Public Document Pack

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - OUR HEALTHIER SOUTH EAST LONDON

Date: MONDAY, 28 NOVEMBER 2016 at 7.00 pm

Bexley Civic Offices
2 Watling Street
Bexleyheath
Kent
DA6 7AT

Enquiries to: John Bardens
Telephone: 0208 314 9976

MEMBERS

Councillor Alan Hall
Councillor John Muldoon

Members are summoned to attend this meeting

Barry Quirk
Chief Executive
Lewisham Town Hall
Catford
London SE6 4RU
Date: 22 November 2016

INVESTOR IN PEOPLE

The public are welcome to attend our committee meetings, however occasionally committees may have to consider some business in private. Copies of reports can be made available in additional formats on request.

ORDER OF BUSINESS – PART 1 AGENDA

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Lewisham

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Our Healthier South East London
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JHOSC Meeting

28th November 2016

Improving adult planned inpatient orthopaedic surgery in south east London

Consultation document and plan

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Consultation document

Further development of content informed by:

- Summary overview of consultation document shared with JHOSC 11/10
- NHS trusts for comments on two occasions
- Patient representatives through our Patient and Public Advisory Group and Reading Group
- Consultation questions and content discussed at Planned Care Reference Group and SEL Stakeholder Reference Group
- Communications and Engagement Steering Group Members (comprising C&E leads from each CCG), and NHS Trust communications and engagement leads
- OHSEL Planned Care Planning Group
- Consultation questions and documentation independently assured by The Consultation Institute

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Changes made to consultation document

Responding to feedback

- Developed a more straightforward description of 'existing hospital improvement plans'
  - This means 'existing NHS trust plans to expand and improve their services in order to meet future demand and GIRFT recommendations'
  - Includes how this information has been used as a comparator when evaluating the consolidated options
- Accepted edited drafts from each trust about their existing plans to improve services (based on their June 2016 evaluation submissions)
- Produced a clear narrative around the scoring and recommendation of options
- Developed and updated financial analysis; travel analysis and a clear patient journey, supported with an infographic for ease of understanding
- Included more evidence around development of wider MSK pathway (out of hospital care)
- Further developed consultation questions to ensure optimum data capture and ease of analysis
- Added STP context for connection to overall plans for local health and care

Resulting in a **simplified consultation document** describing key arguments and recommendations

- supporting documentation available for people to examine the detailed evidence
- to be hosted on digital consultation hub
- submitted for plain English kite marking (or equivalent) – IN PROGRESS

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Consultation plan

Aims of the consultation

- The aim of our consultation is to create meaningful engagement with local people and stakeholders to inform them about our proposals for change; actively listen to their feedback and ensure their feedback impacts the final decision.
- Our approach to consultation will be **responsive and proportionate** to those it will affect the most.
- Our work is guided by the seven best practice principles from The Consultation Institute: integrity; visibility; accessibility; transparency; disclosure; fair interpretation; publication.

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Best practice

We are working with the following partners to deliver a **best practice** and **objective** consultation:

- **Who helped shape our communications and engagement approach**

This plan has been informed through discussions with the programme's Patient and Public Advisory Group, Planned Care Reference Group, Stakeholder Reference Group, Equalities Steering Group and the Communications and Engagement Steering Group.

- **The Consultation Institute assurance**

Our consultation is subject to assurance by The Consultation Institute (TCI) and we have already been awarded with a Certificate of Consultation Readiness for our pre consultation engagement

"The pre-consultation programme you have undertaken appears both thorough and of high quality. We are confident that you are in a position to both ensure the best options are taken into consultation and that you will be starting consultation on the strongest footing." - The Consultation Institute

- **Independence and objectivity**

We will be working with independent delivery partners to deliver activities and to receive, analyse and report on the findings.

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Timeline and overview of activities

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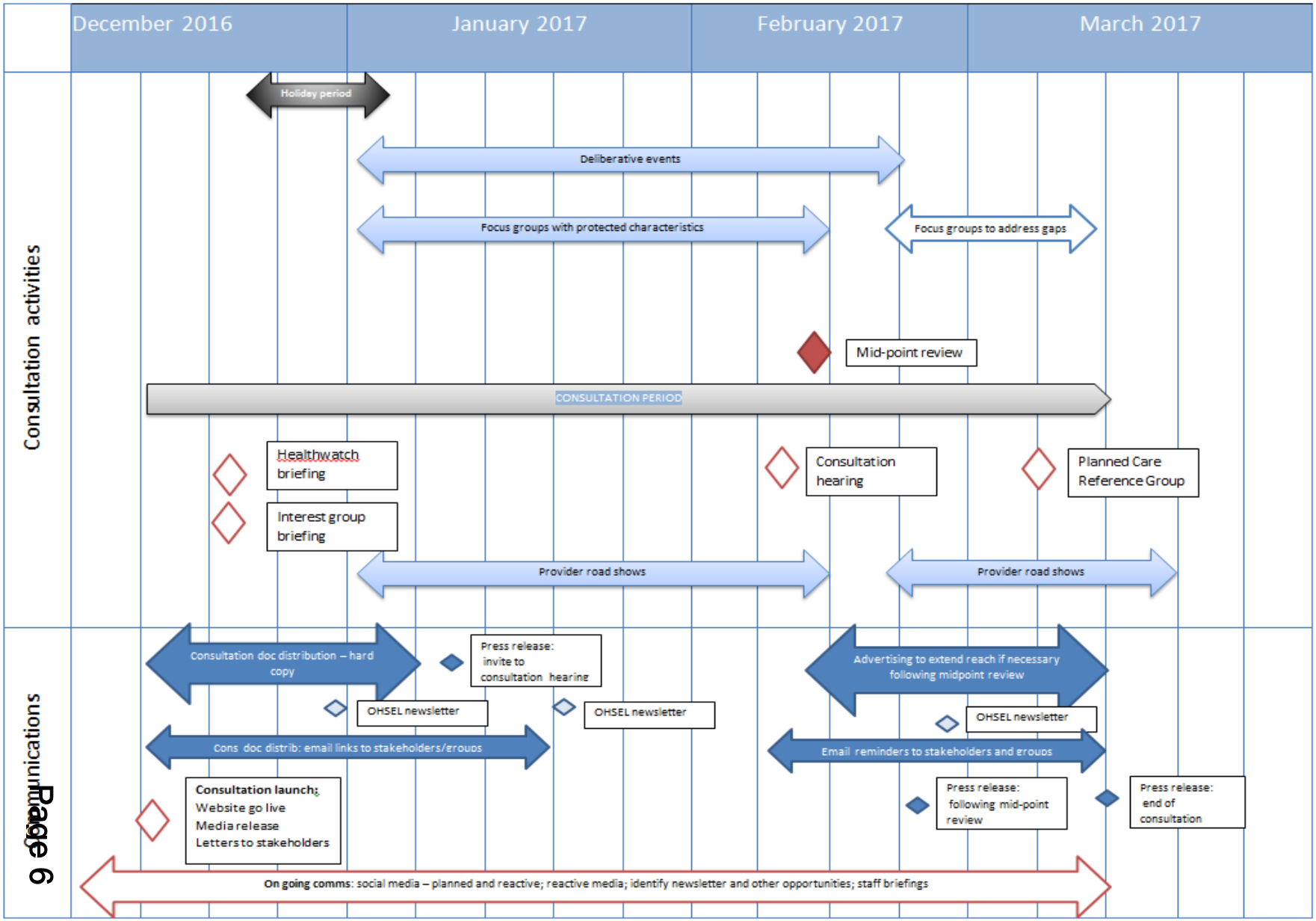

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Who are we consulting?

Patient and the public	Healthcare professionals/providers	Third sector/partner organisations	Political
Residents who access services in south east London	GPs and primary care staff	Voluntary and community sector providers	Local MPs and elected members
Residents who access services outside of south east London	Orthopaedic staff	Independent sector	Mayor of Lewisham
Patients who use services in south east London but live elsewhere	CLAHRC and other research bodies	Orthopaedic charities	London Assembly members
Local patient/resident groups	CCG staff and commissioners	Voluntary community sector (user/carer/advocacy)	Joint Health Overview and Scrutiny Committee
Interest/issues groups	GP members	HealthWatch organisations	Health and wellbeing boards
Equality groups – most impacted	British Orthopaedic Association	Council for voluntary services	Other LA stakeholders - OSC chairs, Directors of Adult / Children's Social care
Patient Participation Groups (PPGs)	Provider trusts (including out of area)	Health Education South London (HESL)	
Media	Local medical councils	Local CEPNs	
	Department of Health	Universities and Medical Schools	
	NHS Improvement	Provider governors and membership	
	Staff Unions	Academy of Royal Medical Colleges	
	Acute provider staff (non-orthopaedic)	Health Improvement Network (HIN) South London	
	Community services providers/staff	Housing organisations	
	Mental health trusts / staff	Staff in neighbouring areas	
	London Ambulance Service		
	Physiotherapists – acute and community		
	Neighbouring CCGs (Wandsworth, Croydon, Tower Hamlets, Newham, City and Hackney, Dartford Gravesham & Swanley)		
	Provider Governors and Members		

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Communications materials

- Consultation document, both printed and digital, including versions: full; summary; easy read; large print; and audio. Other languages will be available on request. We are submitting our documentation for Plain English editing.
- Freepost feedback forms
- Consultation website hub
- Presentations for: staff, public and patients, stakeholders, including Easy Read version
- Posters for GP surgeries, pharmacies, hospital orthopaedic outpatients and other public sites
- Postcard take-away including space for short feedback and capturing names and addresses
- Infographics – printed and digital
- Banners for CCG and trust websites
- Short animation – covering case for change; patient journey; and call to action
- Video of clinicians describing how the new service model will work and describing the changes from current services
- Video archive of the consultation hearing available on demand (likely to be live streamed)
- Pull-up banners
- Targeted advertising to extend reach – e.g. Facebook, promoted Twitter posts and local media

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How will we consult? Summary of key activities (1)

We have a detailed plan per stakeholder (slide 10). Key activities include:

Focus groups

Under the Equality Act 2010, we have a duty to consider potential impacts of any potential service change, on people with **protected characteristics**. In order to help us understand these potential impacts in detail, we will be running focus groups with these populations. **We will hold additional sessions with communities who are most impacted by any change.** These focus groups will be delivered by an independent organisation to preserve objectivity of response.

Deliberative events

We will hold a number of deliberative events across the patch (at least one per borough and more in most impacted boroughs) to enable members of the public, voluntary community sectors stakeholders and interested groups to share their views. The events will be held in areas that maximise coverage across the boroughs and surrounding areas. They will include both **information giving by local clinicians and leaders, as well as table discussions to allow people to share their views and respond to the consultation questions.** These events will be independently delivered and facilitated to ensure their outputs are objectively captured.

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How will we consult? Summary of key activities (2)

Road shows on hospital sites

To provide opportunities for staff and existing patients to find out about the consultation and share their views, we will run a road show in **key orthopaedic areas in each affected trust**. During these sessions we will raise awareness of the consultation and signpost people to our consultation website and response form. We will also provide copies of the consultation document and leaflets for people to take away and consider.

Consultation hearing

We will run a **'consultation hearing' and invite people to submit evidence in advance**. This will be held **mid-way** through the consultation and will be independently facilitated and chaired. It will give interested people and groups the opportunity to challenge our case for change and to provide their own evidence for how services should be run. The consultation hearing will be independently filmed and broadcast.

Briefings

We will hold briefings with key stakeholders – including Healthwatch and interest groups. We aim to hold these briefings **early on in the consultation period** to enable these stakeholders to cascade information to their membership and contacts.

How will we consult? Summary of key activities (3)

Planned Care Reference Group (PCRG)

Towards the end of the consultation period, we will hold another meeting of the PCRG to play back some of the feedback that we have heard to date and to invite you to add to it.

Mail outs

In order to reach past, present and future (those on waiting lists) service users, we will work with local provider trusts to circulate information via their patient lists. We will also publicise our deliberative events and road shows through these mail outs and signpost people to our website and response forms.

Networks and contacts

We will work with our public and voluntary sector colleagues to publicise the consultation and signpost people to our website and response form. This will include contact with key colleagues in clinical commissioning groups, local authorities and the voluntary and community sector (including healthwatch).

How will can people respond and share their views?

- Online hub – hosting all relevant materials and survey
- Online response form
- Hard copy response form
- Via email/Twitter/phone
- Postcards
- In person at deliberative events, focus groups, meetings and roadshows

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Timeframes

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- Consultation to run for 14 weeks (due to Christmas break) from 5th December 2016 – 10th March 2017
- Dates for events and focus groups to be set once consultation has been agreed
- First two weeks activities are detailed below:

Date	Item
Monday 5 December	Website launched hosting key supporting materials and online response form
	Launch social media campaign
	Press release launching consultation
	MP briefings by each CCG
	Electronic distribution of consultation documents to stakeholders and voluntary and community groups
Monday 5 if possible – and within first week	Media briefing – invite local media in and HSJ
First two weeks December	Distribution of hard copy consultation documents to key stakeholders and distribution points
9th December	Meeting with interest groups (38 degrees, Save Lewisham Hospital, Keep Our NHS Public)
16th December	Briefing workshop with all south east London Healthwatch representatives
Mid December	Newsletter article in 'Healthier'
During December	Articles in provider newsletters

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DRAFT consultation document

Improving planned orthopaedic care in south east London

Tell us what you think and help us to shape the future of these services

CONTENTS

1. Introduction
2. What is orthopaedic care?
3. What is included in this consultation
4. Current services
5. The case for change
6. Responding to the case for change
7. Existing hospital improvement plans
8. Our opportunity to consolidate orthopaedic services
9. How we assessed the options and what are we recommending
10. Who we have involved in these proposals
11. Tell us your views

1. Introduction

Since 2014, health and care organisations in south east London have been working together on a shared plan for the local NHS, known as Our Healthier South East London. The ideas developed through this programme are the product of partnership working between clinicians, commissioners, council social care leads and local hospitals, and have been informed by wide engagement with local communities, patients and the public. They sit within a wider plan, called the Sustainability and Transformation Plan, which looks at many services and outcomes for the population of south east London.

One of our priorities is improving the way the NHS provides orthopaedic care – for conditions that affect the bones, joints, ligaments, tendons, muscles and nerves. Specifically, we want to make improvements for non-emergency adult patients who have surgery planned in advance and require an overnight hospital stay (known as inpatient care). This includes routine inpatient procedures, such as hip and knee joint replacements and some specialist procedures, such as hip replacements with infections, or ankle and other complicated joint replacements.

We have some excellent orthopaedic services in south east London, but the standard of care isn't the same for every patient. Planned procedures are sometimes cancelled, leading to distress for the individual and their family and carers. Some patients wait too long for their surgery, meaning their experience of care is not as good as it should be. Importantly, demand is increasing - so we need to find a way to care for a lot more people in the future than we do today. Also, the money available to the NHS is limited, so we must work as efficiently as possible.

To address these challenges, we are proposing to consolidate planned inpatient orthopaedic surgery into fewer specialist facilities, called 'elective orthopaedic centres'. These centres would be shared facilities which all of the NHS hospitals in south east London would use. We also plan to develop an orthopaedic clinical network that will ensure standards are consistently excellent across south east London and that clinicians share learning and expertise.

The benefits of consolidating planned surgery into fewer, specialist centres are set out in *Getting It Right First Time*, a national report published in March 2015 by Professor Sir Tim Briggs, orthopaedic surgeon at the Royal National Orthopaedic Hospital and President of the British Orthopaedic Association.

We have spoken with lots of people in the development of these ideas – including doctors, nurses, orthopaedic specialists, local and national health commissioners, NHS staff and, importantly, patients and their families.

Evidence shows that creating elective orthopaedic centres would help us to address the challenges in these services, including reducing the number of cancelled procedures and increasing the number of patients the NHS can care for. This is the experience in other areas of the country that have established similar centres.

Please read this document carefully and tell us what you think of our proposals by filling in the questionnaire. Your views are important and will help shape the future of planned orthopaedic care for patients across south east London.

FOR SIGN OFF BY CCG CHAIRS - PENDING

Our proposals on orthopaedics are part of our overall strategy, known as the Sustainability and Transformation Plan which 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

2. What is orthopaedic care?

Orthopaedic care treats injuries or conditions involving the musculoskeletal system (bones, joints, ligaments, tendons, muscles and nerves). You may be referred to an orthopaedic consultant for treatment of an injury, such as a bone fracture, or a long-term condition that's developed over many years, such as osteoarthritis.

Annually in south east London hospitals there are:

- 185,600 planned orthopaedic outpatient appointments
- 15,400 planned orthopaedic day cases operations
- **6,870 planned orthopaedic inpatient operations** - the changes we are proposing will only affect people having planned inpatient operations

3. What is included in this consultation?

The NHS in south east London is trying to achieve improvements in planned adult inpatient orthopaedic operations (around 6,870 procedures). This could result in 2,300 to 3,600 people having their surgery carried out at a different hospital site in the future, depending on which sites are chosen for the elective orthopaedic centres. This includes routine procedures such as hip and knee joint replacements as well as some specialist procedures that are planned in advance, carried out at the following hospitals:

- Guy's Hospital (Lambeth)
- King's College Hospital (Southwark)
- Princess Royal University Hospital (Bromley)
- Orpington Hospital (Bromley)
- University Hospital Lewisham (Lewisham)
- Queen Elizabeth Hospital (Greenwich)
-

This consultation includes options for where the sites for planned adult inpatient orthopaedic surgery could be in the future.).

3.1 What is not included

All other planned and emergency orthopaedic care for adults: Around 185,600 outpatient appointments and 15,400 day case procedures per year – would continue to be provided at the same hospitals as today.

- Spinal surgery and children's orthopaedic surgery are not included in the scope of this consultation.
- Emergency and trauma care: Emergency orthopaedic procedures (for patients arriving at A&E departments) are also not included.
- Out of hospital musculoskeletal services: Most musculoskeletal (MSK) conditions are managed outside of hospital by GPs and community staff.
- Darent Valley Hospital: A small number of patients from south east London choose to receive orthopaedic care at Darent Valley Hospital in Kent. Whilst we aim to offer these patients improved services at sites within south east London, the orthopaedic service at Darent Valley Hospital is not included in the scope of this consultation.

4. Current services

Adult patients from south east London currently have planned inpatient orthopaedic surgery (non-emergency) at seven hospital sites, which includes a small number of procedures at Darent Valley Hospital, in Kent.

Table 1: Hospital sites and their provider NHS Trusts

Hospital site	**Provider trust**
Guy's Hospital	Guy's and St Thomas' NHS Foundation Trust
King's College Hospital Princess Royal University Hospital Orpington Hospital	King's College Hospital NHS Foundation Trust
University Hospital Lewisham Queen Elizabeth Hospital	Lewisham and Greenwich NHS Trust
Darent Valley Hospital (Kent)	Dartford and Gravesham NHS Trust

This table will be displayed as a map

Queen Mary's, in Sidcup, also provides outpatient and day case surgery for patients in south east London – these services are not affected.

Each site carries out a different number of procedures each year, and a different combination of what are known as 'routine' and 'specialist' cases (**Table 2**):

- Routine – these are straightforward, high volume procedures where there is a standard approach, such as normal hip replacements
- Specialist – these are more challenging procedures and include revision surgery, hip replacements with infections, or ankle and other complicated joint replacements

Table 2: Number of inpatient orthopaedic procedures carried out on adult patients from south east London at each hospital (Aug 2014 - Sept 2015)

	Routine	Specialist	Total
Site	**Patients**	**Patients**	**Total patients**
Guy's and St Thomas' NHS Trust	1,736	392	2,128
University Hospital Lewisham	714	53	767
Queen Elizabeth Hospital	313	7	320

	Routine	Specialist	Total
King's College Hospital (Denmark Hill)	742	348	1,090
Princess Royal University Hospital	111	14	125
Orpington Hospital	1,919	152	2,071
Dartford and Gravesham NHS Trust	285	19	304
Grand Total	**5,820**	**985**	**6,805**

Analysis based on planned care only, and includes spinal procedures. Please note these figures are different to the average as they are based on Aug 2014-Sep 2015)

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.

5.1 Meeting future demand

Demand is increasing so we need to find a way to care for a lot more people in the future than we do today.

Our projections indicate that demand for planned adult inpatient orthopaedic surgery will increase by at least 25% by 2021 – from around 6,800 procedures to 8,600 per year, and possibly up to 11,000.

There are a number of reasons for this, but increasing levels of obesity and an ageing population are the most significant factors. We are working on more 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.

This is not an issue affecting south east London alone. Nationally, orthopaedic 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. 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 – whilst offering patients the best services and experience.

5.2 Quality, safety and outcomes

The standard of care isn't the same for every patient.

There are opportunities to make orthopaedic services safer by reducing infection rates and minimising complications following surgery[1,2]. While none of the current elective orthopaedic services in south east London have higher than expected infection rates, infection can be a significant problem in replacement joints because, once an infection sets into the metal or plastic components, it is very difficult to remove. Nationally if we could reduce infection rates to 1%, the lives of 6,000 patients would be transformed and the NHS could save £300m per year.

Some surgeons only carry out a small number of specialist procedures each year. National evidence and agreed best practice suggest that where surgeons carry out a larger number of procedures, in larger dedicated units, patient safety and the results from surgery are consistently better[3,4].

[1] Source: Carter, Operational productivity and performance in English NHS acute hospitals: Unwarranted variations

[2] Source: Getting it right first time

[3] Source: NHSE draft specification for specialised orthopaedics

5.3 Patient experience
Surgery is cancelled too often and some patients wait too long for their procedure, which affects their experience.

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

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

	Under 18 weeks	Over 18 weeks	Total waiters	% within 18 weeks
Guy's and St.Thomas' NHS Foundation Trust	1932	246	2145	90.1
King's College Hospital NHS Foundation Trust	5499	1400	6932	79.3
Lewisham and Greenwich NHS Trust	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. This often results in cancellations, which have an adverse impact on patient experience as well as on their families and carers.

Feedback from patients, clinicians and members of the public shows us that experience of these services is variable (Fig. 1).

Figure 1: Patient feedback[5]…
"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."

6. Responding to the case for change

A large amount of research has gone into tackling the challenges faced by orthopaedic services across the NHS and other healthcare bodies. One of the most prominent reports is *Getting It Right First Time*, a national study published in March 2015 by Professor Sir Tim

[4] Source: Public Health England, Surgical Site Infection (SSI) surveillance
[5] SOURCE: Getting it Right First Time
CHART SOURCE DATE: HES, Sept 2014 – Aug 2015

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. The report outlines the benefits of separating emergency and planned orthopaedic surgery and creating specialist orthopaedic centres with standardised processes. The report takes the view that this approach has the potential to achieve better care for patients.

The evidence tells us 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 (Fig. 2).

Figure 2: 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).

It was established by four south west London acute trusts and it 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 outstanding outcomes, low complication rates and high patient satisfaction. Performing around 5,200 procedures a year, SWLEOC is recognised as the largest joint replacement centre in the UK and one of the largest in Europe and 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.

There are two key questions that we have considered in order to come up with proposals for the local NHS which would deliver the best quality outcomes for our patients and also offer the best way for the NHS to spend its money:

- Should we simply expand the services we already have?
- Should we bring all of this surgery together (consolidate) into fewer, high volume units?

"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*

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 and equipment

Each provider has considered what their existing plans could achieve and these are set out in our supporting information. 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.

8. Our opportunity to consolidate orthopaedic services

In 2015/16 there were 6,870 planned inpatient orthopaedic operations carried out on adults at seven south east London hospital sites.

Through discussions with senior doctors, therapists, nurses and other partners we have considered the potential to consolidate procedures like these at fewer sites by establishing highly specialised facilities called 'elective orthopaedic centres'.

Evidence set out in *Getting it Right First Time* and other studies suggests that carrying out orthopaedic surgery at larger units, with ring fenced beds, can improve the patient journey, patient experience and outcomes while making the services more efficient and sustainable. Creating elective orthopaedic centres would separate planned inpatient surgery from emergency surgery, because only surgery planned in advance would be carried out at these facilities.

Surgeons would operate on all but a few very specialist patients at these new units which would each have a dedicated team of health professionals on site, including nursing, anaesthetic staff and therapists. Surgeons would carry out both routine and specialist surgery (excluding spinal procedures) at these centres, in a highly specialised environment supported by this core team.

How many sites would be best for south east London?
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 4,250 procedures each year by 2021 (around 8,500 in total). 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.

Read more about how we've come to this conclusion in our supporting information.

8.1 Clinical network

Surgeons and clinical teams would work closely together in an orthopaedic clinical network across south east London. This will ensure strong joint working between clinical staff, and would help us to make sure that knowledge and expertise is shared.

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 base hospital. They would use the elective orthopaedic centres 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 The patient journey

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

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.

Changes to out of hospital care are not included in the scope of this consultation, but to support the elective orthopaedic centre we have developed a number of standards that patients can expect both pre and post-surgery.
These include:

- Better access to support and information to help patients look after themselves and reduce the need for surgery
- Improved access for clinicians to shared patient records to help decision making
- Assessing patients physical and mental health needs prior to treatment and ensuring there is a mutually agreed treatment and discharge plan before admission

You can read more about developments in these services on our website in our supporting information.

Figure 3: 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.

NB This pathway will be displayed as a graphic to aid understanding

8.3 What wouldn't change

8.3.1 The location of the vast majority of orthopaedic care

185,600 outpatient and follow-up appointments; and 15,400 day case procedures would continue to be provided from the same hospitals as today. Emergency orthopaedic surgery (supporting A&E departments) would also remain at the sites that currently provide this.

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 if you needed inpatient surgery (**Fig. 3**).

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. Other areas that have done this have successfully ensured that support for trauma and emergency is

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

You can read more about the work we have done on this in our supporting information.

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.

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.

You can read more about the work we have done on this in our supporting information.

Figure 4: 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 two sites across south east 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

8.4 How would this address the case for change?
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 and help us to address the issues described in our case for change:

- **Demand** - Creating elective orthopaedic centres would be a 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.
- **Patient experience** - Elective orthopaedic centres would significantly reduce the number of cancelled operations and patients would spend less time in hospital. Earlier discharge, fewer infections and readmissions would improve patient experience. Patients would also wait less time for surgery.
- **Quality, safety and outcomes** – Dedicated, high-volume elective orthopaedic centres could help the NHS achieve improvements such better infection control, fewer cancellations, fewer unplanned returns for surgery and better admission and discharge planning which is likely to result in better overall outcomes for patients.

Performing surgery in fewer places would ensure more patients receive a similar standard of care.
- **Finance** - 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 expansion of the existing configuration of services.

You can read more about these benefits and how the proposals address our case for change on our website in our supporting information.

9. How did we assess the options and what are we recommending?

9.1 We have considered two different approaches to meeting the case for change. These are:

- NHS trusts' existing plans to expand and improve services; and
- Consolidating services into two elective orthopaedic centres as part of a network across south east London.

Having made a comparison between both approaches**, we are recommending consolidating planned adult inpatient orthopaedic surgery at two elective orthopaedic centres**, rather than expanding and improving existing orthopaedic services.

9.2 In this consultation we are asking for your views on three possible options for the location of elective orthopaedic centres in south east London:

	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

This table will be displayed in the form of three maps

We think that all three of these options will give us greater improvements to inpatient orthopaedic care and be more cost effective than the existing plans our hospitals have to meet rising demand and improve care.

9.3 How did we arrive at this recommendation?

We have worked closely with patients, members of the public, orthopaedic clinicians, NHS trust managers and commissioners to develop and agree criteria for evaluating possible options for consolidating elective orthopaedic care.

This included both non-financial criteria and an analysis of the financial impacts of each option. All options were compared and scored against the existing hospital plans to expand and improve services.

9.3.1 The non-financial criteria are outlined below:

Travel and access – Which options mean the least number of people have to travel to a different site than they presently do, and how many would travel further (see 9.4, below).

Deliverability – How easy options would be to implement, how easy it would be to obtain funding to build and how flexible the option would be to if there we need to treat more patients than we expect.

Quality – Which options would deliver the best clinical outcomes for patients in south east London.

Patient Experience – Which options could deliver the best experience for patients and minimises the impact on disadvantaged patient groups.

Research and Education – Which options would give the greatest benefits in terms of developing research and educating clinicians

Workforce – How easy it is to attract, recruit and retain staff

We have also ruled out a number of options and hospital sites that did not meet our minimum criteria; these include sites where it is not clinically appropriate to develop orthopaedic services or where it would not be possible to deliver the agreed model.

9.3.2 Non-financial scoring

	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

All of the three options we have considered offer better quality of care for patients in south east London than existing Trust improvement plans (see section 7).

- Option 2 (Guy's Hospital and Orpington Hospital) offers the most positive benefits to patient experience, quality and other non-financial criteria
- Option 1 (Guy's Hospital and University Hospital Lewisham) and Option 3 (University Hospital Lewisham and Orpington Hospital) offer positive benefits to patient experience and quality

9.3.3 Financial analysis

The financial analysis examined much it would cost to establish the new facilities under each option and how cost effective they would be in the future.

The financial analysis has shown 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	Description	Investment required over 5 years	Minimum projected savings by	Payback period compared	Overall costs over 20 years

			2021	with existing plans	
	Hospital existing improvement plans	£2.1m	-	-	£823m
1	University Hospital Lewisham and Guy's Hospital	£14.3m	£9.2m	6 years	£722.5m
2	Guy's Hospital and Orpington Hospital	£4.1m	£2.4m	10 years	£809.3m
3	University Hospital Lewisham and Orpington Hospital	£13.3m	£5.1m	7 years	£766.3m

- 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 up-front cost 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 up-front cost.
- 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 up-front cost. However, over 20 years Option 3 still offers substantial savings compared to existing Trust improvement plans.

The process of evaluating the options is explained in more detail in our supporting information.

The financial benefits shown here are based on provider submissions that describe how they would each deliver an elective orthopaedic centre, however, we believe a prudent approach has been taken and further efficiencies could be possible. They also include building and staff overhead costs, which probably can be reduced. As we continue to develop our proposals we will work closely with providers to establish further financial benefit.

9.4 Travel and access

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.

Whilst a majority of elective orthopaedic care would still take place at your local hospital (outpatient appointments, follow-ups and day case surgery) patients may need to travel to a different hospital for inpatient surgery.

We analysed where patients currently choose to go, or are referred to, for their inpatient elective orthopaedic care. This showed that:

- 15% of patients currently travel outside of south east London.
- Two thirds of patients who travel to hospitals in south east London do not go to their nearest site.
- Across the options, between 30-50% of patients might have to travel to a different site than the one they currently travel to.

- For almost all patients that would need to travel further by car, the additional journey time is less than 20 minutes for all options.
- For most patients that experience a longer journey on public transport, the additional journey time is less than 30 minutes for all options.

More detail on the travel implications can be found in our supporting information.

As well as the impact of travel on patients we have been looking carefully at the implications of our proposals on potentially disadvantaged groups in the form of an Equalities Analysis. You can read more about this on our website in our supporting information.

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.

10. 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
- Clinicians and patients through the London Clinical Senate

You can read more about how we've involved different people in our plans on our website in our supporting information.

11. Tell us your views

We want to hear what you think of our proposals which aim to help provide planned orthopaedic services in the best way for patients across south east London.
Please remember that this consultation is not a 'vote'. We will take your responses into account along with a wide range of other information, including the views of staff, professional groups and organisations.

The consultation period will last for **14 weeks** from [DATE] to [DATE]. We have planned a range of activities in your local area which will allow us to hear your views. This includes events in each of the six south east London boroughs.

You can find out full details of when and where these events will be taking place on our website, or by calling our freephone number.

We are working with a team from the University of Kent, who will independently process all the feedback we receive. Only the research team will see your questionnaire. They will produce a report, which will include any comments you make. This report will be considered by local NHS commissioners, who will respond to its contents before a final decision is made.

A final decision will be made by the south east London NHS Committee in Common – a joint forum which includes voting members from the six south east London NHS clinical commissioning groups. This will not happen until after the feedback from the consultation has been considered – likely to be the spring of 2017.

We may be asked to release the comments you provide (excluding your personal details) to other people or organisations, under the Freedom of Information Act (2000), the Data Protection Act (1998) or the Environmental Information Regulations (2004).

Any views from individuals that we share or publish will be anonymised.

Contact us

We welcome the views and ideas of anyone in our community. There are a number of ways to tell us what you think:

- Call us free on xxxxxxxxxxxxxxxxxxx
- Complete and send us the form included with this consultation document
- Visit our website: www.ourhealthiersel.nhs.uk
- Write to us: Our Healthier South East London, PO BOX 64529, London SE1P 5LX or
- Email: ourhealthiersel@nhs.net
- Follow us on Twitter: @ourhealthiersel

Find out more about Our Healthier South East London at www.ourhealthiersel.nhs.uk or follow us @ourhealthiersel

Consultation questions

1.a. How far do you agree or disagree that improvements need to be made to planned adult inpatient orthopaedic surgery in south east London?

strongly agree / agree / neither agree nor disagree / disagree / strongly disagree / don't know

1.b. Please tell us why you say that
Free text (max. 2000 characters)

2.a. How far do you agree or disagree with the proposal to establish two elective orthopaedic centres in south east London?

strongly agree / agree / neither agree nor disagree / disagree / strongly disagree / don't know

IN CONTEXT DROP DOWN A (ON RESPONSE TO 2.a.)

2.b. How important were these factors for you when deciding whether or not you agree with the proposal? (please rate each 1 to 5, where 5 is very important and 1 is not important):

Expected positive impacts
LIST 1 – Positive impacts

	Important				Not important
	5	4	3	2	1
Your operation being less likely to be cancelled					
Having a shorter stay in hospital					
Getting a better overall result from your care					
Having a better experience of care					
All patients receiving a consistent standard of care					
Ensuring the NHS can treat a growing number of patients					
Support closer to home before and after surgery					

Impacts which might be less positive
LIST 2 – Negative impacts

	Important				Not important
	5	4	3	2	1
Some patients travelling further for surgery					
There may be a cost to the NHS in					

making these changes					
Financial impact on NHS trusts					
Impact on A&E services					

2.c. Do you have anything else to say about the proposal to establish two elective orthopaedic centres in south east London?
Free text (max. 2000 words)

3.a. We have set out three possible options for improving elective orthopaedic care in south east London. Which option do you think offers the best solution for patients?

(CHOOSE 1):

Option 1 – creating elective orthopaedic centres at Guy's Hospital and University Hospital Lewisham
Option 2 – creating elective orthopaedic centres at Guy's Hospital and Orpington Hospital
Option 3 – creating elective orthopaedic centres at Orpington Hospital and University Hospital Lewisham
None of these

3.b. Please tell us more…
Free text (max. 2000 characters)

4. Are there any reasons why these proposals might affect you, or the people you care for, more than they affect other people in south east London?
Free text (max. 2000 characters)

5 a. To what extent do you agree with the following statement:

I would be prepared to travel further to receive better care

strongly agree / agree / neither agree nor disagree / disagree / strongly disagree / don't know

5. b. Please tell us why you say that
Free text (max. 2000 characters)

5. c. What travel or access issues do you think we need to consider under these proposals and what could be done to make this easier?
Free text (max 2000 characters)

6. Do you have any other comments about how we have developed our proposals, the proposals themselves or the consultation process?
Free text (max 2000 characters)

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]

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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:

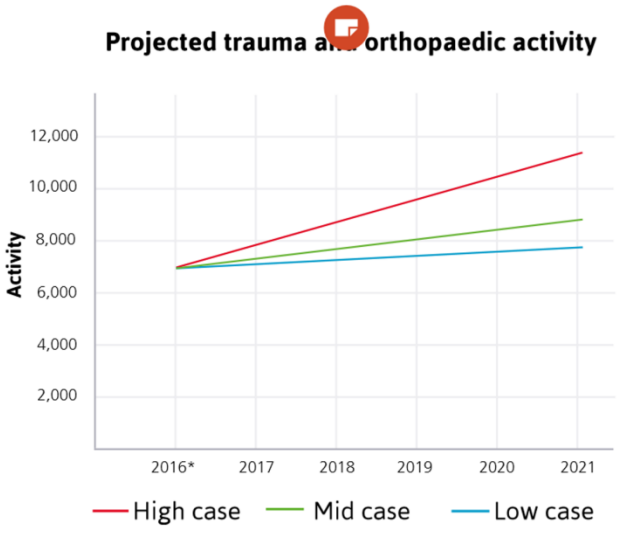
- Low case: This represents the minimum amount of demand we could experience in the future
- Mid case: This represents the middle amount of demand we could experience in the future
- High case: This represents the maximum amount of demand we could experience in the future

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*.

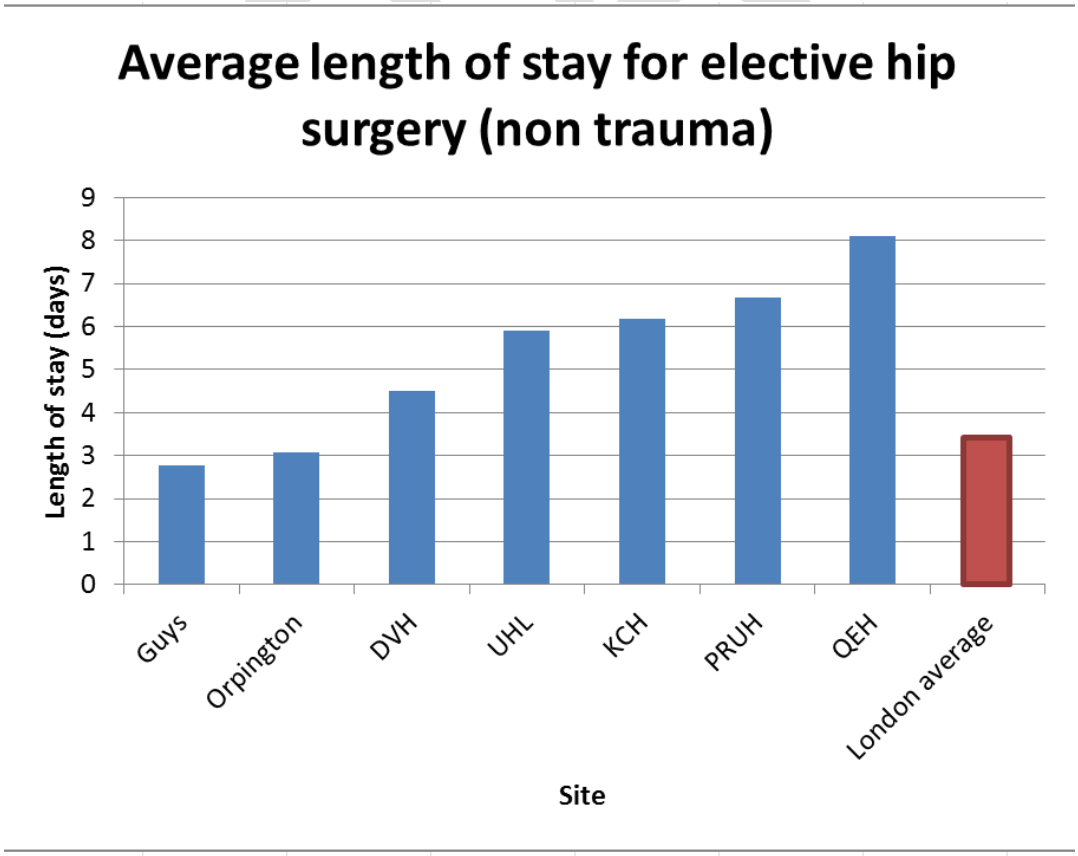
Feedback from patients, clinicians and members of the public shows us that experience of these services is variable. The quotes below are an example of this feedback and are

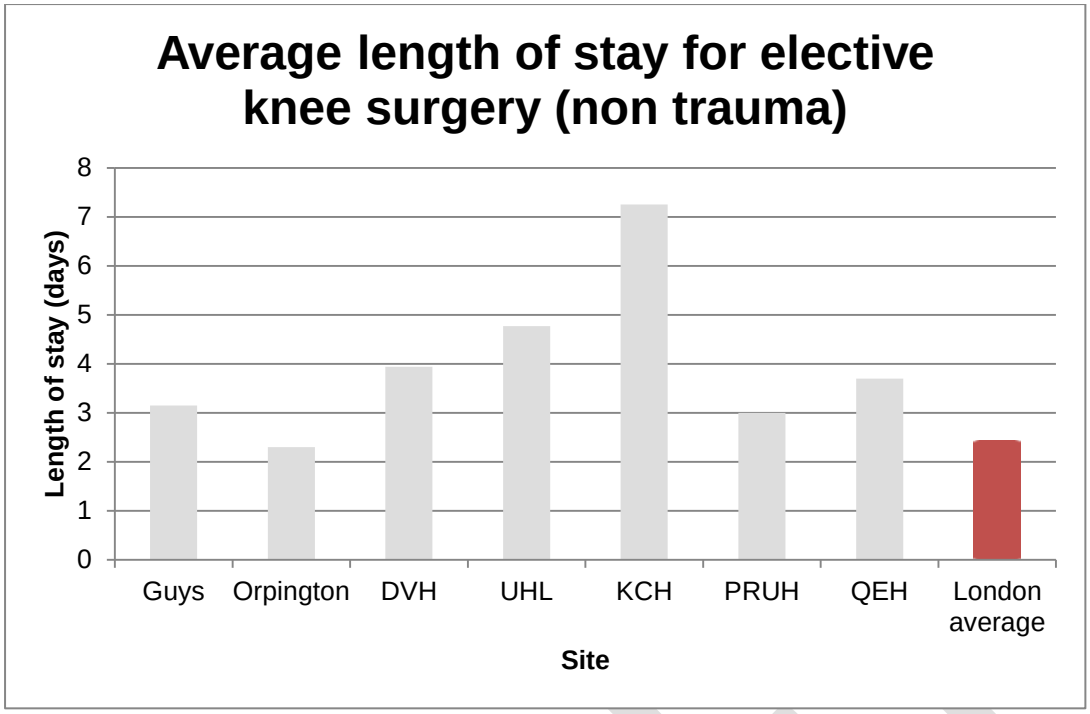
sources from Getting it Right First Time (a national report on the state of orthopaedic care) and through local engagement.

- *"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

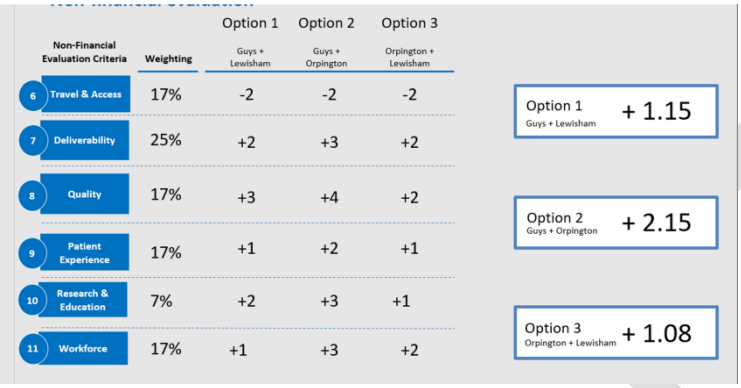
These two-site options were each assessed against the non-financial criteria.

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

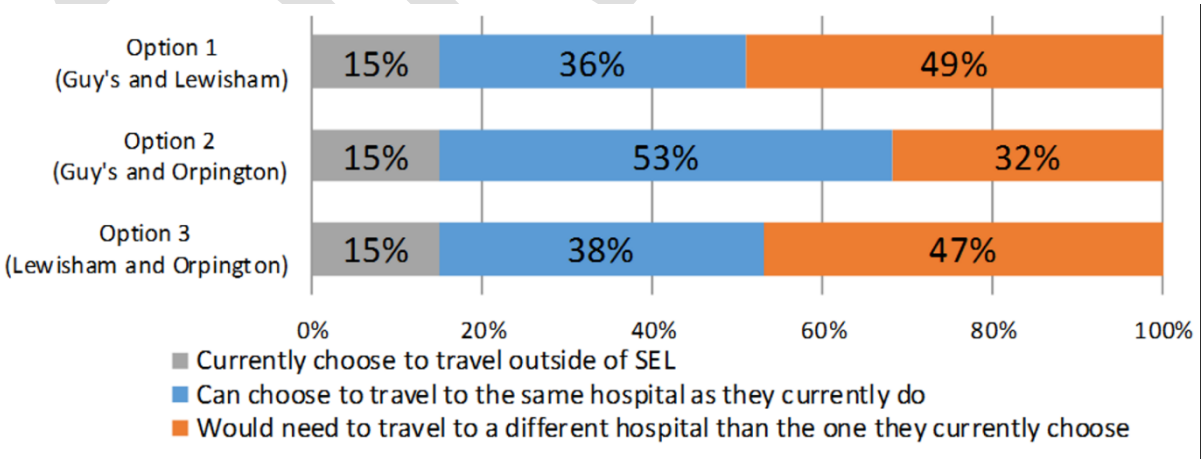


Figure 8: Percentage of orthopaedic inpatients and the impact on their journey under each option (car journeys)

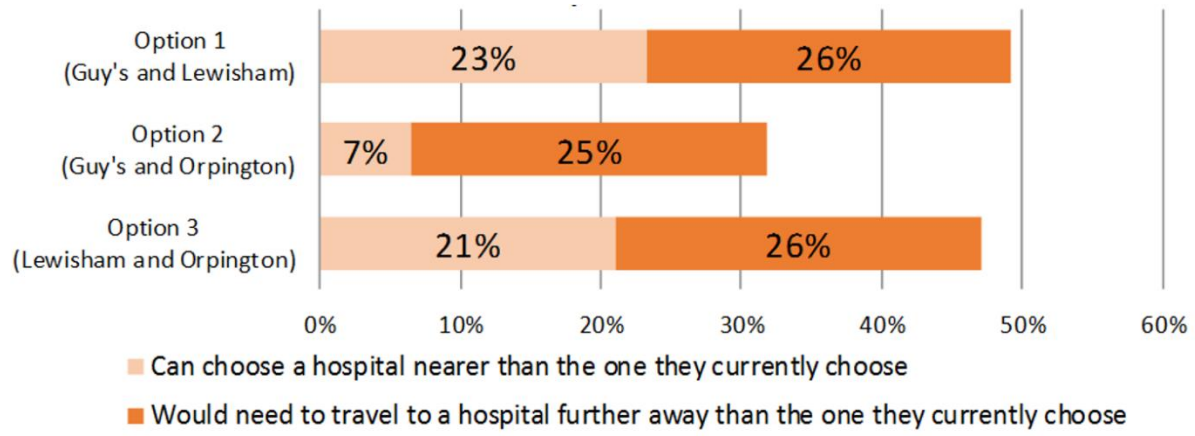


Table 14: Percentage of patients and estimated journey time increases (car journeys)

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)

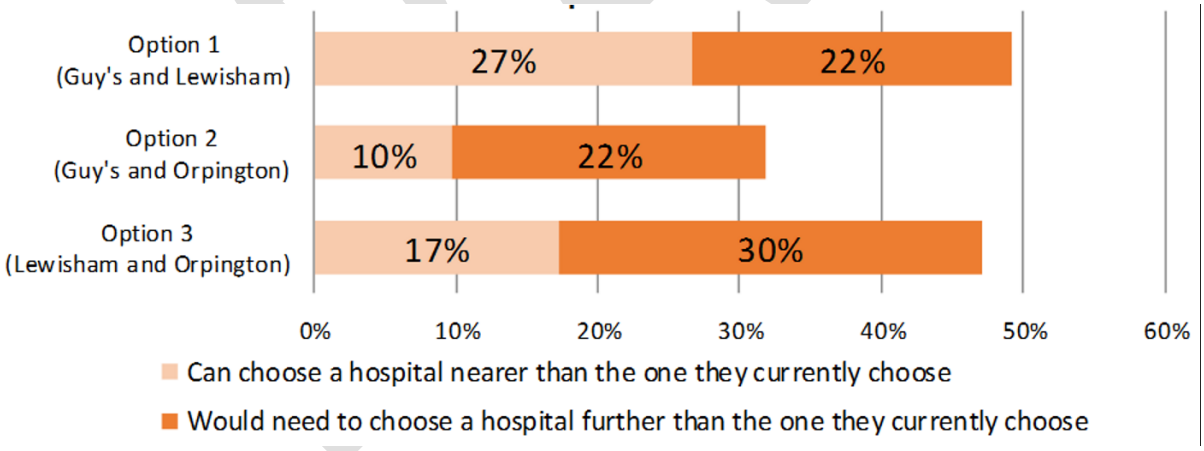


Table 15: Percentage of patients and estimated journey time increases (public transport)

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

Equalities Analysis

NHS South East London

Scoping report

August 2016

Our Healthier South East London

Improving health and care together

MOTT MACDONALD

Review and approvals

Revision	Date	Originator	Checker	Approver	Description
A	25 July 2016	Hannah Grounds Katy Field Frances Parrott	Frances Parrott	Kerry Scott	Draft scoping report for internal review.
B	28 July 2016	Hannah Grounds Katy Field Frances Parrott	Frances Parrott	Kerry Scott	Scoping report for client issue.
C	16 August 2016	Frances Parrott	Kerry Scott	Kerry Scott	Updated scoping report following client comments.

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1. Our Healthier South East London

NHS commissioners and providers are working in partnership with local authorities on a five-year plan for services across six boroughs in south east London: Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark collectively known as 'Our Healthier South East London' (OHSEL).

The approach undertaken by OHSEL has been to look in detail at a number of clinical areas where significant challenges are faced. One of these areas is planned care, of which elective orthopaedic services has been identified as an area for potential reconfiguration.

Elective orthopaedic surgery is currently carried out at eight different sites in south east London. OHSEL has identified the following reasons for improving the care currently available:

- Quality of care and outcomes for patients accessing orthopaedic care varies across south east London.
- Too many procedures are cancelled and there are unnecessary delays in the patient journey.
- Demand is increasing; the report by Professor Tim Briggs 'Getting it right first time' published in March 2015 shows that by 2030 over 15.3 million people in the UK will be over the age of 65 and consequently, the need for planned care including orthopaedic procedures is likely to increase.

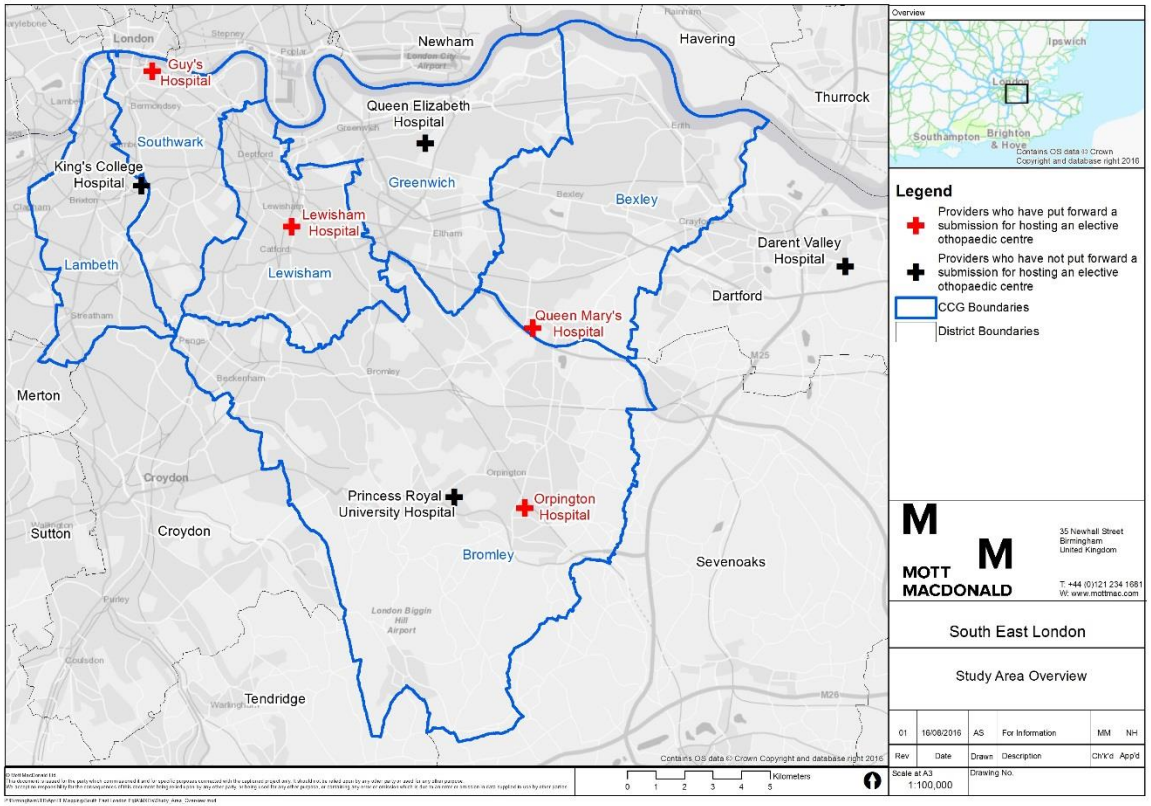
OHSEL wants to find a more reliable and consistently high standard of care for patients while increasing capacity to care for larger numbers of people.

OHSEL is exploring the benefits and feasibility of a consolidated elective orthopaedic service for inpatient operations in south east London. It is proposed that some elective operations should be provided from two centralised centres in future, while outpatient and emergency services remain at local hospitals as is the structure currently.

Seven sites currently offer inpatient elective orthopaedic care to patients from south east London. Through the submission process, four providers have come forward to describe sites that could host an elective orthopaedic centre within the model.

The sites are; Guy's Hospital, Lewisham Hospital, Queen Mary's Hospital and Orpington

The map below shows the sites that currently provide elective orthopaedic care to south east London residents, it should be noted that at present Queen Mary's Hospital provides elective orthopaedic day case surgery not inpatient surgery for south east London patients. Sites in red are those which providers have put forward submissions for hosting an elective orthopaedic centre.



2. Equalities analysis overview

Equalities analysis
To support the public consultation and to fulfil the need to ensure that OHSEL has considered the potential impacts on those characteristics protected under the Equality Act 2010[1], those classified as deprived and carers. Mott MacDonald was appointed to undertake an equalities analysis of the proposals for elective orthopaedic services.

It is important to note that the purpose of this work is not to determine the decision about which option is selected by OHSEL; rather this analysis is to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve.

Scope and objectives
The objectives of this equalities analysis are to:

- Identify the positive and any negative impacts for the population of OHSEL as a result of the proposed reconfiguration.
- Identify which (if any) of the protected characteristics groups are more likely to be affected by the proposals due to their propensity to require different types of health services.
- Set out conclusions about the extent to which proposals accord with the three aims of the Public Sector Equality Duty (PSED): (to eliminate unlawful discrimination; advance equality of opportunity; and to foster community good relations).
- Develop conclusions on the comparative advantages and disadvantages of the different options.
- Provide recommendations on ways in which positive impacts can be maximised and ways in which to mitigate or minimise any adverse effects.

The equalities analysis has been designed to be an iterative process that can be revisited and take on board evidence over the course of the option-development and consultation process. Work is structured around three principal stages.

The table overleaf sets out each stage of the equalities analysis.

1. The protected characteristics are; age, disability, pregnancy and maternity, race and ethnicity, sexual orientation, gender reassignment, religion and belief, marriage and civil partnership and gender.

2. Equalities analysis overview

Stage	Description and deliverables
One: Scoping	**Description** • Desk research into demand for elective orthopaedic services by each protected characteristic group and deprivation and carers. • Socio-demographic profiling of all six CCG localities. • Strategic and community stakeholder engagement through one-to-one telephone interviews. • Confirmation of issues, geographical areas and population groups on which to focus during the next stage of work. **Deliverables** • Interim presentation delivered to the OHSEL Equalities Steering Group. • Scoping report.
Two: Consultation	**Description** • Expert equality advice provided to OHSEL during the public consultation. • Continuing engagement with community stakeholders either through engagement fora or focus groups, to be decided. • Staff engagement through one-to-one telephone interviews. • Equalities training workshop delivered to NHS staff on data required to fulfil Public Sector Equality Duty (PSED). **Deliverable** • Interim report.
Three: Post consultation	**Description** • Review of public consultation findings. • Re-engagement with strategic and community stakeholders through a final workshop. **Deliverable** • Final report.

Please note that the phrase community stakeholders refers to community groups and representatives. Strategic stakeholders include CCG and Trust equality leads, clinical and project leads and directors of public health. A list of stakeholders contacted and invited to share their views is included in appendix A1.

3. Overview of the scoping report

The objectives of the scoping report are to:

- Identify existing health inequalities, access barriers and equality issues to be considered.
- Identify which of the 11 groups have a higher need for orthopaedic services and therefore more likely to experience positive or negative impacts.
- Provide recommendations about key groups to target during consultation.
- Provide advice on equalities questions for inclusion in public consultation.

Evidence for the scoping report has been gathered through:

1. Demographic analysis which sets out the characteristics of the south east London population, and particularly the distribution of residents from different equality groups.
2. An evidence review of available literature which identifies population groups who may have a disproportionate need for services.
3. Strategic and community engagement.

Please note that this report is not inferring that social groups not scoped in have no need for elective orthopaedic services, rather it suggests that there does not presently exist a body of clinical evidence indicating a disproportionate need amongst groups not presently scoped in. This scoping opinion will be supplemented as further evidence is gathered throughout stages two and three.

4. South East London population profile

The total population and the density of population provide a baseline from which to break down the key socio-demographic trends in the study area.

Total population

The table below shows the total population of each of the six CCGs, as well as wider area comparators[2].

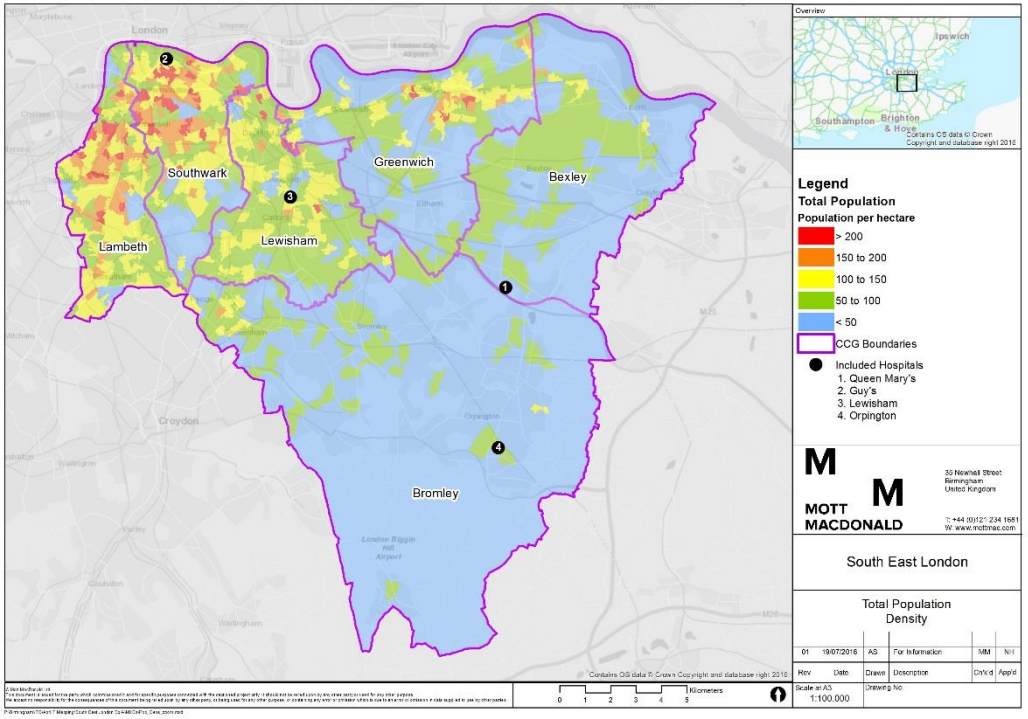
Area	Total population
Bexley	239, 900
Bromley	321, 300
Greenwich	268, 700
Lambeth	318,200
Lewisham	291,900
Southwark	302, 500
South East London	1,742,500
Greater London	8,538,700

Source: ONS, mid-year population estimates, 2014

The table indicates that the largest numbers of people live in the boroughs of Bromley (with 321,300 people) and Lambeth (with 318,200) while the least populated is Bexley (with 239,900). The total population of the study area is over 1.7 million.

The map indicates that there are higher densities of population in the inner London Boroughs of Lambeth and Southwark. Bromley has much lower density of population, despite being the most populated CCG.

Population density



2. Population figures have been rounded to the nearest one hundred.

5. Breakdown of protected characteristic groups

This section of the report considers each of the nine 'protected characteristic' groups in turn, as well considering other disadvantaged groups specifically deprived communities and carers. This includes:

- Age
- Disability
- Pregnancy and maternity
- Race and ethnicity
- Gender
- Sexual orientation
- Gender reassignment
- Religion and belief
- Marriage and civil partnership
- Deprived communities
- Carers.

For each group, it is noted whether there is evidence of disproportionate or differential need for elective orthopaedic services and a summary of this evidence is provided. By differential need, that is to say there is evidence that different sub sections of a protected characteristic group have different needs. For example, females and males have different needs to access a service, but there is no evidence to suggest that either females or males have a disproportionate need.

At the beginning of analysis for each scoped in characteristic, tables on the left hand side of the page are provided to show the total number of that characteristic in each CCG area and the percentage of the total population. On the right hand side of the page, socio-demographic maps are used to demonstrate the density (or distribution) of these population groups across south east London.

Larger versions of these maps and are available in appendix A2.

In the final sections, a summary of the in-scope groups is provided alongside a commentary as to the profile of these population groups across south east London. Other equality impacts are explored and an overview of the next steps provided.

5.1 Age (Older people)

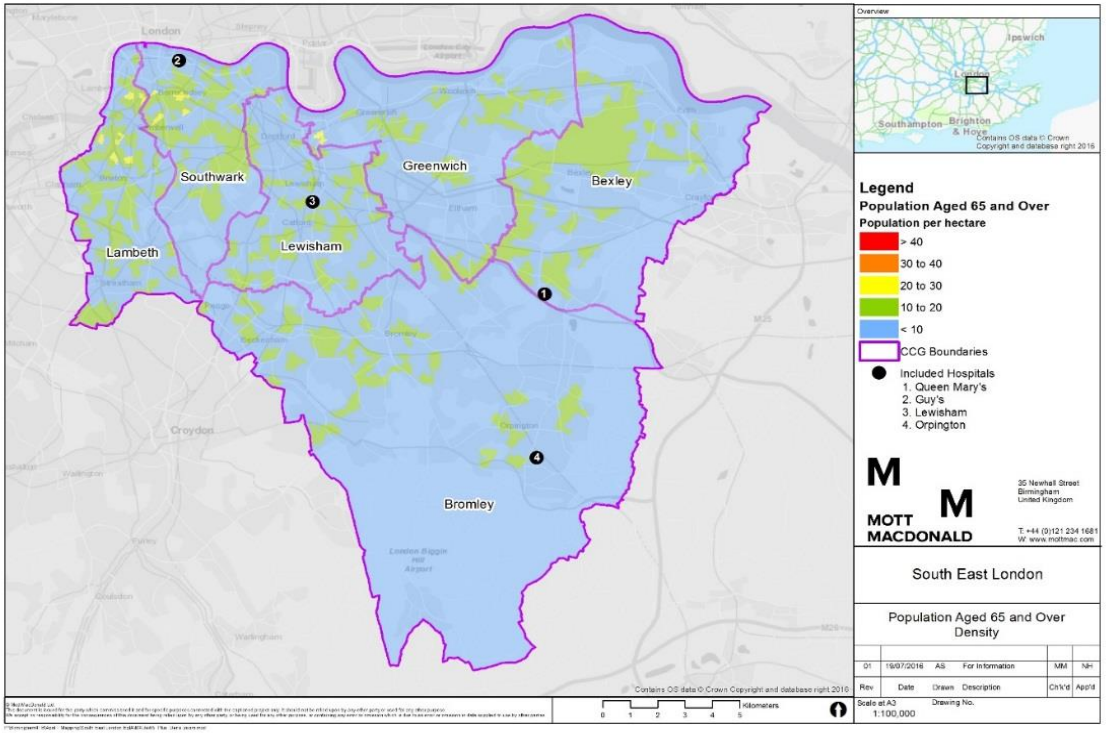
Population aged 65 or over and 75 or over

Area	Aged 65 and over	%	Aged 75 or over	
Bexley	39,800	17	19,600	8
Bromley	56,300	18	27,300	8
Greenwich	28,200	10	12,700	5
Lambeth	24,800	8	11,400	4
Lewisham	27,400	9	12,900	4
Southwark	24,000	8	10,800	4
South East London	200,500	12	94,700	5
Greater London	982, 900	12	459,100	5

Source: ONS, Mid-year Population estimates, 2014

The analysis shows that Bromley has the highest volume of those aged 65 and over and those aged 75 and over. Bromley has significantly more older people than any of the other CCGs. Bexley also has high volumes and proportions of older people.

Population density aged 65 or over



Source: ONS, Mid-year Population estimates, 2014

Evidence to demonstrate disproportionate need for elective orthopaedic care

Osteoporosis, a condition treated with elective orthopaedic care, becomes more likely the older that people get. Around 50% of people over the age of 75 are affected by the condition, and after the age of 50 one in two women and one in five men will break a bone as a result of poor bone health arising from osteoporosis *(Age UK (No date): Osteoporosis: Could you be at risk?).*

Evidence surrounding specialised orthopaedics services in adults also points towards older people having a disproportionate need for revision joint procedures in later life, thereby increasing the demand for elective orthopaedic care with older people . This is because the average age for arthroplasty procedures is falling, and so people are likely to need revision procedures as they are having initial surgery younger. The average age for knee arthroplasty has fallen from 70.6 in 2004 to 67.5 in 2010, and from 68 in 2004 to 6.2 in 2010 for hip arthroplasty patients. It is worth noting that these figures come in a time when the population is ageing. *NHS England (2013): NHS Standard Contract for Specialised Orthopaedics (Adults).*

5.1 Age (Older people) - Continued

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care[3]

Older people are more predisposed to osteomyelitis than the general population as they disproportionally suffer from associated disorders (such as diabetes). *(Biomed Central, 2010: Osteomyelitis in elderly patients).*

Bursitis also disproportionately effects older people due to the joints, muscles and tendons near the bursae being overused *(NHS Choices 2014, Causes of bursitis) .*

The NHS website reports that most people who have a total knee replacement are over 65 years old. The most common reason for knee replace surgery is osteoarthritis. *NHS Choices 2015*

Changing population trends of older people

In line with the national trends, all CCGs will experience an increase in the number of people aged 65 or over. Southwark will experience a doubling of its aged 65 or over population by 2039. Lambeth, Lewisham and Greenwich will also experience increases for the aged 65 or over greater than the OHSEL or Greater London average. Bexley and Bromley will experience an increase of less than the OHSEL or greater London average. However, it is important to note that Bexley and Bromley will still have higher numbers of older people overall .The CCGs with the greatest numbers of people aged 65 or over in 2014 remain the same CCGs in 2039. For further information, please see appendix A3.

2 Please note, that the although we are seeing a significant increase in joint replacement in the young population, it continues to be the older population that is most reliant on orthopaedic services and driving the increasing workload. *Briggs , T (2015)* 'Getting it right first time'

5.2 Disability

Population with long term illness or disability.

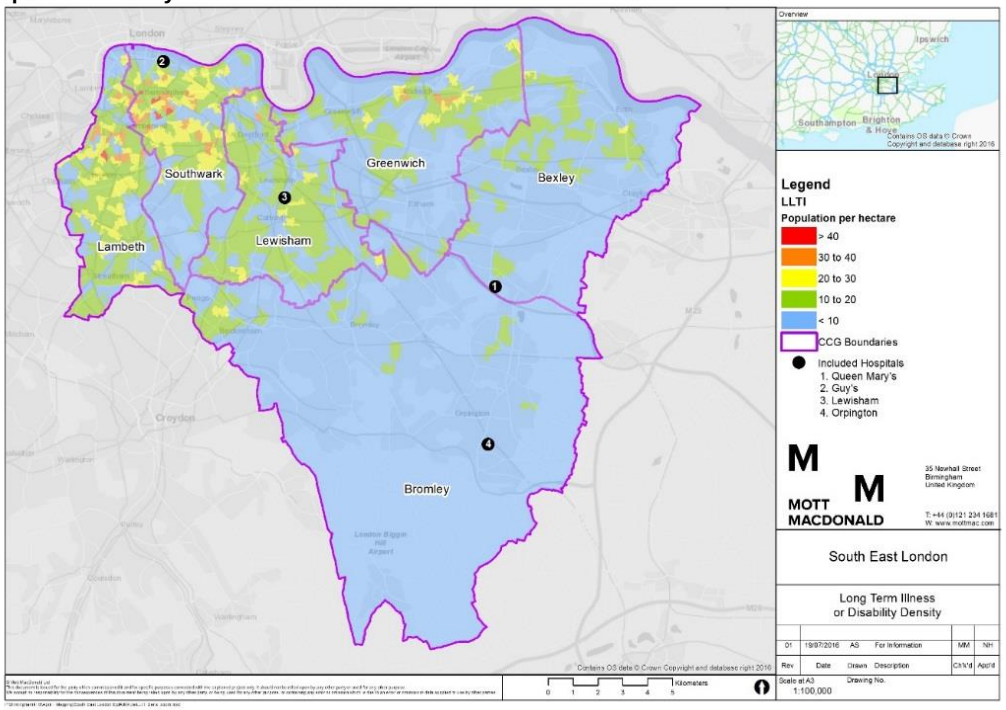
Area	Long term illness or disability	%
Bexley	37,100	16
Bromley	46,300	15
Greenwich	38,400	15
Lambeth	38,700	13
Lewisham	39,700	14
Southwark	39,000	14
South East London	239,200	14
Greater London	1,157,200	14

Source: ONS, Census 2011

Bromley has the most people living with a long term illness or disability. There is relative consistency across the other CCG areas in terms of overall numbers of people with a long term illness or disability.

Lambeth and Southwark have higher densities of those with a long term illness of disability.

Population density



Source: ONS, Census 2011

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

A UK report supported by the Department of Health states that people with learning disabilities may have increased prevalence of osteoporosis and lower bone density than the general population. Contributory factors include their possible lack of weight-bearing exercise, delayed puberty, entering menopause at an earlier-than-average age for women, poor nutrition, being underweight and use of anti-epilepsy medication. The report notes that people with learning disabilities have a greater prevalence of some of the risk factors associated with osteoporosis than other people *(Emerson, E. et al. (2012): Health Inequalities & People with Learning Disabilities in the UK: 2012).*

5.2 Disability - Continued

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Studies have suggested that people who take epilepsy medicine for long periods of time are at higher risk of thinning and breaking bones than those who do not take epilepsy medicine. In 2009, the Medicines, Healthcare Products Regulatory Authority (MHRA) advised that people still taking the following older epilepsy medicines on a long-term basis were at risk of osteoporosis or broken bones; Carbamazepine, Phenytoin, Primidone and Sodium valproate. However, there is little research exploring whether some of the newer types of epilepsy medicines can cause bone problems (*Epilepsy Action (2013): Bone health).*

Epilepsy is also more common in people with a learning disability than in the general population. It is estimated that 1 in 3 people who have a mild to moderate learning disability also have epilepsy, and around 1 in 5 people with epilepsy also have a learning disability. The more severe the learning disability it, the more likely that the person will have epilepsy as well *(Epilepsy Society (2016): Learning disability and epilepsy).*

Orthopaedic surgery may also be necessary for people with cerebral palsy to correct problems with bones and joints. *NHS Choices website 2015*

Changing population trends of those with a disability

Although national datasets are not available for the likely population change of those with disability in the longer term. Local data reports that:

- There are about 5,740 people with learning disabilities in **Southwark,** of whom about 1,230 (21%) have moderate or severe learning disabilities. The number of people in the borough with learning disabilities is projected to increase by 22% to 7,000 by 2030. Looking specifically at adults with moderate or severe learning disabilities, the greatest relative increase is also projected to be seen in the 55 to 64 year age group (a 59% rise over 20 years). *Southwark JSNA (2013): Adults with a learning disability.*

Please note that local data forecasting future trends for other CCGs is not currently available. As engagement continues, stakeholders are being asked if they have access to data pertaining to population trends of people with the disabilities outlined above.

5.3 Gender: Female

Population demographics have not been provided for gender due to the approximate 50/50 split of males/females across all boroughs. Females have been scoped in as having a disproportionate need. The evidence for this is provided below.

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Osteoporosis is more common in women than men. Women tend to live longer, with age leading to an increased likelihood to develop osteoporosis (see section 5.1). In addition, at around the age of 50, women experience the menopause, at which point their ovaries almost stop producing the sex hormone oestrogen, which helps to keep bones strong (*National Osteoporosis Society (No date): Risk factors for osteoporosis and fractures).* A woman's risk of having osteoporosis is also heightened if she has an early menopause or a hysterectomy with removal of the ovaries prior to the age of 45 (*Age UK (No date): Osteoporosis: Could you be at risk?).*

Joint pain is common in the condition lupus, especially in the small joints found in hands and feet. The pain normally moves from joint to joint and is often described as 'flitting'. Joint pain and swelling are often the main symptoms for some people, although it is unusual for Lupus to cause joints to become permanently damaged or deformed. About 1 in 20 people with lupus develop more severe joint problems, and less than 1 in 20 have joint hypermobility or a form of arthritis called Jaccoud's arthropathy, which can change the shape of the joints (*Arthritis Research UK (No date): What are the symptoms of Lupus?).* Lupus is more common in women than men, with around seven times as many women as men having the condition. Whilst drugs are often prescribed to Lupus suffers, some also undergo elective orthopaedic surgery.

Up to 50% of women develop Carpal tunnel syndrome (CTS) during pregnancy. CTS in pregnant women often gets better within three months of the baby being born, although it may need surgical treatment if symptoms fail to subside. In some women, symptoms can continue for more than a year. CTS is also common in women around the time of the menopause. (*NHS Choices, 2014, Causes of carpal tunnel syndrome*). Evidence also suggests that more women than men develop CTS, possibly because women naturally have smaller carpal tunnels *(Bupa (No date): Carpal tunnel syndrome).* Occasionally, some medications can also cause the condition. Exemestane and Anastrazole are both medications used for the treatment of breast cancer, thus taken by a disproportionately large number of women. Both drugs are said to potentially cause carpal tunnel syndrome *(Arthritis Research UK (2012): Carpal tunnel syndrome).*

Finally, women are likely to live longer than men and therefore more likely to use elective orthopaedic care (see section 5.1 on age). The average life expectancy at birth for each of the CCGs according to gender and a south east London average is provided below.

Area	Females	Males
Bexley	84.4	80.3
Bromley	84.5	81.0
Greenwich	82.2	78.5
Lambeth	83.0	78.2
Lewisham	82.6	78.2
Southwark	83.1	78.0
South East London	83.3	79.0

5.4 Gender reassignment

Population demographics are not available for the numbers of people undergoing, or who have undergone, gender reassignment. However stakeholders have noted that the number of gender reassignment procedures is increasing. This is support by figures obtained under a Freedom of Information request, which shows that there has been increases in the number of referrals to all of the UK's gender identity clinics (GIC). The London GIC in Charing Cross is the largest adult clinic. The number of referrals has almost quadrupled in 10 years, from 498 in 2006-07 to 1,892 in 2015-16. In 2015-16, NHS England has provided an additional £3m towards funding adult GIC clinics. *'Gender identity clinic services under strain as referral rates soar' Guardian newspaper 10 July 2016*

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Trans men (female-to-male) and trans women (male-to-female) may be at risk of developing osteoporosis because of the need to take hormones that change the balance of oestrogen and testosterone in the body. After gender reassignment surgery, the level of hormones may decrease and this may also affect bone density. The degree to which either of these factors affect the risk of breaking a bone, however, remains uncertain. Replacement sex hormones (testosterone for trans men and oestrogen for trans women) are necessary to maintain bone strength and are generally continued long-term. The risk of developing osteoporosis may increase if sex hormone replacement is discontinued, or if levels of replacement are too low (*National Osteoporosis Society (2014): Transsexual people and osteoporosis*).

Research has also found that the male-to-female trans population who have their testicles removed can affect bone density as the body's natural levels on testosterone are too low. However, evidence suggests that taking oestrogen instead compensated for the decrease in testosterone. Some trans men who aren't able to take testosterone use Depo-Provera to stop their periods from occurring, and, there is some concern that using Depo-Provera can negatively affect bone density (*Vancouver Coastal Health, Transcend Transgender Support & Education Society and Canadian Rainbow Health Coalition (2006): Trans people and osteoporosis).*

It must be noted that the research available on this issue is limited, however, due to the evidence presented above, gender reassignment has been scoped in as a protected characteristic that may have a disproportionate need. This will be explored further with clinicians and Lesbian, Gay, Bisexual and Trans (LGBT) community groups.

5.5 Race and ethnicity: White

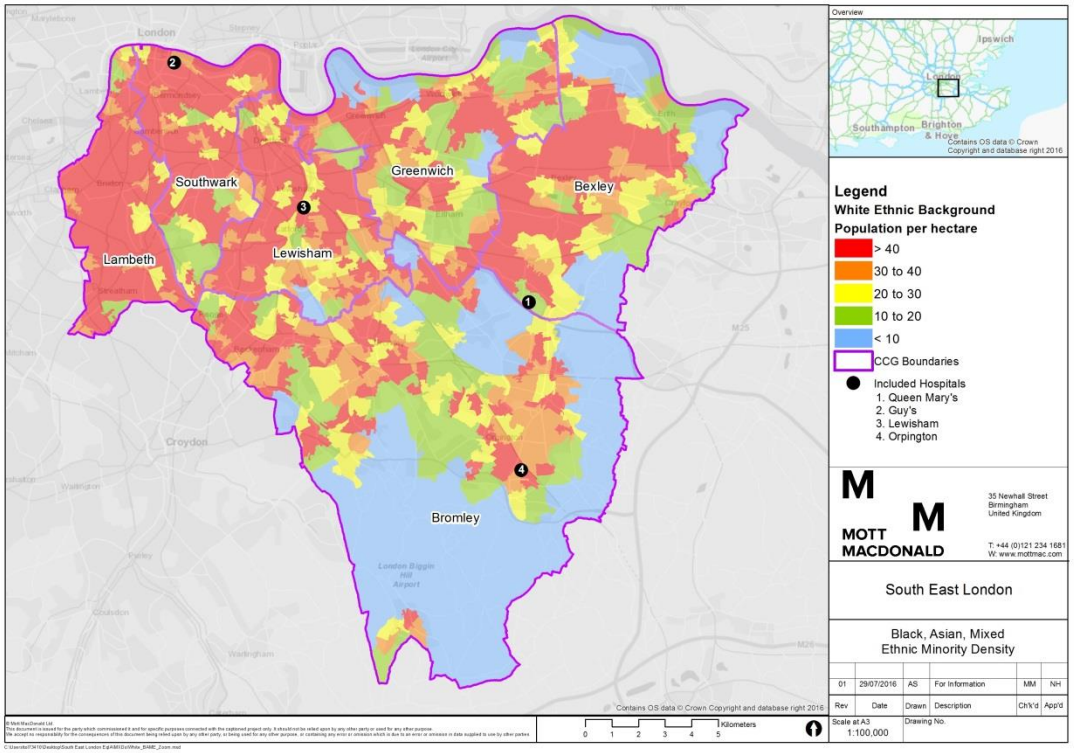
Population with a white ethnic background

Area	White ethnic background	%
Bexley	189,962	82
Bromley	260,870	84
Greenwich	159,002	62
Lambeth	173,025	57
Lewisham	147,686	54
Southwark	156,349	54
South East London	1,086,894	62
Greater London	4,887,435	60

Source: ONS, Mid-year Population estimates, 2014

Bromley and Bexley have the highest volumes and proportions of people from a white ethnic background. Lambeth, Southwark and Lewisham all have high densities, though this is due to their smaller geographies.

Population density



Examples of evidence to demonstrate differential need for elective orthopaedic care

It is important to note that this report is suggesting a differential need amongst ethnic groups, rather than a disproportionate need. This is because there is evidence to suggest that those from different ethnic backgrounds have need for different types of elective orthopaedic care services. The evidence on this page highlights issues pertaining to those from a white ethnic background.

The National Osteoporisis Society states that those from Caucasian background are at higher risk of osteoporosis than Afro-Caribbean people. This is because people from an Afro-Caribbean background tend to have bigger bones. *National Osteoporosis Society (No date): Risk factors for osteoporosis and fractures. See: https://www.nos.org.uk/healthy-bones-and-risks/are-you-at-risk* . In addition, a US study founded that Afro-Caribbean American women's femoral neck bone mineral density (BMD) was 10% to 25% higher when compared to US white women, thereby lessening their risk of developing osteoporosis or hip conditions in their life course *(Dempster, D. et al (2013): Osteoporosis Fourth Edition)*. Data from a UK- cohort of the European Male Aging Study (EMAS) also compared White-British men to a group of Afro-Caribbean British and South-Asian British men. The Afro-Caribbean British group had higher BMD at all sites when compared to South-Asian British and White-British, both before and after adjustment for body size (*Zengin. A. et al (2015): Ethnic differences in bone health).*

5.5 Race and ethnicity: White - Continued

Changing population trends of those from a white ethnic background

Although national datasets are not available for the likely population change. Local data reports that:

- In **Lambeth** the older white population is projected to grow by about 12%. *Lambeth Council State of the Borough 2014*
- By 2020, the white population of **Lewisham** is set to decrease by 2.1%. *Lewisham's Public Health Information Portal*

5.5 Race and ethnicity: BAME

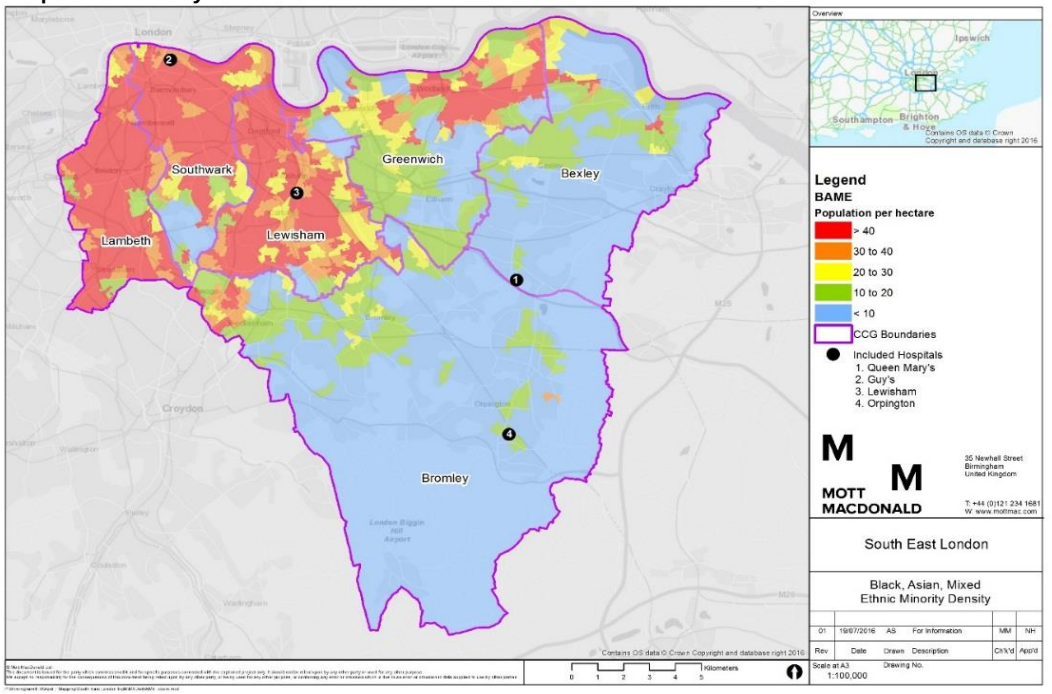
Population with a black, asian or minority ethnic background (BAME)

Area	BAME	%
Bexley	52,700	23
Bromley	69,900	23
Greenwich	121,400	48
Lambeth	184,800	61
Lewisham	161,400	59
Southwark	173,700	60
South East London	763,900	44
Greater London	4,504,700	55

Source: ONS, Mid-year Population estimates, 2014

The table above shows large proportions and numbers of BAME communities in the inner London Boroughs of Lambeth, Lewisham and Southwark. The map shows very high densities of BAME communities in the inner London boroughs. In contrast, Bromley and Bexley have relatively low proportions, populations and density.

Population density



Source: ONS, Mid-year Population estimates, 2014

Examples of evidence to demonstrate differential need for elective orthopaedic care

It is important to note that the report is suggesting a differential need amongst ethnic groups, rather than a disproportionate need. This is because there is evidence to suggest that those from different ethnic backgrounds have need for different types of elective orthopaedic care services. The evidence highlights evidence pertaining to those from BAME backgrounds.

Scientists at the London School of Hygiene and Tropical Medicine discovered that people of non-white ethnicity tend to have more severe disease and have suffered with arthritis for longer by the time they undergo surgery. *(Arthritis Research UK (2012): Socio-demographic factors influence timing of joint replacement surgery).* In addition, reports in the US on differences in knee osteoarthritis between African-Americans and Caucasians report a higher prevalence knee osteoarthritis in African-Americans, as well as more symptomatic knee osteoarthritis in African-Americans than Caucasians. Gait patterns can also differ between ethnic groups in osteoarthritis prevalence. A study has reported that that African-Americans were possibly more prone to lateral compartment knee osteoarthritis than Caucasians *(Chaganti, R. et al. (2011): Risk factors for incident osteoarthritis of the hip and knee).*

Lupus is also more common in some ethnic groups as well, particularly those of African origin (*Arthritis Research UK (No date): Lupus*).

5.5 Race and ethnicity: BAME - Continued

Changing population trends of those from a BAME background

Although national datasets are not available for the likely population change. Local data reports that:

- **Southwark** is predicted to have a 41% increase in 'Black Other' population over the next 10 years. *Southwark Council (2015): Southwark Demographic Factsheet May 2015*
- The Black Caribbean population in **Southwark** is projected to decrease by 1% in the next 10 years. *Southwark Council (2015): Southwark Demographic Factsheet May 2015*
- In **Lambeth** the black Caribbean 60+ population is projected to grow by almost 40%. Similarly, the older black African population, which is currently small, is projected to nearly double. *Lambeth Council State of the Borough 2014*
- The GLA 2013 Round Ethnic Group Projections estimate that, in 2015, the ethnic minority population of **Bromley** is 17.9%, and this is projected to rise to 20% by 2025. The greatest proportional rise is in the Black African group. *Bromley joint strategic needs assessment 2014 - The Population of Bromley: Demography*
- Between 2015 and 2025 it is projected that the largest increases in **Greenwich** will be in: Black African: +10,400 (26.3% increase), Other Asian: +6,800 (37.7% increase) and Chinese: +2,200 (+35.5% increase). By 2041 it is estimated that nearly half of the boroughs residents will be from a BAME background (45%). R*oyal Borough of Greenwich (No date): Ethnic Groups Projections for Royal Greenwich (2001-2041)*
- By 2020, the Black African population of **Lewisham** is set to increase by 16.8% *Lewisham's Public Health Information Portal*
- By 2021, **Bexley's** population will comprise of 24% BAME residents *2014 round ethnic group population projections.*
- By 2037**, Lewisham, Southwark** and **Greenwich** are all projected to have BAME majority populations. *(GLA 2015 round trend-based projections – Results).*

Please note that white background data contains 'white British' but also some other categories such as 'white Gypsy'. Some of these categproes are also included in the definition of BAME category, so percentages will add up to greater than 100%.

5.6 Deprivation

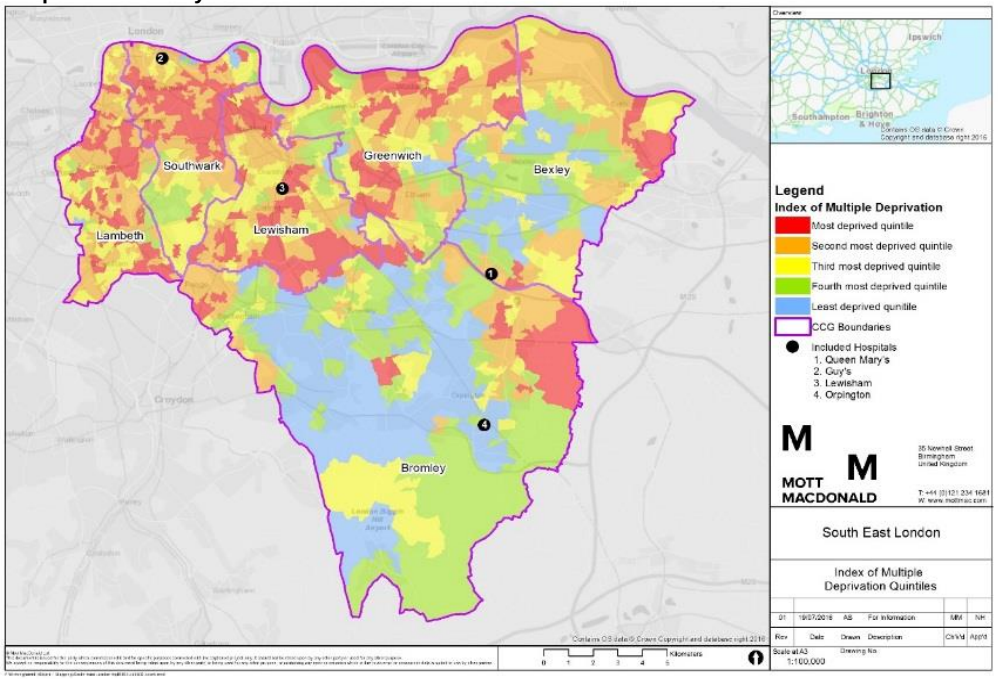
Population classified as deprived[4]

Area	Classified as deprived	%
Bexley	65,900	27%
Bromley	82,300	26%
Greenwich	163,300	61%
Lambeth	232,900	73%
Lewisham	209,00	72%
Southwark	225,700	75%
South East London	979,100	56%
Greater London	4,598,500	54%

Source: IMD, 2015 using Mid-Year Population Estimates, 2014

The data shows that the inner London boroughs are proportionally far more deprived, have higher densities of deprivation and have higher overall numbers of people who are deprived. However, there are also pockets of deprivation in the outer London boroughs too, notably in the north east of Bromley and the north east of Bexley.

Population density



Source: IMD, 2015 using Mid-Year Population Estimates, 2014

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Deprivation is associated with greater need for total hip and knee replacement surgery. Moreover, more deprived patients remain in hospital longer, without morbidity, because of a lack of social support available to them in the community. *(Major elective joint replacement surgery: socioeconomic variations in surgical risk, postoperative morbidity and length of stay, Journal of Evaluation in Clinical Practice, 2009)*

Scientists at the London School of Hygiene and Tropical Medicine also discovered that people from lower socioeconomic backgrounds, tend to have more severe disease and have suffered with arthritis for longer by the time they undergo surgery. The researchers looked at data on 117,736 patients, all of whom underwent hip or knee replacement surgery in England in 2009-10 *(Arthritis Research UK (2012): Socio-demographic factors influence timing of joint replacement surgery).*

4. Deprivation is calculated using the indices of multiple deprivation (IMD). Indices of deprivation are based across seven distinct domains (employment deprivation, health deprivation and disability, education, skills and training deprivation, crime, barriers to housing and services and living environment deprivation.) This overall measure of multiple deprivation is calculated for every lower layer super output area (LSOA) neighbourhood in England. Every neighbourhood is then ranked according to its level of deprivation relative to that of other areas. Deprivation is identified when the LSOA is either in the most deprived or second most deprived quintile.

5.6 Deprivation- continued

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Evidence suggests that malnutrition increases the risk of developing osteomyelitis, as a weakened immune system makes it more likely for infections to spread to the bones *(NHS Choices, 2014, Osteomyelitis – Causes).* Moreover, osteomyelitis is more likely to occur if for some reason an individual's bones are susceptible to infection. Pre existing health conditions, such as diabetes, can cause this. In this instance bones may not receive a steady blood supply, meaning infection-fighting white blood cells cannot reach the site of injury within the bone *(NHS Choices (2014): Osteomyelitis – Causes).* Diabetes prevalence increases with greater levels of deprivation. *Public Health England (2014) Adult obesity and type 2 diabetes.*

In addition, obesity prevalence increases with greater levels of deprivation. *Public Health England (2014) Adult obesity and type 2 diabetes.* Obesity is a strong risk factor for knee osteoarthritis, with obese people 14 times more likely to develop the condition than those of a healthy weight. '*Osteoarthritis and obesity' Arthritis Research Campaign 2013.* Although the main treatments for osteoarthritis include lifestyle measures, in some cases, surgery to repair, strengthen or replace damaged joints is preferred.

Local evidence supports the population demographics shown above. Lambeth is the 14th most deprived Local Authority in England; Greenwich is the 19th most deprived; Southwark is number 41, and Lewisham is the 31st most deprived Local Authority in England. Although Bexley and Bromley (ranking 174 and 203 respectively) score well compared to other south east London Boroughs, they still have significant areas of poor health, exclusion and deprivation. *(Southwark Council (2015): Southwark Demographic Factsheet, Lewisham JSNA: Index of Multiple Deprivation. Joint Strategic Needs Assessment 'Life, Health and Wellbeing in the London Borough of Bexley', Bromley Joint Strategic Needs Assessment 2012, 'Socio-demographic profile of Greenwich' Royal Borough of Greenwich, Documents Lambeth – State of the Borough 2014)*

5.7 Carers

Number of population providing 1-20 hours of care per week and percentage of overall population.[5]

Area	Carers providing 1-20 hours care per week	%
Bexley	14,700	6
Bromley	21,200	7
Greenwich	13,000	5
Lambeth	13,000	4
Lewisham	13,900	5
Southwark	12,400	4
South East London	14,700	5
Greater London	433,400	5

Source: Census, 2011

The percentages of carers in each CCG area are broadly similar to each other and to the greater London average, however Bromley has a significantly higher volume of carers than any other area.

Due to the similar distribution of carers across the six study areas, a density map is not available for carers as it shows no critical mass in any of the six study areas.

Please note that whilst the most up-to-date data on carers is from the 2011 census, figures may have changed since then. In addition, carer figures tend to be under-reported as data requires carers to self-identify. A proportion of those whom the NHS would deem to be carers do not identify themselves in this way. This will be further explored with stakeholders in the next stage of the analysis.

Examples of evidence to demonstrate differential need for elective orthopaedic care

It is important to note here that we are not stating carers have a disproportionate need for elective orthopaedic care, rather they have a differential need due to their caring responsibilities, which is different to non-carers. As older people are more likely to require carers, and they are the greatest users of elective orthopaedic care, carers are likely to be impacted by any service changes.

A report by Carers UK indicated that failing to consider post-hospital support and carers' needs had counterproductive consequences, such as increased readmission *(Carers' UK, 2016: Response to the Public Administration and Constitutional Affair Committee Inquiry into Unsafe Hospital Discharge)*

5. Information is also available on carers providing over 20 hours of care per week. Please refer to appendix A2. There is a reduction in the number of carers providing over 20 hours a week, though trends remain similar in terms of density and proportion of carers within the six boroughs.

6. Summary of 'scoped in' groups

Outlined below is a summary of the groups who have been scoped in as having a disproportionate or differential need for elective orthopaedic care.

Characteristic	Disproportionate need	Differential need	Key conditions
Age: Young people			
Age: Older people	✓		Osteoporosis Osteomyelitis Bursitis Osteoarthritis
Disability	✓		Osteoporosis
Gender: Female	✓		Osteoporosis Lupus CTS
Gender: Male			
Gender reassignment	✓		Osteoporosis
Marriage and civil partnership			
Pregnancy and maternity			
Race and ethnicity: White		✓	Osteoporosis
Race and ethnicity: BAME		✓	Arthritis Osteoarthritis Lupus
Religion and belief			
Sexual orientation			
Deprivation	✓		Arthritis Osteomyelitis Osteoarthritis Hip and knee surgery
Carers		✓	N/A

It is important to note that the report is not suggesting that other groups will not need these services, rather it is to suggest that there does not presently exist a body of evidence indicating a disproportionate or differential need. This will continue to be updated in subsequent phases of work.

6. Summary of the geographical distribution of 'scoped in' groups

At the CCG level, volume and proportion are used as helpful measures to understand the population of each scoped in group and to understand the relative presence of a particular group.

At a pan south east London level, it is useful to look at density as a measure by which to understand where the greatest concentration of scoped in groups are located. This is important because this helps to indicate where impacts, both positive and negative, are more likely to be realised across the study area without the analysis confined to administrative boundaries.

In the case of this equality analysis and its ability to inform the decision making process, it is crucial to look at future service provision across south east London, rather than at a CCG level.

It is important to note that this summary does not take into account which hospitals are being short listed as they is yet to be decided or travel impacts.

Data on how populations are changing has been excluded from this analysis. This is because for age, the boroughs with the largest volumes of people aged over 65 will remain the same in 2039. Please see appendix A3 for further information.

Scoped in groups	Volume	Proportion	Highlight comments at CCG level	Density	Highlight comments at south east London level
Age (Older people)	Bromley has the highest numbers of those aged 65 or over and aged 75 or over. Bexley also has high volumes.	The greatest proportions of older people are in Bromley (18%) and Bexley (17%), both of which are higher than the greater London average (12%).	Bromley and Bexley are areas with high volumes and proportions of older people.	Density of older people is highest in areas of Lambeth and Southwark.	The inner London boroughs in the north west of the study area have the highest density of older people.
Disability	Bromley has the most people living with a long term illness or disability.	As a proportion of the population, greater proportions of disabled people are in Bexley (16%), Bromley (15%) and Greenwich (15%), all of which are higher than the greater London average (14%)	Bromley, has high volume and proportion of those living with a long term illness or disability.	Lambeth and Southwark have higher densities of those with a long term illness of disability, though pockets of high density also exists in Greenwich.	The inner London boroughs in the north west of the study area have the highest density of those with a long term illness of disability.
Gender: Female					

6. Summary of the geographical distribution of 'scoped in' groups continued

Scoped in groups	Volume	Proportion	Highlight comments at a CCG level	Density	Highlight comments at south east London level
Race & ethnicity: White	Bromley has the greatest volume of people from a white ethnic background. It is significantly greater than any other area.	Bexley (82%) and Bromley (84%) have the highest proportion of people from a white ethnic background.	Bromley has the highest volume and proportion of people from a white ethnic background. Bexley is also an area with high volume and proportion of people from a white ethnic background.	Lambeth has the highest density of those from a white ethnic background, Bromley the lowest.	Pockets of high density of people from a white ethnic background exist across the study area.
Race and ethnicity: BAME	The greatest volume of BAME communities is in Lambeth, followed by Southwark and then Lewisham.	Lambeth (61%) and Southwark (60%) have the highest proportion of people from a BAME background.	Lambeth, has the highest volume and proportion on those from a BAME background. Southwark and Lewisham are also areas with high volume and proportion	The greatest densities people with a BAME background is in Lambeth.	The inner London boroughs in the north west of the study area have the highest density of people from a BAME ethnic background. Pockets of high density also exists in the north of the study area.
Gender reassignment					
Deprived communities	The volume of people classified as deprived is far greater in Lambeth, Lewisham and Southwark.	Southwark (75%), Lewisham (72%) and Lambeth (73%) also have the highest proportions of deprivation, all of which are significantly higher than the greater London average (54%).	Lambeth, Southwark and Lewisham all have very high volumes and proportions of people classified as deprived.	Lambeth, Lewisham and Southwark have higher densities of deprivation, though pockets also exist in the north east of Bexley and the north east of Bromley.	The north and north west of the study area has the highest density of people living in deprivation.
Carers	Bromley has the largest volume of carers and is much higher than the other areas.	Bromley (7%) has the highest proportion of carers, though all are similar or identical to that of the greater London average of 5%	Bromley has significantly more carers than any other CCG area. It is also has the highest proportion of carers. This is consistent with the fact that Bromley also has the largest volumes of older people.	N/A	N/A

7. Concluding observations

7.1 Equalities analysis

Our analysis to date shows that the following groups need to be further considered as our research progresses; older people, disabled people, females, people undergoing gender reassignment, people from a white ethnic background, people from a BAME background, people in economic and social deprivation and carers.

It is understood that disability is a heterogeneous category and that people with different disabilities have different needs. This report focuses on those with learning disabilities, epilepsy or cerebral palsy as this is where evidence exists to demonstrate disproportionate need. This will be further explored with stakeholders representing disability as engagement continues.

It is important to note that individuals may have more than one of the protected characteristics scoped into this report. However, this does not necessary make their need greater than an individual with one of the protected characteristics scoped in. By way of example, we can not quantify or specify that a woman over the age of 65 has double the level of need than a woman under the age of 65.

7.2 Recommendations for OHSEL consultation

In the public consultation phase of the work, it is suggested that OHSEL considers asking questions on issues such as the location and access of services, the design of services and monitoring and feedback. This will enable OHSEL to understand to what extent location, the design of services and how feedback is captured is important to patients. This is to be discussed with OHSEL prior to the consultation phase.

The social demographic analysis demonstrates difference in population groups across the CCGs. The north west of OHSEL, including Lambeth, Southwark and Lewisham tend to have higher densities of deprivation and those with a disability. In comparison, the south of the study area tends to have higher densities of the older people and carers. In planning the programme of public consultation, OHSEL may want to undergo consultation activities focused on certain groups in specific areas, according to the trends identified in this paper.

We are happy to discuss these issues in more detail with communications and engagement leads at OHSEL and the constituent CCG areas as necessary.

8. Next steps

The next steps in this equalities analysis are as follows:

- Continue with a programme of engagement with stakeholders. These will take the form of individual one-to-one telephone interviews with strategic and community stakeholders. It has been challenging to engage with stakeholders to date, in order to ensure that we provide stakeholders with the maximum chance to participate, we are extending this engagement phase into stage two of the work.

- In advance of commencing the second phase of work, a meeting will be held with OHSEL to discuss the findings of this report. The engagement strategy going forward into stage two will also be discussed with OHSEL and relevant stakeholders. One-to-one interviews with community groups have failed to engage large numbers of stakeholders to date. Whilst the scope of work originally suggested holding engagement forums in stage two involving community and patient groups, alternative ways to engage communities scoped in will be explored. Specifically, the use of focus groups comprising of participants with one or more of the characteristics identified as having either disproportionate or differential need.

- To date stakeholders have highlighted some potential overarching equality impacts, which we will look to explore in more detail in stage two, namely:
    - **Patient experience and quality of care:** Some vulnerable groups find it more challenging to understand and accommodate change in service provision, either due to challenges in terms of comprehension, anxiety around unfamiliar journeys or venues and/or a lack of independence. This may affect patient experience before and during service receipt.
    - **Travel and access for certain protected characteristic groups:** Centralisation of some services will require longer journey times for some patients. Understanding the extent to which these longer journey times affect the protected characteristics will be critical. This is particularly the case because several equality groups have a higher reliance on public transport than the general population which can compound any accessibility impacts. It is recommended that OHSEL might want to consider this issue quantitatively using travel and access analysis, based on different service options. We can discuss the benefits of this with OHSEL in more detail

- Stage two of the equalities analysis will then begin. Stage two consists of the following activities:
    - Providing expert advice to OHSEL during the public consultation phase.
    - Continuing engagement either through engagement for a or focus groups, to be decided.
    - Undergoing staff engagement through one-to-one interviews.
    - Delivering an equalities training workshop to NHS staff on the data required to fulfil the PSED.

An interim report will then be produced by the end of November 2016.

Appendices

Appendix A Stakeholders engaged	29-30
Appendix B Population density maps	31-36
Appendix C Older people population projections	37

A1. Stakeholders contacted during phase one engagement

The following community stakeholder groups have been contacted by Mott MacDonald. This is in addition to stakeholders contacted directly by OHSEL. Stakeholders highlighted green have responded to the opportunity for interview and have been engaged as part of this process. Stakeholders representing disability (Lambeth Mencap), race (Greenwich Race Inclusion Project and Greenwich Migrant Hub) and sexual orientation (Southwark LGBT Network) have been engaged. OHSEL are continuing to extend invitations to engage in the process particularly with groups scoped into this research via their existing contacts and relationships.

Age Exchange	Lambeth Youth Council	Bridge Mental Health	Trans London	Greenwich Race Inclusion Project
Age UK Bromley	Carers Bromley	British Lung Foundation Breatheasy Group, Lambeth	Bexley Maternity Services Liaison Committee (MSLC)	Multifaith forum, Southwark
Basaira Pensioners Forum	Carer's Hub Lambeth	Bromley Mencap	Bromley MSLC	Faiths Together in Lambeth
Bexley Youth Service	Carer's Hub Lewisham	Greenwich Association for Disabled People	Greenwich MSLC	Greenwich Peninsula Chaplaincy
Bromley and Greenwich Age UK	Carers Lewisham	Greenwich Mind	Lambeth MSLC	Brimley Inter Faith Forum
Bromley Childrens and Families Voluntary Forum	Carers Support Bexley	Lambeth Learning Disability Assembly	Lewisham MSLC	Bromley Gay and Bisexual Men's Group
Danson Youth Centre	Greenwich Carers Centre	Lambeth Mencap	Southwark MSLC	Community Empowerment and Support Initiatives, Greenwich
Elders People Support Group	Lambeth Young Carers	Lewisham Disability Coalition	Bexley Multicultural Centre CIC	Haven, Bexley
Greenwich Older Voices	Lewisham Parent Carers Forum	Lewisham Mencap	Ethnic Health Foundation	Lambeth LGBT network
Lambeth and Southwark Integreted Care Citizens' Forum	Southwark Parent Carers Council	Mind in Bexley	Federation of Refugees from Vietnam in Lewisham	Metro
Lambeth Youth COOP	Southwark Young Carers	Mosaic Clubhouse	Indo-Chinese Community Centre,Lewisham	LGBT Community Plan London
Lewisham Youth Aid	Young Carers, Greenwich	Thamesreach Lambeth	Lewisham Ethnic Minority Partnership	Southwark LGBT Network
Oakwood School	Association for Disabled Children, Bexley	Voluntary Organisations Disability Group, Lambeth	Lewisham Irish Community Centre	999 Club
Southwark Young Council	Bexley Deaf Centre	FTM London	Lewisham Turkish Elders Club	Bench outreach project

A1. Stakeholders contacted during phase one engagement continued

Blenheim Nexus Outreach

Bromley and District Osteoporosis Group

Bromley Homeless Shelter

Community Options, Bromley

CRI Lewisham Young People Substance Misuse Service

Deptford Reach

Emmaus Greenwich

Give us a buzz, Greenwich

Greenwich Migrant Hub

Indoamerican Refugee and Migrant Organisation, Lambeth

Lambeth Resolve

SHP-Lambeth Projects

St Mungos

Thames Reach Employment Academy

Thamesreach Greenwich

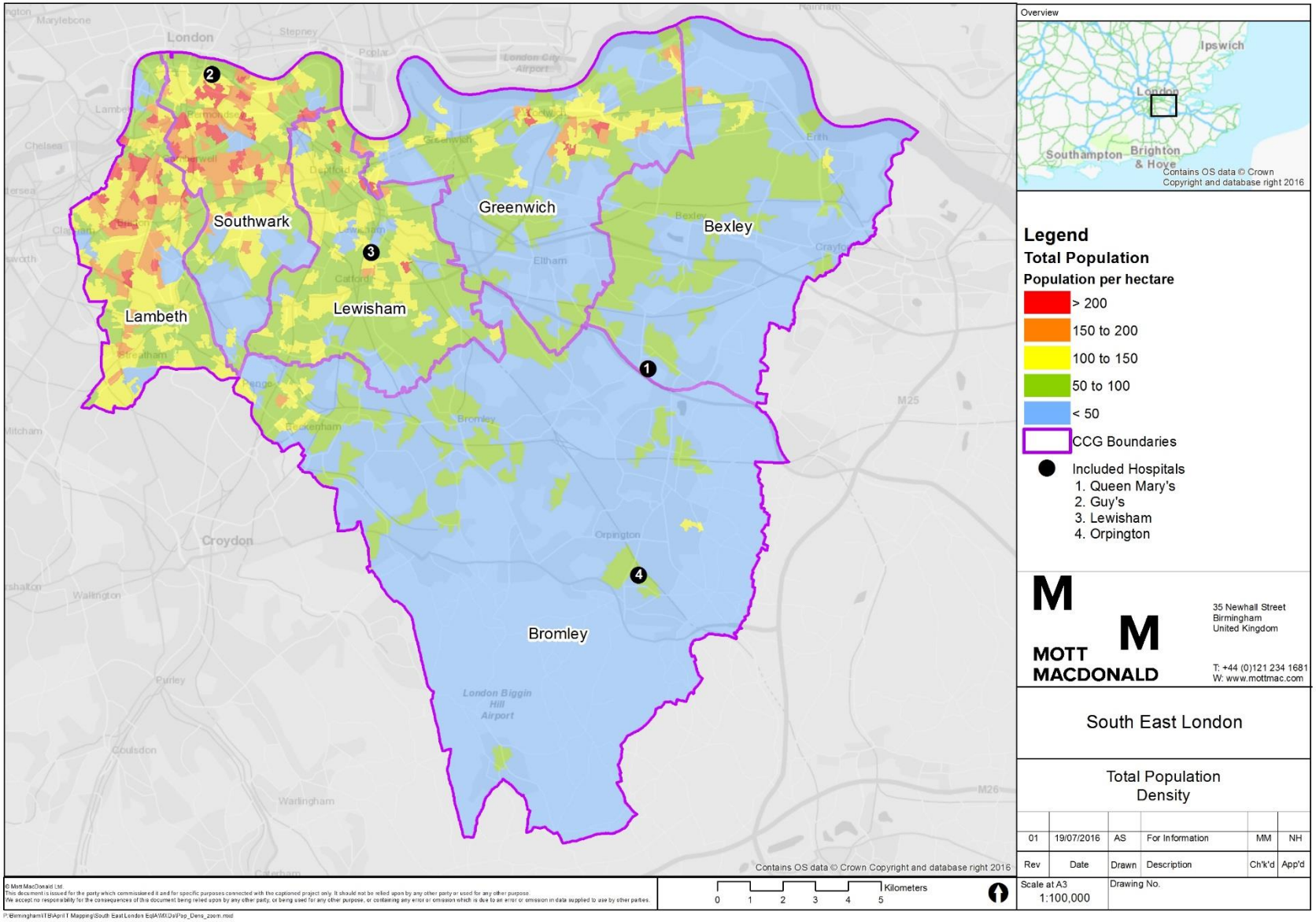
Thamesreach Lewisham

The Scarlet Centre, Greenwich

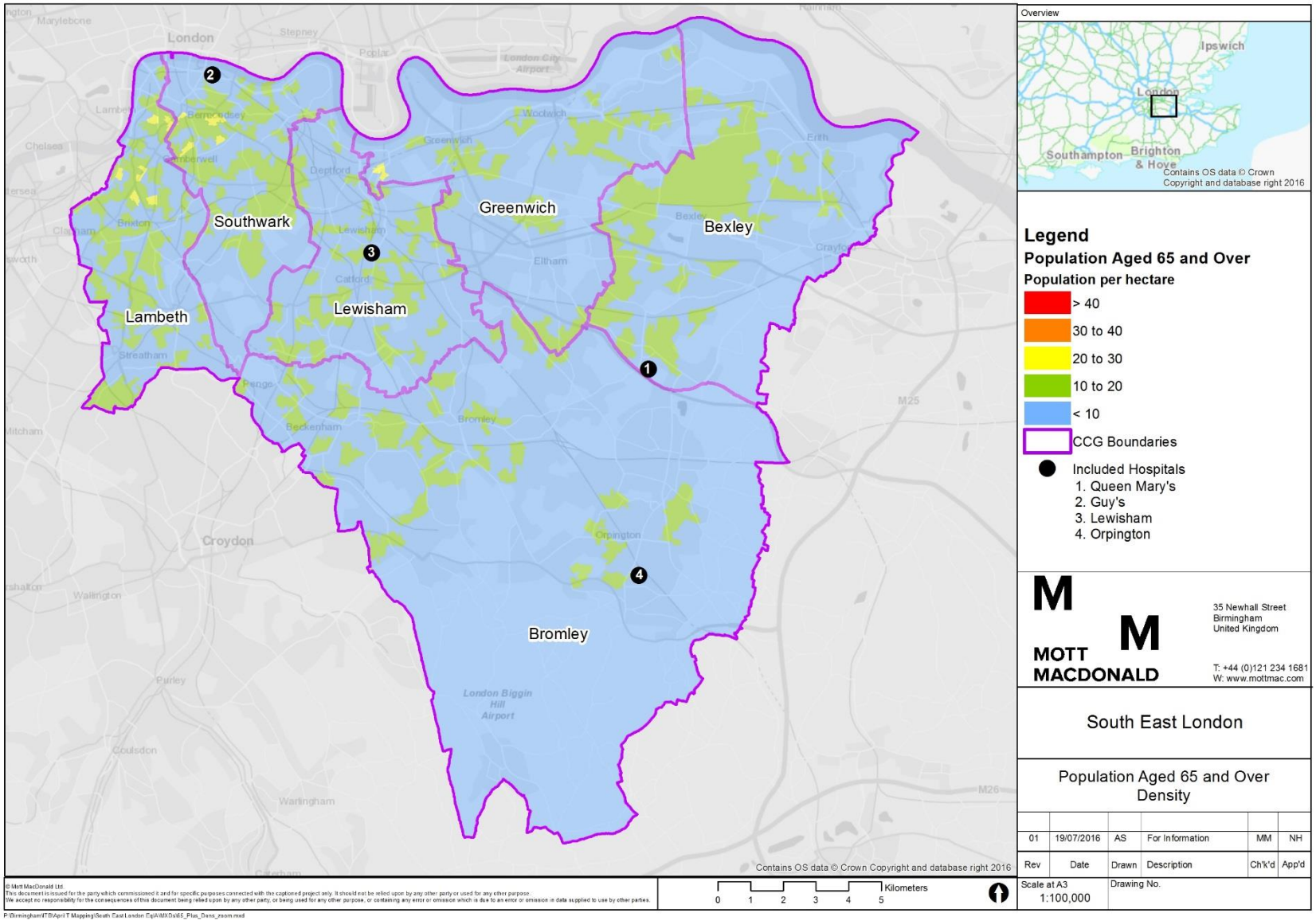
In addition to the community stakeholders, strategic stakeholders from all six CCGs have been contacted. These include equality, engagement and

clinicians from the six CCGs.

A2.1 Population density OHSEL

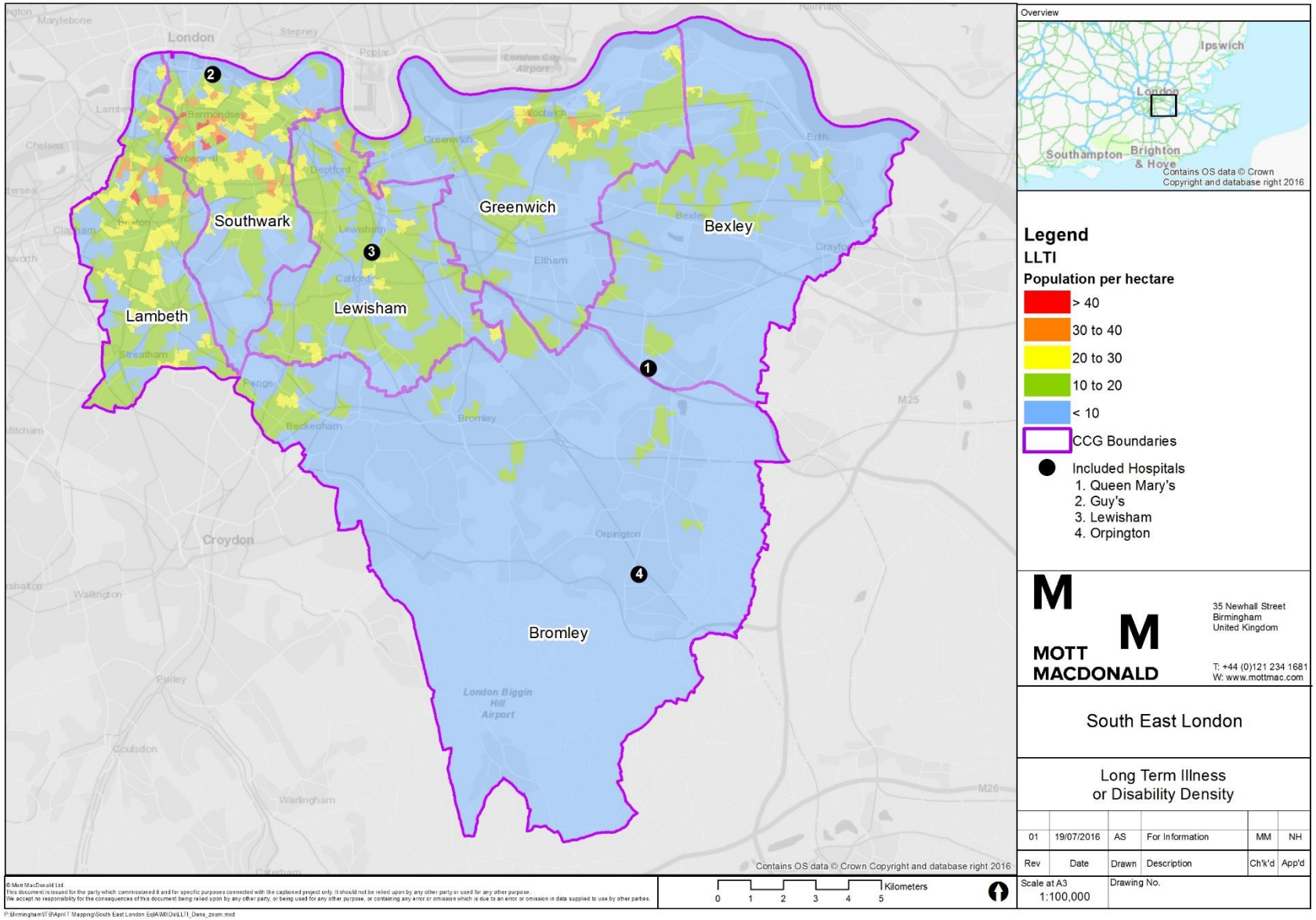


A2.2 Population density older people (aged 65 or over)

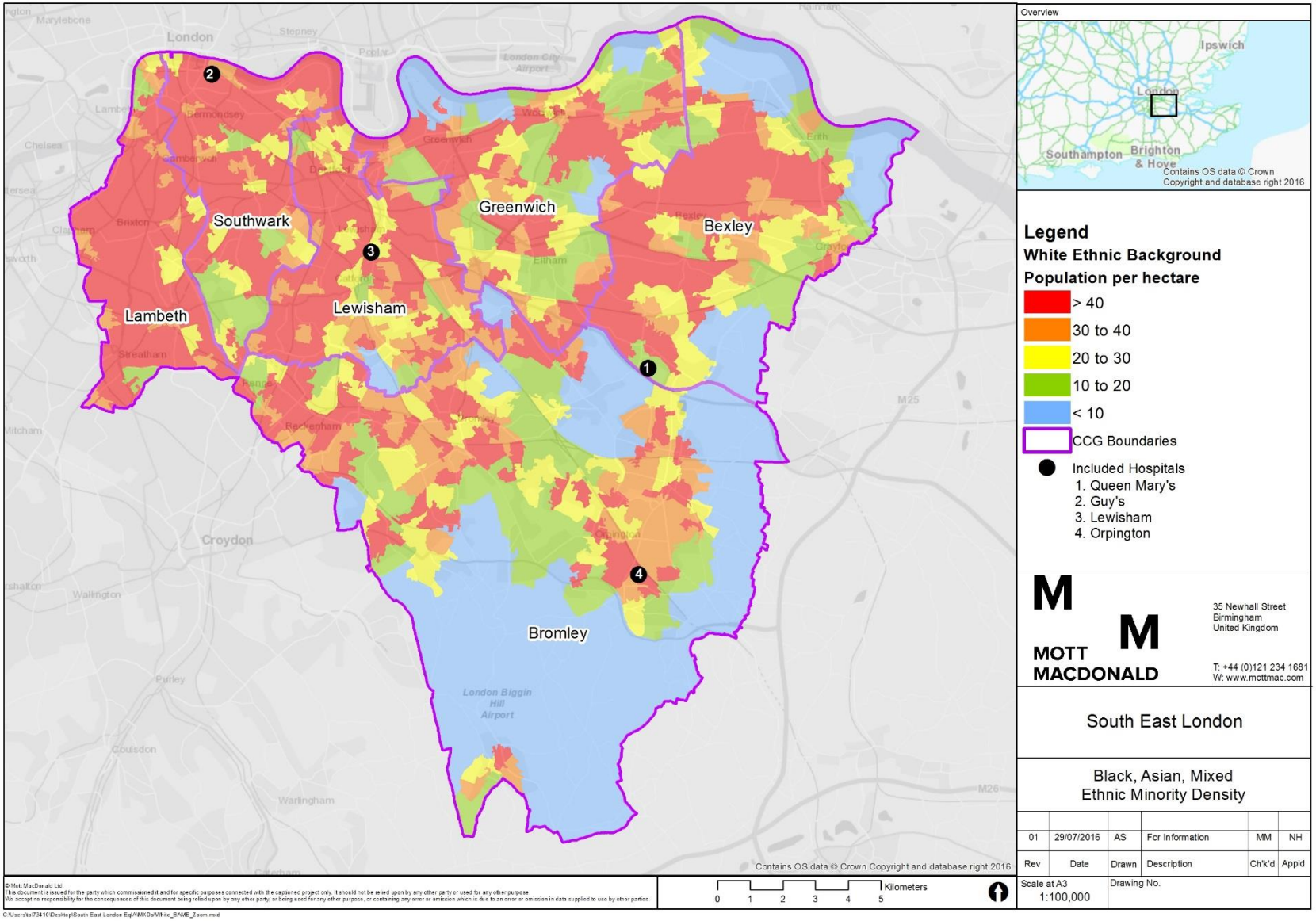


P:\Birmingham\IT\BApril T Mapping\South East London Eng\AMX\Dot66_Plus_Dens_zoom.mxd

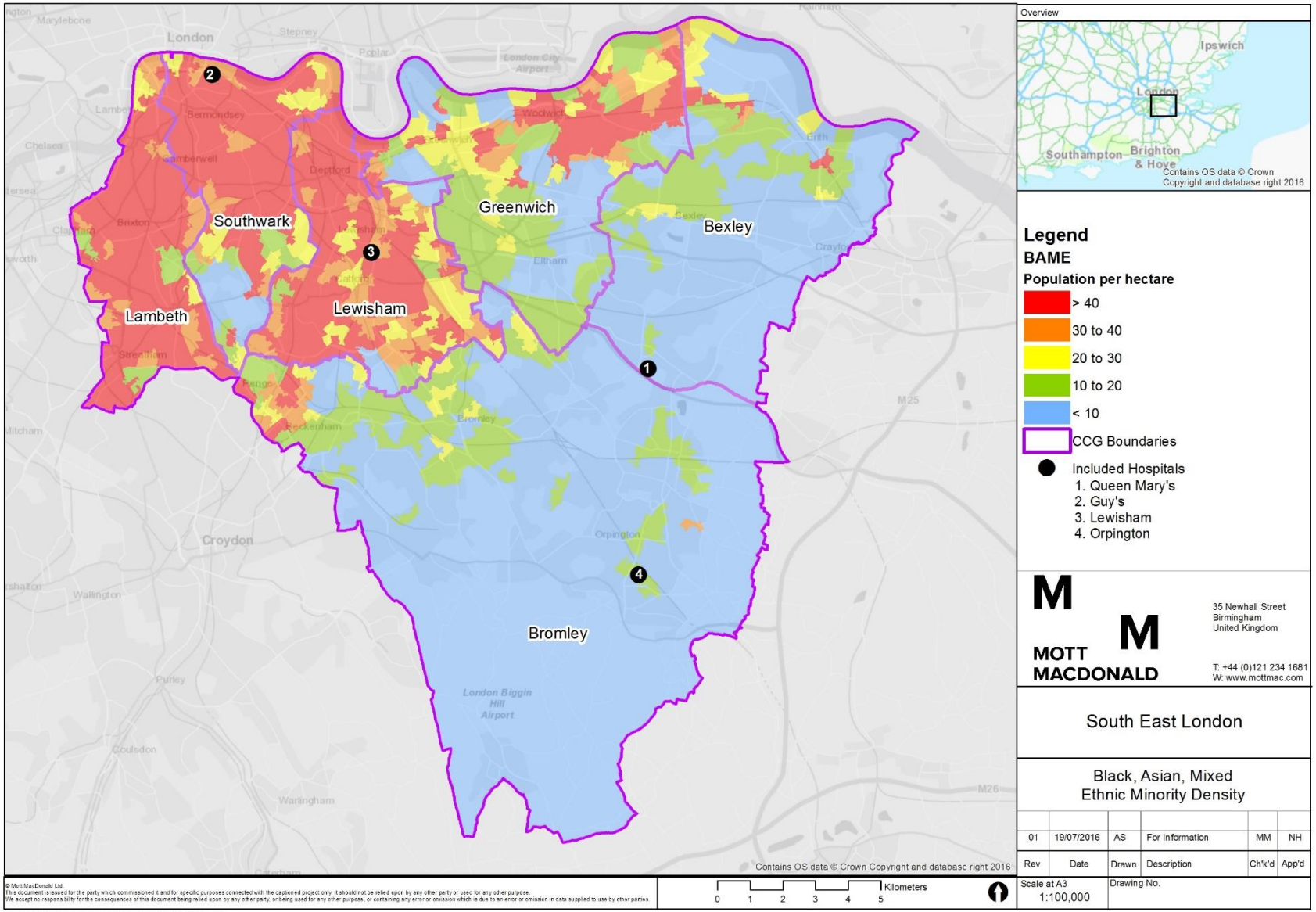
A2.3 Population density disability



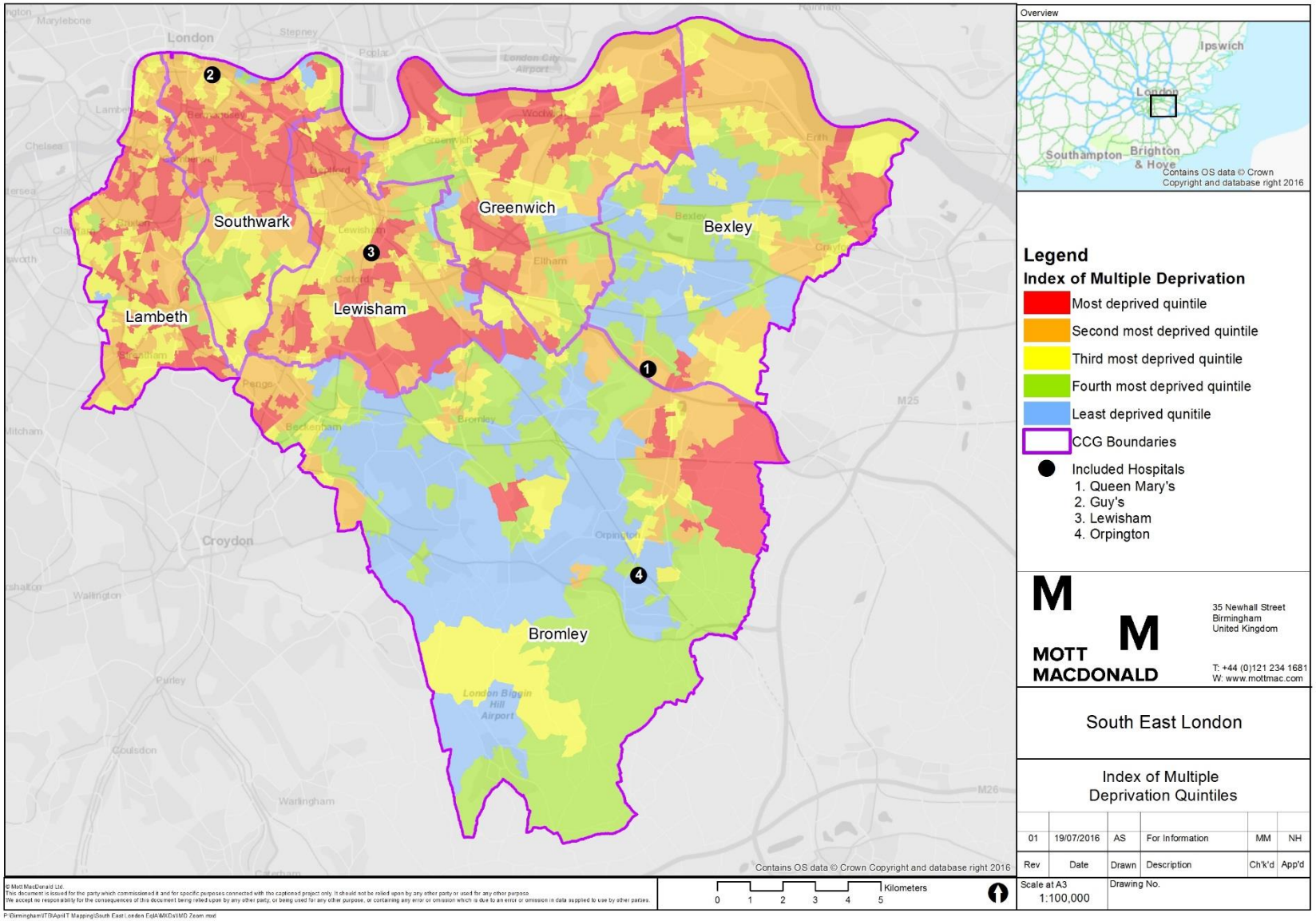
A2.4 Population density white ethnic background



A2.5 BAME


Overview
Ipswich
London
Southampton
Brighton & Hove
Contains OS data © Crown Copyright and database right 2016
Legend
BAME
Population per hectare
> 40
30 to 40
20 to 30
10 to 20
< 10
CCG Boundaries
Included Hospitals
1. Queen Mary's
2. Guy's
3. Lewisham
4. Orpington
Southwark
Lambeth
Lewisham
Greenwich
Bexley
Bromley
Contains OS data © Crown Copyright and database right 2016
Kilometers
0 1 2 3 4 5
35 Newhall Street
Birmingham
United Kingdom
T: +44 (0)121 234 1681
W: www.mottmac.com
MOTT MACDONALD
South East London
Black, Asian, Mixed
Ethnic Minority Density
01 19/07/2016 AS For Information MM NH
Rev Date Drawn Description Ch'k'd App'd
Scale at A3
1:100,000
Drawing No.

A2.6 Population density deprivation



A3 Population trends: Older people volume and percentage change

	Aged 65+ 2014	Aged 65+ 2039	Total Population % Change	Aged 65+ % Change
Bexley	40,000	62,000	28%	55%
Bromley	56,000	88,000	28%	56%
Greenwich	28,000	52,000	32%	86%
Lambeth	25,000	48,000	23%	94%
Lewisham	27,000	52,000	31%	89%
Southwark	24,000	48,000	29%	100%
South London Average	33,000	58,000	28%	75%
Greater London	983,000	1,775,000	29%	81%

Source: ONS Population Projections, 2014

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NHS

South East
Commissioning Support Unit

South East London – NHS 111

Update – September2016

SOUTH EAST / CSU

111 now

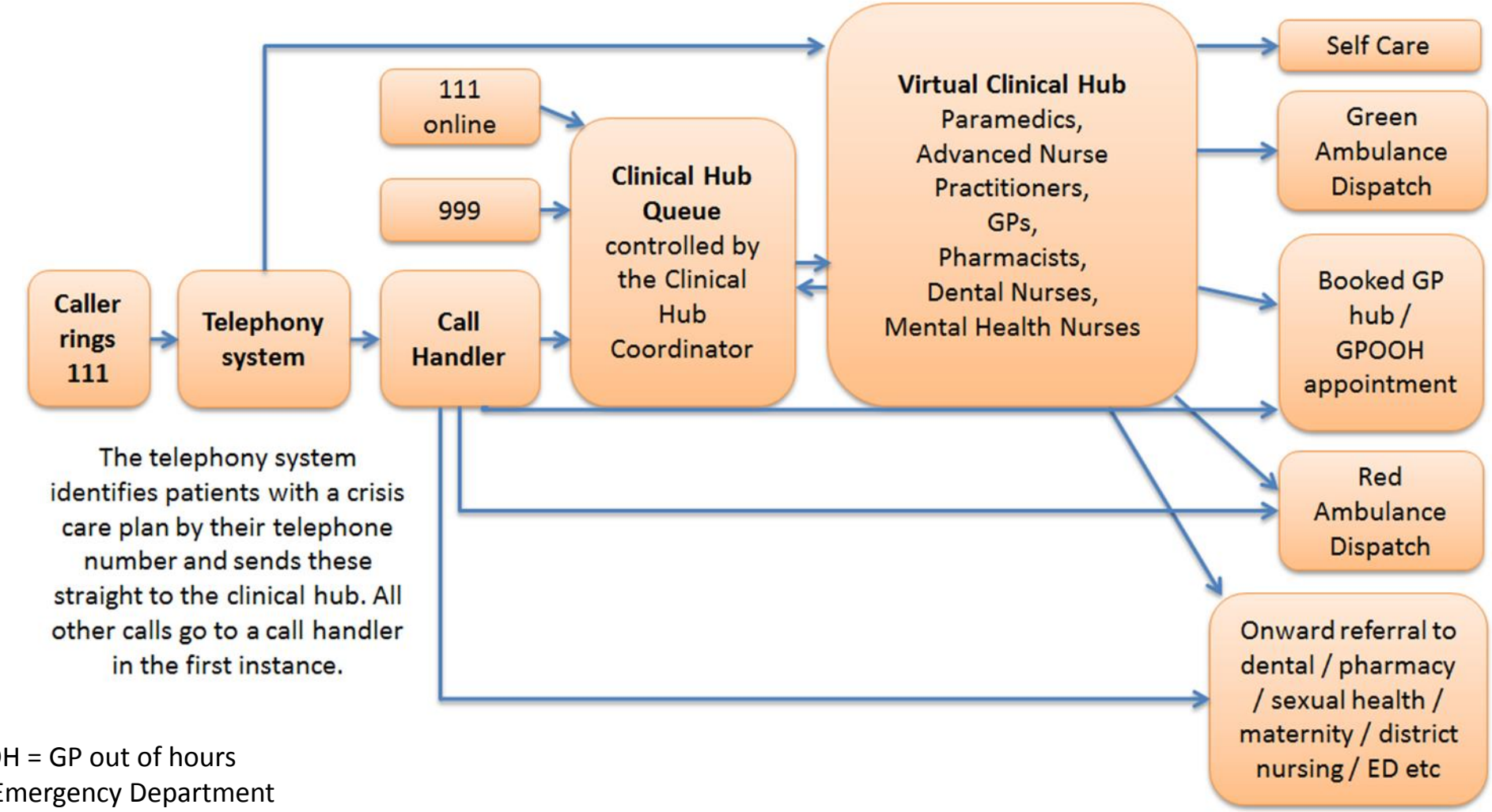
- 111 staff can arrange a translator to join the call if necessary.
- There is a British Sign Language interpretation service for 111.
- 111 call handlers are supported by nurses and paramedics.
- 75% of calls are completed by call handlers.
- 25% of calls are completed by the nurses and paramedics.
- 111 staff assess patients' medical needs and signpost them or refer them onto appropriate services.
- 111 staff can dispatch an ambulance if required.
- 111 staff use a Directory of Services to provide patients with service information e.g. pharmacy opening hours, contact details for dental practices etc.
- All calls are confidential. Patient consent is requested prior to sending patient information on to other health services such as the patient's GP practice.

What is changing

- Throughout England, local NHS 111 services are being redesigned so that they are integrated with the rest of the local healthcare service.
- NHS 111 will be a single entry point to fully integrated urgent care services. Organisations will work together to deliver high quality, clinical assessment, advice and treatment to shared standards and processes, with clear accountability and leadership.
- A 'clinical hub' will offer patients who need it access to a range of clinicians.
- The clinicians in the hub will be supported with clinical records such as the Summary Care Record (SCR).
- IT systems will be developed to support referrals and the direct booking of appointments.
- A future plan for NHS 111 online will make it easier for the public to access urgent health advice and care. This will offer a personalised and convenient service that is responsive to people's health care needs when:
  - they need medical help fast, but it is not a 999 emergency
  - they do not know whom to contact for medical help
  - they think they need to go to A&E or another NHS urgent care service
  - they need to make an appointment with an urgent care service
  - they require health information or reassurance about how to care for themselves or what to do next.

"If I have an urgent need, I can phone 111 and they will, if necessary, arrange for me to speak to a GP or other health professional at any time."

The South East London Vision



Key:
GPOOH = GP out of hours
ED = Emergency Department

The virtual clinical hub

Key

24/7

Out of hours only

SOUTH EAST/CSU

111 of the future

- Access via one free phone number (111) and 111 online
- Call handlers, and clinicians within a virtual clinical hub
- The clinical hub is overseen by a clinical hub coordinator (a clinician)
- The clinical hub provides telephone support to both patients and healthcare professionals (e.g. paramedics)
- 999 can transfer calls to 111 for further assessment within the clinical hub.
- Call handlers to identify callers who would benefit from access to a clinician
- The clinical hub include GPs 24/7
- The clinical hub includes a mix of clinicians in line with local needs (not necessarily 24/7)
- Clinicians have access to patients' crisis care plans and GP records (where patients have given consent) and share relevant information with the services that they refer the patients onto (subject to consent).
- Where possible patients are directly transferred to other telephone services (e.g. mental health crisis line).
- If possible, patients have their appointment booked for other face to face services (e.g. GP hubs).
- Patients are texted or emailed information about the service they have been referred onto.

The 111 service will have fewer nurses and paramedics than the current service, as some calls will be handled by GPs.

Calls that are planned to be dealt with by the virtual clinical hub (and by which skill set):

- Under 5 year olds (GPs)
- Over 80 year olds (GPs)
- All callers with a crisis care plan (nurses/paramedics/GPs)
- All calls currently dealt with by 111 clinical advisors, including green ambulance re-triage (split between nurses/paramedics/GPs depending on most appropriate skill set)
- Most primary care issues during the out of hours period (GPs)
- Secondary care mental health issues (mental health nurses)
- Medication enquiries (pharmacists)
- Dental advice (dental nurses)

There will be direct booking from NHS 111 into GP services by both clinical hub staff and call handlers.

Analysis will be undertaken to establish which call types should be booked by call handlers and which would benefit from clinical review within the virtual clinical hub, prior to booking.

Procurement Timeline

Dates dependent on the outcome of checkpoint 1

- Checkpoint 1 with NHS England – December 2016
- Procurement Process – January 2016 to March 2017
- Mobilisation – April 2017 to Feb 2018
- **Go live – March 2018**

TRIGGER TEMPLATE

Scrutiny welcomes early drafts of this form for proposals 'under consideration'.

NHS Trust or body & lead officer contacts:	Commissioners e.g. CCG, NHS England, or partnership. Please name all that are relevant , explain the respective responsibilities and provide officer contacts:
	South East London CCGs

Trigger	Please comment as applicable
1 Reasons for the change & scale of change	
What change is being proposed?	Throughout England, local NHS 111 services are being redesigned so that they are integrated with the rest of the local healthcare service. NHS 111 will be a single entry point to fully integrated urgent care services. Organisations will work together to deliver high quality, clinical assessment, advice and treatment to shared standards and processes, with clear accountability and leadership. A 'clinical hub' will offer patients who need it access to a range of clinicians. The clinicians in the hub will be supported with clinical records such as the Summary Care Record (SCR). IT systems will be developed to support referrals and the direct booking of appointments. A future plan for NHS 111 online will make it easier for the public to access urgent health advice and care. This will offer a personalised and convenient service that is responsive to people's health care needs when: • they need medical help fast, but it is not a 999 emergency • they do not know whom to contact for medical help • they think they need to go to A&E or another NHS urgent care service • they need to make an appointment with an urgent care service • they require health information or

	reassurance about how to care for themselves or what to do next.
Why is this being proposed?	The contracting authority and potential suppliers can benefit from early two-way communication; Aids deeper understanding of the requirements and reduces dependencies based on assumptions; Avoids the risk of falling foul of the law if changes are made during the formal procurement process; Helps to provide a better understanding of the feasibility of the requirements, the best approach, the capacity of the market to deliver and possible risks involved; Reduces procurement timescales – This will help to complete all but the most complex procurements within 120 working days (from tender publication via the Official Journal of the European Union to award); Encourages a more responsive market – by giving the market sufficient time to prepare to meet demand e.g. by ensuring the right skills and resources are in place; and Provides the market with an opportunity to ask questions/raise queries and any issues are addressed at an early stage.
What is the scale of the change? Please provide a simple budget indicating the size of the current investment in the service, and any anticipated changes to the amount being spent.	The new vision developed by NHSE involves additional GP presence within the 111 service which in turn will work to have a positive the impact on other elements of the health economy; particularly A&E and emergency services. The new vision also involves additional expectations around interoperability between OOH providers and the 111 service to create the virtual clinical hub. Due to this additional clinical representation within the 111 service and the interoperability expectations it is expected that the financial value of the contract for 111 will need to increase over and above the level of normal growth however will have additional benefits in reducing the number of attendances in SEL in services such as A&E and emergency services. With early clinical input in 111 it also expected to reduce the activity within the OOH services which, following successful negotiation from CCG commissioners, will reduce the financial value paid for those services. This saving will vary dependant

	on the existing provider's current operating model and the level of success of those negotiations. The activity and finance expectations are currently being finalised following an expected change to the service commencement date and will be shared as soon as possible.
How you planning to consult on this? (please briefly describe what stakeholders you will be engaging with and how) . If you have already carried out consultation please specify what you have done.	Prior to March 2016, two patient engagement events were held and a survey was distributed to patients through the SEL CCGs' communications and engagement leads; the resulting feedback was incorporated into the service specification subsequently approved by the SEL CCGs' Governing Bodies (or their delegated committees) in March 2016. Post March 2016, an information pack detailing our response to the patient feedback received – in the form of 'you said, we did' – and the more recent developments to the IUC design, was produced and shared with the SEL CCGs communications and engagement leads for distribution through their usual patient engagement channels. Additionally, patient groups were identified for further targeted engagement. These groups were identified on the basis of those who had access issues (Deaf or hard of hearing; patients for whom English is not their first language; patients with learning disabilities) and groups that the equality impact analysis had highlighted as not having been engaged with so far (e.g. LGBT). Each CCG was asked to choose one of the patient groups and facilitate engagement with that group. Where possible, this was through the programme team attending an existing patient engagement meeting or convening a meeting for this express purpose. Where this was not possible, information was sent to relevant organisations that liaised with their service users and responded on their behalf. The following activity was undertaken: • Information sent to Bromley Deaf Access group; response received providing advice relating to staff training, promotion of the service,

	and the use of deaf friendly language. • Engagement session held with a Vietnamese group in Lewisham – 9 out of the 10 attendees had never heard of 111 before. Discussed the differences between 111 and 999, the translation service available through 111, the redesign of 111 and the best ways to promote the service to the Vietnamese community. The current service and the new design were both very well received. • Information sent to a KeyRing representative who phoned members of Speaking Up – Southwark (a group for people with learning disabilities) to get their views on the new design for 111. Response received "I've spoken to each member of the group and unfortunately none of them have used the 111 line. This was because they haven't needed to. They had all heard of it and said they would use it if they needed to." • Information sent to Metro (a SEL wide LGBT group); response received providing advice relating to staff training, promotion of the service, monitoring LGBT usage and links to voluntary services. • Engagement session with Our Healthier SEL Patient Group – 3 attendees, knowledgeable about 111. Very detailed discussion about the current service and the proposed changes. The group approved of the proposed changes. All of the feedback received has been incorporated into the revised service specification.
2 Are changes proposed to the accessibility to services? Briefly describe:	
Changes in opening times for a service	The service will remain 24-7.
Withdrawal of in-patient, out-patient, day patient or diagnostic facilities for one or more speciality from the same location	None
Relocating an existing service	None.

Changing methods of accessing a service such as the appointment system etc.	999 can transfer calls to 111 for further assessment within the clinical hub. 999 can transfer calls to 111 for further assessment within the clinical hub. There will be direct booking from NHS 111 into GP services by both clinical hub staff and call handlers. Analysis will be undertaken to establish which call types should be booked by call handlers and which would benefit from clinical review within the virtual clinical hub, prior to booking.
Impact on health inequalities across all the nine protected characteristics - reduced or improved access to all sections of the community e.g. older people; people with learning difficulties/physical and sensory disabilities/mental health needs; black and ethnic minority communities; lone parents. Has an Equality Impact Statement been done?	The Equality Impact Statement has been completed.
3 What patients will be affected? (please provide numerical data)	**Briefly describe:**
Changes that affect a local or the whole population, or a particular area in the borough.	This improved service change has the potential to affect all those within SEL. The expected call volumes into 111 are expected to be c. 410,000 per annum. The population size (based on NHSE estimated registered populations 2014-15) are shown below for the commissioning CCGs: NHS Bexley CCG – 231,274 NHS Bromley CCG – 339,929 NHS Greenwich CCG –276,754 NHS Lambeth CCG – 371,185 NHS Lewisham CCG – 305,700 NHS Southwark CCG – 308,760
Changes that affect a group of patients accessing a specialised service	As above
Changes that affect particular communities or groups	As above

4 Are changes proposed to the methods of service delivery? Briefly describe:	
Moving a service into a community setting rather than being hospital based or vice versa	No expected change.
Delivering care using new technology	Clinicians have access to patients' crisis care plans and GP records (where patients have given consent) and share relevant information with the services that they refer the patients onto (subject to consent).
Reorganising services at a strategic level	The procurement of the service will impact urgent care provision throughout SEL
Is this subject to a procurement exercise that could lead to commissioning outside of the NHS?	Yes
5 What impact is foreseeable on the wider community? Briefly describe:	
Impact on other services (e.g. children's / adult social care)	The new integrated urgent care virtual clinical hub will include links to social care, mental health and community services and will also allow direct booking into GP hubs. The increased clinical input in the 111 service will ensure that less patients need further intervention in services such as A&E. and enable faster and easier resolution of their health concern.
What is the potential impact on the financial sustainability of other providers and the wider health and social care system?	As previously referenced, the service will mean changes to OOH services activity levels and as a result these contracts will need to be renegotiated. The result of the reduced activity levels may mean that some providers are not as financial efficient as with the previous model and commissioners will need to engage with them early to ensure they are fully aware of the changes ahead and the impact this will have on this service. There is also potential that the OOH providers will not be able to meet the interoperability requirements or only be able to do so at cost. There is no expected impact on other elements of the health and social care system.
6 What are the planed timetables & timescales and how far has the proposal progressed ?	**Briefly describe:**
What is the planned timetable for the decision making? (Please note that the timeline **must** include the date that scrutiny is asked to respond to the proposal by, and the date that the NHS body/ Commissioners intend to make the decision on the proposal. If relevant it would be helpful include dates that any consultation will take place.)	This is dependent on the agreement of the dates referenced below by the Programme Board.
What stage is the proposal at?	Specification has been finalised to be signed off by the SEL governing bodies
What is the planned timescale for the change(s)	Dates dependent on the outcome of

	checkpoint 1 Checkpoint 1 with NHS England – December 2016 Procurement Process – January 2016 to March 2017 Mobilisation – April 2017 to Feb 2018 Go live – March 2018
7 Substantial variation/development	**Briefly explain**
Do you consider the change a substantial variation / development?	This is more of an evolution of the current service.
Have you contacted any other local authority OSCs about this proposal? (Please note that if this is viewed as a substantial variation by OSCs / NHS bodies / Commissioners , and the proposal impacts on more than one borough, then regulations stipulate that the relevant boroughs **must** consider forming a Joint Health Overview & Scrutiny Committee, a JHOSC)	Yes, in the process of contacting their chairs

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