United Lincolnshire Hospitals NHS Trust

To:	Trust Board
From:	Mark Brassington
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Healthcare Standard	

Title:	Trauma and Orthopaedic Getting It Right First Time (GIRFT)

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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	X	Assurance	X

Summary/Key Points:

- Work is being led by Trust clinicians on improving orthopaedic services
- Principles for taking the ideas forward have been proposed
- Further work is required by clinicians and in conjunction with commissioners, stakeholders, patients and the public.

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 to date

Assurance Implications

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

Equality Impact : Full QIA and EIA to be completed on any proposed changes

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 Director for Clinical Quality and Efficiency, 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.

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 separation 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 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 site separation is attractive to the workforce, including core and foundation trainees and nurse specialists as people are able to complete the work that they are employed to do. This improves job satisfaction so in turn morale, safety and productivity.

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

3.0 2018/19 Planned Activity

The table below shows activity splits by site based on 18/19 contracted activity.

	Louth	**Pilgrim**	**Grantham**	**Lincoln**
Daycases	606	1098	842	565
Electives	264	654	607	841
Trauma	0	1,774	551	2,338

As an organisation we currently do not offer a hot-cold separation 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 definitions 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, 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 across the service
-Trauma and Orthopaedics is managed as a single specialty to deliver the best outcome for all Lincolnshire patients.

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

7.0 Next Steps

- Agree as a clinical group to the elements of a proposed model in keeping with the principles outlined and the way forward
- Engage with commissioner, stakeholder groups, patients and the public on options for any proposed model
- Bring back proposals for the Board to consider.

8.0 Recommendation

The Trust Board is asked to note information, agree principles and the proposed way forward.