minimising complications following surgery. This can be found in: Carter, Operational productivity and performance in English NHS acute hospitals: Unwarranted variations; and Getting it right first time report published by Prof Sir Tim Briggs.

Some surgeons carry out a small number of particular procedures each year. National evidence and agreed best practice suggest that where surgeons carry out a larger number of procedures, in dedicated facilities, patient safety and the results from surgery are consistently better. The full evidence for this can be found in the NHSE draft specification for specialised orthopaedics and Public Health England, Surgical Site Infection (SSI) surveillance.

5.3 Patient experience

Hospitals are struggling to manage existing numbers of orthopaedic patients and, because of this, waiting times for these services are longer than other NHS specialties (Table 2). Some trusts are also struggling to treat 90% of patients within 18 weeks of their referral (Table 3) – an important national performance target.

Table 2: Waiting times, south east London orthopaedics vs all other specialties

	Percentage of patients seen within 18

	weeks
Orthopaedics in south east London	88.2%
All other specialties in south east London	93.6%

Source: Getting it Right First Time, 2015

Table 3: South east London orthopaedic patients waiting (as of 31 Aug 2016):

	Under 18 weeks	Over 18 weeks	Total waiters	% within 18 weeks
Guy's	1932	246	2145	90.1
King's	5499	1400	6932	79.3
L&G	3158	683	3841	82.2

** Not all of these patients will necessarily progress to surgery*

Not all orthopaedic hospital beds and operating theatres in south east London are ring-fenced (reserved just for planned surgery) so planned procedures are often disrupted by emergency cases from A&E departments. The mixture of emergency and planned surgery does not make most effective use of our surgeons' time and skills and emergency surgery for fractures is understandably given priority over surgery planned in advance.

This often results in cancellations (Table 4), which have an adverse impact on patients' experience as well as on their families and carers.

Table 4: Planned procedures cancelled at each NHS trust in south east London compared to rates nationally and those at the Royal National Orthopaedic Hospital (a specialist centre with protected beds).

	Number of last minute planned operations cancelled for non clinical reasons	Number of patients not treated within 28 days of last minute cancellation of planned procedure	Percentage of patients not treated within 28 days of last minute cancellation of planned procedure
Royal National Orthopaedic Hospital	124	3	2%
Guy's and St Thomas'	816	44	5%
Lewisham and Greenwich	284	14	5%
King's College	1,155	79	7%
Dartford and Gravesham	270	36	13%
National	71,434	5,013	7%

** 'Planned operations' refers to all planned procedures, not solely orthopaedic operations*.

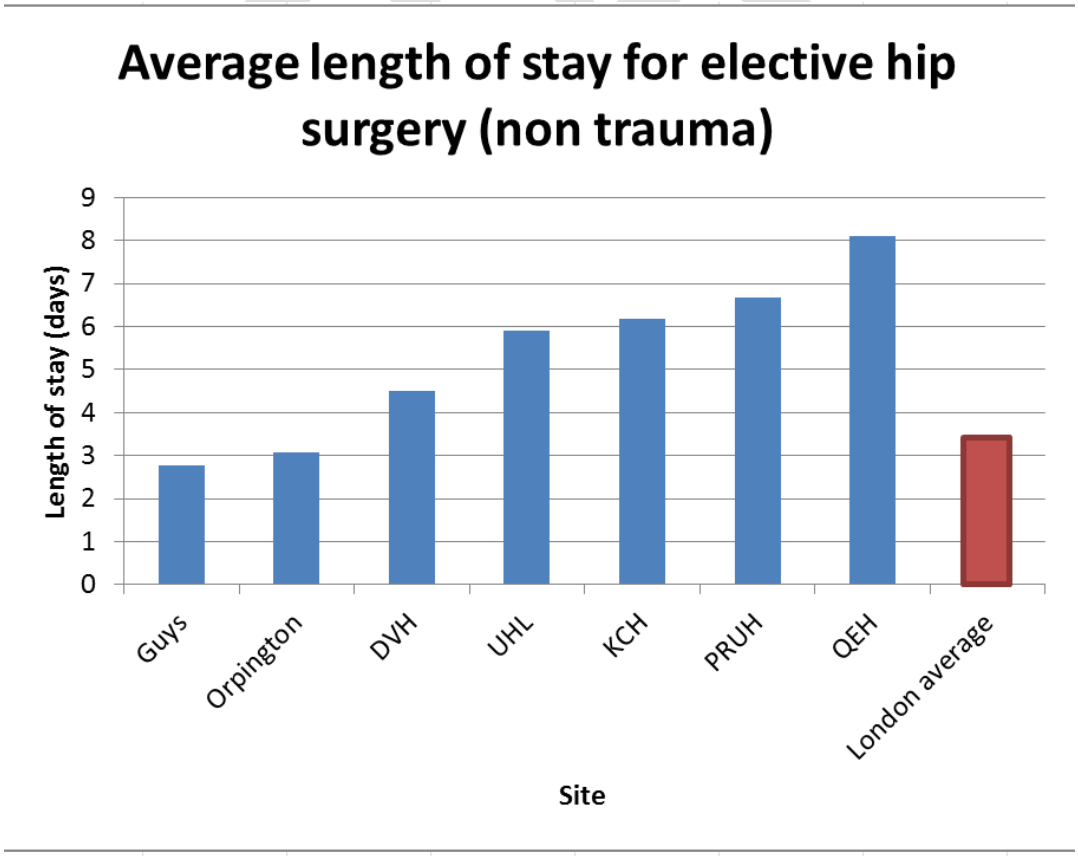
Feedback from patients, clinicians and members of the public shows us that experience of these services is variable. The quotes below are an example of this feedback and are

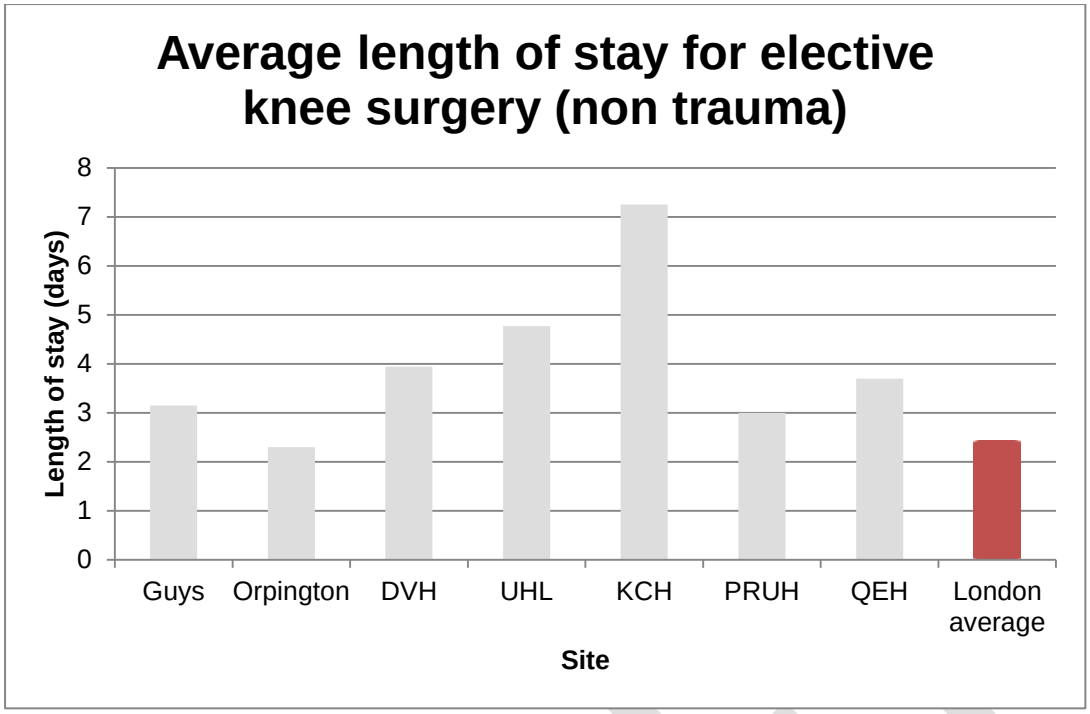
sources from Getting it Right First Time (a national report on the state of orthopaedic care) and through local engagement.

- *"With current services there are frequent delays. Pressures within hospitals to deliver emergency care are responsible for the cancellation of planned operations."*
- *"There is high demand for planned orthopaedics among patients with learning disabilities - cancelled operations are a major issue because these patients come to hospital earlier to prepare, then have to stay in hospital while their surgery is re-scheduled. It is very negative for them, carers and families."*
- *"Cancelled operations have a significant impact on patients' families and carers, so it is not just about the patient. We need to consider this carefully."*
- *"There are more cancellations where hospitals have a co-located A&E – it would be good to resolve this issue so that A&E cannot take beds away from planned services – ring-fenced beds would solve this dilemma."*

The length of time orthopaedic patients stay in hospital has improved. It does vary depending on the type of surgery undertaken at each hospital but, overall, it is longer in south east London hospitals than the London average (Fig. 3).

Figure 3: Current length of stay per procedure compared to the London average:





** HES data Aug 2014 – Sept 2015*

Supporting information to section 6: Responding to the case for change

Much research has gone into tackling the challenges faced by orthopaedic services across the NHS and other healthcare bodies, as outlined in section 6. This section includes further information about the *Getting It Right First Time* national study, as well as other sources of evidence.

Getting it Right First Time was published in March 2015 by Professor Sir Tim Briggs, orthopaedic surgeon at the Royal National Orthopaedic Hospital (RNOH) and President of the British Orthopaedic Association. The report considers the current state of England's orthopaedic surgery provision and suggests that changes can be made to improve the patient journey, patient experience and outcomes while working much more efficiently. It outlines the benefits of separating emergency and planned orthopaedic surgery and creating specialist orthopaedic centres with standardised processes, taking the view that this approach has the potential to achieve better care for patients.

In addition to *Getting it Right First Time* there is a range of guidance from bodies such as the National Institute for Clinical Excellence (NICE) and the British Orthopaedic Association, recommending the separation of planned and emergency surgery.

The Royal College of Surgeons, in this report, suggests that separating planned surgery and emergency surgery can result in earlier investigation, better treatment and better continuity of care, and can minimise hospital-acquired infections and the length of time patients have to stay in hospital.

Other evidence also demonstrates a link between the number of procedures carried out by a hospital (or an individual surgeon) and the chances of a successful outcome for the patient.

This indicates that:

- Hospitals and surgeons that care for larger numbers of patients are likely to produce better than average results
- Hospitals and individual surgeons treating very low numbers of patients are not likely to produce the best outcomes or best value for money

Similar approaches have been successful in England, such as the Royal National Orthopaedic Hospital (RNOH) and the South West London Elective Orthopaedic Centre (SWLEOC, Fig. 4). These are specialist orthopaedic centres, carrying out large volumes of surgery where high quality, cost efficient, planned orthopaedic services are ranked among the best available.

Centres like these, which have brought together surgery from across several hospitals into fewer, highly efficient facilities, consistently produce excellent results for patients, low complication rates and high patient satisfaction.

Figure 4: South West London Elective Orthopaedic Centre

SWLEOC (South West London Elective Orthopaedic Centre) is an NHS treatment centre providing regional elective orthopaedic surgery services (including inpatient, day case and outpatient).

Established by the four south west London acute trusts to deliver strategic change in the delivery of planned orthopaedic care, SWLEOC provides high quality, cost efficient, elective orthopaedic services ranked among the best in the world.

Since opening in January 2004, SWLEOC has earned a reputation as a centre of excellence for elective orthopaedic surgery with excellent outcomes, low complication rates and high patient satisfaction. Performing around 5,200 procedures a year, 3,000 of these joint replacements, SWLEOC is recognised as the largest joint replacement centre in the UK and one of the largest in Europe.

The unit consists of five state of the art operating theatres, a 17-bed post anaesthetic unit (PACU) recovery area with high dependency and critical care facilities and two wards of 27 beds.

SWLEOC was rated as outstanding by the Care Quality Commission in November 2015.

For more information, visit www.eoc.nhs.uk

In developing our ideas we have taken into account the recommendations from *Getting it Right First Time* and other studies, as well as evidence from what has been successful in other places.

Supporting information to section 7: Existing hospital improvement plans

The NHS doesn't want to make changes unnecessarily, so it's important that we understand how existing services might tackle the challenges we face by improving what they currently offer.

As part of our planning, we asked each NHS trust to tell us what steps they could take within their current services to help them treat more patients in the future, but also improve their efficiency and patient experience. Each provider was asked how they would ensure they meet important recommendations outlined in *Getting It Right First Time*, such as:

- Reducing the number of cancelled procedures
- Improving patient experience
- Treating more patients within 18 weeks of their referral
- Reducing the number of patients who experience complications or who have to return for revision surgery
- Reducing infection rates
- Ensuring that all surgeons carry out a sufficient volume of procedures
- Standardising prosthetics (replacement joints) and equipment

Below are detailed responses from each NHS trust.

Guy's and St Thomas' told us:

The Trust already has plans to develop an additional theatre at Guy's Hospital and has also started implementing a project to streamline their product ranges, lower costs, and reduce wastage. They would also increase the use of their theatres and carry out more operations on Saturdays. This would increase the number of patients they could care for by 1,500 cases. They also said they could reduce their cancellation rate to 2% and reduce the length of time patients have to stay in hospital. They would aim to reduce follow-up and readmissions by expanding their outreach team which enables a specialist group of clinical staff to implement post-operative care in a home setting.

The Trust said it had a track record of introducing innovations to make improvements and increase capacity, including targeted programmes to reduce follow-up, readmissions/complications and infection rates. The trust recently achieved a 3% reduction in the number of cancelled procedures, and to achieve the 18-week waiting time they would comply with an 18-week performance programme.

King's told us:

The Trust's proposal is to expand and build upon their existing elective orthopaedic centre at Orpington where a significant volume of south east London's elective inpatient activity is already delivered in dedicated, ring-fenced facilities, including:

- 3 laminar flow, ring-fenced orthopaedic theatres
- 43 ring-fenced inpatient beds
- 5 recovery bays in a dedicated area
- A bespoke dedicated admissions and discharge lounge

- Therapy gym facilities
- Dedicated theatres and ward nursing teams
- A dedicated therapy team (occupational & physio)
- A dedicated pre-assessment service
- An established joint school (with gym facilities)

Patient satisfaction levels are high - 'Friends and Family' survey indicated 100% of patients would recommend it as a place to receive surgery and NHS Choices gives it a five star rating.

Whilst the Trust is unlikely to need an additional theatre immediately, given the levels of growth projected the Trust has indicated that it will need an extra theatre in the near future and that this could be delivered relatively easily. The Trust believes there are sufficient beds to accommodate increases in demand, and staffing requirements would be minimal.

Productivity and quality are currently good but there are, of course, opportunities for further improvement. To improve productivity they aim to focus on reducing the length of time patients need to stay in hospital. This would be done by improving preparation for patients before their surgery as well as discharge planning and reducing infection rates. They also plan to increase their theatre utilisation from 70% to 90%. This would be done by carrying out more operations on Saturdays, appointing more staff (four senior fellows), improving pre-assessment of patients and moving day-case procedures from Orpington Hospital to Princess Royal University Hospital and King's College Hospital.

The Trust has already standardised its use of prosthetics and other equipment in line with the recommendations in *Getting it Right First Time*. They aim to reduce their cancellation rate from 4% to 1% by improving pre-assessment. Orpington's readmission rates are comparable to other centres but they would focus on community based rehabilitation as a key way of improving this, as well as seek support through the orthopaedic clinical network. King's fully endorses the recommendations in *Getting it Right First Time* regarding surgeons carrying out a minimum number of procedures, and would aim to work closely through the orthopaedic clinical network to set and implement agreed standards.

Lewisham and Greenwich told us:

In 2017 a new Arthroplasty (joint replacement) Centre will be established at Lewisham Hospital which is part of the Trust's existing plan to address the projected growth in demand for orthopaedic care. By the end of 2016/17, the Trust will have: built a new laminar flow operating theatre at Lewisham Hospital; ring-fenced the orthopaedic ward; implemented separate care pathways for routine day surgery procedures; and doubled inpatient capacity for major joint replacements to enable the Trust to deliver 2,500 joint replacements each year. The dedicated, ring-fenced major joint centre will meet the Trust's demand (identified as 22% above the OHSEL high case) and recover and sustain the 18-week waiting time standard. The operating model of the Arthroplasty Centre will offer future resilience, increasing the number of patients they can care for. This will reduce waiting times, sustain low cancellation rates and improve productivity. Orthopaedic day surgery will be supported by separate theatres and day care units.

The Trust is expanding its existing community orthopaedic service and rehabilitation services to increase pre- and post-operative care to ensure that the length of time patients stay in

hospital remains in line with consolidated centres like the South West London Elective Orthopaedic Centre. The Trust already has a low deep wound infection rate and the Arthoplasty Centre means that this will be maintained below 1%. Configuration of the service will mean that no surgeons would perform fewer than the recommended five procedures per year. The Arthroplasty Centre would have its own dedicated orthopaedic staff. The Trust has already consolidated its procurement for orthopaedic equipment. The Arthoplasty Centre and increase in activity it delivers will enable further opportunities for rationalisation of equipment and value for money.

Dartford and Gravesham/Oxleas

Dartford and Gravesham NHS Trust and Oxleas NHS Foundation Trust do not currently undertake inpatient orthopaedic procedures at their proposed site, Queen Mary's, Sidcup.

We have considered these plans and even though providers have been able to improve their services in recent years, the question is whether they are able to achieve the significant improvements in waiting times, quality standards, and deliver the financial benefits that have been demonstrated at specialist sites, such as the Royal National Orthopaedic Hospital and the South West London Elective Orthopaedic Centre, when they have not done so in the past.

Supporting information to section 8: Our opportunity to consolidate orthopaedic services

A combination of creating additional capacity, so that the NHS can treat more patients, and optimising the way orthopaedic care is provided would help us to meet future demand. At the same time, a standard journey for patients would help us to reduce the number of patients experiencing complications, shorten the length of time patients need to stay in hospital and make sure the NHS is working as productively as possible. This section gives additional information and context on the opportunities outlined in our consultation document.

How many sites would be best for south east London?

We have considered whether an appropriate alternative to expanding and improving existing hospital services would be one, two or three elective orthopaedic centres. To help with this we have looked at the size of other similar services, such as the Royal National Orthopaedic Hospital (RNOH) and the South West London Elective Orthopaedic Centre (SWLEOC) in Epsom (**Table 5**).

Table 5: One, two and three site demand projections compared to established consolidated services. Table shows volumes of patients per year

	Patients seen per year
SWLEOC (current)	5,200
One site in south east London (by 2021)	8,500
Two sites in south east London (by 2021)	4,250
Three sites in south east London (by 2021)	2,833

These established consolidated orthopaedic services carry out more than 5,000 procedures each year. We've talked to clinicians, patients and other people from our community and think that elective orthopaedic centres in south east London should aim to provide a similar number of procedures. Evidence from the *Getting It Right First Time* report suggests that this would help us achieve the best possible clinical and quality benefits.

If we established three elective orthopaedic centres in south east London, by 2021 each centre would be carrying out around 2,800 procedures per year. This is not dissimilar to the volumes currently delivered at the existing higher volume sites in south east London - Guy's and Orpington.

The evidence in *Getting it Right First Time (GiRFT)* and other studies suggests that these volumes are too low to achieve the potential efficiency and quality improvements that have been demonstrated in high volume, specialist sites like RNOH and SWLEOC. Professor Briggs and the GiRFT team have given us further advice regarding minimum critical volumes at organisational level. Whilst the team have not yet defined the critical volumes for procedures at individual sites, they are commissioning a review of evidence to develop this and have told us that:

- Based on long standing evidence and experience from visiting every orthopaedic provider in the UK, the volume/quality discussion is relevant for all procedures and

particularly important for the more complex procedures such as revision joint replacements.

- Dedicated units, with their extensive experience of high volumes of complex procedures, can best provide the type of multidisciplinary teams and leading-edge treatment that are vital for patients with a range of very rare conditions or serious complications.
- Through ensuring a critical mass of these patients are these units more likely to be able to achieve the high quality outcomes and maintain clinical competence; maintain the training of specialist staff; improve cost-effectiveness; and make the best use of scarce skills and equipment.

We have also considered the potential of a single elective orthopaedic centre. However, consolidating onto one site would require us to create the largest orthopaedic centre in the country, performing around 8,500 procedures by 2021. Obtaining the necessary site and money to invest in a facility like this is unlikely to be achievable. It would also result in a greater impact on journey times for patients across south east London, as a single site would be less accessible.

The work we have done suggests that **two is the optimum number of elective orthopaedic centres** for south east London. Two centres would each carry out around 4250 procedures each year by 2021. This volume of procedures is more likely to achieve the quality and performance benefits demonstrated at other consolidated services than three sites, and is more realistic to develop than one site.

8.1 Clinical network and out of hospital care

Creating a clinical network to co-ordinate and support surgeons and other orthopaedic staff would ensure standards are consistently excellent across south east London and that surgeons share learning and expertise.

As outlined in our consultation document, surgeons would continue to be employed by their existing NHS trust and would continue to carry out emergency orthopaedic surgery, outpatient appointments and day case procedures at their host hospital. They would use an elective orthopaedic centre for carrying out planned surgery on adult inpatients.

To ensure surgery is safe and access is equitable, governance for the care provided at elective orthopaedic centres would also be co-ordinated through the network that works with all hospital trusts in south east London..

8.2 Potential patient journey

People have told us that patient care before and after any surgery should be of consistently high quality across south east London. Through the network we would agree a common set of standards for patient care at all stages of treatment, which would help us to achieve consistent quality for everyone.

Clinical governance for the care provided at elective orthopaedic centres would also be co-ordinated through the network, which would sit across all the hospital Trusts.

Rapid recovery programmes would ensure patients have a standard and high quality journey during and after surgery which would improve their outcome and minimise the length of time

they need to stay in hospital. Through education and teamwork, patients would be better informed and better prepared for their procedure and their recovery.

Out of hospital care is not included in the scope of this document, but these services will support any changes in orthopaedic care. We know that we also need to improve out of hospital pre- and post-operative services and support, not just the surgical elements of your care. We are working to ensure that all patients receive high quality support before their operation and during their recovery – the kinds of things we are working towards are outlined below, in fig 5.

Figure 5: We want to ensure that:
Primary, secondary, and community care should be able to access 'live' electronic patient records
Support and education is available and accessible (including the option to self-refer to physiotherapy)
The initial clinician seeing the patient should be able to provide advice on prevention and self-management techniques to patients
IT systems should support referral
Clinical triage should occur before onward referral which will identify most urgent patients
Everyone referred to the service should have their psychosocial factors considered
All the appropriate specialists and diagnostics should be available to diagnose the patient at the initial consultation
Specialists should co-design the treatment plan and follow-up plan with each patient and explain how their care and condition will evolve over the short to long term
Hospitals should send an e-discharge letter within 48 hours to the appropriate practitioners who will be involved in the patients' ongoing care
A clearly set out and agreed follow-up plan should be communicated to appropriate providers and patients. This should enable patients to receive timely follow up and ongoing care
Patients' psychosocial factors should be re-assessed at discharge and monitored during follow-up care

We have published the first reports from our south east London group developing this work on our website. *[to be added]*

Figure 6: Potential patient journey

Patient is referred to a specialist following diagnosis by their GP, physiotherapist, or other health professional

An initial outpatient hospital appointment will take place at the local hospital of the specialist (this will be a named consultant). Unless patients choose otherwise, they remain under the care of this consultant throughout their treatment.

The patient undergoes diagnostic tests at the local hospital of the named consultant

A decision to operate will be made by the named consultant with the patient and a treatment and follow-up plan will be agreed.

This will be at an elective orthopaedic centre unless the patient is outside the clinical criteria for an elective centre. If this is the case, the patient will be treated at the hospital most appropriate for their needs.

If the patient does meet the criteria, they **will have a pre-operative assessment** at elective the orthopaedic centre and welcome pack. Patient's mental as well as physical health needs will be considered prior to admission.

Patient will **return to the elective orthopaedic centre for their operation** which will be undertaken by the named consultant
Patient will **stay overnight** at the elective orthopaedic centre following their operation
The patient will be **discharged from the centre** to their own home or to an appropriate alternative setting. Staff at elective orthopaedic centres will ensure discharges happen smoothly and efficiently. A clearly set out and agreed follow-up plan will be communicated to appropriate providers and patients, which enables patients to receive appropriate and timely follow up and on-going care, that also take their mental health needs into consideration.
Post-operative care such as physiotherapy will take place either in the patient's home or at the hospital of the named consultant
Follow up outpatient appointments will be either at the hospital of the named consultant or via telephone or at the centre
Once well enough, the patient will be **discharged to their GP**

KEY: At local hospital
At elective orthopaedic centre

A small number of patients with very complex medical needs that require support of specific specialist services may need to receive all of their care at the site most suitable for their needs.

8.3 What wouldn't change

8.3.1. The location of most orthopaedic care would not change (around 210,000 a year). Emergency orthopaedic surgery (supporting A&E departments), day case procedures, outpatient and follow-up appointments would continue to be provided from the same hospitals as today.

8.3.2 You would still be able to choose which hospital you are referred to for orthopaedic care – just as you can today. Following referral to a specialist you would have your outpatient appointments at your choice of local hospital and the same surgeon would oversee your care, even if your operation were to take place at an elective orthopaedic centre.

You would only go to an elective orthopaedic centre for your inpatient surgery (**Fig. 6**).

8.3.3 Complex spinal surgery would also remain at existing sites, as would children's surgery.

8.3.4 A&E and trauma services

Throughout our planning it has been a key principle that any changes to elective orthopaedic care does not put at risk emergency orthopaedic surgery or the continuation of our A&E departments in south east London. The south east London trauma network commented on the proposals[1] to ensure that the separation of emergency and planned orthopaedic care would not be a risk to emergency orthopaedic care (including trauma). Other areas who

[1] The London trauma network commented on the proposals as part of the London Clinical Senate assessment

have done this have successfully planned consultants' workloads to ensure that the separation of sites is not a risk and cover for trauma and emergency is maintained.

We will continue to test for the impact on trauma care during the consultation and intend to involve the clinical senate and trauma network and providers again before any decision is taken.

8.3.5 NHS trust stability Similarly, the future stability of the NHS trusts in south east London is a key test in the viability of our plans. We have looked at this issue very carefully throughout our planning and believe it is possible to introduce orthopaedic centres without destabilising any local hospital. There are several reasons for this:

- **Hospitals will continue to receive the income from the patients they treat**, even if they operate from an elective orthopaedic centre
- The proposed arrangements offer the opportunity to increase efficiency and throughput, generating a surplus that can be re-invested
- The NHS in south east London has a capacity problem - any free capacity generated by orthopaedic changes represents an opportunity for the expansion of other services for which capacity is currently constrained
- Our proposals are based on the South West London Elective Orthopaedic Centre (more detail in supporting information iii, figure 4) which has a track record of surplus for the trusts that use it

NHS organisations are increasingly working together on joint ventures in south east London and one of the principles we work to is that the benefits of our collaborative work are shared. We are developing a commercial model for the elective centres that ensures that there are no “winners and losers” financially.

We will continue to test this throughout the consultation. We are planning to commission an independent assessment of the impact this will have on hospital finances, and what potential opportunities there are to mitigate any downsides.

8.4 How would this address the case for change?

Reducing the number of sites providing surgery would mean that some patients may have to travel further for that part of their care (you can read more about the potential impact of this in supporting information section vi – 9.4).

However, evidence from established consolidated orthopaedic services, such as the Royal National Orthopaedic Hospital and the South West London Elective Orthopaedic Centre, suggests that creating elective orthopaedic centres would result in a number of important benefits which would improve the quality of care and experience for every patient, and make planned adult orthopaedic services sustainable in the long term:

Fewer cancellations

Elective orthopaedic centres would significantly reduce the number of cancelled operations. This is because the surgical theatres and beds would be protected (ring-fenced) for planned orthopaedic surgery, so planned procedures wouldn’t be disrupted by emergency cases arriving at A&E departments.

Shorter hospital stays

With better planning in advance and more streamlined care, patients would spend less time in hospital and avoid unplanned returns for more complex and costly surgery. This would also in turn reduce pressure on families, carers and social care services.

Shorter waits

By reducing the length of time each patient needs to stay in hospital, alongside a more efficient service with ring-fenced beds, this would help us to reduce the length of time patients wait on a list for surgery.

Better infection control and reduced complications

While none of tour current elective orthopaedic services in south east London have higher than expected infection rates, dedicated, high-volume elective orthopaedic centres could further reduce infection and complication rates. The best infection control rates, for hospital acquired infections such as MRSA, are seen at consolidated or specialist centres[2].

Better patient experience

Earlier discharge, fewer infections and readmissions would improve patient experience. Rapid/enhanced recovery programmes would ensure patients have a standard and high quality journey during and after surgery which would improve their outcome and minimise the length of time they need to stay in hospital. Patients would be better informed and better prepared for their procedure and their recovery.

Better outcomes

Improvements such better infection control, fewer cancellations, fewer unplanned returns for surgery and better admission and discharge planning is likely to result in better overall outcomes for patients[7] such as faster recovery from surgery and less likely to need additional operations.

Consistent quality

It would also help the NHS deliver care of consistent high quality so that more patients get a similar experience and outcome from their procedure.

More procedures

Creating elective orthopaedic centres would be the most cost-effective way of coping with the increases in demand we are expecting in the future.

These centres would only carry out planned adult orthopaedic procedures and surgeons would work in a standardised and efficient way which would increase the number of procedures the NHS can offer.

Financial benefits

[2] SOURCE: Getting it Right First Time

In south east London, expenditure in the NHS is predicted to exceed revenue if the way care is provided isn't changed. The funding gap is estimated to be £934m by the end of 2021. Consequently, services across south east London must become more efficient while reducing overall expenditure to cater for growing numbers of patients.

Our financial analysis has shown that consolidating orthopaedic services will make them less expensive for the NHS to run in the future, compared to the existing configuration of services.

Supporting information to section 9: The options and how we assessed them

This section provides further detail and background on the options we are recommending; and on how we evaluated the proposals, including:

- how the recommended options meet the case for change (9.1.2 below)
- full hurdle criteria used to assess options (9.2.1)
- financial impact (9.2.3)
- travel analysis (9.2.4)
- equality analysis (9.2.5)
- and the recommendations of the Evaluation Group (9.2.6)

9.1 Our recommendations

We have considered the two different approaches to meeting the case for change described in detail earlier in this document. These are:

- provider's existing plans to expand services; and
- consolidating services into two elective orthopaedic centres for south east London.

We are recommending consolidating planned adult orthopaedic surgery at **two elective orthopaedic centres**, rather than expanding and improving existing orthopaedic services.

Over the last year through a series of events and engagement with the public, and through national studies such as *Getting it Right First Time*, it has been shown that there is a case for changing the way that we provide planned inpatient orthopaedic surgery in south east London.

Patients are not getting treated in line with waiting time standards, and pressure is increasing on waiting times. Too many patients have their procedure cancelled at short notice, there is variation in the length of time patients have to stay in hospital, and there are opportunities for making efficiency savings which are not being taken.

We have considered the opportunity to expand and improve south east London's existing services. However, the work done to date suggests that changing the way these services are provided, by consolidating into fewer high volume units, would achieve **better quality care for patients** throughout south east London and would also represent **better value for money** for the NHS than expanding and improving existing services (you can read more about the evidence for this in ii - supporting information to section 5).

9.2 Where could elective orthopaedic centres be hosted?

Under our proposals, elective orthopaedic centres would be hosted at two of the hospitals which currently provide elective orthopaedic surgery in south east London. Both sites would carry out routine and complex procedures (excluding spinal) for adult patients.

We are asking for your views on three options for the proposed location of these services:

	Site A	Site B
Option 1	Guy's Hospital	University Hospital Lewisham
Option 2	Guy's Hospital	Orpington Hospital
Option 3	University Hospital Lewisham	Orpington Hospital

9.3 How did we arrive at this recommendation?

Before we asked local NHS trusts to put forward proposals for where it might be possible to create elective orthopaedic centres, we engaged with a wide range of stakeholders including patients, public, clinicians, providers and commissioners, to help us understand how their proposals should be judged.

Over the course of 2016, and through a number of groups and engagement events, we worked with patient and public representatives, orthopaedic clinicians and service managers, voluntary group representatives, and the six south east London NHS clinical commissioning groups, to develop criteria that could be used to evaluate Trust proposals and test them against their existing plans to expand and improve orthopaedic services.

We agreed a set of criteria which were applied in two stages.

Stage 1: Hurdle criteria

'Hurdle criteria' reflect essential tests that options must meet in order to progress to the second stage of assessment. Proposals were therefore given a 'pass' or 'fail' score against each criterion (**Table 6**).

TABLE 6: Hurdle criteria

Safety and sustainability	- Emergency departments can continue to be delivered from the current locations in south east London - Trauma continuing to be provided in current locations - Located in south east London
Clinical requirements	- Has the potential to meet the clinical requirements (provider characteristics) set out in the model
Patient experience/accessibility	- Where there is a multi-site option, sites are distributed between inner and outer south east London to be accessible to south east London patients (e.g. an option does not have two sites both inner)
Finance	- The option has a positive

	contribution to addressing the whole system financial challenge when compared to the 'do nothing' scenario - The proposed option demonstrates commitment to the commercial principles set out in the specification
Deliverability	- The option is able to deliver the demand and capacity requirements for a consolidated elective centre (50% of south east London activity, based on central case assumptions)

Proposals which received a 'pass' score against all the hurdle criteria progressed to the second stage of assessment.

Stage 2: Evaluation criteria

The second stage is known as 'evaluation criteria'.

We agreed six non-financial criteria, to help us examine things such as patient experience and quality.

We agreed we would evaluate the financial aspects of the proposal separately using two criteria (**Table 8**), which explore issues of cost and sustainability.

We also agreed a 'weighting' for each of the non-financial criteria which reflects what people told us was most important and should have the most influence (**Table 7**).

Table 7: Non-financial criteria:

Description	**Weighting**
Travel and access	17%
Deliverability	25%
Quality	17%
Patient experience	17%
Research and education	7%
Workforce	17%

Table 8: Financial criteria

Financial affordability	People told us that affordability of the options is important and that we should use the following criteria to assess the options: - Capital expenditure required - Productivity projections (how efficient would it be) - Revenue and cost projections
Organisational sustainability	People told us that not destabilising any of our existing healthcare trusts or commissioners is

	important and that we should use the following criteria to assess the options: - Impact analysis on trust current vs future revenue and costs

Scoring the proposals against the criteria

We asked providers to develop proposals for potential sites and received submissions for:

- **Guy's Hospital** (received from Guy's and St Thomas' NHS Foundation Trust)
- **Orpington Hospital** (received from King's College NHS Foundation Trust)
- **University Hospital Lewisham** (received from Lewisham and Greenwich NHS Trust)
- **Queen Mary's, Sidcup** (received in a joint response from Oxleas NHS Foundation Trust and Dartford and Gravesham NHS Trust)

An evaluation panel was established to evaluate site proposals against the financial and non-financial criteria. The panel comprised voting members from the six NHS clinical commissioning groups (CCGs) as well as non-voting members, including patient representatives, local authorities and an independent expert clinician.

The evaluation panel reviewed information provided via a joint response from Oxleas NHS Foundation Trust and Dartford and Gravesham NHS Trust, and recognised that Queen Mary's, Sidcup does not meet the agreed criteria for an inpatient elective orthopaedic centre. This is because the hospital could not offer a suitable high dependency unit to support medically complex patients. It also was not able to accommodate 50% of the expected volume of orthopaedic procedures in south east London by 2021.

For these reasons this site failed two of the hurdle criteria ('clinical requirements' and 'deliverability') and was not passed for further evaluation.

In the evaluation of the accessibility criteria, the evaluation panel agreed that this hurdle criteria related to understanding the accessibility and travel impact on patients. The panel decided that it therefore did not make sense to discount the Guy's and Lewisham option on the basis that Lewisham site is within an inner London borough (as defined by the Greater London Authority (GLA) definition of inner and outer London boroughs). The panel agreed that the accessibility of all options would be considered in the analysis of travel information as part of the scoring of the non-financial criteria.

The remaining sites were assessed in pairs, which made three, two-site options:

- **Guy's Hospital** and **University Hospital Lewisham**
- **Guy's Hospital** and **Orpington Hospital**
- **University Hospital Lewisham** and **Orpington Hospital**

9.3.2 Non-financial scoring

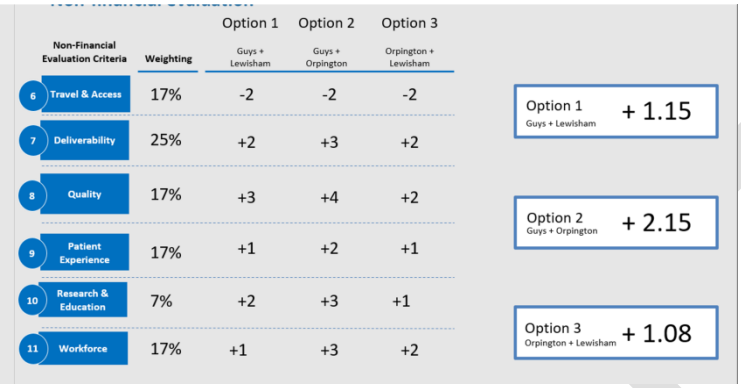
These two-site options were each assessed against the non-financial criteria.

Options were scored against a -5 to +5 scale with 0 representing trust's existing pans to develop services to meet rising demand and deliver the GiRFT recommendations at their sites

- A score of -1 to -5 represents an impact which is potentially worse than existing service provision
- A score of 1 to 5 represents an impact which is potentially better than existing service provision

Where an option achieves a positive score, it was therefore judged by the evaluation panel to have an advantage over existing plans (**Table 9**).

Table 9: Overall scores against the criteria for each two-site proposal



Non-Financial Evaluation Criteria	Weighting	Option 1 Guys + Lewisham	Option 2 Guys + Orpington	Option 3 Orpington + Lewisham
6 Travel & Access	17%	-2	-2	-2
7 Deliverability	25%	+2	+3	+2
8 Quality	17%	+3	+4	+2
9 Patient Experience	17%	+1	+2	+1
10 Research & Education	7%	+2	+3	+1
11 Workforce	17%	+1	+3	+2

In summary, the assessment has shown that:

- All of the options are considered to offer better quality of care for patients in south east London than trust plans to expand and improve existing services to meet rising demand and deliver the recommendations in *Getting It Right First Time* at their sites
- Option 2 (Guy's Hospital and Orpington Hospital) offers the most positive benefits to patient care and quality
- Option 1 (Guy's Hospital and University Hospital Lewisham) and Option 3 (University Hospital Lewisham and Orpington Hospital) offer similar positive overall benefit to patient care and quality

People told us that, although spending money in the best way is important, the location of elective orthopaedic centres should be determined by non-financial benefits – things like quality of patient care, patient experience, research and education – providing options are more cost-effective than the current arrangement of services and affordable.

9.3.3 Financial analysis

We also assessed the financial impact of each option (pair of sites). Trusts were asked to produce estimated costs from 2015/16 to 2020/21 in three potential scenarios:

1. Costs if orthopaedic services expand under the existing configuration of sites
2. Costs associated with hosting an elective orthopaedic centre; and
3. Costs if an elective orthopaedic centre was not hosted

Tables 10, 11 and 12 provide an overview of the key findings of the financial evaluation, comparing each option against hospital plans to expand and improve existing services.

Table 10: Overview of financial outputs

	Existing trust plans to expand and improve orthopaedic services	Option 1 – Guy's Hospital and University Hospital Lewisham	Option 2 – Guy's Hospital and Orpington Hospital	Option 3 – University Hospital Lewisham and Orpington Hospital
Five year total cost	£323.5m	£330.5m	£335.8m	£333.7m
2021 recurrent cost	£53.7m	£48.0m	£54.9m	£52.1m
20 year net present value	£823.0m	£722.5m	£809.3m	£766.3m
20 year internal rate of return	n/a	25%	8%	20%
Payback period*	n/a	6 years	10 years	7 years
2021 reduction in cost per patient	0.0%	-16%	-4.1%	-8.8%
Five year capital expenditure	£2.1m	£14.3m	£4.1m	£13.3m
Five year total non-recurrent expenditure	-	£0.3m	-	£0.3m

*The payback period gives an indication of how quickly a given EOC reconfiguration option is expected to start delivering net financial benefits relative to existing provider plans.

Table 11: Projected savings that could be achieved for each option up until 2021, compared with existing provider plans.

	2017	2018	2019	2020	2021
Option 1 – Guy's Hospital and University Hospital Lewisham	-£10.4m	-£14.4m	£3.6m	£5.0m	£9.2m
Option 2 – Guy's Hospital and Orpington Hospital	-£5.2m	-£8.4m	-£1.1m	£0.1m	£2.4m
Option 3 – University Hospital Lewisham and Orpington Hospital	-£5.1m	-£11.4m	-£1.3m	£2.5m	£5.1m

Table 12: Projected annual capital and operating expenses 2016-2021

Capital and Operating Expense by Year		FY16	FY17	FY18	FY19	FY20	FY
Existing trust plans to expand and improve	Operating Expenses	£49.8m	£50.1m	£52.8m	£55.1m	£56.3m	£57.
	Capital	-	-	£2.1m	-	-	
	Total	**£49.8m**	**£50.1m**	**£54.8m**	**£55.1m**	**£56.3m**	**£57.**
Option 1	Operating Expenses	£49.8m	£55.3m	£61.3m	£51.6m	£49.8m	£48.
	Capital	-	£5.1m	£7.9m	-	£1.5m	
	Total	**£49.8m**	**£60.4m**	**£69.3m**	**£51.6m**	**£51.3m**	**£48.**
Option 2	Operating Expenses	£49.8m	£55.3m	£60.7m	£56.2m	£54.8m	£54.
	Capital	-	-	£2.6m	-	£1.5m	
	Total	**£49.8m**	**£55.3m**	**£63.3m**	**£56.2m**	**£56.3m**	**£54.**
Option 3	Operating Expenses	£49.8m	£50.1m	£57.8m	£56.4m	£53.9m	£52.
	Capital	-	£5.1m	£8.4m	-	-	
	Total	**£49.8m**	**£55.2m**	**£66.2m**	**£56.4m**	**£53.9m**	**£52.**

The financial analysis shows that **all three options would save the NHS money** over a 20-year period, which includes repaying any initial investment required. All options would also achieve cheaper annual running costs by 2021 than existing hospital plans.

- **Option 1** (University Hospital Lewisham and Guy's Hospital) offers the greatest benefit both in terms of reduction in cost by 2020/21 and in terms of overall cost over 20 years. However, this option also has the greatest capital requirement (up-front cost of establishing the centres) and the highest double running costs.
- **Option 2** (Guy's Hospital and Orpington Hospital) offers the least financial benefit of the options. However, it requires the lowest capital expenditure (up-front cost of establishing the centres)
- **Option 3** (University Hospital Lewisham and Orpington Hospital) offers less financial benefit than Option 1 (University Hospital Lewisham and Guy's Hospital) but requires a smaller capital investment (up-front cost of establishing the centres). However, over 20 years Option 3 still offers substantial savings compared to existing provider plans.

All three options would save the NHS money over a 20-year period, which includes repaying any initial investment required. All options would also achieve cheaper annual running costs by 2021 than existing hospital plans.

The financial benefits are based on provider submissions that describe how they would each deliver an elective orthopaedic centre however there may be further efficiencies that could be included. They also include the cost implications for each Trust of moving services to a new centre, which can be further refined. As we continue to develop our proposals we are working closely with providers to establish further significant financial benefit.

9.4 Travel and access

The evaluation panel also looked at a detailed travel analysis.

People have told us that being able to easily get to hospital for their procedure and then home again afterwards is an important issue. We have given a lot of thought to travel and access in developing these proposals.

If adult inpatient orthopaedic surgery was consolidated at two elective orthopaedic centres, for some patients these facilities may not be hosted at their local hospital.

For these patients, and their carers, most of their care would still take place at their local hospital (outpatient appointments, follow-ups, day case surgery) but they may have to travel further for inpatient surgery.

Similar elective orthopaedic centres, such as the South West London Elective Orthopaedic Centre, run successful transport services for inpatients and we are looking at what works elsewhere, as well as taking your views, to understand how we could minimise the impact of this.

Travel analysis

We commissioned an independent analysis to help us understand how the options might impact on patient travel.

We analysed the postcodes of the 6,870 patients who used these services between April 2015 and March 2016 (12 months) to help us understand where patients live and where they choose to receive or were referred for their care. We then used this information to see how patients might be affected under each of our three options.

The analysis assessed the impact on people travelling by car and by public transport. These were our key findings:

Where do patients currently choose to travel for their care?

- 15% of patients currently choose to have their care at a hospital outside of south east London
- Of the remaining 85%, two out of three patients choose to travel to a hospital that isn't the nearest
- This indicates that most patients (around 70%) do not currently choose or are not referred to their nearest hospital to receive orthopaedic care.

How many patients would travel to a different hospital for surgery (Fig 7)?

- Between 32% and 49% of patients would travel to a different hospital for inpatient surgery than the one they currently choose, depending on the option. This may be a closer hospital, or one that is further away
- Between 51% and 68% would not experience a change

Would car journeys be longer (Fig 8)?

- Some patients already choose or are referred to a hospital that isn't their nearest, so under our proposals between 7% and 23% could experience a shorter journey for inpatient surgery, depending on the option
- Around 25% to 26% of patients would experience a longer journey travelling by car for inpatient surgery

How much longer would car journeys take (Table 14)?

- For almost all patients that would need to travel further by car, the additional journey time is less than 20 minutes for all options.

Would journeys by public transport be longer (Fig 9)?

- Some patients already choose or are referred to a hospital that isn't their nearest, so under our proposals between 10% and 27% of patients could experience a shorter journey on public transport for inpatient surgery
- 22% to 30% of patients would experience a longer journey on public transport, depending on the option

How much longer would journeys by public transport take (Table 15)?

- For most patients that experience a longer journey on public transport, the additional journey time is less than 30 minutes for all options.

The full travel analysis, including the methodology and detailed impacts, can be downloaded from our website www.ourhealthiersel.nhs.uk.

Figure 7: Percentage of orthopaedic inpatients and the impact on their journey under each option

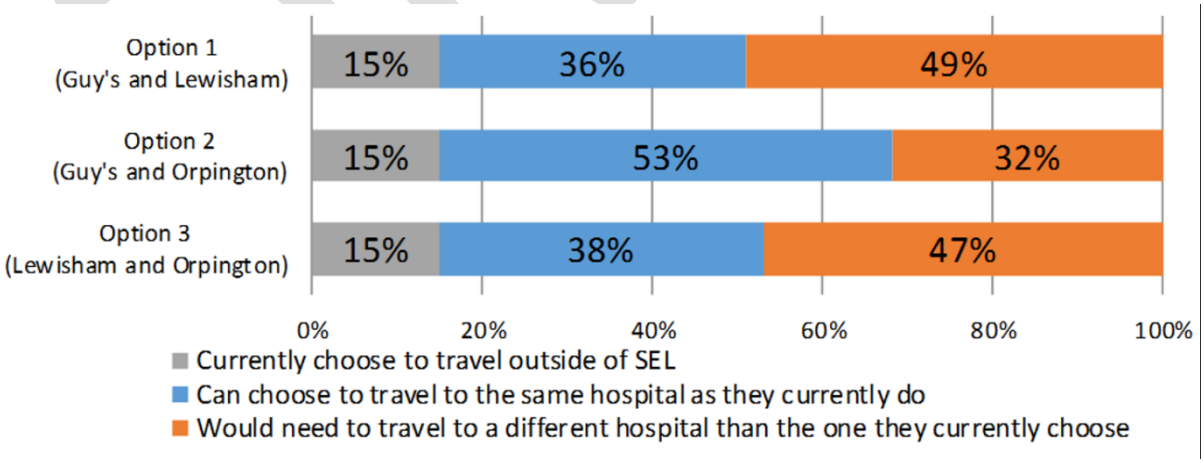


Figure 8: Percentage of orthopaedic inpatients and the impact on their journey under each option (car journeys)

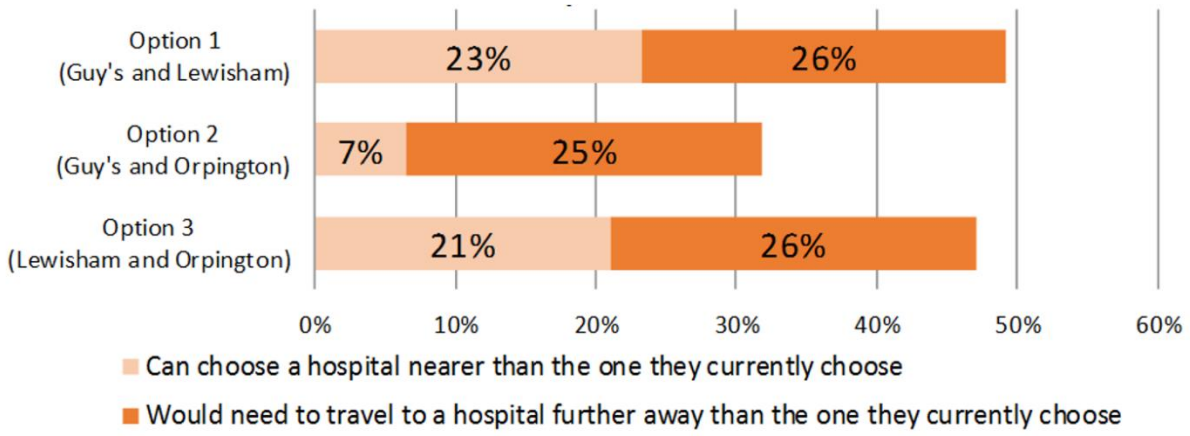


Table 14: Percentage of patients and estimated journey time increases (car journeys)

Car Travel (AM peak, 7-10am)	% of elective orthopaedic inpatients who live in SEL (6,870 patients) with an increase in journey time		
	<10 minute increase	10-20 minute increase	20-30 minute increase
Option 1 (Guys' and Lewisham)	14%	10%	2%
Option 2 (Guys' and Orpington)	10%	14%	2%
Option 3 (Lewisham and Orpington)	12%	14%	0%

Figure 9: Percentage of orthopaedic inpatients and the impact on their journey under each option (public transport)

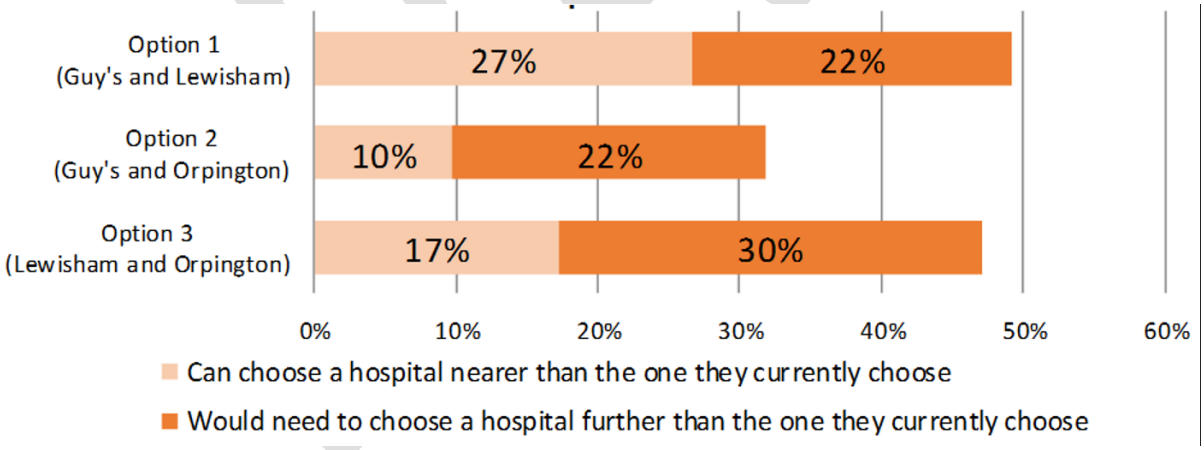


Table 15: Percentage of patients and estimated journey time increases (public transport)

Public Transport Travel (AM peak, 7-10am)	% of elective orthopaedic inpatients who live in SEL (6,870 patients) with an increase in journey time			
	<10 minute increase	10-20 minute increase	20-30 minute increase	>30 minute increase
Option 1 (Guys' and Lewisham)	9%	6%	4%	3%
Option 2 (Guys' and Orpington)	11%	7%	4%	1%
Option 3 (Lewisham and Orpington)	7%	10%	11%	1%

The evaluation also took into account equality impacts

It's important to us that we try to understand the impact of any changes on different members of our community. We have an Equalities Steering Group, which includes equality and public engagement experts from each of the south east London clinical commissioning groups, patient and public voices and public health specialists. Through this group we have looked in detail and taken actions to make sure that people with different characteristics are appropriately involved and considered.

Equalities is an on-going consideration in our planning. We commissioned an independent Equalities Analysis which is being used to inform our engagement plans before, during and after consultation. This work is helping us to understand the potential impacts on those with protected characteristics, so that we can seek to mitigate and/or limit the impact our proposals may have on these groups.

The first phase of our Equalities Analysis was completed in September 2016 and the report findings have shaped our approach to pre-consultation engagement. It helped us identify people and groups in our community who we could speak to in order to help shape our plans before consultation and better understand the impact of our work.

In response to the report, in-depth conversations were held with the following groups: older people; carers; people who live in areas of socioeconomic deprivation; people with physical disabilities (including those who have visual or hearing impairments); people with learning disabilities and people undergoing gender reassignment. Within the groups, particular efforts were made to ensure there was representation from white women (also disproportionately affected by changes to planned care services) and people from BME backgrounds.

The next, and more detailed, phase of our Equalities Analysis will be carried out during consultation. The phase 2 report is aimed to be delivered mid-consultation in order for us to consider the findings and, if required, update our consultation approach.

You can read the first phase of our independent Equality Analysis on our website www.ourhealthiersel.nhs.uk

Findings and recommendations to the Committee in Common

The full recommendations from the Evaluation Group to the Committee in Common were:

1. The following sites should not be considered for hosting an EOC in the SEL model:

- St Thomas' Hospital (GSTT)
- Queen Elizabeth Hosptial (LGT)
- Denmark Hill (KCH)

- Princess Royal University Hospital (KCH)
- Queen Mary's Hospital (Oxleas/DGT)

2. The assessment of the non-financial criteria showed that:

- All of the paired configuration options were considered better for patients in south east London than the scenario where providers plan to continue to meet growth in demand and deliver GiRFT recommendations without consolidating.
- Option 2 (Guy's and Orpington) scored the highest on non-financial criteria + 2.15 out of 5.
- The scoring of Option 1 (Guy's and Lewisham) and Option 3 (Lewisham and Orpington) was more comparable, +1.15 and +1.08 respectively.

3. The assessment of the financial implications of each configuration shows that:

- All configurations are cheaper over a 20 year NPV and have cheaper running costs in the financial year 2021 than the scenario where providers continue with plans to meet growth in demand and deliver GiRFT recommendations without consolidating.

4. Compared to the scenario where providers continue with plans to meet growth in demand and deliver GiRFT recommendations without consolidating:

- Option 2 (Guy's and Orpington) represents the lowest capital investment, roughly a quarter of the other two options.
- Option 1 (Lewisham and Guy's) has the fasted payback period of 6 years (i.e. by the end of financial year 2021). Option 2 (Guy' and Orpington) will break even in financial year 2026.
- All options' 20 year NPV are within c. 10% of each other with Option 1 (Lewisham and Guy's) offering the largest savings.

Therefore, the evaluation panel recommended to the Committee in Common that all the three configuration options put forward under the two-site consolidated model should be taken forward for public consultation.

These three configurations should all be considered as preferred options when compared against the existing provider plans to develop services individually to meet demand and deliver *Getting it Right First Time*. This is due to all three having evaluated better than providers' existing plans on both the non-financial and financial criteria.

Supporting information to section 11: Who we have involved in these proposals

We have been developing our understanding of the issues facing orthopaedic services since 2014, and have taken the views of a wide range of groups throughout the development of these proposals, including:

- Patients and the public
- Doctors, nurses, other healthcare staff and health commissioners
- Representatives from providers (hospitals, GP surgeries etc)
- Healthwatch and other voluntary bodies in the community

Patient and Healthwatch representatives have participated in the development of our plans alongside clinicians, care professionals and commissioners in our orthopaedic planning group (known as a Clinical Leadership Group).

We have been testing the proposals with patients and representatives from voluntary and community groups through our Planned Care Reference Group. We formed this group specifically to increase the involvement of people that could be most impacted by any potential changes to orthopaedic services, such as older people, carers and people with a disability. The group has fed in its views to help shape the options appraisal criteria.

Equalities analyses have been carried out to help us further understand which groups may be most affected by any change. This is being fed into the development of the ideas as well as informing priorities for further engagement.

Engagement activity has been independently reviewed by a south east London stakeholder reference group (which includes voluntary and community sector representatives), including the process for options appraisal.

We have published a series of 'You Said We Did' reports to show how we have taken account of the feedback people have given us so far. Our approach to engagement is being externally assured by independent experts The Consultation Institute.

A Joint Health Overview and Scrutiny Committee is providing oversight on our plans. This committee includes councillors from health scrutiny committees across the six south east London boroughs.

Clinical senate

We have also presented these proposals to an independent panel of expert clinicians and patient representatives from across the UK, organised through the London Clinical Senate. The panel reviewed documentation and interviewed more than 40 clinicians and patient representatives.

The overall Our Healthier South East London programme is clinically-led, with over 300 clinicians, nurses, allied health professionals, social care staff, commissioners and others working through six Clinical Leadership Groups – one of which is 'planned care' which has been considering how orthopaedic services could be improved.

We have completed a phase of 'early engagement' involving more than 1,700 people, which included discussions on planned care services.

We have viewed clinicians' expert opinions. In May 2016 the London Clinical Senate convened a panel of expert clinicians and patient representatives from across the UK to examine our ideas for consolidating planned orthopaedic procedures.

The panel interviewed over 40 clinicians and patient representatives who have been involved in creating our plans to advise on whether there is clear clinical evidence for such a change, and whether our model will improve the safety and quality of patient care.

The Senate's findings overall showed that there are opportunities to improve the way that elective orthopaedic care is delivered in south east London. The review team felt that the case for change should be developed further to consider the whole patient journey, including out of hospital musculoskeletal care and support. This is because providing excellent care in hospitals will not lead to sustainable patient outcomes if patients receive inadequate care as soon as they are discharged.

This additional work is underway to make sure that patient care before and after any surgery is of consistently high quality across south east London. Planning has begun with a wider pool of clinicians and patients from all six boroughs to agree a common set of standards for patient care at all stages of treatment. A first report from this group was published in November 2016. This makes a number of recommendations, including strengthening help for people with mental health needs and reducing unnecessary GP visits by improving direct access to rehabilitation and other support. The full report can be read on our website www.ourhealthierselnhs.uk.

Our commitment to patient and public engagement was praised by the Clinical Senate and the panel suggested we build on this by making sure that we obtain detailed feedback from groups of people in our community that could be most impacted by our proposals – this has been taken forward in our Equalities Analysis (read more about this in section vi of our supporting information).

We have also presented these ideas to GPs across south east London through the membership of local NHS clinical commissioning groups. These GPs recognise the challenges facing orthopaedic services and have given their support to our proposals.

The senate report and our response can be read on our website www.ourhealthiersel.nhs.uk.

Hospital consultants from across south east London have been involved in our plans and have contributed to the design of the options (**Fig. 10**).

Figure 10: Orthopaedic clinician support for consolidation

"Consolidating planned orthopaedic services in south east London is a huge opportunity to improve the quality of patient care and reduce the number of cancelled operations."

Patrick Li - Consultant Orthopaedic Surgeon, King's College Hospital NHS Foundation Trust

"This model offers the opportunity to consolidate complex and routine surgery which will significantly reduce clinical variation and improve outcomes for patients."

Peter Earnshaw - Clinical Director, Guy's and St Thomas' NHS Foundation Trust

"The consolidation of routine and complex elective orthopaedic surgery at 2 sites across SE London will reduce clinical variation and facilitate the improvement of outcomes for patients."

Sam Gidwani - Clinical Lead, Guy's and St Thomas' NHS Foundation Trust

"If orthopaedic services, within a certain geographical area and with an appropriate critical mass were brought together, either onto one site or within a network… and worked within agreed quality assurance standards, not only would patient care improve but billions of pounds could be saved."

Professor T. Briggs - *Getting it right first time: Improving the Quality of Orthopaedic Care within the National Health Service in England*

You can read more about how we've involved different people in our plans on our website www.ourhealthiersel.nhs.uk

Further supporting documentation

- *Getting it Right First Time*

The following will be published on our consultation website:

- Pre-consultation Business Case (PCBC)
  This is the business case (full proposal) that the Committee in Common (CiC) and NHS England will assure and which the CiC will use to decide whether to continue into consultation with this proposal. This describes the development of the proposal in full detail. It includes further information including further financial analysis.
- Early travel analysis
- Equalities Analysis
- Evaluation panel report
- Clinical Senate report
- Clinical Senate programme response
- Pre consultation engagement report
- Our Healthier South East London report on supporting the development of community based care: muscular-skeletal (MSK) out-of-hospital orthopaedics pathway