United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Mark Brassington
Date:	18th May 2018
Healthcare Standard	

Title:	Trauma and Orthopaedic GIRFT

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Responsible Director/s: Mark Brassington

Purpose of the Report:
Update to the Trust Board on the clinically-led Trauma and Orthopaedic GIRFT review

The Report is provided to the Board for:

Information		Assurance	X
Decision	X	Discussion	X

Summary/Key Points:

Recommendations:
The Trust Board is recommended to support the proposed direction of travel proposed in this paper

Strategic Risk Register	**Performance KPIs year to date** Admitted RTT – 63.3% SLR Deficit - £11m Cancellation rate – 32% BPT loss – £336k

Resource Implications (eg Financial, HR)
Nil identified

Assurance Implications

Patient and Public Involvement (PPI) Implications: Communication and engagement as required

Equality Impact : Full QIA and EIA to be completed

Information exempt from Disclosure: No

Requirement for further review? Yes

Trauma and Orthopaedic Get It Right First Time (GIRFT) Update

1.0 Background

Trauma and Orthopaedics (T&O) have been undergoing a review of all emergency and planned services for a number of years. More recently this has been via the Get It Right First Time programme (GIRFT) in June 2017 and the internal Clinical Service Review (CSR) in September 2017. These reviews were initiated to build on National best practice to tackle unwarranted variation in practice and poor access resulting in significant performance issues, which are impacting on patient care across the county. These issues are caused principally by the way the services are configured across the four hospital sites. These reviews have and continue to be clinically led.

Professor Tim Briggs, National GIRFT Lead, former president of the British Orthopaedic Association and experienced Orthopaedic surgeon has been supporting the clinical body with reviewing current services and designing the proposed changes.

At the GIRFT meeting in December 2017 Professor Briggs invited the clinical body to be part of a pilot to reconfigure Trauma and Orthopaedic services to separate Trauma and Elective pathways building on the successful pilot at Cheltenham and Gloucester. The clinical body from different professional groups and all three sites agreed to participate in the work. As a result we joined a cohort of three other organisations of Kings College London, East Kent University Hospital and Royal Cornwall Hospitals.

The Trust Board agreed in April a set of improvement principles to inform the proposed clinical model. These can be found within section 4. This paper outlines the proposed trial model for the Trust Board to consider.

2.0 Drivers for change

The drivers for change are:

- No ring fenced or segregated orthopaedic beds on any hospital site thereby increasing the risk of infection
- Poor compliance with Best Practice Pathways across the three hospital sites resulting in sub optimal pathways. As well as not consistently achieving compliance to best practice for patients there is a financial penalty of £336k
- Unacceptable cancellation rate in T&O - 32% in 2017/18
    - 900 patients cancelled a combined 1,200 times (c.80% due to no beds)
    - Financial loss c. £3m

Cancer patients take priority for any available elective slots, with patients who are clinically urgent and patients that have been previously cancelled taking the next level of priority. Orthopaedic patients are not cancer patients, and have typically lower levels of clinical urgency over non-orthopaedic surgical patients, so are often the first electives to be cancelled when there are limited beds. However, while patients may not be clinically at risk due to the cancellation they are often left in varying levels discomfort if cancelled.

- Poor utilisation rates for theatres
- Poor admitted RTT performance (63.3% treated within 18 weeks in March 2018)
- Low market share for elective Orthopaedics (42% of Lincolnshire patients)

- Service Line Reporting deficit of c.£11m in 2017/18

Increasingly organisations are separating the urgent (or "hot") work from the planned (or "cold") work. The hot and cold split has a number of clinical benefits that are widely accepted:

- Hot sites are able to utilise inpatient areas to provide Trauma Assessment Units, allowing for trauma patients to be seen in a shorter time by a more specialised clinicians. This reduces unnecessary admissions and gets the patients to the right care in a quicker timescale.
- Cold capacity is ring-fenced. If cold procedures are offered on a site where there is no / limited trauma there is a significantly lower risk of cancellation. With the emergency pressures at trauma sites it would be difficult, if not impossible, to ring-fence inpatient areas.
- Elective specialty sites have better clinical outcomes. Elective sites have lower rates of re-admission, reduced length of stay, reduced risk of hospital-acquired infections and injuries, and evidence shows that patients are typically more satisfied with the services due to the reduced risk of cancellation.
- Elective and hot splits are attractive to the workforce, core and foundation trainees and nurse specialists as people are able to complete the work that they are employed to do.

Currently, the Trust operate both hot and cold work on three of the four sites.

3.0 Activity

3.1 2017/18 Plan V Actual Activity

During 2017/18 as an organisation 900 orthopaedic patients were cancelled. The table below shows that the contract underperformed by 852.

2017/18	Louth	Pilgrim	Grantham	Lincoln	TOTAL
Planned Daycases	638	1131	825	622	**3216**
Daycase Delivered	563	884	782	579	**2808**
Daycase Variance	-75	-247	-43	-43	**-408**
Planned Electives	271	664	646	920	**2501**
Electives Delivered	281	584	500	692	**2057**
Elective Variance	10	-80	-146	-228	**-444**
Contracted Trauma	0	1183	423	1674	**3280**
Trauma Delivered	0	1267	327	1825	**3419**
Trauma Variance	0	84	-96	151	**139**

3.2 2018/19 Contracted Activity

The table below shows activity splits by site based on 18/19 contracted activity if service provision remained unchanged.

	Louth	Pilgrim	Grantham	Lincoln	Total
Daycases	606	1098	842	565	3,111

Electives	264	654	607	841	2,366
Trauma	0	1,774	551	2,338	4,663
Total	870	3,526	2,000	3,744	

As an organisation we currently do not offer a hot-cold split on three of our sites. At Lincoln, the daycase area is used as an escalation area for emergency pressures, meaning that daycase cancellations onsite are proportionally higher.

It is worth noting that the above splits of activity; Daycase, Electives and Trauma are broad categories of patient pathways. Within these categories there are an extensive range of procedures that vary between sites depending on operation and skills required, level of post-operative support, adult / paediatric patients, time of day or significance of injury. For example Elective and Trauma patients are referred to Nottingham, Derby or Sheffield for more specialist input.

4.0 Principles for Improvement

The paper so far has clearly identified where the service needs to improve. The clinical teams, supported by professor Briggs and with executive support have been discussing the potential opportunities. The principles for any proposal are as follows:

- The service is meeting the highest national standards
- Quality of care is improved for Trauma and Elective patients
- The productivity of the workforce and utilisation of resources is improved
- Unwarranted clinical variation is eliminated
- Patient outcomes are consistently captured, reported and tracked
- Trauma and Orthopaedics is managed as a single specialty

In light of above principles and following the conclusion of required discussions with commissioners, stakeholders and the public the clinicians wish to move as quickly as possible to trial a different way of working in order to test proposed operating models.

5.0 Clinically Proposed Trial Model

United Lincolnshire Hospital Trust are proposing a trial model, clinically developed and supported by the National GIRFT team to commence from the 16th of August 2018 lasting until 31st March 2019.

The Trust clinical leads, supported by Professor Tim Briggs, have been discussing possible clinical models. Initially, the group considered one hot site , but due to the geographical distance between the southern and eastern ends of the county and Trauma Unit requirements this model was discounted. Therefore a two hot and two cold model was proposed.

The clinical view is that Grantham is ideally suited to be an elective hub, in addition to retaining its limited trauma services:

- It has the benefit of a level one clinical care facility which could support c.95% of all elective orthopaedic procedures
- It has a well-established anaesthetic on-call cover
- While there is emergency take onsite the pressures are far less than at Pilgrim and Lincoln
- Central geographical placement

The trial will not materially change the trauma services available to patients at Grantham. It will, result in change in working practices to improve our Trauma offer to our 4663 patients across our sites.

Lincoln County Hospital and Pilgrim Hospital at Boston have specialist support to care for patients with fractured neck of femurs, including specialist Geriatric Orthopaedic surgeons and Trauma Assessment Units, and will therefore become the centres for fractured neck of femur care in the county. This will result in an additional c.85 patients with a confirmed fractured neck of femur being treated at Lincoln, Pilgrim or another appropriate location. Trauma attending by ambulance, from EMAS or via walk in to the Emergency Department will not change. This change will enable us to improve our compliance with expected best practice pathways for fractured neck of femur patients and outcomes for patients. This change has full clinical consensus.

The trial will not change the location, times or days of outpatient appointments. These will be kept local and are a key part of the successful delivery of the model.
The proposed, model for the trial is as follows:

	Lincoln	Pilgrim	Grantham	Louth
Walk-in Trauma	☑	☑	☑	
EMAS Trauma	☑	☑	☑	
Trauma Assessment Unit – NEW	☑	☑		
Fractured Neck of Femur	☑	☑		
Consultant Out of Hours On-call Rota	☑	☑		
SAS Out of Hours On-call Rota	☑	☑	☑	
F2 Out of Hours On-call Rota	☑	☑	☑	
Speciality ED Support	☑	☑	☑	
Trauma Triage	☑	☑	☑	☑
Elective Orthopaedic L0-1 post-op			☑	
Elective Orthopaedic L2-3 post-op	☑	☑		
Paediatric	☑			
Daycase	☑	☑	☑	☑
New and Follow-up Fracture Clinics	☑	☑	☑	
Elective Outpatient Services	☑	☑	☑	☑

The indicative activity for each site during 2018/19 following the implementation of the trial would be as follows:

	Louth	Pilgrim	Grantham	Lincoln	Total
Daycases	842	1,335	844	90 (CC & Paeds)	3,111
Electives	0	105 (Crit Care)	2209	110 (CC & Paeds)	2,424
Trauma	0	1775	466	2,422	4,663
Total	842	3,215	3,518	2,622	

- Lincoln County Hospital does not currently have ring-fenced elective or daycase Orthopaedic beds, leaving patients at high risk of cancellation. During the trial only patients requiring specialist high level critical care or paediatric support not provided at the other hospitals will be treated at Lincoln. The hospital will make specific designated and isolated bed space for these patients during the trial. All other patients can be appropriately managed on our other hospital sites. Trauma arrangements will introduce an orthopaedic assessment unit which will improve timelines of care and reduce time spent within the Emergency Department therefore speeding up access to specialist care.

- Similarly, Pilgrim Hospital does not have ring-fenced elective Orthopaedic inpatient beds. Only critical care electives will be treated at Pilgrim during the course of the trial. Pilgrim does have ring-fenced daycase beds, allowing the site to support an increase in day case activity. Trauma arrangements will introduce an orthopaedic assessment unit which will improve timelines of care and reduce time spent within the Emergency Department therefore speeding up access to specialist care.

- Louth cannot appropriately segregate Orthopaedic patients from the rest of the surgical inpatients. For overnight stays this increases the risk of acquiring post-operative infections. Patients can be appropriately treated at the other hospital sites. Therefore we are not able to continue inpatient orthopaedic cases irrespective of the trial.

- **There is clinical consensus on the proposed trial.**
  Trust-wide Consultant and Associate Specialist Orthopaedic Surgeons were invited to provide anonymous feedback on the proposed model. Out of the 30 senior clinicians 28 responded, with 24 in support of the model (over 85%). From the four clinicians not in support of the model:
    - Three did not feel it was suitable for any trauma to attend Grantham; the clinical view of these clinicians was that there should be a complete split of trauma and elective activity by site
    - One consultant suggested that there should be a daily fracture clinic at Louth Hospital

6.0 Benefits of the proposed trial model:

- Significant and permanent reductions in the number of elective cancellations, with the view to totally eliminate the cancellations due to no beds (which cause c.80% of the current total number of cancellations)
- Move towards segregation of elective and trauma patients, in line with clinical guidance and best practice
- Ensure 100% compliance of Best Practice pathways for T&O patients
- Reduce length of stay, readmission, hospital acquired infection and injury rates for both emergency and planned patients
- Release of around 20 beds at Lincoln and 10 beds a Pilgrim, which could be used for emergency escalation
- Recovery of under-delivered elective contracted activity, greatly improving the Trusts financial position (c.£3m lost for 17/18)
- Repatriation of Lincolnshire patients back into Lincolnshire
- Improved recruitment and retention, critically for core and foundation trainees

- Investment in the Grantham site, showing the Trust's intentions to make it a major part of the Trust's future. Multi-million pound investment planned across 2018/19 and 2019/20 to increase theatre capacity.

As a result we are able to address the improvement principles namely, meet hihest national standards, improvement quality of care for trauma and elective patients, increase productivity, reduce unwarranted clinical variation, capture, report and track outcome and benefit from the trauma and orthopaedic services being managed across the Trust.

8.0 Next Steps

- Continue Engagement with commissioner, stakeholder groups and public on the proposed model
- Recruit to additional theatre nursing and operating department practitioners to support the increased patient numbers at Grantham
- Continue engagement and dialogue with staff groups at all sites
- Receive update report in July

9.0 Recommendation

The Trust Board is asked for agree and approve to the trial of the clinically-developed model of care and receive a progress report in July.