

## ELECTIVE CARE in SOUTH EAST LONDON – unaddressed risks

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London Clinical Senate Review June 2016

### Introduction

- This document represents the views of local campaigners from the Save Lewisham Hospital campaign and Lambeth Keep Our NHS Public.
- The Joint Health Overview & Scrutiny Committee is being consulted by OHSEL about its public consultation on plans for two Elective Orthopaedic Centres in SE London.

### Elective care

- Elective care – or planned care – is non-emergency health care.
- Planned care is one of the 6 main strands of the work undertaken by the OHSEL programme.
- OHSEL's work commenced December 2013 and work on elective orthopaedic surgery commenced Spring 2014.
- OHSEL has settled on the consolidation of planned orthopaedic surgery in two centres rather than continuing to provide it across all the hospitals in SE London.
- The cost of this is two-fold: capital expenditure is in the 10s of £millions. There is no capital funding available *other than private finance*. **This is extremely costly for the next generation.**
- The Foundation Trusts are wealthier than Lewisham and Greenwich Trust and at an unfair advantage in raising capital.
- In reaching this decision, **OHSEL has failed so far to evaluate the very realistic option of investing to improve the current provision.** After 2½ years of work on planned care, **this omission is not acceptable.**
- The London Clinical Senate report strongly recommends that the enhanced status quo option be evaluated fully, and points to numerous concerns about the consequences of pursuing the two elective centres option, with relative lack of regard to the rest of the pathway, before and most importantly after surgery after discharge.
- Enhancing the status quo could realistically raise standards to the required level (see Briggs Report) whilst avoiding both the financial risks and the risks of destabilisation of local health providers, whose integrated service and 'business plan' would be jeopardised.
- OHSEL's justification for centralising surgery in order to guarantee that surgeons have enough experience with procedures is unjustified and not backed up by any figures. There is a sufficiently high volume of work for the majority of elective orthopaedic procedures in South East London in local hospitals.
- Centralisation of low volume specialist procedures is already supported.

The points we raise here are, in our opinion, endorsed by the London Clinical Senate Review, June 2016.

### **OHSEL's own clear hurdle criteria *failed***

We have major concerns about the elective care proposals. In our view they significantly fail to meet two of OHSEL's own criteria (which, if not met, would theoretically rule out the option):

- **Firstly:** that the proposals do not undermine the stability (financial or clinical) of local NHS providers.

*‘Financial Criteria*

*The option maintains or improves all organisational positions. Any option which could destabilise the ongoing financial and organisational viability of individual providers or commissioners without a compensating strategy will be ruled out.’*

**OHSEL document Planned Care reference group 29.09.16: Improving elective orthopaedics**

**There is an undeniable risk to the providers where the centres are not based.**

- Tariff-based funding of the NHS leads to penalising of hospitals who lose activity to a specialist centre.
  - Staff recruitment will be affected if there is a loss of activity in essential surgical experience required for training and job satisfaction
- **Secondly:** that there should be sound clinical and financial evidence supporting the proposed change. The soundness of the evidence must be in context: ie in comparison to the clinical and financial evidence of other options – notably the ‘enhanced status quo’.
- There are other clinical consequences, both direct and indirect, of reconfiguring this high volume area of surgical activity away from the local hospitals, such as Lewisham and QE Woolwich.**
- Disruption to local care pathways already established around the district’s hospital, multidisciplinary teams including social services – the Clinical Senate states that insufficient attention has been given to this significant part of the pathway (pre- and post-surgery).
  - Impact on **the training of staff** (medical, nursing in particular) if high volume activity important to training is diverted from the local hospital teaching and training environment and trainees cannot easily leave that hospital to experience the surgery at the centres.

**OHSEL has failed to evaluate the enhanced status quo option and this is not acceptable**

The process has completely failed to seriously evaluate the most obvious option: that of building on the already good performance and outcomes in the SE London health economy to enhance current provision. That option was highlighted **repeatedly** by the Clinical Senate Report and **MUST** be taken up (see appendix).

Why? Because current clinical performance is not far short of the Briggs national standards and London average, and relatively much more affordable investment in current services could attain those standards. **At least that option must be fully evaluated.**

**OHSEL’s failure to evaluate the ‘status quo’ option to date** necessarily means that the evaluation of site options for the proposed centres has been biased, incomplete and fatally flawed. OHSEL belatedly plans to cover this failing, but too late to correct a flawed process.

**This consultation must be halted, the enhanced status quo option fully explored, and then the full set of options subjected to a new option appraisal.**

Representatives from our campaigns have attended reference group meetings (check), Committee in Common meetings, have given evidence to the Clinical Senate Review meeting and a group of us

met with OHSEL on 30 September 2016. These same points have been raised throughout this process.

#### **ADDITIONAL POINTS:**

##### **Is elective surgery really the clinical priority?**

Given the relatively high performing current elective surgery services in SE London (not far short of the London average) this is simply not the priority given the financial and clinical risk, the disruption to current services and extra travel involved for patients.

Higher priorities include the emergency pathway, care of the elderly, primary care and mental health. This is where 10s of £millions should go rather than into private financing schemes to fund the elective centres.

##### **The model is based on flawed activity data**

The model has not included the large amount of added capacity required to meet the waiting list numbers, on top of activity data, which in itself is already 2-3 years out of date being based on 2013/14 data.

##### **Improvements to care?**

Clinical improvements, according to Briggs, are not just about actual times spent in hospital but about improving pre- and post-operative pathways. These are relatively ignored aspects of care, separate from the proposed new centres, but essential to the success of the pathway.

The London Clinical Senate review contains **no fewer than 30 requests** to OHSEL that it addresses these aspects of the pathway without which the proposals cannot be safely evaluated. (See Appendix Analysis of Advice on Proposal for elective orthopaedic care in South East London, London Clinical Senate Review June 2016)

#### **EQUALITIES IMPACT ASSESSMENT**

**The London Clinical Senate Review stated on five occasions that there had been insufficient attention to the impact on equalities:**

*'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.'*

See Appendix Analysis of Advice on Proposal for elective orthopaedic care in South East London, London Clinical Senate Review June 2016)

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<b>APPENDIX</b>		
<b>Analysis of Advice on Proposal for elective orthopaedic care in South East London London Clinical Senate Review June 2016</b>		
		<b><u>30 requests for greater development of the whole pathway</u></b>
1	page 5- paragraph 7	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.
2	page 6- paragraph 1	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.
3	page 6- paragraph 3	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.
4	page 10- paragraph 2	The review team believes however that in seeking to make these improvements, the whole planned care pathway needs to be considered
5	page 10- paragraph 2	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.
6	page 11- paragraph 4	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.
7	page 13- paragraph 3	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 <sup>13</sup> 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.
8	page 14 - whole page	Differences and variability.....ongoing medical problems exist
9	page15- third bullet point	· 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.

10	page 15-paragraph 2	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.
11	page 15-paragraph 3	Particular concerns related to the lack of reference to local services in the community including links to social care and primary care.
12	page 17-paragraph 6	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 <sup>16</sup> , 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.
13	page18-paragraph 3	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
14	page18 bullet points 7 and 8	<ul style="list-style-type: none"> <li>· 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;</li> <li>· 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.</li> </ul>
15	page 21-paragraph 22	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.
16	page22-bullet points 1 and 2	<ul style="list-style-type: none"> <li>· Improvements to the inpatient part of the pathway creates new pressures and challenges elsewhere in the pathway, including the risk that inequalities could increase</li> <li>· The benefits envisaged are not achieved because the wider pathway changes needed to support them do not take place</li> </ul>
17	page22-paragraph 2	Particular issues include the need for greater standardisation; difficulties in repatriating patients to local hospitals and discharge into community services; provision of timely, proactive rehabilitation, including specialist rehabilitation in the community and ensuring effective integration with primary care and social care.
18	page 28-paragraph 5	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

19	page 29- paragraph 6	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.
20	page 30- paragraph 5	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.
21	page 31- bullet point 1	Addressing current differences in processes, approaches and services available within community services is a key area. If not tackled, this could contribute to inequalities.
22	page 31- bullet point 5	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.
23	page 32- bullet point 2	· 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
24	page 34 - point 9	The case for change should now be extended to encompass the pre-referral, preoperative 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.
25	page 36 - 18 a	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;
26	page 36 18d	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;
27	page 37- point 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.

28	page 37- point 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.
29	page 40- point 45	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 preoperative assessment and post-operative care which could be for a defined group of patients initially e.g. older people with comorbidities.
30	page 41- point 49	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

		<b><u>8 Requests for the consideration of the Enhanced Status Quo</u></b>
1	page 18 paragraph 3	The review team felt that the rationale for including or discounting options was not explicit in the information we received
2	page 20 paragraph 2	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.
3	page 20 paragraph 4	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.
4	page 20 paragraph 5	The rationale for continuing to explore or discount specific options was not explicit in the documentation we received.
5	Page 34 Bullet point 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.
6	page 35 bullet point13	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.
7	page 36 bullet point17	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

8	page 37 bullet point 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.
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<b><u>5 Requests for more consideration of the Equalities impact</u></b>		
1	page5 paragraph 6	We also noted the case for change currently lacked evidence of being informed by an equalities impact assessment.
2	page 6 paragraph 4	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.
3	page12 paragraph 3	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.
4	page 17 paragraph 1	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.
5	Page 18 paragraph 3 bullet point 3	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;

Wendy Horler, October 2016